Hospital Accreditation

Survey Process Guide

September 2026

Issue Date: August 24, 2026

Summary of Changes

Note: Updates from the last published version of the Survey Process Guide are identified by underlined and ~~strikethrough~~ text throughout this document.

Changes effective July 1, 2026

- Updated Hospital Accreditation Survey Activity List and Descriptions
- Updated Hospital Document List
- Removed the Column with CMS Conditions of Participation (CoP) information; CoP references are now indicated under each Element of Performance (EP) in the left column
- Updated Hospital Patient Rights Evaluation Module (482.13)
- Updated Hospital Medical Staff Evaluation Module (482.22) including Psychiatric Special Staff Requirements (482.62) (b)
- Updated Hospital Nursing Services Evaluation Module (482.23) including Psychiatric Nursing Services. Requirements (482.62) (d)
- Updated Hospital Medical Record Services Evaluation Module (482.24)
- Updated Hospital Physical Environment Evaluation Module (482.41)
- Updated SPG Section 482.41(d)(2) to reflect manufacturer's instructions for use requirements apply to all maintenance programs (including alternative equipment maintenance (AEM)
- Updated Hospital Infection Prevention and Control and Antibiotic Stewardship Programs Evaluation Module (482.42)
- Updated Hospital Discharge Planning Evaluation Module (482.43)
- Updated Hospital Organ, Tissue, and Eye Procurement Evaluation Module (482.45)
- Updated Hospital Surgical Services Evaluation Module (482.51)
- Updated Hospital Emergency Services Evaluation Module (482.55)
- Updated Hospital Special Provisions Applying to Psychiatric Hospitals Evaluation Module (482.60)
- Updated Psychiatric Hospitals Special Medical Record Requirements Evaluation Module (482.61)
- Updated Hospital Special Staff Requirements for Psychiatric Hospitals Evaluation Module (482.62)
- Updated Hospital Swing Beds Evaluation Module (482.58)
- Updated Hospital Emergency Management Evaluation Module (482.15)

Changes effective September 1, 2026

- For all survey tools, please see the NEW *Survey Tools Guide (STG)* just released for September 2026. This will serve as a companion to the Hospital Survey Process Guide.
- Updated compliance with Federal, State, and Local Laws evaluation module (482.11)

Contents

Hospital Accreditation Survey Process

The purpose of a Joint Commission survey is to evaluate an organization's compliance with standards based on CMS Conditions of Participation (CoPs) and Joint Commission National Performance Goals (NPGs), that is, principles of patient safety and quality of care. A standard defines the performance expectations, structures, or processes that must be substantially in place in an organization to enhance the quality of care, treatment, or services being provided. Using observation, interviews, and document review surveyors evaluate an organization's compliance with applicable standards in all locations where patient care, treatment, and services are being provided.

During a survey, an organization must be prepared to provide evidence of its compliance with each applicable standard. To attain accreditation, an organization must demonstrate compliance with the applicable standards and associated elements of performance (EPs).

On-site Surveys

All hospital surveys are unannounced[1]. Although not a routine practice, Joint Commission surveyors may conduct some survey activities during early morning, evening, night, and weekend hours, as necessary. These "off-shift" visits do not occur before the opening conference at the start of the survey.

Joint Commission determines the length of a survey, and the number and type of surveyors assigned based on information supplied in the Electronic Application for Accreditation (E-App) that describes the organization's size and scope of services.

Survey Team

Based on the size and complexity of the organization being surveyed, an accreditation survey may be conducted by one surveyor or a team of surveyors, with a minimum of at least one nurse surveyor assigned to the event. A *Life Safety Code* surveyor will also be part of every hospital survey.
The composition of an organization's survey team is based on the information provided in its E-App.

On surveys with more than one surveyor, one of the surveyors is designated as the team leader. The team leader is responsible for integration, coordination, and communication of survey activities. In addition to being one of the surveyors conducting the survey, the team leader serves as the primary point of contact between the organization and Joint Commission. Among other responsibilities, the team leader leads the opening conference and the daily and exit briefings.

Pre-Survey Preparation

Surveyor Preparation

In preparation for the survey event, the surveyor(s) reviews available information about the organization, including the following:

- Electronic Application for Accreditation (E-App) to determine the scope of survey that will be required and begins planning

[1] See the Accreditation Manual for Hospitals, Accreditation Process chapter for exceptions to this rule.

- Report of available Basic Building Information (BBI) which contains sites/buildings information and the history and audit trail
- Organization website, if available, to compare the services noted to those reported on the E-App
- Report(s) and the organization's historical SAFER™ matrix(s) from previous survey events
- CMS complaint surveys (for deemed organizations)
- ORYX data
- 2567 Report (for deemed organizations)

The surveyor(s) will use what they learn from review of the above information to prepare a preliminary plan for the on-site survey event that is customized to the organization and that covers all required evaluation activities. If this is a team survey, the team leader will begin formulating this plan. Team members are expected to review this same data in preparation to aid the team leader in verifying that all required activities are covered in the preliminary survey plan.

Organization Preparation

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 Joint Commission and educate them about what to do upon arrival of the surveyor(s). 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(s) 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. The surveyor(s) 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 in the organization will handle the validation of the survey and confirm the identity of the surveyor(s). and supply instructions for this activity.
- Being prepared with requested documents for surveyor(s) review. Surveyor(s) will begin the survey with an individual tracer if documentation is not readily available.
- Identifying who will provide the Safety Briefing for the surveyor(s).
    - The purpose of the Safety Briefing is for your organization to inform surveyor(s) 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 surveyor(s) 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 surveyor(s) 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 surveyor(s).

- Identifying who will assist the surveyor(s) with review of the patient health record.

Surveyor Arrival and Preliminary Planning

The surveyor(s) arrives no earlier than 7:45 a.m. on the first day of an unannounced survey. If more than one surveyor is assigned, the entire team will enter the organization together on the first day of survey.

Upon arrival, surveyors will check in with reception, present their identification, and indicate their purpose for visiting. Surveyors will initiate confirmation of the unannounced survey by attesting to their arrival and introduction to organization personnel in survey technology.

Organization staff should be prepared with a plan and instructions for how to proceed, including the name and extension of the representative(s) who can access the organization's extranet site.

Surveyors will ask staff to check the organization's Joint Commission *Connect* extranet site for confirmation of the unannounced Joint Commission event authorizing the presence of the surveyor(s), and surveyors' names, pictures and biographical sketches.

> **NOTE: If** the organization is **unable** to validate the authenticity of the survey via computer, they should contact their Account Executive for validation and surveyor identity. The surveyor will call the Field Director to inform them of the situation. Surveyors will not begin the survey until the organization verifies authenticity of the survey event and confirms surveyor(s) identity, or they receive directions to begin from Joint Commission's Central Office.

Once the survey is validated, the organization can escort the surveyor(s) to the location that will serve as their working base for the survey event and where they can secure their belongings.

The organization is asked to provide the surveyor(s) with a **Safety Briefing** (informal, no more than five minutes) at this time. Refer to the Pre-Survey Preparation, Organization Preparation section above.

Confirmation of Eligibility for Survey

The surveyor(s) is required to see the following organization information before proceeding with the survey:

- Average daily census **If there are fewer than two inpatients the surveyor needs to call into central office and discuss these findings to determine next steps.** [§ 482.1]
- Scope of services to determine what specifically is included under the hospital provider number (CCN), including identifying any significant changes from information reported in the E-App.
- Evidence that the hospital meets the statutory definition of a hospital, specifically:
  - The hospital must be primarily engaged in providing by or under the supervision of physicians to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons. To be primarily engaged in providing inpatient care, a hospital needs to have at least two inpatients at the time of the survey.
- Hospital license, in accordance with law and regulation.
- An overall plan and budget in effect.

- Evidence that the organization maintains clinical records on all patients.
- Medical staff bylaws.
- Evidence of a requirement that every patient is under the care of a physician (patient receiving qualified psychologist services may be under the care of a clinical psychologist).
- Evidence of the provision of 24-hour nursing services rendered or supervised by a RN and has an LPN or RN on duty at all times.
- Utilization review plan.
- Discharge planning process.
- Resurveys only – Notifying the public it serves about how to contact organization management or Joint Commission to report concerns about patient safety and quality of care. [APR.09.01.01, EP 1]

In addition to the above noted items the surveyor(s) will also require the following information to facilitate survey activity.

- A list of current inpatients, providing each patient's name, room number, diagnosis(es), admission date, age, attending physician, and other significant information as it applies to that patient.
- A list of department heads with their locations and telephone numbers;
- A copy of the facility's organizational chart;
- The names and addresses of all off-site locations operating under the same provider number (CCN);
- A list of employees by department;
- Medical staff bylaws [requested above] and rules and regulations;
- A list of contracted services; and
- A copy of the facility's floor plan, indicating the location of patient care and treatment areas;

If this is a team survey, the designated team leader will review and confirm the scope of the survey with the team and what sites, services, and topics each member is assigned to as lead evaluator.

Additional Planning Notes

Owned and Contracted On-site Laboratory Services in a Joint Commission Accredited Hospital

Some hospitals may have a combination of owned and contracted on-site laboratory services. For example, the hospital may operate its own general and point-of-care laboratory services but engage a local donor center to provide on-site blood bank services. All owned and contracted on-site laboratory services must be accredited by Joint Commission or one of its cooperative partners, namely the College of American Pathologists (CAP), ASHI, or the state of Washington. An organization with contracted on-site laboratory services that are solely either state inspected or accredited by another laboratory agency (AOA, AABB) does not meet the accreditation policy. Surveyors will communicate this information to the organization's Account Executive via the surveyor comments. After the survey, the Account Executive will work with the organization on their submission of an application for accreditation of the laboratory services.

If the surveyor(s) discovers significant changes in organization volume, sites and services before or upon arrival on site they will contact the organization's Account Executive or the Field Director On-Call immediately to determine next steps related to these circumstances. The surveyor(s) will ask the organization to provide them with as much information about the changes as possible before calling Joint Commission's Central Office. [APR.01.03.01, EP 1]

Opening Conference

The surveyor, or designated survey team leader will continue with the on-site event by sharing some introductory remarks and plans as follows:

- Explain the purpose, scope, and structure of the survey.
- Introduce themselves (name, length of time with Joint Commission (optional), and one or two items of biographical information that is specific to the organization), including any additional surveyors who may join the team at a later time or at another location.
- Briefly explain the survey process.
    - Most survey activity occurs at the point where care, treatment, and services are provided. Tracer methodology will be the primary means of evaluation which includes a combination of interview, document review, and observation.
    - Interviews will be conducted privately with patients, staff, and visitors, unless requested otherwise by the interviewee
    - Emphasize with the organization the importance of surveyors being able to interact with and observe direct care givers.
    - **The surveyor(s) may occasionally request a small gathering of individuals if necessary to understand, for example, a workflow or a cross-department process, or multi-disciplinary team's function and interaction. The surveyor(s) will work with the organization's survey coordinator on arrangements.**
    - Provide a preliminary date and time for interim exit conferences when applicable (for example Life Safety Code Surveyor exiting before clinical team) and the final exit conference.
    - When a situation is identified that could be a threat to health and safety, surveyors contact Joint Commission's administrative team. Joint Commission either sends a different surveyor to evaluate the issue or the surveyor on site will be assigned to conduct the evaluation. Evaluations include interviews, observation of care, treatment and service delivery and document review. Your cooperation is an important part of this process. Surveyors collaborate with Joint Commission's administrative team and outcomes will be communicated to your organization when a determination is reached.
- Review the ground rules that will be observed during the survey event and invite the organization to contribute any additional rules.
- Discuss arrival times with leaders and staff for subsequent survey days.
- Answer questions about the on-site visit, activity schedule, availability of documents or people, and any other related topics.
- Ask attendees to introduce themselves (name, title, functional responsibility).

Orientation to the Organization

The surveyor(s) will continue engaging staff and leaders in an interactive dialogue to learn more about the organization such as how it is governed and operated, leaders' planning priorities, patient population and community health care needs, staffing and availability of licensed practitioners, and performance monitoring and improvement processes.

Initial On-Site Team Meeting

The surveyor(s) will gather one final time before setting out on tracers. This meeting is to review and adjust the preliminary plan, if necessary, based on the information gathered during the Opening and Orientation to the Organization activities.

Sample Size and Selection

Whenever possible and appropriate, the surveyor(s) selects patients who are admitted to and receiving, or accessing patient care, treatment and services during the time of survey. Surveyors will make their selections of patients to trace, which includes open record review, by proceeding to the various locations throughout the organization. Upon arrival, surveyors will engage staff in identifying patients that will allow for evaluation of patient care, treatment, and services being provided in the location. Open records allow surveyors to conduct a patient-focused survey and enable surveyors to validate the information obtained through record reviews with observations and patient and staff interviews. There may be situations where closed records are needed to supplement the open records reviewed (e.g., too few open records, complaint investigation, etc.), surveyors should use their professional judgment in these situations and select a sample that will enable them to make compliance determinations. If it is necessary to remove a patient from the sample during the survey, (e.g., the patient refuses to participate in an interview), replace the patient with another who fits a similar profile. This should be done as soon as possible in the survey.

Select the number of patient records for review based on the facility's average daily census. The sample should be at least 10 percent of the average daily census, but not fewer than 30 inpatient records. For small general hospitals (this reduction does not apply to surgical or other specialty hospitals) with an average daily census of 20 patients or less, the sample should not be fewer than 20 inpatient records, provided that number of records is adequate to determine compliance. Within the sample, select at least one patient from each nursing unit (e.g., med/surg, ICU, OB, pediatrics, specialty units, etc.). In addition to the inpatient sample, select a sample of outpatients in order to determine compliance in outpatient departments, services, and locations. The sample size may be expanded as needed to assess the hospital's compliance with the CoPs.

The surveyor(s) assigns each patient in the sample a unique identifier. The standardized medical record naming convention requires the use of the last 4 digits of the medical record identifier used by the healthcare organization followed by the patient's initials. See examples below:

	Patient Name	Medical Record Identifier Used by the HCO	Standardized TJC Medical Record Naming Convention

Non-VA HCOs	John Jones	123456789	6789JJ
VA HCOs	Peter Piper	SS# 123459876	9876PP

Organizations are provided with a report that allows them to understand which RFIs are tied to specific records so that they can take targeted action and correct any deficiencies associated with those records. Following is a sample of the Record Review Report.

Record Review Report**

Program: Hospital

Record Number	Reviewed/Observed	Standard	EP	CoP
6789JJ	Observed	PC.11.02.03	EP 2	§482.61(b)(7)-(A-1637)
9876PP	Observed	RC.12.01.01	EP 1	

Organizations can access the report on their Joint Commission *Connect* extranet site under the "Survey Process" tab, by selecting "Accreditation Record Review Reports." Once the user accesses the .pdf icon it will open to the Record Review Report.

Initial Surveys

To conduct an initial survey of a hospital there must be enough inpatients currently in the hospital and patient records (open and closed) for the surveyor(s) to determine whether the hospital can demonstrate compliance with all the applicable standards. The number of current and discharged inpatients and outpatients in relation to the complexity of care provided to patients and the length of stay of those patients needs to be large enough for surveyors to evaluate the manner and degree to which the hospital satisfies all the standards within each CoP including any CoP applying to optional services offered by the hospital. Utilize the same sample size and selection methods as previously discussed.

Information Gathering and Evaluation Activity

During an accreditation survey, Joint Commission evaluates an organization's performance of functions and processes for compliance with standards based on CMS Conditions of Participation (CoPs) and Joint Commission National Performance Goals (NPGs). Throughout the event, the surveyor(s) will work to minimize any disruption to patient care when conducting survey activities.

The survey process focuses on assessing performance of important patient-centered and organization functions that support the safety and quality of care, treatment, and services. Surveyors perform this assessment by

- Tracing the care, treatment, and services provided to patients throughout the organization and visiting locations and evaluating services that are part of an individual patients' health care encounter.
- Observing patient care, treatment, and services provided by organization staff.
- Interviewing organization staff who plan, direct, facilitate, provide, and monitor patient care, treatment, and services, and interviewing patients or their families.
- Reviewing a variety of organization documentation, such as policies and procedures, patient health care records, performance monitoring and improvement data, planning and operations-related information, governance and leadership meeting minutes, human resources files and records, and contracts.
- Evaluating compliance with standards based on *NFPA 99-2012 Health Care Facilities Code* and *NFPA 101-2012 Life Safety Code®* requirements through observation, document review, and interviews with the leaders and staff responsible for the physical environment in which patient care, treatment and services are provided.

These activities will take place in the locations and at facilities where the organization provides patient care, treatment, and services as identified in the E-App.

Locations to Survey

For hospitals with either no or a small number of provider-based locations, survey*† all departments, services, and locations that bill for services under the hospital's provider number and are considered part of the hospital.

For hospitals with many provider-based locations (locations that bill for services under the hospital's provider number and are considered part of the hospital) survey*:

- All hospital departments including all types of inpatient units that provide patient care services at the main site and other hospital locations †
- Visit 100% of all moderate or deep sedation and anesthetizing locations – inpatient and outpatient
- All locations where complex out-patient care (e.g. Intensive chemotherapy, complex wound care, advanced cardiac rehab, intensive medication management for chronic conditions) is provided by the hospital; and
- Select a sample of each type of other services provided at additional outpatient locations. †
    - Sample a mix of large, medium, and small volume clinics
    - Sample both onsite and offsite clinics.
    - If Behavioral Health services are provided, all services should be sampled (additional time is not allowed for outpatient sampling, surveyor may visit one site and perform record review to cover others.)

For hospitals that use Joint Commission accreditation for deemed status purposes: The team leader and/or the assigned clinical ambulatory surveyor for the event is expected to coordinate and communicate a plan for incorporating the off-site, provider-based locations into the survey. This includes working with both clinical and Life Safety surveyors to identify which locations will be visited during the survey. This work is expected to be performed prior to the survey so all team members understand their responsibilities and can plan their respective schedules accordingly.

*Survey methods include the following: Direct observation, interviews with staff and patients, medical record review, performance data review, personnel file and credentials file review, other documentation.

†When multiple units or outpatient locations provide the same type of care, visit one unit or location of each type. For example, in a hospital that has six medical/surgical units, surveyors must visit at least one of these types of units, and more if there are concerns. If a hospital provides the same types of rehabilitative services in three outpatient locations, surveyors must visit at least one of these outpatient locations, and more if there are concerns.

Visit the main pharmacy to include observing sterile medication compounding (if compounding occurs at the organization). In addition, visit:

- All locations which conduct High Risk (Non-Sterile to Sterile Medication Compounding)
- All locations which conduct Hazardous Sterile Medication Compounding

Note: Primary pharmacy and medication storage areas at each hospital location must be observed during survey. This includes situations where there are multiple hospitals under one CCN number. If these areas are not staffed and readily accessible 24/7, arrangements must be made with the organization to have an authorized pharmacy representative available to provide surveyor access to these areas at the time of visit.

The Life Safety Code Surveyor conducts a comprehensive assessment of compliance with all applicable standards, including surveying the physical environment and NFPA 99-2012 Health Care Facilities Code (NFPA 101-2012) at the following locations:

- Inpatient
- Surgical
- Free-standing emergency departments
- **For hospitals that use Joint Commission accreditation for deemed status purposes:** All provider-based locations selected for survey by the clinical surveyor(s) based on the criteria above.

Note: The clinical and Life Safety Code surveyor visits to locations may or may not coincide based on their respective schedule of survey activities.

"Psychiatric Hospitals" Hospital Accreditation Program – Deemed Status Business Summary

- Visit 100% of child/adolescent sites that are under inpatient, residential, or supervised living categories (including outpatient MRDD and ACT programs)
- Visit 100% of ECT sites

Patient Review

A comprehensive review of care and services received by each patient in the sample is part of the hospital survey. A comprehensive review includes observations of care/services provided to the patient, patient and/or family interview(s), staff interview(s), and medical record review. After obtaining the patient's permission, observe each sample patient receiving treatments (e.g., intravenous therapy, tube feedings, wound dressing changes) and observe the care provided in a variety of treatment settings, as necessary, to determine if patient needs are met.

Observations

Observations provide first-hand knowledge of hospital practice. Surveyors will refer to the standards, regulations, and interpretive guidelines for guidance in conducting observations. Observation of the care environment provides valuable information about how the care delivery system works and how hospital departments work together to provide care. Surveyors are encouraged to make observations, complete interviews, and review records and policies/procedures by stationing themselves as physically close to patient care as possible. While completing a chart review, for instance, it may be possible to also observe the environment and the patients, as far as care being given, staff interactions with patients, safety hazards, and infection control practices. **When conducting observations, particular attention should be given to the following:**

- Patient care, including treatments and therapies in all patient care settings;
- Staff member activities, equipment, documentation, building structure, sounds, and smells;
- People, care, activities, processes, documentation, policies, equipment, etc., that are present that should not be present, as well as those that are not present that should be present;
- Integration of all services, such that the facility is functioning as one integrated whole;
- Whether quality assessment and performance improvement (QAPI) are facility-wide activities, incorporating every service and activity of the provider and whether every facility department and activity reports to, and receives reports from, the facility's central organized body managing the facility-wide QAPI program; and
- Storage, security and confidentiality of medical records.

The surveyor will take complete notes of all observations and document the date and time of the observation(s); location; patient identifiers, individuals present during the observation, and the activity being observed (e.g., therapy, treatment modality, medication administration, patient education).

A surveyor should have observations verified by the patient, family, facility staff, other survey team member(s), or by another mechanism. For example, when finding an outdated medication in the pharmacy, ask the pharmacist to verify that the drug is outdated. In addition, a surveyor should integrate the data from observations with data gathered through interviews and document reviews.

Interviews

Interviews provide a method to request and collect information, and to verify and validate information obtained through observations. Informal interviews should be conducted throughout the duration of the survey. Use the information obtained from interviews to determine what additional observations, interviews, and document and record reviews are necessary. When conducting interviews, observe the following:

- Maintain detailed documentation of each interview conducted. Document the interview date, time, and location; the full name and title of the person interviewed; and key points made and/or topics discussed.
- Interviews with facility staff should be brief. Use a few well-phrased questions to elicit the desired information. For example, to determine if a staff member is aware of disaster procedures and his/her role in such events, simply ask, "If you smelled smoke, what would you do?"
- When interviewing staff, begin your interviews with staff that work most closely with the patient.

- Conduct patient interviews regarding their knowledge of their plan of care, the implementation of the plan, and the quality of the services received. Other topics for patient or family interview may include patient rights, advanced directives, and the facility's grievance/complaint procedure.
- Interviews with patients must be conducted in privacy and with the patient's prior permission.
- Use open-ended questions during your interview.
- Validate all information obtained.
- Telephone interviews may be conducted, if necessary, but a preference should be made for in-person interviews.
- Integrate the data from interviews with data gathered through observations and document reviews.

Staff interviews should gather information about the staff's knowledge of the patient's needs, plan of care, and progress toward goals. Problems or concerns identified during a patient or family interview should be addressed in the staff interview in order to validate the patient's perception, or to gather additional information.

Patient interviews should include questions specific to the patient's condition, reason for hospital admission, quality of care received, and the patient's knowledge of their plan of care. For instance, a surgical patient should be questioned about the process for preparation for surgery, the patient's knowledge of and consent for the procedure, pre-operative patient teaching, post-operative patient goals and discharge plan.

Document Review

Document review focuses on a facility's compliance with the standards. When conducting a document review, document the source and date of the information obtained. Once a surveyor completes review of a document, they will integrate the data obtained with data gathered through observations and interviews to decide if the hospital is compliant with standards. Documents reviewed may be both written and electronic and include the following:

- Patient's clinical records, to validate information gained during the interviews, as well as for evidence of advanced directives, discharge planning instructions, and patient teaching. This review will provide a broad picture of the patient's care. Plans of care and discharge plans should be initiated immediately upon admission and be modified as patient care needs change. The record review for that patient who has undergone surgery would include a review of the pre-surgical assessment, informed consent, operative report, and pre-, inter-, and post-operative anesthesia notes. Although team members may have a specific area assigned during the survey, the team should avoid duplication of efforts during review of medical records and each surveyor should review the record as a whole instead of targeting the assigned area of concern. Surveyors should use open patient records rather than closed records, whenever possible;
- Closed medical records may be used to determine past practice, and the scope or frequency of a deficient practice. Closed records should also be reviewed to provide information about services that are not being provided by the hospital at the time of the survey. For example, if there are no obstetrical patients in the facility at the time of the survey, review closed OB records to determine care practices, or to evaluate past activities that cannot be evaluated using open records. In the review of closed clinical records, review all selected medical

records for an integrated plan of care, timelines of implementation of the plan of care, and the patient responses to the interventions.

- Personnel files to determine if staff members have the appropriate educational requirements, have had the necessary training required, and are licensed, if it is required;
- Credential files to determine if the facility complies with CMS requirements and State law, as well as, follows its own written policies for medical staff privileges and credentialing;
- Maintenance records to determine if equipment is periodically examined and to determine if it is in good working order and if environmental requirements have been met;
- Staffing documents to determine if adequate numbers of staff are provided according to the number and acuity of patients;
- Policy and procedure manuals. When reviewing policy and procedure manuals, verify with the person in charge of an area that the policy and procedure manuals are current; and
- Contracts, if applicable, to determine if patient care, governing body, QAPI, and other standards and CoP requirements are included.

Surveyor Planning and Team Meetings

The surveyor(s) will take time daily to assess the progress of the survey, review areas of concern, and plan for subsequent tracer selection and focus. If this is a team survey the designated team leader will lead this meeting and expect a report out from each surveyor that includes:

- All significant issues, adverse events, potential threats to health and safety
- Patient tracers conducted, including areas and locations visited, observations of care, treatment and services, interviews conducted, documentation reviewed
- Review of observations, issues for further follow-up
- National Performance Goals that have been evaluated
- Personnel and medical staff files reviewed
- Inpatient and outpatient medical/health records reviewed
- Any outstanding requests for information, and
- Topics to cover at the Daily Briefing.

Daily Briefings

The surveyor(s) will summarize the events of the previous day and communicate observations according to standards areas that may or may not lead to findings of non-compliance. If a surveyor is visiting a remote location, organizations may be asked for assistance with setting up a conference call to include all surveyors and appropriate staff from locations that were visited.

Accreditation Report Preparation

The surveyor(s) will use this time to compile, analyze, and organize the data collected throughout the survey into a Preliminary Accreditation Report reflecting the organization's compliance with standards and CoPs.

The performance expectations for determining if a standard is in compliance are included in its elements of performance (EPs). If an EP is determined to be out of compliance, then it will be cited as a requirement for improvement (RFI). Each RFI is placed in the SAFER[2] Matrix according to how likely it is that the RFI will harm a patient(s), staff, and/or visitor (low, moderate, high) and the scope, or prevalence, at which the RFI was cited (limited, pattern, widespread). As the risk level of a finding or an observation increases, the placement of the standard and EP moves from the bottom left corner (lowest risk level) to the upper right corner (highest risk level).

Determining Standard Level and Condition Level Deficiencies

For organizations that utilize Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Exit Conference

The surveyor(s) will offer to meet with the most senior leader, usually the CEO or administrator, or the leadership team to conduct a private Exit Briefing. During the Exit Briefing, the surveyor(s) will present the survey findings and review the Preliminary Accreditation Report (including the SAFER Matrix results), discuss any concerns senior leaders have with the preliminary report, and determine the need for any special arrangements for the Organization Exit Conference.

The organization determines which staff will attend the exit conference.

During the Organization Exit Conference the surveyor(s) will review the survey findings (if desired by senior leaders), review the issues of standards compliance that have been identified during the survey, and review required follow-up actions, as applicable. The surveyor(s) will not reveal any identifying information for either patients or staff members during the presentation of survey results.

Post-Survey Activities

Refer to the Accreditation Manual for Hospitals, the Accreditation Process chapter for detailed information.

[2] Survey Analysis for Evaluating Risk (SAFER) Matrix. The SAFER Matrix is only a visual representation of risk associated with survey findings. Placement of findings on the SAFER Matrix does not enter into the accreditation decision process.

Hospital Accreditation Survey Activity List and Descriptions

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
Surveyor Arrival and Preliminary Planning (Includes the Safety Briefing)	Surveyors will learn about any current organization safety or security concerns and how they should respond if organization safety plans are implemented. Surveyor(s) will begin review of available documents to become acquainted with your organization. Surveyor(s) will plan for tracer activity. 1st day, upon arrival	The organization's accreditation contact or survey coordinator, individual or individuals that will provide the Safety Briefing to surveyors.
Opening Conference and Orientation to the Organization	Surveyors will describe the structure of the survey, and answer questions about the survey at the Opening Conference . During Orientation to the Organization, the surveyors(s) will learn how your organization is governed and operated, discuss leaders' planning priorities, and explore your organization's performance improvement process. 1st day, as early as possible	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; and accreditation contact.
Individual Tracer - Infection Control - Medication Safety and Pharmacy Review	Surveyor(s) will evaluate the organization's compliance with standards related to the care, treatment, and services provided to patients. The Individual Tracer activity occurs each day throughout the survey tracing the care experiences of patients. The number of patients that surveyors trace varies by organization. The evaluation includes processes and procedures to prevent patient harm and errors related to ordering of medications through monitoring; and evaluating medication safety practices (including medication reconciliation). Infection prevention practices (including antibiotic use, appropriate use of PPE, and hand hygiene) and infection prevention practices related to CLABSI, CAUTI, and/or MDROs will be evaluated during patient tracer activity. If travel is required to perform tracer activity (e.g., to an outpatient setting), it will be planned into this time.	Staff, physicians, other licensed practitioners, and management involved in the individual's care, treatment, and services.
Lunch	At a time negotiated with the organization	
Issue Resolution **OR** Surveyor Planning / Team Meeting	Issue Resolution is dedicated time 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, documented care procedures additional file review required, etc.).	For Issue Resolution, the surveyor(s) will identify individuals if needed. None for Surveyor Planning / Team Meeting

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	The surveyor(s) will summarize the events of the previous day and communicate observations according to standards areas that may or may not lead to findings. Start of each survey day except the first day; can be scheduled at other times as necessary	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.
Competence Assessment	The surveyor will review your organization's competence assessment process for staff and review identified personnel/staff files. After some individual tracer activity has occurred; at a time negotiated with the organization	Participants include: Staff responsible for human resources functions, orientation and education of staff and assessing staff competency; individual(s) with authority to access information contained in personal files.
Medical Staff Credentialing & Privileging	The surveyor will evaluate 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). The surveyor will evaluate the credentialing and privileging process for the medical staff and other physicians and licensed practitioners who are privileged through the medical staff process. This will include credentials/privileges file review. After some individual tracer activity has occurred; at a time negotiated with the organization	President of the medical staff; medical director and medical staff coordinator, if applicable; and medical staff credentials committee representatives.
Emergency Management	The surveyor will 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. After some individual tracer activity has occurred; group interview at a time negotiated with the organization May be conducted with Life Safety surveyor.	Leaders and other individuals familiar with all aspects of the Emergency Management (EM) program. 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, and Information technology.
Organization Quality and Performance Improvement	The surveyor will evaluate how data is used to monitor performance and improve processes throughout the organization; and assess how the organization is using process and outcome data to evaluate the safety and quality of care being provided to patients. After some individual tracer activity has occurred; at a time negotiated with the organization	Participants may 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),

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
		administrator(s), Pharmacy staff, Medical Staff, and Nursing
Organization governance, administration, and management or "Leadership"	The surveyor will evaluate the responsibilities and accountabilities of leaders for the hospital's total operation (including priority setting) and for administering policies to provide quality health care in a safe environment. This is a group interview at a time negotiated with the organization.	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.
Report Preparation	This time for the surveyor to compile, analyze, and organize the data collected during the survey into a report reflecting your organization's compliance with the standards. This will be the last opportunity for the organization to provide any outstanding surveyor requests or further evidence to present from the last day of survey activity. Last day of survey	None
CEO Exit Briefing	The surveyor(s) 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. Last day of survey	Participants include the Chief Executive Officer (CEO) or Administrator, if available
Organization Exit Conference	The surveyor(s) 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. Last day, final activity of survey	Participants include the CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.
Interim Exit – w/ early departing surveyors and organization	This is an activity for a scheduled early departure of survey team member. the LSC Surveyor and the Team Leader conduct a verbal interim exit briefing with staff designated by the organization to review your observations. At the end of any day another program surveyor or Life Safety Code surveyor is departing from the survey in advance of the team	Participants include the CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.
Life Safety Code® Survey Activity		
Life Safety Code Surveyor ~~Arrival and Preliminary Planning Session~~Arrival	**Day 1 LSC surveyor arrival**: The surveyor arrives with the team and after meeting with the surveyor coordinator, requests to meet with facilities staff to conduct the facilities orientation.	The organization's accreditation contact or survey coordinator and/or individual who manages your organization's facility(ies)

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
	Other than day 1 arrival: The surveyor arrives with the team and attends the daily briefing for introductions and proceeds to facilities orientation. ~~Surveyors will learn about any current organization safety or security concerns and how they should respond if organization safety plans are implemented.~~ ~~The surveyor(s) will begin review of available Physical Environment (PE) documents to become acquainted with your organization.~~ ~~LSCS survey 1st day, early~~	
Facility Orientation ~~and Document Review~~	The LSC surveyor, accompanied by hospital facilities staff, evaluates the fire alarm system main control panel, fire pump(s), emergency power systems, medical gas systems, and any other essential utility systems as time permits. Any essential systems that are not able to be evaluated at this time will be evaluated during the LSC building assessment. ~~The surveyor will review identified building systems; life safety drawings, including construction drawings, if available; and select policies to support the building assessment (tour) activities. Take note of the building construction type identified in the SOC/BBI to prepare for discussion with the organization and confirmation with visual observation.~~ ~~The surveyor will determine the type of building construction and where it will be possible, without disturbing patient care, confirm by direct observation the structure and building materials used in construction. Exposed areas above the ceiling or vertical pips shafts may provide insight.~~ ~~At a time negotiated with the organization~~	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 on-site, please be prepared to facilitate this activity upon their arrival.**
Document Review	The surveyor will review identified building systems; life safety drawings, including construction drawings, if available; and select policies to support the building assessment (tour) activities. Take note of the building construction type identified in the SOC/BBI to prepare for discussion with the organization and confirmation with visual observation. The surveyor will review evidence of compliance of the items addressed in the Hospital Physical Environment Document List and Review Tool (such as fire drills; environmental risk assessment; inspection, testing and maintenance activities). Refer to the tools section of this document for this tool.	Participants include the individual who manages your organization's facility(ies) and other staff at the discretion of your organization.
Life Safety Code® Building Assessment	The surveyor will evaluate the degree of compliance with relevant *Life Safety Code® (NFPA 101-2012)* and	Participants include the individual who manages organization facilities and

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
	Health Care Facilities Code (NFPA 99-2012) requirements.* *Non-deemed organizations may have other applicable provisions of the Codes. The surveyor will determine the type of building construction and where it will be possible, without disturbing patient care, confirm by direct observation the structure and building materials used in construction. Exposed areas above the ceiling or vertical pips shafts may provide insight. ~~The surveyor will visit areas where it can be confirmed by direct observation the structure and building materials used in construction. Exposed areas above the ceilings or vertical pipe shafts may provide insight.~~ The surveyor will conduct the appropriate scope of Life Safety Code® (NFPA 101-2012), physical environment, and NFPA 99-2012 Health Care Facilities Code assessment at the additional provider-based locations selected for survey by the clinical surveyor. The surveyor will meet with the survey team to determine the additional provider-based locations the clinical team member(s) is surveying to plan for the LSC visit and evaluation. At a time negotiated with the organization	other staff at the discretion of your organization.
Lunch	At a time negotiated with the organization	
Emergency Management (**See above description)**	At a time negotiated with the organization. May be conducted by a LSC surveyor and/or with a Clinical surveyor.	**See above**
Report Preparation	This time for the surveyor to compile, analyze, and organize the data collected during the LSC survey into a report reflecting your organization's compliance with the Physical Environment standards. This will be the last opportunity for the organization to provide any outstanding surveyor requests or further evidence to present from the last day of survey activity. Towards the end of last day of survey	None
Interim Exit	This is an activity for a scheduled early departure of a survey team member. The LSC Surveyor and the Team Leader conducts a verbal interim exit briefing with staff designated by the organization to review your observations. Last activity on last day of survey.	Participants include the individual who manages your organization's facility(ies), CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.

Hospital Document List

To facilitate the survey activities and compliance evaluation work, please have the following information and documents (as they become available) for the surveyor(s) to begin reviewing during the Surveyor Arrival and Preliminary Planning activity. This review will continue throughout the survey.
Note*: The 12-month reference in the following items is not applicable to initial surveys.*

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

Needed During …	Requested Documents
Surveyor Arrival and Preliminary Planning	1. Name of key contact person who can assist surveyors in planning tracer selection. 2. Any available regulatory reports (CMS, State). 3. Waivers and variances if they exist. 4. Complexity of services offered, including outpatient services to include, names and addresses of all off-site locations operating under the same provider number. a) List of all sites that are eligible for survey. b) List of sites where deep or moderate sedation is in use. c) List of sites where high-level disinfection and/or sterilization is in use. d) List of sites where medication compounding (simple, hazardous, etc.) within the organization. e) List of departments, units, area, programs, and services within the organization, if applicable f) List of Department or Service leaders with locations/area responsibility and phone numbers 5. Copy of facilities floor Plan indicating location of patient care and treatment areas
Surveyor Arrival and Preliminary Planning	Hospital license, Prior to Survey Activities; **Note:** *Refer to Hospital Compliance with Federal, State, and Local Laws Evaluation Module (482.11)*
Surveyor Arrival and Preliminary Planning	1. List of current inpatients a) patient's name b) room number c) diagnosis(es) d) admission date e) age f) attending physician,

Needed During ...	Requested Documents
	g) and other significant information as it applies to that patient 2. Lists of scheduled surgeries and special procedures ➢ *For example, cardiac catheterization, endoscopy lab, electroconvulsive therapy, caesarian sections, including location of procedure and time.*
Surveyor Arrival and Preliminary Planning	Medical Staff 1. Medical Staff Bylaws 2. Rules and Regulation 3. Medical Staff Policies *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.)* 4. Medical Executive Committee meeting minutes
End of Day 1	List of employees 1. Name 2. Position (LPN, RN, RT, PT, Pharmacy Tech, etc.) 3. Primary Location of Work
End of Day 1	Infection Control 1. Annual infection risk assessment 2. Infection Control surveillance data from the past 12 months
Survey Activities	Antibiotic Stewardship 1. Organization approved antibiotic stewardship protocols *For example, policies, procedures, or order sets* 2. Antibiotic stewardship data 3. Antibiotic stewardship program reports to leadership and prescribers
Pharmacy Tracer	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)
Survey Activities	1. Performance improvement data from the past 12 months 2. 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) 3. Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (including reasons for conducting the

Needed During ...	Requested Documents
	projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping 4. Analysis from a high-risk process 5. Most recent culture of safety and quality evaluation data 6. ORYX data – an organization should be prepared to share ORYX Performance Measurement data and/or Accelerate PI Dashboard reports.
Survey Activities	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
Survey Activities	1. Blood transfusion policy 2. Agreement with outside blood supplier 3. Autopsy policy 4. CLIA Certificates 5. Waived testing policy and quality control plan 6. Organ Procurement Organization agreement 7. Tissue and Eye Procurement Organization agreement 8. Organ, tissue, and eye procurement policies
Survey Activities	1. Organization chart 2. Governing Body minutes for the last 12 months 3. List of Contracted Services
Survey Activities	1. Abuse and neglect policy for inpatient, and ambulatory sites, if applicable 2. Fall risk assessment and policy 3. Complaint/grievance policy 4. Restraint and seclusion policy 5. 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)* 6. Medication management policy (which defines what is a complete medication order and therapeutic duplication
Survey Activities	1. ~~Environment of Care data~~Required documents from the ~~(see~~ Physical Environment Life Safety & Environment of Care Document List and Review Tool~~)~~ 2. Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey

Needed During ...	Requested Documents
Survey Activities	Emergency Management documentation* for each of the following (each must be updated and reviewed at least every 2 years): a) Emergency management program b) Hazard vulnerability analysis c) Emergency operation plan and policies and procedures i. Fire response and evacuation plans 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) * Specific documentation requirements can be found in the Emergency Management Documentation Review Tool

Basis and Scope (482.1) and Hospital Compliance with Federal, State, and Local Laws Evaluation Module (482.11)

Joint Commission Standards / EPs	Hospital Survey Process
LD.13.01.01, EP 1: The hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) definition of a hospital in accordance with 42 CFR 482.1(a)(1) and (b). (Refer to https://www.ecfr.gov/ for the language of this CMS requirement) **§ 482.1 (a) *Statutory basis.* § 482.1 (b) *Scope***	**Interview, Document Review, Observation** ☐ Verify there are at least two inpatients currently in the hospital at the time of survey ☐ If yes, proceed with evaluating whether the hospital is primarily engaged in providing the requisite services of a hospital, as well as in the Conditions of Participation. ☐ If there are currently no inpatients in the hospital, no survey is to be conducted and surveyors should ask to see the following, in order to make the proper determination of the hospital's status and to make the proper recommendations to the RO: o ADC over the last 12 months (or less for facilities operational for less than 12 months) ▪ Look for patterns and trends in the ADC by the day of the week. o ALOS over the last 12 months (or less for facilities operational for less than 12 months) o The number of provider-based off-campus emergency departments. o The volume of outpatient surgical procedures compared to inpatient surgical procedures o Staffing schedules by day of week and shift over the last 12 months (or less for facilities operational for less than 12 months) o Verify the facility is providing the appropriate types and adequate numbers of staff to support 24/7 inpatient services (i.e. nursing, pharmacy, physicians, etc.) o Review the number of inpatient beds in relation to the size of the facility and services offered. o Determine if the number of inpatient beds could support emergency or unplanned admissions from the volumes of other services offered by the facility, such as ED patients or outpatient surgery patients? ☐ If the initial review of the above information indicates that the facility is most likely not providing care to inpatients, then a second survey will not be conducted. However, if the review of the information indicates the facility has had an ADC and ALOS of two over the last 12 months (or less for facilities

Joint Commission Standards / EPs	Hospital Survey Process
	operational for less than 12 months) and there are no other concerns regarding facility's eligibility to be surveyed as a hospital, then a second survey will be scheduled for a future unannounced date after consulting with the RO. Dd □ Whenever the SA or AO is unable to complete a survey because the hospital did not have a sufficient number of inpatients that is a representative sample of the different types of services and patient populations that are treated at that hospital, it must immediately report this information to the RO. d □ Determine through interview, observation, and record review that the hospital meets the statutory requirements as defined by 1861(e), including the CoPs. Verify the facility does the following: o Maintains clinical records on all patients; o Has medical staff bylaws; o Has a requirement that every patient with respect to whom payment may be made under this title must be under the care of a physician except that a patient receiving qualified psychologist services (as defined in section 1861(ii) of the Act) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law; o Provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times…; □ Has in effect a hospital utilization review plan which meets the requirements of section 1861(k) of the Act; □ Has in place a discharge planning process that meets the requirements of section 1861(ee) of the Act; □ If located in a state in which state or applicable local law provides for the licensing of hospitals, be licensed under such law or be approved by the agency of the State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; □ Has in effect an overall plan and budget that meets the requirements of section 1861(z) of the Act.
HR.11.01.03, EP 1: All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation.	**Interview** □ CEO or appropriate individual designated by the hospital to determine if the hospital is in compliance with Federal laws related to patient health and

Joint Commission Standards / EPs	Hospital Survey Process
§482.11(c) **LD.13.01.01, EP 1:** The hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) definition of a hospital in accordance with 42 CFR 482.1(a)(1) and (b). (Refer to https://www.ecfr.gov/ for the language of this CMS requirement) §482.11(a); **LD.13.01.01, EP 2:** The hospital is licensed, or approved as meeting the standards for licensing established by the state or responsible locality, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from Joint Commission. §482.11(b)(1) **MS.17.01.03, EP 3:** The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information for the applicant: - Current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - Relevant training - Current competence §482.11(c) **MS.17.02.01, EP 9:** All physicians and other licensed practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation. §482.11(c)	safety. *(For example, ask if the hospital was cited since its last survey for any violation of Section 504 of the Rehabilitation Act of 1973 related to denying people with disabilities access to care. If so, verify that satisfactory corrections have been made to bring the hospital into compliance with that law.)* **Document Review** **General** □ Prior to the survey, determine whether the hospital has a current license issued by the state or local authority in which it operates, or, if it is located within a State that does not license hospitals, verify that the responsible State agency has approved the hospital as meeting the State's established standards for the licensing of hospitals. □ Verify the hospital has established and follows procedures for determining that personnel are properly licensed, certified, and/or permitted as required by the state. □ Verify that the hospital has an established process which is followed to determine that staff and personnel meet all standards (such as continuing education, basic qualifications, hold permits) required by State and local laws or regulations. **Personnel/Credential File** □ Review a sample of personnel files to verify that licensure and/or other required credentials information is up to date. □ Verify State licensure compliance of the direct care personnel as well as administrators and supervisory personnel. □ When telemedicine is used and the practitioner and patient are located in different states is the practitioner providing the patient care service licensed and/or meets the other applicable standards that are required by State or local laws in both the state where the practitioner is located and state where the patient is located. Note: Hospitals that handle, store, or issue tissue are required to comply with Title 21 Code of Federal Regulations (CFR), Parts 1270 and 1271 addressing human cells, tissues, and cellular/tissue-based products (HCT/Ps).

Hospital Governing Body Evaluation Module (482.12)

Joint Commission Standards / EPs	Hospital Survey Process
LD.11.01.01, EP 1: The hospital has a governing body that assumes full legal responsibility for the conduct of the hospital. If the hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital carry out the functions that pertain to the governing body. **§482.12**	**Interview** ☐ Leaders to determine there is an organized governing body or there is written documentation that identifies the individual(s) responsible for the conduct of hospital operations. **Document Review** **General** ☐ If the hospital is part of a hospital system that uses one governing body for several of the hospitals separately certified within the system: o Review the governing body minutes to determine if it is clear which actions pertain to which hospitals. o Review several policies or procedures adopted by the system governing body to determine if it is clear that they apply to the hospital being surveyed. o Look for evidence that the hospital being surveyed has its own nursing service and QAPI program.
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients	**Document Review** **General** Governing Body Mtg Minutes/Med Staff Bylaws ☐ Verify that the governing body has determined and stated the categories of physicians and practitioners that are eligible candidates for appointment to the medical staff or to be granted medical staff privileges.

Joint Commission Standards / EPs	Hospital Survey Process
- Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations **§482.12(a)(1)**	
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations **§482.12(a)(2)**	**Document Review** **Credential File** ☐ Review records of medical staff appointments to determine that the governing body is involved in appointments of medical staff members. ☐ Confirm that there is evidence that the governing body considered recommendations of the medical staff before making medical staff appointments.
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process	**Document Review** **General** Review Medical Staff Bylaws

Joint Commission Standards / EPs	Hospital Survey Process
- Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations **§482.12(a)(3)**	☐ Verify that the medical staff operates under current bylaws that are in accordance with Federal and State laws and regulations.
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon	**Document Review** **General** ☐ Verify that the medical staff operates under current bylaws, rules and policies that have been approved by the governing body. ☐ Verify that any revisions or modifications in the medical staff bylaws, rules and policies have been approved by the medical staff and the governing body, for example, bylaws are annotated with date of last review and initialed by person(s) responsible.

Joint Commission Standards / EPs	Hospital Survey Process
certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations §482.12(a)(4)	
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations §482.12(a)(5)	**Interview** ☐ Medical staff leaders to verify that the governing body is periodically apprised of the medical staff evaluation of patient care services provided hospital wide, at every patient care location of the hospital. **Document Review** **Credential File** ☐ Verify that any individual providing patient care services is a member of the medical staff or is accountable to a member of the medical staff qualified to evaluate the quality of services provided, and in turn, is responsible to the governing body for the quality of services provided.
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff	**Interview** ☐ Ask medical staff leaders, hospital leaders, or medical staff office representatives how they ensure bylaws governing medical staff membership or the granting of privileges are applied equally to all practitioners in each professional category of practitioners. **Document Review** **General**

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- Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations **§482.12(a)(6)**	Review the medical staff bylaws for the following: ☐ Description of the hospital's privileging process ☐ Written criteria for appointments to the medical staff and granting of medical staff privileges. ☐ Granting of medical staff membership or privileges, both new and renewal, is based upon an individual practitioner's meeting the medical staff's membership/privileging criteria. ☐ At a minimum, criteria for appointment to the medical staff/granting of medical staff privileges are individual character, competence, training, experience, and judgment.
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society	**Document Review** **General** ☐ Review the medical staff bylaws to verify that written criteria for appointment to the medical staff and granting of medical staff privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.

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- Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations §482.12(a)(7)	
MS.20.01.01, EP 1: When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating hospital, the originating hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the hospital's	Please see survey process for §482.12(a)(9) below

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patients and complaints the hospital has received about the distant-site physician or other licensed practitioner. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). **§482.12(a)(8)**	
LD.13.03.03, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: When telemedicine services are furnished to the hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation - The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.17.01.01 through MS.17.04.01). - The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. The written agreement includes that it is the responsibility of the governing body of the distant-site hospital to meet the requirements of this element of performance. **§482.12(a)(9)**	**Interview** ☐ Ask the hospital's leadership whether it uses telemedicine services. **Document Review** ☐ If the hospital uses telemedicine services ask to see a copy of the written agreement(s) with the distant-site hospital(s) or telemedicine entity(ies). ○ Does each agreement include the required elements concerning credentialing and privileging of the telemedicine physicians and practitioners? ○ Does the hospital have documentation indicating that it granted privileges to each telemedicine physician and practitioner? ○ Does the documentation indicate that for each telemedicine physician and practitioner there is a medical staff recommendation, including an indication of whether the medical staff conducted its own review or relied upon the decisions of the distant-site hospital or telemedicine entity?

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LD.11.01.01, EP 5: For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body consults directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or with the individual's designee. At a minimum, this direct consultation occurs periodically throughout the fiscal or calendar year and includes a discussion of matters related to the quality of medical care provided to the hospital's patients. For a multi-hospital system using a single governing body, the single multihospital system governing body consults directly with the individual responsible for the organized medical staff (or the individual's designee) of each hospital within its system. **§482.12(a)(10)**	**Interview** ☐ Ask the hospital's CEO how the hospital complies with the requirement for periodic consultations by the governing body with the leader of the hospital's medical staff, or the leader's designee. ○ Is there evidence that such consultations have occurred, for example, meeting agendas and lists of attendees, or meeting minutes. ○ Does the hospital track these consultations by the calendar year or its fiscal year; ask to see a copy of the policy that establishes the approach and the number and frequency of these consultations and the various factors they are based on specific to the hospital, or to each of the hospitals within a multihospital system. ○ Is there evidence that the consultations were "direct?" ○ Is there evidence that the governing body met with the medical staff leader or designee at least twice during the previous year? ○ Is there evidence that the discussion concerned matters related to the quality of medical care in the hospital? ☐ Ask the leader of the hospital's medical staff, or his/her designee, whether he or she has had meetings with either the whole governing body or a subcommittee of it to discuss the quality of medical care in the hospital. ○ Has the leader/designee ever requested a meeting in addition to those regularly scheduled, to discuss a matter of urgent concern to the medical staff? If yes, did the governing body respond by setting up a meeting? *Note: If the hospital shares a unified medical staff with other separately certified hospitals in a multi-hospital system, the interview with the leader of the medical staff, or designee, may have to be conducted by telephone.* ○ Ask the leader/designee how he/she gathers information about the concerns/views of members of the medical staff

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	practicing at the hospital being surveyed about the quality of medical care provided at that hospital. **Document Review** **General** ☐ Review governing body policies and procedures on the requirement for periodic, direct consultations with the leader of the medical staff or the designee.
LD.11.01.01, EP 6: The governing body appoints the chief executive officer responsible for managing the hospital. **§482.12(b)**	**Document Review** ☐ Review board meeting minutes to o Verify that the hospital has only one chief executive officer for the entire hospital. o Verify that the governing body has appointed the chief executive officer. o Verify that the chief executive officer is responsible for managing the entire hospital.
LD.11.01.01, EP 7: The governing body makes certain that patients are under the care of the appropriate licensed practitioners. **§482.12(c)(1)** **MS.16.01.03, EP 4:** For hospitals that use Joint Commission accreditation for deemed status purposes: Every Medicare patient is under the care of at least one of the following: - A doctor of medicine or osteopathy (This requirement does not limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care staff to the extent recognized under state law or a state's regulatory mechanism.) - A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the state and who is acting within the scope of their license - A doctor of podiatric medicine, but only with respect to functions which they are legally authorized by the state to perform - A doctor of optometry who is legally authorized to practice optometry by the state in which they practice - A chiropractor who is licensed by the state or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by	**Document Review** **Personnel/Credential File** ☐ Verify that Medicare patients are under the care of a licensed practitioner as follows: o Doctor of medicine or osteopathy o Doctor of dental surgery or dental medicine o Doctor of podiatric medicine o Doctor of optometry o Chiropractor o Clinical psychologist

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x-ray to exist - A clinical psychologist as defined in 42 CFR 410.71, but only with respect to clinical psychologist services as defined in 42 CFR 410.71 and only to the extent permitted by state §482.12(c)(1)	
LD.11.01.01, EP 7: The governing body makes certain that patients are under the care of the appropriate licensed practitioners. §482.12(c)(2) **MS.16.01.03, EP 1:** Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the state to admit patients to a hospital. For hospitals that use Joint Commission accreditation for deemed status purposes: If a Medicare patient is admitted by a practitioner not specified in MS.16.01.03, EP 4, that patient is under the care of a doctor of medicine or osteopathy. §482.12(c)(2)	**Document Review** **Personnel/Credential File** ☐ Verify that admitting privileges are limited to those categories of practitioners as allowed by State law. ☐ Verify that patients are admitted only by those practitioners who are currently licensed and have been granted admitting privileges by the governing body in accordance with State laws and medical staff bylaws. **Patient Health Record** If the hospital grants admitting privileges to practitioners, for example nurse practitioners and midwives, ☐ Select Medicare and Medicaid patients (select only Medicare patients admitted by midwives) that are admitted to the hospital by these practitioners to determine if they are/were under the care of an MD/DO.
LD.11.01.01, EP 7: The governing body makes certain that patients are under the care of the appropriate licensed practitioners. §482.12(c)(3) **MS.16.01.03, EP 2:** A doctor of medicine or osteopathy is on duty or on call at all times. §482.12(c)(3)	**Interview** ☐ Ask nursing staff: o How they know who is on call? o If they are able to call the on-call MD/DO and speak with him/her at all times? o When appropriate, if on-call MD/DOs come to the hospital to provide needed care. ☐ Ask hospital leaders how they monitor and ensure that an MD/DO is on duty or on call at all times to provide medical care and on-site supervision when necessary. **Document Review** **General**

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	☐ Review the "call" register or other available documentation that leaders and staff would consult to determine who the doctor of medicine or osteopathy is on duty or on call at all times.
LD.11.01.01, EP 7: The governing body makes certain that patients are under the care of the appropriate licensed practitioners. **§482.12(c)(4)** **MS.16.01.03, EP 3:** A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization and is not specifically within the scope of practice, as defined by the medical staff and in accordance with state law, of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 12(c)(1)(v); or clinical psychologist. **§482.12(c)(4)**	**Document Review** **Patient Health Record** ☐ Verify that an assigned MD or DO is responsible for and is monitoring the care of each Medicare or Medicaid patient with respect to all medical or psychiatric problems during the hospitalization. ☐ If non-MD/DOs admit patients, verify that every Medicare/Medicaid patient is being monitored by an MD/DO who is responsible for any medical or psychiatric problem outside the scope of practice of the admitting practitioners.
LD.13.01.05, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an overall institutional plan that meets the following conditions: - The plan includes an annual operating budget that is prepared according to generally accepted accounting principles and that has all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense. - The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget is applicable. **§482.12(d)** **LD.13.01.05, EP 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan includes and identifies in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Social Security Act [42 U.S.C. 1320a–1(g)(1)], by the state in which the hospital is located) that relates to any of the following: - Acquisition of land - Improvement of land, buildings, and equipment - The replacement, modernization, and expansion of buildings and equipment	**Document Review** **General** ☐ Verify that an institutional plan and budget exist, and include: o An annual operating budget that is prepared according to generally accepted accounting principles. o All anticipated income and expenses. o A plan that provides for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in paragraph (d)(2) of this section is applicable. o A plan that includes and identifies in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Act, by the State in which the hospital is located) that relates to any of the following: (i) (ii) Acquisition of land; Improvement of land, buildings, and equipment; or (iii)The replacement, modernization, and expansion of buildings and equipment. *Note: Do not review the specifics or format in the institutional plan or the budget.*

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§482.12(d)	
LD.13.01.05, EP 4: For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is submitted for review to the planning agency designated in accordance with section 1122(b) of the Social Security Act [42 U.S.C. 1320a–1(b)], or if an agency is not designated, to the appropriate health planning agency in the state. A capital expenditure is not subject to section 1122 review if 75 percent of the health care facility's patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Social Security Act (42 U.S.C. 1395mm(b)), and if the US Department of Health and Human Services determines that the capital expenditure is for services and facilities that are needed by the HMO or CMP in order to operate efficiently and economically and that are not otherwise readily accessible to the HMO or CMP because of one of the following: - The facilities do not provide common services at the same site. - The facilities are not available under a contract of reasonable duration. - Full and equal medical staff privileges in the facilities are not available. - Arrangements with these facilities are not administratively feasible. - The purchase of these services is more costly than if the HMO or CMP provided the services directly. §482.12(d)(5)	**Document Review** **General** ☐ Determine that the hospital's plan for capital expenditures has been submitted to the planning agency designated to review capital expenditures. In certain cases facilities used by HMO and CMP patients are exempt from the review process.
LD.13.01.05, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is prepared by representatives of the hospital's governing body, the administrative staff, and the medical staff under the direction of the governing body. The institutional plan is reviewed and updated annually. §482.12(d)(6)	**Document Review** **General** ☐ Verify that the plan and budget are reviewed and updated annually.
LD.13.01.05, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is prepared by representatives of the hospital's governing body, the administrative staff,	**Document Review** **General**

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and the medical staff under the direction of the governing body. The institutional plan is reviewed and updated annually. §482.12(d)(7)	☐ Verify that the governing body, administrative staff, and medical staff have participated in the development of the institutional plan and budget.
LD.13.03.03, EP 1: The hospital maintains a list of all contracted services, including the scope and nature of the services provided. §482.12(e); §482.12(e)(2) **LD.13.03.03, EP 2:** The governing body is responsible for all services provided in the hospital, including contracted services. The governing body assesses that services are provided in a safe and effective manner and takes action to address issues pertaining to quality and performance. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body makes certain that a contractor of services (including one for shared services and joint ventures) provides services that permit the hospital to that comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services. §482.12(e); §482.12(e)(1)	**Interview** ☐ Ask leaders and staff about procedures for monitoring care, treatment, and services furnished under contracts. ☐ Who is responsible for assessing contracted services to determine they are provided in compliance with the Medicare Conditions of Participation? ☐ Does the assessment process follow QAPI principles (identify problems, implement corrections/improvements, and monitor effect of corrections/improvement and for sustainability) and is it part of the QAPI program activities and reporting? ☐ Is the governing body kept apprised of the performance of contracted services? **Document Review** **General** ☐ Current list of services being furnished under contract including scope and nature of the services being provided. ☐ Procedures for assessing quality and effectiveness of contracted services. ☐ Current QAPI plan to ensure that every contracted service is evaluated.
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff	**Interview** ☐ Interview hospital staff at various locations. Can they state their duties and what they are to do if an individual seeks or needs emergency care at their location? ☐ Interview off-campus hospital department staff. Can they state their duties and what they are to do if an individual seeks emergency care?

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- Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations **§482.12(f)(2)** **LD.13.03.01, EP 8:** For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. **§482.12(f)(1)**	☐ Verify that the medical staff has adopted written policies and procedures for the management of medical emergencies 24 hours per day and 7 days per week. **Document Review** ☐ Review emergency care policies and procedures to determine they address the following: o Conducting appraisals of persons with emergencies. o Immediately available RN, as needed, to provide bedside care to any patient o Among such RN(s) who are immediately available at all times, there must be an RN(s) who is/are qualified, through a combination of education, licensure, and training, to conduct an assessment that enables them to recognize the fact that a person has a need for emergency care. o MD/DO (on-site or on-call) to directly provide appraisals of emergencies or provide medical direction of on-site staff conducting appraisals. o Providing the initial treatment needed by persons with emergency conditions. o Availability of an RN(s) who are qualified, through a combination of education, licensure, and training, to provide initial treatment to a person experiencing a medical emergency. o Identifying situations in which a person's emergency needs may exceed the hospital's capabilities and require transfer. o Patient transportation o Emergency procedures for all on-campus and off-campus locations.

Hospital Governing Body Evaluation Module Continued (Additional Joint Commission Requirements)

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LD.11.01.01, EP 3: The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff**.** **LD.11.01.01, EP 4:** Organized medical staff members are eligible for full membership in the hospital's governing body, unless legally prohibited.	**Document:** ☐ Review governing body meeting minutes to ensure that the medical staff is eligible for full membership of the governing body and is represented through attendance or voice
MS.17.01.03, EP 1: The governing body approves the credentialing process. **MS.17.01.03, EP 2:** The hospital verifies that the physician or other licensed practitioner requesting approval is the same person identified in the credentialing documents by viewing one of the following: - Current picture hospital ID card - Valid picture ID issued by a state or federal agency (for example, a driver's license or passport)	Documentation General ☐ Verify the governing body has approved the credentialing process Credential File Review ☐ Verify that the physician or other licensed practitioner requesting approval if verified by a photo
MS.17.02.01, EP 1: The hospital, based on recommendations by the organized medical staff and approval by the governing body, develops and implements criteria that determine if a physician or other licensed practitioner is allowed to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - Specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the hospital	**See survey process for 482.12(a)(6)**

MS.17.02.01, EP 2: The hospital has a clearly defined procedure approved by the organized medical staff for processing applications for the granting, renewal, or revision of clinical privileges. **MS.17.02.01, EP 3:** An applicant submits a statement that no health problems exist that could affect their ability to perform the privileges requested. **MS.17.02.01, EP 4:** The hospital queries the National Practitioner Data Bank (NPDB) in accordance with applicable law and regulation. **MS.17.02.01, EP 5:** Completed applications for privileges are acted on within the time period specified in the medical staff bylaws, rules, and regulations, or in policies and procedures. **MS.17.02.03, EP 2:** Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of clinical privileges. **MS.17.02.03, EP 3:** The hospital completes the credentialing and privileging decision process in a timely manner.	
PC.11.01.01, EP 1 The hospital develops and implements a written process for accepting a patient that addresses admission criteria and procedures for accepting referrals.	**Document Review** **General** Review written process for accepting patients that addresses admission criteria and procedures for accepting referrals.

Hospital Patient Rights Evaluation Module (482.13)

Joint Commission Standards / EPs	Hospital Survey Process
RI.11.01.01, EP 1: The hospital develops and implements written policies to protect and promote patient rights. **§482.13**	
RI.11.01.01, EP 2: The hospital informs each patient, or when appropriate, the patient's representative (as allowed, under state law) of the patient's rights in advance of providing or discontinuing patient care whenever possible. **§482.13(a)(1)**	**Interview** ☐ Ask staff how the hospital communicates information about patient rights to diverse patients, including individuals who need assistive devices or translation services. o Does the hospital have alternative means, such as written materials, signs, or interpreters (when necessary), to communicate patients' rights? ☐ Ask staff and patients or patients' representatives (as appropriate) to examine how the hospital determines whether the patient has a representative, who that representative is, and whether notice of patient rights is provided as required to patients' representatives. o Ask patients to describe what the hospital has told them about their rights. ☐ Does staff know what steps to take to inform a patient about their rights, including those patients with special communication needs? **Document Review** **General** ☐ Verify that the hospital has a policy for notifying all patients, both inpatient and outpatient, of their rights. **Note:** *Whenever possible, this notice must be provided before providing or stopping care.* ☐ Determine that the hospital's policy identifies when a patient has a representative and who that representative is, consistent with this guidance and state law. **Patient Health Record**

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	☐ Review a sample of patient health records to assess how the hospital communicates information about patient rights to diverse patients, including individuals who need assistive devices or translation services. ☐ Review records to examine how the hospital determines whether the patient has a representative, who that representative is, and whether notice of patient rights is provided as required to the patient's representative. ☐ Review a sample of inpatient medical records for Medicare beneficiaries to determine whether the records contain a signed and dated IM provided within 2 days of the admission of the patient. For patients whose discharge occurred more than 2 days after the initial "Important Message from Medicare" (IM) was issued, determine whether the hospital provided another copy of the IM to the patient prior to discharge in a timely manner.
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial	**Interview** ☐ Ask Medicare patients if they are aware of their right to appeal premature discharge. ☐ Ask a sample of patients or their legal representative if they know how to file a complaint (grievance) and who to contact if they have a complaint (grievance). ☐ Confirm that patients or their representative know they have the right to file a complaint with the state agency as well as or instead of using the hospital's grievance process. ☐ Confirm that the hospital provided the telephone number for the state agency to patients or their patient representatives. ☐ Ask if beneficiaries are aware of their right to seek review by the QIO for quality of care issues and coverage decisions and to appeal a premature discharge. **Document Review** **General** ☐ Confirm that the hospital has a process for prompt resolution of patient grievances and informs each patient whom to contact to file a grievance. ☐ Confirm that the grievance process includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate utilization and quality control quality improvement organization (QIO). ☐ Verify that the hospital's governing body approved the grievance process.

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treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations **§482.13(a)(2)** **RI.14.01.01, EP 1**: For hospitals that use Joint Commission accreditation for deemed status purposes: The process for resolving grievances includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. **§482.13(a)(2)** **RI.14.01.01, EP 2:** The hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance. **§482.13(a)(2)**	☐ Verify that the governing body is responsible for the effective operation of the grievance process and reviews and resolves grievances unless delegated in writing to a grievance committee. ☐ Review patient discharge materials. o Is the hospital in compliance with 42 CFR §489.27 (beneficiary notice of discharge rights)? o Does the hospital grievance process include a mechanism for timely referral of Medicare patient concerns to the QIO? What time frames are established? ☐ Determine how effectively the grievance process works. o Are patient's or the patient representative's concerns addressed in a timely manner? o Are patients informed of any resolution to their grievances? o Does the hospital apply what it learns from the grievance as part of its continuous quality improvement activities? ☐ Verify that the grievance process is reviewed and analyzed through the hospital's quality assurance/performance improvement or some other mechanism that provides oversight of the grievance process ☐ Review the hospital's policies and procedures to confirm that its grievance process encourages all personnel to alert appropriate staff concerning any patient grievance. **Note:** *A "patient grievance" is a formal or informal written or verbal complaint that is made to the hospital by the patient or the patient's representative about the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation, or a Medicare beneficiary billing issue related to rights and limitations provided by 42 CFR §489.* ☐ Confirm that the hospital adheres to its policy or procedure established for grievances. ☐ Verify that the hospital's process assures that grievances involving situations or practices that place the patient in immediate danger are resolved in a timely manner.
RI.14.01.01, EP 2: The hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit	**Interview** ☐ Ask a sample of patients or their representatives (if they are incapacitated) if they know about the grievance process and how to submit a grievance. **Document Review** **General**

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written or verbal grievances and specify timeframes for the review of and response to the grievance. §482.13(a)(2)(i)	☐ Confirm that the information provided to patients about the hospital's grievance procedures clearly explains how they submit either a verbal or written grievance.
RI.14.01.01, EP 2: The hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance. §482.13(a)(2)(ii)	**Document Review** **General** ☐ Confirm that the time frames established to review and respond to patient grievances are clearly explained in the information provided to patients explaining the hospital's grievance process. ☐ Verify that, on average, the hospital provides a written response to most of its grievances within the time frame specified in its policy. **Note:** *On average, a time frame of 7 days for the provision of the response would be considered appropriate. Not every grievance must be resolved during the specified time frame, although most should be resolved.*
RI.14.01.01, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In its resolution of grievances, the hospital provides the patient with a written notice of its decision, which contains the following: - Name of the hospital contact person - Steps taken on behalf of the individual to investigate the grievances - Results of the process - Date of completion of the grievance process §482.13(a)(2)(iii)	**Document Review** **General** ☐ Review the hospital's copies of written notices of its decision (responses to grievances) to patients to confirm that all patients are provided a written notice and that the notices comply with the requirements of §482.13(a)(2)(iii). **Note:** *The written notice of the hospital's determination regarding a grievance must be communicated to the patient or their representative in a language and manner the patient or their legal representative understands.*
PC.11.03.01, EP 2: The hospital involves the patient in the development and implementation of their plan of care. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed, in advance, of changes to their plan of care. §482.13(b)(1)	**Interview** ☐ Ask staff and patients or patients' representatives (as appropriate) if the hospital involves the patient or their representative (as appropriate) in the development and implementation of the plan of care. ☐ Verify that revisions in the plan of care were explained to the patient and/or their representative (when appropriate). **Document Review** **General**

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	☐ Confirm that the hospital has policies and procedures to involve the patient or their representative (as appropriate) in the development and implementation of their inpatient treatment/care plan, outpatient treatment/care plan, discharge plan, and pain management plan. ☐ Verify that the hospital's policies and procedures provide for determining when a patient has a representative who may exercise the patient's right to participate in developing and implementing their plan of care, as well as who that representative is, consistent with this guidance and state law. **Patient Health Record** ☐ Review a sample of patient health records to determine how the hospital involves the patient or their representative (as appropriate) in the development and implementation of their plan of care. ☐ Confirm that there is evidence that the patient or their representative was included or proactively involved in the development and implementation of their plan of care.
RI.12.01.01, EP 1: The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate. **§482.13(b)(2)**	**Interview** ☐ Ask current patients and/or hospital personnel to determine their understanding of the hospital's informed decision-making policies and how they are implemented. ☐ Determine whether patients or their representatives are provided adequate information about the patient's medical status, diagnosis, and prognosis and then are allowed to make informed decisions about their care planning and treatment. ☐ Determine whether informed consent prior to their non-emergency surgery, as applicable 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. ☐ Determine whether informed consent prior to an intimate/sensitive examination (such as breast, pelvic, prostate, and rectal exams) or invasive procedure without sedation or anesthesia 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,

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	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. **Document Review** **General** ☐ Confirm that there is a hospital policy addressing the patient's or the patient representative's (as appropriate) right to make informed decisions. ☐ Verify that the hospital's policy provides for determining when a patient has a representative who may exercise the patient's right to make informed decisions, as well as who that representative is, consistent with this guidance and state law. **Note:** *Hospitals are expected to take reasonable steps to determine the patient's wishes concerning designation of a representative.* ☐ Confirm that there is a hospital policy addressing the patient's right to have information on their medical status, diagnosis, and prognosis that articulates the hospital's process for ensuring that patients have this information. ☐ Review the hospital policy addressing how the patient will be involved in their care planning and treatment. ☐ Review the hospital policy for 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). **Patient Health Record** ☐ Review a sample of patient health records to determine whether patients or their representatives are provided adequate information about the patient's medical status, diagnosis, and prognosis and then are allowed to make informed decisions about their care planning and treatment. **Assessing Required Disclosures: Physician Ownership** **Interview** ☐ Ask staff whether the hospital furnishes its list of physician owners and investors at the time a patient or patient's representative requests it.

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	☐ Ask staff whether a physician-owned hospital's medical staff membership and admitting privileging requirements include a requirement that, as a condition of continued membership or admitting privileges, physician owners who refer patients to the hospital agree to provide written disclosure of their own or any immediate family member's ownership or investment interest to all patients at the time of the referral to the hospital. **Document Review** **General** ☐ *If the hospital is physician owned but not exempt from the physician ownership disclosure requirements:* o Verify that appropriate policies and procedures are in place to ensure that necessary written notices are provided to all patients at the beginning of an inpatient or outpatient stay. o Review the notice the hospital issues to each patient to verify that it discloses, in a manner reasonably designed to be understood by all patients, that the hospital meets the federal definition of "physician owned," that a list of owners and investors who are physicians or immediate family members of physicians is available upon request, and that such a list is provided to the patient at the time the request is made by or on behalf of the patient. o Review policies, procedures, and staff records to determine whether a physician-owned hospital's medical staff membership and admitting privileging requirements include a requirement that, as a condition of continued membership or admitting privileges, physician owners who refer patients to the hospital agree to provide written disclosure of their own or any immediate family member's ownership or investment interest to all patients at the time of the referral to the hospital. **Observation** ☐ Observe whether the hospital furnishes its list of physician owners and investors at the time a patient or patient's representative requests it. **MD/DO 24/7 On-Site Presence** **Interview** *For each required location where an MD/DO is not present:* ☐ Ask a sample of inpatients and affected outpatients whether they were provided notice about an MD/DO not being present at all times in the hospital.

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	Document Review **General** □ *For each required location where a doctor of medicine or osteopathy (MD/DO) is not present:* o Verify that the hospital has policies and procedures to ensure that a written notice stating an MD/DO is not present at all times is provided at the beginning of an inpatient stay or outpatient stay to all inpatients and all outpatients receiving observation services, surgery, or another procedure requiring anesthesia. o Review the written notice to verify that it indicates how the hospital will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present at that hospital, including any remote location or satellite. **Patient Health Record** □ Verify that there is signed acknowledgment by patients of receiving the written notice obtained by the hospital prior to the patient's admission or before applicable outpatient services were provided. **Observation** □ Observe whether an MD/DO is present in the hospital at each campus or satellite location providing inpatient services 24 hours a day, seven days a week. □ *For each required location where an MD/DO is not present:* o Verify that the hospital's emergency department has signage with the appropriate disclosure information about an MD/DO not being present at all times in the hospital.
RI.12.01.01, EP 5: Staff and licensed practitioners who provide care, treatment, or services in the hospital honor the patient's right to formulate advance directives and staff comply with these directives, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Law and regulation includes, at a minimum, 42 CFR 489.100, 489.102, and 489.104.	**Interview** □ Ask staff about their knowledge of the advance directives of the patients in their care. □ Ask patients about the hospital's process to allow them to formulate an advance directive or to update their current advance directive. □ Confirm that the hospital is promoting and protecting each patient's right to formulate an advance directive. **Document Review**

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§482.13(b)(3)	**General** ☐ Review the hospital's advance directive notice to confirm that it advises inpatients or applicable outpatients, or their representatives, of the patient's right to formulate an advance directive and to have hospital staff comply with the advance directive (in accordance with state law). ☐ Confirm that the notice includes a clear, precise, and valid statement of limitation if the hospital cannot implement an advance directive on the basis of conscience. At a minimum, a statement of limitation should do the following: • Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians or other practitioners. • Identify the state legal authority permitting such an objection. • Describe the range of medical conditions or procedures affected by the conscience objection. ☐ Review the hospital's process to allow patients to formulate an advance directive or update their current advance directive. ☐ Confirm that the hospital is promoting and protecting each patient's right to formulate an advance directive. ☐ Determine to what extent the hospital complies, as permitted under state law, with patient advance directives that delegate decisions about the patient's care to a designated individual. **Patient Health Record** ☐ Review a sample of patient health records for evidence of hospital compliance with advance directive notice requirements. ☐ Verify that every inpatient or applicable outpatient record contains documentation that notice of the hospital's advance directives policy was provided at the time of admission or registration and there is documentation of whether or not each patient has an advance directive. ☐ For those patients who have reported an advance directive, verify that a copy of the patient's advance directive been placed in the medical record.
RI.12.01.01, EP 2: The hospital asks the patient whether they want a family member, representative, or physician or other licensed practitioner notified of their admission to the hospital. The hospital promptly notifies the identified individual(s). Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the	**Interview** ☐ Interview staff who is responsible for providing notification of a patient's family or representative and physician when the patient is admitted as an inpatient. ☐ Ask them how they identify the persons to be notified and the means of notification and what they do in the case of an incapacitated person to identify a family member or representative and the patient's physician.

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notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. **§482.13(b)(4)**	**Document Review** **General** ☐ Verify that the hospital has policies that address notification of a patient's family or representative and physician when the patient is admitted as an inpatient. **Patient Health Record** ☐ Review a sample of inpatient medical records to confirm the following: 1. Evidence that the patient was asked about notifying a family member or representative and their physician 2. Record of when and how notice was provided 3. Evidence that the notice was provided promptly 4. Record of the patient declining to have notice provided to a family member or representative and their physician 5. Documentation of whether the patient was incapacitated at the time of admission and, if so, what steps were taken to identify a family member or representative and the patient's physician
RI.11.01.01, EP 5: The hospital respects the patient's right to personal privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, refer to Standard IM.12.01.01. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. **§482.13(c)(1)**	**Interview** ☐ Ask patients or their representatives if they are provided reasonable privacy during examinations or treatments, personal hygiene activities and discussions about their health status or care, and other appropriate situations. ☐ Ask staff about their understanding of the use of patient information in the facility directory. ☐ Confirm with staff that the policy addresses the opportunity for the patient or patient's representative to restrict or prohibit use of patient information in emergent and nonemergent situations. ☐ Ask staff if reasonable safeguards are used to reduce incidental disclosures of patient information. **Document Review** **General** ☐ Review hospital policy about the use of patient information in the facility directory.

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	○ Confirm that the policy addresses the opportunity for the patient or patient's representative to restrict or prohibit use of patient information in emergent and nonemergent situations. ☐ Determine if reasonable safeguards are used to reduce incidental disclosures of patient information. **Observation** ☐ Observe whether patients are provided reasonable privacy during examinations or treatments, personal hygiene activities and discussions about their health status or care, and other appropriate situations. ○ Observe whether reasonable safeguards are used to reduce incidental disclosures of patient information. ○ If audio and/or visual monitoring is used in the medical-surgical or intensive care unit setting, observe whether monitor screens and/or speakers are not readily visible or audible to visitors or the public. **Note:** *Audio/video monitoring (not include recording) of patients in medical-surgical or intensive care type units would not be considered violating the patient's privacy, as long as a clinical need exists, the patient or patient's representative is aware of the monitoring, and the monitors or speakers are located so that the monitor screens are not readily visible and speakers are not readily audible to visitors or the public. Video recording of patients undergoing medical treatment requires the consent of the patient or their representative.*
NPG.08.01.01, EP 1: For psychiatric hospitals and psychiatric unis in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). For nonpsychiatric units in hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital. Note: Nonpsychiatric units in hospitals do not need to be ligature	**Interview** ☐ Ask staff in patient care areas about their training ~~to identify risks in the care environment~~on assessment of the patient care environment upon hire, before providing patient care or working independently, and whenever policies and procedures are updated. ☐ Ask staff about processes to keep staff members current on meeting the needs of the patient population served and to identify risks in the environment. If risks are found, how does staff report those findings? ☐ Verify that the hospital uses a validated screening tool. ☐ Verify that the hospital uses an evidence-based process for conducting suicide assessments and reassessments. ☐ Ask staff how the hospital defines continuous visual observation or 1:1 ~~observation~~ monitoring in which a staff member is assigned to observe only one patient at all times.

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resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible). §482.13(c)(2) **NPG.08.01.01, EP 2:** The hospital screens all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool. Note: Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above. §482.13(c)(2) **NPG.08.01.01, EP 3:** The hospital uses an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation. §482.13(c)(2) **NPG.08.01.01, EP 4:** The hospital documents patients' overall level of risk for suicide and the plan to mitigate the risk for suicide. §482.13(c)(2) **NPG.08.01.01, EP 5:** The hospital follows written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following:	☐ In units where infants and children are inpatients, ask staff whether there are appropriate security protections (such as alarms, arm banding systems) in place, and confirm that they are functioning. ☐ Interview staff to verify processes are established to protect patients identified as at risk for suicide or harm to self or others and ensure care is provided in a safe setting. **Document Review** **General** ☐ Review and analyze patient and staff incident and accident reports to identify any incidents or patterns of incidents concerning a safe environment. Expand the review if ~~a~~ more widespread or pervasive problems with safe environment issues in the hospitals is suspected. ☐ Verify that the hospital has a policy or procedure ~~for defining continuous visual observation or 1:1 observation in which a staff member is assigned to observe only one patient at all times~~.to determine how the hospital defines continuous visual observation or 1:1 monitoring in which a staff member is assigned to observe only one patient at all times. ☐ Verify that the hospital has a policy or procedure for curtailing unwanted visitors, contaminated materials, or unsafe items that pose a safety risk to patients and staff. ☐ ~~Access~~ Assess the hospital's security efforts to protect vulnerable patients, including newborns, children, the elderly, and patients at risk of suicide or intentional harm to self or others. - Confirm that the hospital is providing appropriate security to protect patients and that appropriate security mechanisms are in place and being followed to protect patients. - Confirm that security mechanisms are based on nationally recognized standards of practice. ☐ Determine if the hospital has a policy for assessing and reassessing patients identified as being at risk for suicide or harm to self or others, according to nationally accepted standards of practice. ☐ Review policies **Observation** ☐ Observe patient care environments for unattended items, such as utility or housekeeping carts, that contain hazardous items that may pose a safety risk to patients, visitors, and staff.

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- Training and competence assessment of staff who care for patients at risk for suicide - Guidelines for reassessment - Monitoring patients who are at high risk for suicide **§482.13(c)(2)** **NPG.08.01.01, EP 7:** The hospital monitors implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and takes action as needed to improve compliance. **§482.13(c)(2)** **RI.11.01.01, EP 3:** The patient has the right to receive care in a safe setting. **§482.13(c)(2)**	☐ Observe units where infants and children are inpatients to determine whether appropriate security protections (such as alarms, arm banding systems) are in place and functioning. **Note:** *Examples of hazardous items include cleaning agents, disinfectant solutions, mops, brooms, and tools.*
RI.13.01.01, EP 1: The hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also protects the resident from misappropriation of property. **§482.13(c)(3)**	**Interview** ☐ Ask staff to identify various forms of abuse or neglect. ☐ Ask staff if they know what to do if they witness abuse or neglect. **Document Review** **General** ☐ Verify that the hospital has a system in place to protect patients from abuse, neglect, and harassment of all forms, whether from staff, other patients, visitors, or other persons. In particular, determine the extent to which the hospital does the following: o Staffing levels across all shifts are sufficient to care for individual patient's needs. o The hospital has a written procedure for investigating allegations of abuse and neglect, including methods to protect patients from abuse during investigations of allegations. o How does the hospital substantiate allegations of abuse and neglect? o Incidents of substantiated abuse and neglect result in appropriate action. o The hospital has implemented an abuse protection program that it is effective and complies with federal, state, and local law and regulation.

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	○ Appropriate agencies are notified in accordance with state and federal laws regarding incidents of substantiated abuse and neglect. ○ - Allegations of abuse and neglect are thoroughly investigated. ○ The hospital conducts criminal background checks as allowed by state law for all potential new hires. ○ The hospital does not employ people with a history of abuse, neglect, or harassment.
IM.12.01.01, EP 1: The hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Policies and procedures also address the resident's personal records. **§482.13(d)(1)**	**Interview** ☐ Ask staff to about their understanding of and compliance with the hospital's policies and procedures for protecting medical record information. **Document Review** **General** ☐ Verify that the hospital has policies and procedures addressing the protection of information in patients' medical records from unauthorized disclosures. **Observation** ☐ Observe locations where medical records are stored to determine whether appropriate safeguards are in place to protect medical record information.
RI.11.01.01, EP 6: The hospital provides the patient, upon an oral or written request, with access to medical records, including past and current records, in the form and format requested (including in electronic form or format when available). If electronic is unavailable, the medical record is provided in hard copy form or another form agreed to by the hospital and patient. The hospital does not impede the legitimate efforts of individuals to gain access to their own medical records and fulfills these electronic or hard-copy requests within a reasonable time frame (that is, as quickly as its recordkeeping system permits). **§482.13(d)(2)**	**Document Review** **General** ☐ Confirm that the hospital promotes and protects the patient's right to access information contained in their clinical record. ☐ Confirm that the hospital has a procedure for providing records to patients within a reasonable time frame. ☐ Determine whether the hospital's system frustrates the legitimate efforts of individuals to gain access to their own medical record. ☐ Verify that the procedure for providing records to patients includes a method to identify what documents were not provided and the reason.
RI.13.01.01, EP 1: The hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary	**Interview**

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seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also protects the resident from misappropriation of property. **§482.13(e)** **PC.13.02.01, EP 1:** The hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. **§482.13(e)**	☐ Ask staff who work directly with patients to determine their understanding of the restraint and seclusion policies. If any patients are currently in restraint or seclusion, determine the rationale for use and when the patient was last monitored and assessed. ☐ Confirm that the actual use of restraints or seclusion was consistent with hospital restraint and seclusion policies and procedures, as well as CMS requirements. ☐ Interview a sample of patients who were restrained to manage nonviolent, non-self-destructive behavior to determine whether the reasons for the use of a restraint to manage such behavior were explained to the patient in understandable terms. ☐ Confirm that the patient could articulate their understanding of the reasons for the use of restraint. **Document Review** **General** ☐ Review the restraint and seclusion policies and procedures to determine if they address, at a minimum the following: o Who has the authority to discontinue the use of restraint or seclusion (based on state law and hospital policies) o Circumstances under which restraint or seclusion should be discontinued. *Also see §482.13(e)(3)*. ☐ Review incident and accident reports to determine whether patient injuries occurred proximal to or during a restraint or seclusion intervention. Are incidents and accidents occurring more frequently with restrained or secluded patients? ☐ If record review indicates that restrained or secluded patients sustained injuries, determine what the hospital did to prevent additional injury. Did the hospital investigate possible changes to its restraint or seclusion policies? ☐ Review data on the use of restraint and seclusion for a specified time period (for example, 3 months) to determine any patterns in their use for specific units, shifts, days of the week, and so on. Did the number of patients who were restrained or secluded increase on weekends, on holidays, at night, on certain shifts, where contract nurses were used, or in one unit more than other units? **Note:** *Such patterns of restraint or seclusion use may suggest that the intervention is not based on the patient's need but on issues such as convenience, inadequate staffing, or lack of staff training. Obtain nursing staffing schedules during the time*

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	periods in question to determine if staffing levels impact the use of restraint or seclusion. **Patient Health Record** ☐ Review a sample of medical records of patients for whom restraints were used to manage nonviolent, non-self-destructive behavior, as well as a sample of medical records of patients for whom restraint or seclusion was used to manage violent or self-destructive behavior. ☐ Include in the review patients who are currently in restraint or seclusion, as well as those who have been in restraint or seclusion during their hospital stay (include both violent or self-destructive patients and nonviolent, non-self-destructive patients). ☐ Determine if there is evidence that hospital staff identified the reason for the restraint or seclusion and that other less restrictive measures would not be effective before applying the restraint.
PC.13.02.01, EP 4: The hospital restraint policies are followed when any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). **§482.13(e)(1)(i)(A); §482.13(e)(1)(i)(B); §482.13(e)(1)(i)(C)**	**Interview** ☐ Ask hospital staff whether they know the definition of a restraint. ☐ Ask hospital staff if they can identify when the use of a drug or medication is considered a chemical restraint. ☐ Ask hospital staff if they know the definition of a restraint, particularly with respect to use of bedside rails. **Document Review** **General** ☐ Determine whether the hospital's policy and procedures employ a definition or description of what constitutes a restraint that is consistent with the CMS regulation. ☐ Verify that the hospital's policies and procedures include a definition or description of what constitutes the use of drugs or medications as a restraint that is consistent with the CMS regulation. ☐ Verify that the hospital's policies and procedures include a definition or description of what constitutes a restraint that is consistent with the regulation. **Observation** ☐ While touring hospital units, look for restraints in use. Where a restraint is in use, check the medical record for appropriate documentation.

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	☐ While touring hospital units, look for bedside rail use to determine whether it is consistent with the definition of a restraint. Where bed side rails are being used as a restraint, check the medical record for appropriate documentation.
PC.13.02.01, EP 5: The hospital seclusion policies are followed when a patient is involuntarily confined alone in a room or area from which the patient is physically prevented from leaving. Note: Seclusion is only used for the management of violent or self-destructive behavior. **§482.13(e)(1)(ii)**	**Interview** ☐ Ask hospital staff if they know the definition of seclusion. **Document Review** **General** ☐ Verify that the hospital's policy and procedures include a definition or description of what constitutes seclusion that is consistent with the CMS regulation. **Observation** ☐ While touring hospital units, look for cases where a patient is in seclusion.
PC.13.02.01, EP 1: The hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. **§482.13(e)(2)**	**Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. ○ Confirm that the physician's or other practitioner's orders specify the reason for restraint or seclusion, the type of restraint, and the duration of restraint or seclusion. ○ Verify that the severity of the patient's behavior justifies seclusion or restraint usage by identifying an immediate and serious danger to the physical safety of the patient or others. ○ Confirm that the hospital considers factors other than the individual patient in determining causes for the need for restraints or seclusion (that is, environmental factors). ○ Review the medical record for documentation of an individual patient assessment and a revision of the plan of care. ○ Confirm that the medical record reflects changes in behavior and staff concerns regarding safety risks to the patient, staff, or others, prompting use of seclusion or restraints. ○ Verify that the patient's behavior placed the patient or others at risk for harm and that the patient's behavior was violent or self-destructive. ○ Determine if other, less restrictive interventions were tried and documented. Or is there evidence that alternatives were considered and determined to be insufficient?

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PC.13.02.01, EP 2: The hospital uses the least restrictive form of restraint or seclusion that will be effective to protect the patient, a staff member, or others from harm. **§482.13(e)(3)**	**Document Review** **General** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o Is there documentation in the record describing the steps or interventions used prior to the use of the needed restraint or seclusion? That is, what documentation is in the record to explain the rationale for the use of restraint or seclusion? o Confirm that there is documentation in the record showing that less restrictive measures were tried or considered. o Verify that the restraint or seclusion intervention was the least restrictive intervention to meet the patient's clinical needs and protect the safety of the patient, staff, or others. o Confirm that staff determined that less restrictive alternatives would not meet the patient's clinical needs or protect the patient's safety or the safety of others. o Verify that ongoing documented assessments demonstrate that the restraint or seclusion intervention was needed at that time (or at a time in the past) and that the restraint or seclusion intervention remained the least restrictive way to protect the patient's safety. o If the time of restraint or seclusion use was lengthy, look for evidence that the symptoms necessitating the use of restraint or seclusion persisted. Look for evidence indicating that staff evaluated whether the restraint or seclusion could be safely discontinued.
PC.13.02.03, EP 1: The hospital's use of restraint or seclusion meets the following requirements: - In accordance with a written modification to the patient's plan of care. - Implemented by trained staff using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation	**Document Review** **General** ☐ Verify that the hospital's procedures are consistent with the requirements of §482.13(e)(4)(i). ☐ Review the hospital's policies and procedures to determine if they reflect current standards of practice regarding safe and appropriate restraint and seclusion techniques. Are there any references to state law statutes or any indication state laws were reviewed and incorporated?

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§482.13(e)(4)(i); §482.13(e)(4)(ii)	**Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. ○ Does the plan of care or treatment reflect a process of assessment, intervention, and evaluation when restraint or seclusion was used? ○ Confirm that there is evidence of the assessment of the identified problem or of an individual patient assessment. ○ Verify that the patient's plan of care reflects that assessment. ○ Identify the goal of the intervention. ○ Identify the described intervention. ○ Confirm who is responsible for implementation. ○ Verify that the patient was informed of the changes in their treatment plan or plan of care. ○ Confirm that the physician or other practitioner wrote orders that included a time limit and that these orders were incorporated into the plan of care. ○ After the discontinuation of the restraint or seclusion intervention, confirm that this information was documented in an update of the plan of care or treatment plan. **Patient Health Record** ☐ Review a sample of health records for patients who required the use of restraint or seclusion for the management of both violent, self-destructive behaviors and non-violent, non-self-destructive behaviors. ○ Were restraints properly and safely applied? ○ After restraints were applied, was an assessment immediately made to ensure that the hospital's policies and procedures were followed? ○ Was the use of restraint or seclusion effective in achieving the purpose for which it was ordered? If not, were timely changes made? Was there any evidence of injury to the patient?
PC.13.02.05, EP 1: The hospital uses restraint or seclusion as ordered by a physician or other authorized licensed practitioner responsible for the patient's care in accordance with hospital policy and state law and regulation. §482.13(e)(5)	**Document Review** **General** ☐ Review hospital policies and medical staff bylaws to ensure that they include clinical practice guidelines describing the responsibilities of medical staff and clinicians who are privileged to order restraint and seclusion. ☐ Confirm that the hospital's written policies identify what categories of practitioners the state recognizes as a licensed practitioner or as having the authority to order restraint and seclusion.

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	☐ Verify that the hospital has written policies indicating which practitioners are permitted to order restraint or seclusion in the facility. ☐ Confirm that the hospital's written policies conform to state law. ☐ Determine whether the hospital has established policies for who can initiate restraint or seclusion. ☐ Confirm that the hospital uses protocols for the use of restraint or seclusion. If so, verify that the use of protocols is consistent with the requirements of the regulation. **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o Do records identify the physician or licensed practitioner who ordered each use of restraint or seclusion? o Was the order from the physician or licensed practitioner obtained prior to the initiation of restraint or seclusion? o When emergency application of restraint or seclusion was necessary, verify that the order from the physician or licensed practitioner was obtained immediately (within a few minutes) after application of the restraint or seclusion.
PC.13.02.05, EP 2: The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion. **§482.13(e)(6)**	**Document Review** **Patient Health Record** ☐ Review a sample of medical records for patients from whom restraint or seclusion as used. Review orders, progress notes, flow sheets, and nursing notes to do the following: o Verify that there is an order from a physician or other licensed practitioner for each episode of restraint or seclusion. o Evaluate patterns of use and verify that orders were obtained when necessary. o Verify that documentation specifically addresses the patients' behaviors or symptoms. o Determine if restraint or seclusion is being improperly implemented on a PRN basis. *Note: The use of standing or PRN orders for the use of restraint or seclusion is prohibited. The ongoing authorization of restraint or seclusion is not permitted. Each episode of restraint or seclusion must be initiated in accordance with the order of a physician or other licensed practitioner.*

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PC.13.02.05, EP 3: The attending physician is consulted as soon as possible, in accordance with hospital policy, if they did not order the restraint or seclusion. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **§482.13(e)(7)**	**Interview** ☐ Ask staff if actual practice is consistent with the hospital's policies and procedures for consulting with the attending physician if the attending physician did not order the restraint or seclusion. **Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o Is there documentation showing that the attending physician was notified if they did not order the restraint or seclusion and that the attending physician was notified "as soon as possible?" **General** ☐ Review the hospital's policies and procedures for consulting with the attending physician if the attending physician did not order the restraint or seclusion. ☐ Verify that hospital policies and procedures address the definition of "as soon as possible" based on the needs of their particular patient population(s). However, any established time frames must be consistent with "as soon as possible."
PC.13.02.05, EP 4: Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits: - 4 hours for adults 18 years of age or older - 2 hours for children and adolescents 9 to 17 years of age - 1 hour for children under 9 years of age Orders may be renewed according to the time limits for a maximum of 24 consecutive hours. **§482.13(e)(8)(i)**	**Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o When restraint or seclusion is used to manage violent or self-destructive behavior, confirm that the order for restraint or seclusion contains the appropriate time frames based on the patient's age and that the total number of hours covered by an order or its renewal does not exceed 24 hours. o If more restrictive state laws apply, verify that they are being followed in the order. o Each order may only be renewed in accordance with the following limits: ▪ 4 hours for adults 18 years of age or older ▪ 2 hours for children and adolescents 9 to 17 years of age ▪ 1 hour for children under 9 years of age

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	▪ If more restrictive state laws apply, verify that they are being followed in the order. o Confirm that a renewal order for restraint or seclusion is based on a comprehensive individual patient assessment. o Verify that there is evidence in the record that the symptoms necessitating the continued use of restraint or seclusion have persisted.
PC.13.02.05, EP 5: Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed practitioner responsible for the patient's care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation. **§482.13(e)(8)(ii)**	**Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o If restraint or seclusion was used to manage violent or self-destructive behavior for longer than 24 hours, confirm that there is documentation of a new written order, patient assessments, and a reevaluation by a physician or other licensed practitioner in the record. o Confirm that the documentation provides sufficient evidence to support the need to continue the use of restraint or seclusion and there is evidence in the record that the symptoms necessitating the continued use of restraint or seclusion have persisted. o Verify that the patient's plan of care or treatment plan addresses the use of restraint or seclusion. o Review the patient's documented clinical response to the continued need for restraint or seclusion.
PC.13.02.05, EP 6: Orders for restraint used to protect the physical safety of a nonviolent or non-self-destructive patient are renewed in accordance with hospital policy. **§482.13(e)(8)(iii)**	**Interview** ☐ Ask staff to confirm that actual practice is consistent with the policy on renewal of restraint orders for the management of nonviolent, non-self-destructive patient behavior. **Document Review** **General** ☐ Review the hospital's policy on renewal of restraint orders for the management of nonviolent, non-self-destructive patient behavior. **Patient Health Record** ☐ Review a sample of patient health records for documentation showing that actual practice is consistent with the policy on renewal of restraint orders for the management of nonviolent, non-self-destructive patient behavior.

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PC.13.02.01, EP 1: The hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. **§482.13(e)(9)**	**Interview** ☐ Ask staff whether they are aware that use of a restraint or seclusion must be discontinued as soon as is safely possible. **Document Review** **General** ☐ Confirm that the hospital has policies and procedures for ending restraint or seclusion and that the policies include a requirement to end the restraint or seclusion as soon as is safely possible. **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. Verify that the record contains evidence that the decision to continue or discontinue the use of restraint or seclusion was based on an assessment and a reevaluation of the patient's condition.
PC.13.02.07, EP 1: Physicians, other licensed practitioners, or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. **§482.13(e)(10)**	**Document Review** **General** ☐ Review the hospital's policies on assessment and monitoring of a patient in restraint or seclusion. o Verify that the hospital's monitoring policies are put into practice for all restrained or secluded patients. o Confirm that the policies identify which categories of staff are responsible for assessing and monitoring patients. o Verify that the policies include time frames for offering fluids and nourishment, toileting or elimination, range of motion, exercise of limbs, and systematic release of restrained limbs and that the time frames are documented in the patient's medical record. **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o Confirm that there was a valid rationale for the decision on the frequency of assessment and monitoring of a patient in restraint or seclusion documented in the medical record. o Verify that the documentation was consistent, relevant, and reflective of the patient's condition. o Verify the time frames for how often a patient is monitored for vital signs, respiratory and cardiac status, and skin integrity checks are documented.

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	○ Confirm that there is documentation of ongoing patient monitoring and assessment (for example, skin integrity, circulation, respiration, intake and output, hygiene, injury). ○ Determine whether the patient's mental status was assessed and that this was documented in the medical record. ○ Confirm that the patient was assessed for the continued need for the use of seclusion or restraint. ○ Verify that there was adequate justification for continued use of restraint or seclusion and that this is documented. ○ Determine whether the level of supervision was appropriate to meet the safety needs of patients who are at a higher risk for injury (for example, self-injurious, suicidal).
PC.13.02.09, EP 1: The hospital's policies and procedures regarding the use of restraint or seclusion include the following: - Definitions for restraint and seclusion that are consistent with state and federal law and regulation - Physician and other licensed practitioner training requirements - Staff training requirements - Who has authority to order restraint or seclusion - Who has authority to discontinue the use of restraint or seclusion - Who can initiate the use of restraint or seclusion - Circumstances under which restraint or seclusion is discontinued - Requirement that restraint or seclusion is discontinued as soon as is safely possible - Who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion **§482.13(e)(11)** **PC.13.02.09, EP 2:** Physicians and other licensed practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint or seclusion. **§482.13(e)(11)**	**Document Review** **General** ☐ Review the hospital's policy on restraint and seclusion training requirements for physicians and other licensed practitioners. Confirm that the hospital's minimum training requirements are addressed. **Personnel/Credential File** ☐ Review a sample of medical staff credentialing and privileging files to determine if physicians or other licensed practitioners involved in restraint and seclusion activities have completed the required training.

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PC.13.02.11, EP 1: A physician or other licensed practitioner responsible for the patient's care evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; if they are trained in accordance with the requirements in PC.13.02.17, EP 3. Note: The hospital also follows any state statute or regulation that may be more stringent than the requirements in this element of performance. **§482.13(e)(12) (i) (A) (B)**	**Interview** ☐ Ask staff if actual practice is consistent with the hospital's policy on the 1-hour face-to-face evaluation. **Document Review** **General** ☐ Review the hospital's policy on the 1-hour face-to-face evaluation. Identify which categories of practitioners the policy authorizes to conduct the evaluation. **Note:** *The 1-hour face-to-face patient evaluation must be conducted in person by a physician or other licensed practitioner or a trained registered nurse (RN) or physician assistant. A telephone call or telemedicine methodology is not permitted.*
PC.13.02.11, EP 2: The in-person evaluation is conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. The evaluation includes the following: - An evaluation of the patient's immediate situation - The patient's reaction to the intervention - The patient's medical and behavioral condition - The need to continue or terminate the restraint or seclusion **§482.13(e)(12)(ii)(A) (B) (C) (D)**	**Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. Confirm that the 1-hour face-to-face evaluation was conducted by a practitioner authorized by hospital policy in accordance with state law to conduct this evaluation. o If the 1-hour face-to-face evaluations were conducted by RNs who are not advanced practice nurses (APNs), verify that those RNs have documented training that demonstrates they are qualified to conduct a physical and behavioral assessment of the patient that addresses the following: 1. Patient's immediate situation 2. Patient's reaction to the intervention 3. Patient's medical and behavioral condition 4. Need to continue or terminate the restraint or seclusion ☐ Verify that documentation of the 1-hour face-to-face evaluation in the patient's medical record includes all the listed elements of this requirement. ☐ Determine whether the evaluation indicated that changes in the patient's care were required and, if so, the changes were made. **Observation** Confirm that actual practice is consistent with the hospital's policy on restraint and seclusion and state law.

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PC.13.02.11, EP 1: A physician or other licensed practitioner responsible for the patient's care evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; if they are trained in accordance with the requirements in PC.13.02.17, EP 3. Note: The hospital also follows any state statute or regulation that may be more stringent than the requirements in this element of performance. **§482.13(e)(13)**	**Document Review** **General** ☐ When preparing for the hospital survey, determine whether there are state provisions governing the use of restraint or seclusion that are more restrictive than those found in §482.13(e)(12)(i). ☐ When state requirements are more restrictive, apply those requirements instead of those found in §482.13(e)(12)(i).
PC.13.02.11, EP 3: When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse, they consult with the attending physician or other licensed practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy. **§482.13(e)(14)**	**Document Review** **General** ☐ Review the hospital's restraint and seclusion policy to confirm that it clarifies expectations regarding the "as soon as possible" requirement. **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. Verify that documentation in the records indicate consultation with the attending physician or other licensed practitioner when the 1-hour face-to-face evaluation was conducted by a trained RN or PA. **Observation** ☐ Confirm that actual practice is consistent with the hospital's restraint and seclusion policy.
PC.13.02.13, EP 1: The patient who is simultaneously restrained and secluded is continually monitored by trained staff, either in person or through the use of both video and audio equipment that is in close proximity to the patient. Note: In this element of performance continually means ongoing without interruption. **§482.13(e)(15)(i) (ii)**	**Interview** ☐ Ask staff if actual practice is consistent with the hospital's policy on simultaneous use of restraint and seclusion and if uninterrupted audio/visual monitoring is provided as required. ☐ Ask whether the staff member monitoring the patient with audio/video equipment was trained in such monitoring. **Document Review** **General**

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	☐ Review the hospital's policy on simultaneous use of restraint and seclusion to determine whether it provides for continual monitoring and otherwise complies with all requirements of §482.13. ☐ Review documents to determine if actual practice is consistent with the hospital's policy and if uninterrupted audio/visual monitoring is provided as required. **Observation** ☐ Determine if actual practice is consistent with the hospital's policy and if uninterrupted audio/visual monitoring is provided as required. ☐ Confirm that audio/visual monitoring equipment is appropriately maintained and in working condition. ☐ Observe whether the staff member monitoring the patient with audio/video equipment was trained in such monitoring and is in close proximity to ensure prompt emergency intervention if a problem arises. ☐ Ensure that the video equipment covers all areas of the room or location where the patient is restrained or secluded. ☐ Observe whether the audio/video equipment is located in an area that ensures patient privacy.
PC.13.02.15, EP 1: Documentation of restraint or seclusion in the medical record includes the following: - The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior - Description of the patient's behavior and the intervention used - Alternatives or other less restrictive interventions attempted (as applicable) - Patient's condition or symptom(s) that warranted the use of the restraint or seclusion - Patient's response to the intervention(s) used, including the rationale for continued use of the intervention **§482.13(e)(16)(i) (ii) (iii) (iv) (v)**	**Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o Confirm that records include documentation of the1-hour face-to-face medical and behavioral evaluation when restraint or seclusion is used to manage violent or self-destructive behavior. o Confirm that the records include a clear description of patient behaviors that warranted the use of restraint or seclusion. o Verify that the intervention employed was appropriate for the identified behavior. o Identify the patient's clinical response to the intervention(s). o Review a sample of health records for patients for whom restraint or seclusion was used. Confirm that the records document any alternatives or less restrictive interventions attempted by staff, if appropriate. o Review the effect of less restrictive interventions, if attempted by staff. o Determine whether the interventions selected were appropriate to the targeted patient behaviors.

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	○ When an immediate and serious danger to the patient or others occurred, determine whether the more restrictive intervention(s) was effective. ○ Assess whether a less restrictive intervention could have been used to ensure the safety of the patient, staff, or others. ○ Confirm that the records include descriptions of the patient's condition or symptom(s) that warranted the use of restraint or seclusion. ○ Confirm that the records include descriptions of the impact of the intervention on the patient behavior that resulted in the use of restraint or seclusion. ○ Verify that the records include a detailed assessment of the patient's response to the intervention and a well-reasoned plan for the continued use of restraint or seclusion.
PC.13.02.03, EP 1: The hospital's use of restraint or seclusion meets the following requirements: - In accordance with a written modification to the patient's plan of care. - Implemented by trained staff using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation **§482.13(f)**	**Document Review** **General** ☐ Verify that the hospital has a staff training and education program that protects the patient's right to safe implementation of restraint or seclusion. **Observation** ☐ Observe patients in restraint or seclusion to verify safe application of the restraint or seclusion.
PC.13.02.17, EP 1: The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals: - At orientation - Before participating in the use of restraint or seclusion - On a periodic basis thereafter, as determined by hospital policy **§482.13(f)(1) (i) (ii) (iii)**	**Document Review** **General** ☐ Confirm that the hospital has a documented training program for the use of restraint and seclusion interventions employed by staff at the hospital. ☐ Verify that the hospital has documented evidence that all levels of staff, including agency or contract staff, who have direct patient care responsibilities and any other individuals who may be involved in the application of restraints (for example, security guards) have been trained and can demonstrate competency in the safe use of seclusion and the safe application and use of restraints. **Personnel/Credential File** ☐ Review a sample of personnel files to verify restraint and seclusion education staff training documentation for all new employees and contract staff. ☐ Confirm that the training included demonstration of required competencies.

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	☐ Identify the topic areas that were included in this training program. ***Note:*** *Verify that staff competency was demonstrated initially as part of orientation and subsequently on a periodic basis consistent with hospital policy. Hospitals have the flexibility to identify a timeframe for ongoing training based on the level of staff competency, and the needs of the patient population(s) served.*
PC.13.02.17, EP 3: Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion - Use of nonphysical intervention skills - Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition - Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia) - Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion - Use of first aid techniques and certification in the use of cardiopulmonary resuscitation (CPR), including required periodic recertification **§482.13(f)(2) (i) (ii) (iii) (iv) (v) (vi) (vii)**	**Interview** ☐ Ask staff about their knowledge of the restraint and seclusion techniques addressed in §482.13(f)(2)(i). ☐ Ask staff about their nonphysical intervention skills. ☐ Ask staff if they are able to assess the patient to determine the least restrictive intervention as described in §482.13(f)(2)(iii). ☐ Verify that staff are able to identify signs of physical and psychological distress in a timely manner. ☐ Confirm that staff are able to respond to and appropriately treat signs of physical and psychological distress. ☐ Ask staff if they are able to identify specific behavioral changes that indicate that restraint or seclusion is no longer necessary as described in §482.13(f)(2)(v). ☐ Ask staff if they are able to demonstrate the competencies addressed in §482.13(f)(2)(vi). **Document Review** **General** ☐ Confirm that the hospital's educational program on restraint and seclusion includes techniques related to the specific patient populations being served. ☐ Determine whether the program provides more in-depth training for restraint and seclusion for staff members who routinely provide care to patients who exhibit violent or self-destructive behavior (for example, staff who work in the emergency department or psychiatric unit). ☐ Verify that the program includes techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion. ☐ Verify that the hospital's educational program on restraint and seclusion addresses the use of nonphysical intervention skills. • Confirm that the program complies with §482.13(f)(2)(ii).

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	☐ Confirm that the hospital's educational program on restraint and seclusion addresses choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition. • Verify that the program addresses how to conduct an assessment of a patient's medical and behavioral conditions. • Determine whether the program addresses types of interventions appropriate to the specific needs of the patient population(s) served and ranging from less to more restrictive. ☐ Confirm that the hospital's educational program on restraint and seclusion addresses recognition and response to patient signs of physical and psychological distress. ☐ Review hospital data (that is, incident reports, patient injury or death reports) to identify any patterns of patient injuries or death that may indicate that staff are not adequately trained to recognize and respond to patient signs of physical and psychological distress. ☐ Confirm that the hospital's educational program on restraint and seclusion addresses identification of specific behavioral changes that may indicate that restraint or seclusion is no longer necessary. ☐ Confirm that the hospital's educational program on restraint and seclusion addresses monitoring the physical and psychological needs of patients who are restrained or secluded, including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation. ☐ Verify that the program addresses the specific requirements for the training of RNs and PAs that the hospital authorizes to conduct the 1-hour face-to-face evaluation. ☐ Confirm that the hospital's educational program on restraint and seclusion addresses first aid techniques. ☐ Determine whether the program includes, or provides for, staff training and certification in cardiopulmonary resuscitation (including provisions for recertification). ***Note:*** *The hospital is expected to provide education and training at the appropriate level to the appropriate staff based upon the specific needs of the patient population being served. For example, staff routinely providing care for patients who exhibit violent or self-destructive behavior that jeopardizes the immediate*

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	physical safety of the patient, a staff member, or others (such as in an emergency department or on a psychiatric unit) generally require more in-depth training about restraint and seclusion than staff routinely providing medical/surgical care. **Personnel/Credential File** ☐ Determine if all staff, including contract or agency personnel, identified by the hospital as direct caregivers are trained and able to demonstrate competency in the safe use of all types of restraints or seclusion used in the hospital. ☐ Verify that appropriate staff are certified in cardiopulmonary resuscitation.
PC.13.02.17, EP 4: Individuals providing staff training in restraint or seclusion are qualified as evidenced by education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion. **§482.13(f)(3)**	**Document Review** **Personnel/Credential File** ☐ Review personnel files of individuals responsible for providing staff education and training to determine whether the individuals providing the education and training possess education, training, and experience to teach the staff. ☐ Are they qualified to identify and meet the needs of the patient population(s) being served? ☐ Does the hospital have a system for documenting and ensuring that the individuals providing education and training have the appropriate qualifications required by §482.13(f)(3)?
PC.13.02.17, EP 5: The hospital documents in staff records that they have completed restraint and seclusion training and demonstrated competence. **§482.13(f)(4)**	**Document Review** **Personnel/Credential File** ☐ Review a sample of staff personnel records, including contract or agency staff, to determine if the training and demonstration of competency for restraint and seclusion have been completed during orientation and on a periodic basis consistent with hospital policy.
PC.13.02.19, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death	☐ **Interview** Ask staff about their knowledge of the hospital's death reporting policy. **Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §482.13(g). ☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following:

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Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation. **§482.13(g)**	o Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion o Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion o Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were reported to CMS. Does documentation include the date and time the death was reported to CMS?
PC.13.02.19, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record. **§482.13(g)(1)**	**Interview** ☐ Ask staff in various types of inpatient units, including a psychiatric unit if applicable, if they are aware of any patients who died while in restraints or seclusion or within one day of restraint or seclusion discontinuation, excluding cases involving only the use of two-point soft wrist restraints and no seclusion. If yes, determine whether the hospital has any evidence that these cases were reported to CMS. **Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths reportable to CMS and for implementing the reporting and recordkeeping requirements. ☐ Can the hospital provide examples of restraint- or seclusion-associated deaths that were reported to CMS? o If yes, review the report and medical records to determine whether the following occurred: • The reports met the criteria for reporting to CMS. • The reports were submitted in a timely fashion to CMS. • The reports were complete.

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	• The date and time the death reported to CMS was entered into the patient's medical record. o If no, do the following: • Ask how the hospital ensures that there were no reportable restraint- or seclusion-associated deaths. • If the hospital's system relies on staff identification of reportable deaths, interview several applicable staff members to determine if they are aware of the hospital's policy and know when and where to internally report a restraint- or seclusion-associated death. Ask if there have been any patient deaths that met the reporting requirements.
PC.13.02.19, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion : - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation. **§482.13(g)(1)(i) (ii) (iii)**	**Interview** ☐ Ask staff about their knowledge of the hospital's death reporting policy. **Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §482.13(g). ☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following: o Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion o Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion o Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were report to CMS. Does documentation include the date and time the death was reported to CMS?
PC.13.02.19, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has	**Interview**

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been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request **§482.13(g)(2) (i) (ii)**	☐ Ask inpatient unit staff if they have had patients die while 2-point soft wrist restraints are being used without seclusion or within 24 hours of their discontinuance. If yes, ask the hospital to demonstrate that it has recorded such deaths. ☐ If the hospital's log or tracking system relies on staff identification of reportable deaths, interview several applicable staff members to determine if they are aware of the hospital's policy and know when and where to report internally a restraint- or seclusion-associated death. **Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths that must be recorded in an internal hospital log or tracking system and for implementing the reporting and recordkeeping requirements. ☐ Verify how the hospital ensures that each death that must be captured in the log or tracking system is identified and entered. ☐ Review the log/tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if the following requirements were met o Each entry was made within 7 days of the patient's death o Each entry contains all the information required under the regulation. ☐ Confirm that the hospital is able to make the log or tracking system available immediately on request. **Patient Health Record** ☐ Review a sample of medical records of patients whose deaths were entered in the log or tracking system. o Confirm that the medical record indicates that only soft, 2-point wrist restraints were used. ☐ Verify that there is documentation in the medical record of the entry into the log or tracking system.
PC.13.02.19, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed	**Interview** ☐ Ask staff about their knowledge of the hospital's death reporting policy.

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in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record. **§482.13(g)(3)(i)**	**Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §482.13(g). ☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following: o Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion o Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion o Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were reported to CMS. Does documentation include the date and time the death was reported to CMS?
PC.13.02.19, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system	**Interview** ☐ Ask inpatient unit staff to determine whether they have had patients die while 2-point soft wrist restraints are being used without seclusion or within 24 hours of their discontinuance. If yes, ask the hospital to demonstrate that it has recorded such deaths. ☐ If the hospital's log or tracking system relies on staff identification of reportable deaths, interview several applicable staff members to determine whether they are aware of the hospital's policy and know when and where to report internally a restraint- or seclusion-associated death. **Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths that must be recorded in an internal

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- Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request **§482.13(g)(3)(ii)**	hospital log or tracking system and for implementing the reporting and recordkeeping requirements. ☐ Determine how the hospital ensures that each death that must be captured in the log or tracking system is identified and entered. ☐ Review the log or tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if the following requirements were met: o Each entry was made within 7 days of the patient's death. o Each entry contains all the information required under §482.13(g). ☐ Confirm that the hospital is able to make the log or tracking system available immediately on request. **Patient Health Record** ☐ Review a sample of medical records of patients whose deaths were entered in the log or tracking system. o Confirm that the medical record indicates that only 2-point soft wrist restraints were used. o Determine whether there is documentation in the medical record of the entry into the log or tracking system.
PC.13.02.19, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed	**Interview** ☐ Ask inpatient unit staff whether they have had patients die while 2-point soft wrist restraints are being used without seclusion or within 24 hours of their discontinuance. If yes, ask the hospital to demonstrate that it has recorded such deaths. ☐ If the hospital's log or tracking system relies on staff identification of reportable deaths, interview several applicable staff members to determine whether they are aware of the hospital's policy and know when and where to report internally a restraint- or seclusion-associated death. **Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths that must be recorded in an internal hospital log or tracking system and for implementing the reporting and recordkeeping requirements.

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practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request **§482.13(g)(4)(i) (ii) (iii)**	☐ Verify that the hospital ensures that each death that must be captured in the log or tracking system is identified and entered. ☐ • Review the log or tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if the following requirements were met: o Each entry was made within 7 days of the patient's death. o Each entry contains all the information required under the regulation. ☐ Confirm that the hospital is able to make the log or tracking system available immediately on request. **Patient Health Record** ☐ Review a sample of medical records of patients whose deaths were entered in the log or tracking system. ☐ Confirm that the medical record indicates that only 2-point soft wrist restraints were used. ☐ Determine whether there is documentation in the medical record of the entry into the log or tracking system. ☐ Confirm that each entry in the patient's medical record related to any death that occurs while a patient in is restraints or any death that occurs within 24 hours after a patient has been removed from such restraints was made no later than 7 days after the date of death of the patient. ☐ Confirm that each entry in the patient's medical record related to any death that occurs while a patient in is restraints or any death that occurs within 24 hours after a patient has been removed from such restraints documents the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es). ☐ Verify that information about any death that occurs while a patient in is restraints or any death that occurs within 24 hours after a patient has been removed from such restraints is made available in either written or electronic form to CMS immediately upon request.
RI.11.01.01, EP 7: The hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The	**Interview** ☐ Determine whether hospital staff are aware of the hospital's visitation policies and procedures and confirm that staff on a given unit can correctly describe the policies for that unit.

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patient also has the right to withdraw or deny such consent at any time. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies and procedures include any restrictions or limitations that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights. **§482.13(h); §482.13(h)(1); §482.13(h)(2)**	☐ Ask staff responsible for providing the required notice of the patient's visitation rights how they accomplish this. Ask staff if they are familiar with the concept of a patient's "support person" and what it means. ☐ Ask a sample of current hospital patients or patients' support persons (where appropriate) whether they were provided notice of their right to have visitors. Ask if they were able to have visitors when they wanted to. If not, verify that the restriction or limitation on visitors was addressed in the hospital's visitation policies and notice and does not violate the regulations at §482.13(h)(3&(4). (See interpretive guidelines for the latter provisions.) ☐ Ask a sample of current hospital patients or patients' support persons (where appropriate) if the hospital failed to limit some or all visitors, contrary to the patient's wishes. **Document Review** **General** ☐ Verify that the hospital has written policies and procedures that address the right of patients to have visitors. ☐ Review the policy to determine if there are limitations or restrictions on visitation. If so, confirm that the policy explains the clinical rationale for the restrictions or limitations and that the rationale is clear and reasonably related to clinical concerns. ☐ Confirm that there is documentation of how the hospital identifies and trains staff who play a role in facilitating or controlling access of visitors to patients. ☐ Determine whether the hospital's visitation policies and procedures require providing notice of the patient's visitation rights to each patient or, if appropriate, to the patient's support person and/or, as applicable, the patient's representative. **Note:** *A patient's "support person" does not necessarily have to be the same person as the patient's representative who is legally responsible for making medical decisions on the patient's behalf. A support person could be a family member, a friend, or another* *individual who supports the patient during the course of the hospital stay. Hospitals must accept a patient's designation, orally or in writing, of an individual as the patient's support person.* ☐ Review the hospital's standard notice of visitation rights to confirm that it clearly explains the following:

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	○ Hospital's visitation policy, including any limitations or restrictions, such as visiting hours, numbers of visitors, or unit-specific restrictions, and the clinical rationale for such limitations or restrictions ○ Right of the patient to have designated visitors, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and the right to withdraw or deny consent to visitation **Patient Health Record** ☐ Review a sample of medical records to determine if there is documentation that the required notice of the patient's visitation rights was provided. How was the notice provided?
RI.11.01.01, EP 4: The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges. The hospital allows all visitors to have full and equal visitation privileges consistent with patient preferences. **§482.13(h)(3); §482.13(h)(4)**	**Interview** ☐ Ask the hospital how it educates staff to ensure that visitation policies are implemented in a nondiscriminatory manner. ☐ Ask staff how about the education they received to ensure that visitation policies are implemented in a nondiscriminatory manner. ☐ Ask hospital staff who play a role in facilitating or controlling visitors to discuss their understanding of the circumstances under which visitors may be subject to restrictions or limitations and whether the restrictions or limitations are appropriately based on the hospital's clinically based policies. ☐ Ask hospital patients (or patients' support persons, where appropriate) whether the hospital has restricted or limited visitors against their wishes. If yes, verify whether the restriction or limitation on visitors was addressed in the hospital's visitation policies and in the patient notice and whether it was appropriately based on a clinical rationale rather than impermissible discrimination. **Document Review** **General** ☐ Review the hospital's visitation policies and procedures to determine whether they restrict, limit, or otherwise deny visitation to individuals on a prohibited basis.

Hospital Patient Rights Evaluation Module (Additional Joint Commission Requirements)

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RI.15.01.01, EP 1: The hospital develops and implements a written policy that defines patient responsibilities, including but not limited to the following: - Providing information that facilitates their care, treatment, and services - Asking questions or acknowledging when they do not understand the treatment course or care decision - Following instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals in the hospital - Supporting mutual consideration and respect by maintaining civil language and conduct in interactions with staff - Meeting financial commitments **RI.15.01.01, EP 2:** The hospital informs the patient about the patient's responsibilities in accordance with its policy. Note: Information about patient responsibilities can be shared verbally, in writing, or both.	**Document Review:** ☐ Review the policy regarding patient rights and verify that it addresses the following list in EP 1. **Patient Medical Record/or Interview:** ☐ Verify the patient has been notified of their rights

Hospital Quality Assessment and Performance Improvement Evaluation Module (482.21)

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LD.11.01.01, EP 8: The governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital's organization and services; involve all departments and services including services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. (For more information on contracted services, see Standard LD.13.03.03) Note: For hospitals that do not use Joint Commission accreditation for deemed status purposes: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities. **§482.21** **LD.12.01.01, EP 1:** The hospital develops, implements, maintains, and documents an effective, ongoing, data-driven, hospitalwide quality assessment and performance improvement program. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains and demonstrates evidence of its QAPI program for review by CMS. **§482.21** **PI.14.01.01, EP 1:** The hospital acts on improvement priorities. **§482.21**	**Document Review** ☐ Quality assurance/performance improvement (QAPI) program documents to verify the program meets the following requirements: ○ Includes processes for systematically examining the quality of care delivered and implementing specific improvement projects on an ongoing basis ○ Facilitates the continuous study and improvement of processes and service delivery ○ Takes a proactive approach to improve their performance ○ Is based on, and reflects, the size and complexity of the organization and services ○ Is hospitalwide (including services under contract or arrangement).[3] ▪ All hospital departments and services are included in the QAPI program ▪ Documentation shows participation by all contracted services ▪ Written contracts include QAPI requirements and roles and responsibilities of the contractor ○ Is data driven ▪ Documentation indicates which data are used to make QAPI program decisions ○ Focuses on quality indicators or measures related to improved health outcomes, as well as the prevention and reduction of medical errors ▪ Does the program focus on nonclinical measures, such as employee satisfaction data, as opposed to clinical measures, such

[3] While it is not expected that all departments and services be continuously engaged in large scale or resource-intensive QAPI projects, all departments and services (including those provided under arrangement or contract) should provide evidence that there is continuous monitoring of the quality and safety of the services provided and take corrective actions as necessary to ensure patient safety and to improve the quality of care provided.

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	as infection control incidence rates and/or nationally recognized quality indicators? □ Evidence of continuous data collection, data analysis (with identified areas for improvement), and implementation of changes, including ongoing monitoring of changes for effectiveness. □ Evidence that the governing body is engaged in oversight of QAPI program □ Evidence of services provided under an arrangement or contract are included in its QAPI program.
LD.12.01.01, EP 2: As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities related to health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas - Identify the frequency and detail of data collection for performance improvement activities **§482.21(b)(3);** **PI.11.01.01, EP 2:** The hospital has an ongoing quality assessment and performance improvement program that shows measurable improvement for indicators that are selected based on evidence that they will improve health outcomes and aid in the identification and reduction of medical errors. The program incorporates quality indicator data, including patient care data and other relevant data to achieve the goals of the program. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Relevant data includes data submitted to or received from Medicare quality reporting and quality performance	**Interview** □ Ask QAPI staff to provide a list of the quality indicators they are currently tracking. Verify that the o List includes the tracking of adverse events. o Quality indicator data include patient care data and other relevant data, such as that received from Medicare quality reporting (hospital readmissions and hospital-acquired conditions) and performance programs. o Quality indicators are reflective of the hospital's patient population. □ Ask QAPI staff to provide evidence (measurement data) of measurable improvements in the quality indicators it has selected for its program. o Verify that improvements are ongoing (several data analyses showing improvement over time) and not just one-time events. o If the evaluation did not show improvements or sustained improvements, is there evidence that the hospital implemented a revised or new solution? □ Ask to see evidence that the governing body has specified the frequency and detail of QAPI program data collection.[4]

[4] ***Governing body responsibility for frequency and detail of data collection*** *The governing body is responsible for specifying the frequency and the detail of the data collection, which may include, but is not limited to, what data will be collected, what the data is intended to measure, in what areas of the hospital*

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programs including but not limited to data related to hospital readmissions and hospital-acquired conditions. **§482.21(a)(1); §482.21(b)(1)** **PI.12.01.01, EP 3:** The hospital measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations. **§482.21(a)(2)** **PI.13.01.01, EP 1:** The hospital analyzes and compares internal data over time and uses the results of data analysis to do the following: - Monitor the effectiveness and safety of services - Monitor the quality of care - Identify opportunities for improvement and changes that will lead to improvement **482.21(b)(2)(i); 482.21(b)(2)(ii)**	○ Look at governing body meeting minutes. ○ Do QAPI program reviews include this information? □ Verify that the hospital is using the data being collected to monitor the safety and quality of care. ○ Select a sample of data being collected and ask the governing body or other appropriate leaders to explain how the collection of the particular data is used to monitor quality and safety. □ Verify that the hospital is using the data being collected to identify opportunities for improvement. ○ Select a sample of data being collected and ask the governing body or other appropriate leaders to give examples of how the specific data has identified opportunities for improvement. ○ Ask to see documented evidence of the opportunities the hospital has identified for improvement based on the collection of data.
LD.12.01.01, EP 2: As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities related to health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas - Identify the frequency and detail of data collection for performance improvement activities	**Interview** Ask QAPI leaders or staff to see □ A list of current or recent performance improvement activities. ○ Ask about the actions taken, post action measurement to determine improvement, and measurement to determine sustained improvement. □ Evidence that the hospital tracks data for the identified indicators, which may include but are not limited to blood product transfusion reactions,

the data will be collected, and how frequently the various types of data will be collected. This does not mean that the governing body is expected to have a high degree of technical expertise in the area of quality data collection. However, the governing body must have information that describes the hospital's QAPI data collection program in sufficient detail so that the governing body is able to determine what program data requirements to approve. There must be evidence that the governing body has had an active role in the development and ongoing planning of the frequency and detail of QAPI data collection. Such evidence may be documentation in the governing body meeting minutes that it has reviewed and approved the frequency and detail of the QAPI data collection program.

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§482.21(c)(1)(i); §482.21(c)(1)(ii); §482.21(c)(1)(iii) **PI.12.01.01, EP 4:** The hospital takes action to improve its performance. After implementing changes, the hospital measures its success, and tracks performance to ensure that improvements are sustained. §482.21(c)(3) **PI.13.01.01, EP 1:** The hospital analyzes and compares internal data over time and uses the results of data analysis to do the following: - Monitor the effectiveness and safety of services - Monitor the quality of care - Identify opportunities for improvement and changes that will lead to improvement §482.21(b)(2)(ii) **PI.14.01.01, EP 1:** The hospital acts on improvement priorities. §482.21(c)(3)	drug reactions, errors in medication administration, and infection control–related errors and events. Ask the governing body or the leaders who oversee the QAPI program to provide evidence □ That its improvement activities are focused on high-risk, high-volume, or problem-prone areas. o Does it have any data (either derived from its own QAPI data collection or public data) on incidence, prevalence, or severity to support its choices? o Does it have evidence that the activities affect health outcomes through improving quality of care or patient safety? □ QAPI activities that were initiated based on data reported through the medical error/adverse event tracking system.
PI.11.01.01, EP 2: The hospital has an ongoing quality assessment and performance improvement program that shows measurable improvement for indicators that are selected based on evidence that they will improve health outcomes and aid in the identification and reduction of medical errors. The program incorporates quality indicator data, including patient care data and other relevant data to achieve the goals of the program. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Relevant data includes data submitted to or received from Medicare quality reporting and quality performance programs including but not limited to data related to hospital readmissions and hospital-acquired conditions. §482.21(a)(1) **PI.12.01.01, EP 1:** The hospital tracks medical errors and adverse patient events, analyzes their causes, and implements preventive	**Interview** □ Interview staff in various units to assess their understanding of identifying and reporting medical errors and adverse events. **Document Review** **General** □ Verify that the hospital has a medical error and adverse patient event reporting policy. □ Select a sample of several **(at least three)** adverse events or errors the hospital has tracked and ask to see written evidence showing that it has used a systematic approach (for example, root cause analysis) to o Analyze the cause of the events and errors, o Implement changes based on the identified causes to prevent further events or errors,

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actions and mechanisms that include feedback and learning throughout the hospital. Medical errors and adverse patient events include but are not limited to the following: - Medication administration errors - Surgical errors - Equipment failure - Infection control errors - Blood transfusion-related errors - Diagnostic errors **§482.21(c)(2)** **PI.12.01.01, EP 3:** The hospital measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations. **§482.21(a)(2)** **LD.12.01.01, EP 3:** The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for the following: - An ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained - The hospitalwide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated - Clear expectations for safety are established - Adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients - The determination of the number of distinct improvement projects is conducted annually **§482.21(e)(3)**	○ Conduct periodic data collection to verify if the changes resulted in improvements, and ○ Analyze the post-implementation data to assess whether the improvement (if there was an improvement) was sustained over time. **Observation** □ Look for evidence of the medical error/adverse event reporting system. □ Ask QAPI staff for a demonstration of the system and explain how the system is able to organize the reported data for meaningful analysis. ○ Can the system organize the data by type of error or adverse event, and by actual or near misses? ○ Can the system organize the data by dates to show trends over time? ○ Can the system organize the data by shift, by unit where the error occurred, and so on? □ Look for evidence of hospitalwide staff education and training regarding what errors and adverse events must be reported and how to report them. Review the materials used for education and training. ○ Are there records to show staff received the training? **Prospective hospitals applying for initial certification in Medicare** A facility seeking Medicare program initial certification as a hospital may not have been in operation long enough to demonstrate extensive internal data collection for the identification of opportunities for improvement based on the monitoring data. However, it □ Must be able to show that it has an active data collection and analysis infrastructure in place, and indicate when it expects to have sufficient data to begin analysis. In addition, because hospitals may utilize quality indicators from outside sources to prioritize QAPI program activities,

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	□ An initial applicant would still be expected to provide evidence of implementing improvement actions based on selected indicators from outside sources.
PI.11.01.01, EP 3: The hospital conducts performance improvement projects as part of its quality assessment and performance improvement program. The number and scope of distinct improvement projects conducted annually is proportional to the scope and complexity of the hospital's services and operations. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. In the initial stage of development, this project, does not need to demonstrate measurable improvement in indicators related to health outcomes. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital is not required to participate in a quality improvement organization cooperative project, but its own projects are required to be of comparable effort. **§482.21(d); §482.21(d)(1); §482.21(d)(2); §482.21(d)(4)** **PI.12.01.01, EP 2:** The hospital documents what quality improvement projects it is conducting, the reasons for conducting these projects, and the measurable progress achieved on these projects. **§482.21(d)(3)** **PI.14.01.01, EP 1:** The hospital acts on improvement priorities. **§482.21(d)(4)**	**Document Review** **General** □ Ask QAPI leader and staff to provide a list of distinct performance improvement projects it is currently conducting and has conducted within the last three years to verify that the hospital is conducting annual QAPI projects. □ Ask to see documentation showing why each project was conducted and evidence to support the progress being made on each project. **Interview** □ Ask the governing body or responsible leaders to explain how the selection (number and scope) of the specific projects is in alignment with the hospital's complexity and the scope of services it provides. o Consider the size of the facility and the intensity of its services, such as critical care services/units, complex surgeries, transplant services, maternal/child health services, and oncology services, including radiation and chemotherapy.
LD.12.01.01, EP 3: The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for the following: - An ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained	**Interview** □ Ask staff if they are aware of the hospital's expectations for safety and how they learned about these. o Do they know their roles and responsibilities in quality assessment and performance improvement?

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- The hospitalwide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated - Clear expectations for safety are established - Adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients - The determination of the number of distinct improvement projects is conducted annually **§482.21(e)(1); §482.21(e)(2) §482.21(e)(5)** **PI.14.01.01, EP 1:** The hospital acts on improvement priorities. **§482.21(e)(1)**	**Document Review** **General** □ Ask to see **evidence** that the governing body, hospital CEO, medical staff (or its executive committee), and other administrative officials are **providing oversight** for the QAPI program. o Are there QAPI **meeting minutes** that document their attendance? o Do the governing body **meeting agendas** provide evidence that the QAPI program has been addressed? o Do the governing body meeting minutes include evidence of QAPI discussions? o Are there documents such as annual QAPI program reviews that include signatures from the governing body? □ Ask to see **evidence** that the governing body, medical staff (or its executive committee), and administrative officials do the following: o Approve the number of distinct QAPI projects to be conducted annually. o Review the results of QAPI data collection, analyses, activities, and projects and make decisions based on such review. □ For those services the hospital provides under arrangement or contract, ask to see **evidence that the contractor is actively involved in the QAPI program.** o Do the governing body, medical staff, and administrative officials periodically receive and review **quality data from the contractor**? o Is the contracted service involved in any current or past hospital QAPI projects? o Does the contract or agreement include the hospital's expectations regarding the **contractor's roles and responsibilities for QAPI**? o Does the data from the contractor demonstrate positive outcomes related to the services provided?

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	Observation □ Look for evidence of communications and reminders to staff about safety expectations.
LD.12.01.01, EP 3: The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for the following: - An ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained - The hospitalwide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated - Clear expectations for safety are established - Adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients - The determination of the number of distinct improvement projects is conducted annually **§482.21(e)(4)**	**Document Review** **General** □ Ask QAPI leader and staff to see detailed evidence of the resources (for example, staff, staff time, education, information systems) that are provided to support required QAPI functions. □ For QAPI services provided under contract, ask to see evidence that contracted services have been incorporated into the QAPI program and that there is governing body oversight of these services and the QAPI program. **Personnel/Credential File** □ Ask to see evidence that staff are qualified to engage in their respective QAPI responsibilities. o Have all staff been educated and trained on how to report errors and adverse events? o Have staff who are required to conduct data collection and analysis received training or possess experience in these functions?
LD.11.01.01, EP 9: For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a system consisting of multiple 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 a unified and integrated quality assessment and performance improvement program for all of its member hospitals after determining that such decision is in accordance with all applicable state and local laws. Each separately certified hospital subject to the system governing body	**Document Review** **General** *If the hospital is part of a multihospital system:* □ Ask if there are any descriptions of the unified and integrated QAPI program. o Does the program include governing body expectations for each certified hospital?

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demonstrates that the unified and integrated quality assessment and performance improvement program does the following: - Accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered - Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 482.21. **§482.21(f); §482.21(f)(1); §482.21(f)(2)**	○ Does it take into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital? □ Ask to see policies and procedures that guide the unified and integrated QAPI program to ensure that the following requirements are met: ○ The needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration. ○ The unified and integrated QAPI program has procedures in place to ensure that issues localized to particular hospitals are duly considered and addressed. □ Ask to see reports provided to the governing body about QAPI performance. ○ Do such reports reveal the performance of each certified hospital? **Interview** *If the hospital is part of a multihospital system:* □ Ask staff if their system governing body has elected to have a unified and integrated QAPI program. ○ Did the system check state and local laws to determine if a unified program was acceptable? □ Ask leaders and QAPI staff at each individual hospital how they participate in the unified and integrated program and if it addresses their unique circumstances.

Hospital Medical Staff Evaluation Module (482.22) including Psychiatric Special Staff Requirements (482.62) (b)

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MS.16.01.01, EP 1: The hospital has an organized medical staff that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided by the hospital. **§482.22**	**Interview** Leaders (senior leaders and medical staff leader(s)) to confirm there is one medical staff for the entire hospital (including all campuses, provider-based locations, satellites, remote locations, etc.) The organized medical staff is responsible for the quality of medical care provided to patients by the hospital. **Note:** If this is a hospital system, it can have a unified and integrated medical staff ("unified medical staff") for multiple, separately certified hospitals. The medical staff is organized and integrated as one body that operates under one set of bylaws approved by the governing body. These medical staff bylaws apply equally to all practitioners within each category of practitioners at all locations of the hospital and to the care provided at all locations of the hospital.
MS.14.01.01, EP 2: The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 42 CFR 482.12(c)(1) and other licensed practitioners who the governing body determines are eligible for appointment. Note 2: Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership. **§482.22(a)**	**Interview** ☐ Who can be members of the medical staff or who may be granted medical staff privileges (MDs, DOs, other licensed practitioners such as CRNA, APPs?). ☐ Does state law include other licensed practitioners such as PT/OT/SLT ☐ If the hospital grants medical staff privileges and/or membership to physicians who are not MDs/DOs, ask about the process the used to ensure that any privileges granted are consistent with state law. ☐ What is the oversight process for non-physician practitioners? **Document Review** **General** ☐ Determine whether the documentation of the categories of practitioners who are members of the medical staff supports the description of categories of practitioners who are members of the medical staff or who may be granted medical staff privileges. ☐ Determine if documentation supports the process described to ensure that any privileges granted are consistent with state law.

MS.18.02.03, EP 1: The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner's professional practice. Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter. **§482.22(a)(1)**	**Interview** □ Determine whether the medical staff has a system in place that is used to reappraise each of its current members and their qualifications at regular intervals, or, if applicable, as prescribed by State law. **Document Review** □ Determine whether the medical staff by-laws identify the process and criteria to be used for the periodic appraisal. □ Determine whether the criteria used for reevaluation comply with the requirements of this section, State law and hospital bylaws, rules, and regulations. □ Determine whether the medical staff has a system to ensure that practitioners seek approval to expand their privileges for tasks/activities/ procedures that go beyond the specified list of privileges for their category of practitioner.
MS.17.01.03, EP 4: The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). **§482.22(a)(2)**	**Interview** □ The medical staff leaders about methods used to ensure that all medical staff members and nonmember practitioners who hold privileges adhere to the medical staff bylaws, rules, and regulations and are afforded the protections and due process rights provided for under the bylaws, rules, and regulations. Ask for specific examples of actions taken. □ The practitioners how they are made aware of their rights and responsibilities with respect to medical staff bylaws, rules, and regulations. How are they informed that they've been granted (or denied) privileges □ Ask medical staff how they conduct periodic appraisals of any current member of the medical staff who has not provided patient care at the hospital or who has not provided care for which they are privileged to patients at the hospital during the appropriate evaluation time frames. Is this method in accordance with state law and the hospital's written criteria for medical staff membership and granting privileges? □ How are constraints such as limitations or revoking privileges reported to appropriate state and federal authorities, registries, and/or databases (such as NPDB)?

	Document Review **General:** ☐ Verify that the medical staff bylaws identify the process and criteria to be used for the periodic appraisal and how often reappraisals occur. ☐ Determine what criteria is used to reappraise each of the current medical staff members and their qualifications – do they comply with CoPs, state law, bylaws, rules and regulations? ☐ Determine whether the medical staff has a system to ensure that practitioners seek approval to expand their privileges for tasks, activities, or procedures that go beyond the specified list of privileges for their category of practitioner. ☐ Does each medical staff member have their own file? ☐ Review meeting minutes - are recommendations for privileging decisions taken to the governing body? **General** ☐ The medical staff bylaws identify the process and criteria to be used for the evaluation of candidates for medical staff membership/privileges. The criteria complies with CoPs, state law, bylaws, rules, and regulations ☐ Determine there is a process to examine the following credentials when appointing/reappointing medical staff members: o Request for clinical privileges o Evidence of current licensure o Evidence of training and professional education o Documented experience o Supporting references of competence ☐ There is a system to ensure that practitioners seek approval to expand their privileges for tasks/ activities/procedures that go beyond the specified list of privileges for their category of practitioner
MS.20.01.01, EP 1: When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site	**Document Review** **General** If the hospital provides telemedicine services to its patients under an agreement with a distant-site hospital and has exercised the option to have medical staff rely on the credentialing and privileging decisions of the

physicians and other licensed practitioners providing such services if the hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating hospital, the originating hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the hospital's patients and complaints the hospital has received about the distant-site physician or other licensed practitioner. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). **§482.22(a)(3); §482.22(a)(3)(1-iv)**	distant-site hospital in making privileging recommendations on telemedicine physicians and other licensed practitioners: ☐ Review the written agreement with the distant-site hospital. Does the agreement address the following? o Does the distant-site participate in the Medicare program? o Does the distant-site hospital provide a list of all physicians and practitioners covered under the agreement? Is the list current? o Does each physician or other licensed practitioner hold a license recognized by the state where originating hospital is located? Are they privileged for the services they are providing? o Does the originating hospital review the telemedicine services provided to its patients and provide feedback to the distant-site hospital for use in the provider's appraisal?
MS.20.01.01, EP 1: See above **§482.22(a)(4); §482.22(a)(4)(i-iv)**	**Interview** If the hospital has an agreement with one or more distant-site telemedicine entities to provide care to their patients via telemedicine: ☐ Has the hospital's governing body exercised the option to have the medical staff rely on the credentialing and privileging decisions of

	the distant-site telemedicine entity in making privileging recommendations on telemedicine physicians and practitioners? ○ If it has, how has the governing body verified that the telemedicine entity employs a credentialing and privileging process that meets or exceeds what is required for hospitals under the Medicare Conditions of Participation? **Note:** *Surveyors: Do not attempt to independently verify whether the distant-site telemedicine entity's credentialing and privileging process fulfills the regulatory requirements. Focus only on whether the hospital takes steps to ensure that the distant-site telemedicine entity complies with the terms of the written agreement.* **Document Review** **General** **If medical staff relies on the credentialing and privileging decisions of the distant-site entity:** ☐ Review the written agreement(s) with the distant-site telemedicine entity(ies). Does each agreement address the following? ○ Required elements concerning the distant-site telemedicine entity's use of a medical staff credentialing and privileging process that meets the requirements of the hospital's Conditions of Participation ○ Appropriate licensure of telemedicine physicians and practitioners ○ Current list of telemedicine physicians and practitioners specifying their privileges ○ Written hospital review of the telemedicine physicians' and practitioners' services and provision of information based on its review to the distant-site hospital ☐ Review the list provided by the distant-site telemedicine entity of the telemedicine physicians and practitioners covered by the agreement, including their current privileges and pertinent licensure information. ☐ Ensure that the hospital reviews the services provided by the telemedicine physicians and practitioners, including any adverse events and complaints, and provides written feedback to the distant-site telemedicine entity.

LD.11.02.01, EP 1: The hospital has an organized medical staff that is accountable to the governing body for the quality of care provided to patients. **§482.22(b)** **LD.11.02.01, EP 2:** The governing body approves the structure of the organized medical staff. **§482.22(b)(1)** **MS.15.01.01, EP 3:** The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital. Note: All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee. **§482.22(b)(1)**	**Document Review** **General** ☐ Verify that the medical staff has a formal, organized structure reflected in the medical staff bylaws, rules, and regulations and that the functions and responsibilities of the medical staff and the governing body are reflected. ☐ Is the individual who leads the medical staff and is responsible for the organization and conduct of the medical staff a doctor of medicine or osteopathy (or if permitted by state law where the hospital is located, a doctor of dental surgery, dental medicine, or podiatric medicine)? ☐ If there is a medical staff executive committee, are the majority of the members doctors of medicine or osteopathy?
LD.11.02.01, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy, or, if permitted by state law, a doctor of dental surgery or dental medicine, or a doctor of podiatric medicine is responsible for the organization and conduct of the medical staff. **§482.22(b)(3); §482.22(b)(3)(i);§482.22(b)(3)(ii); §482.22(b)(3)(iii)**	**Interview** ☐ The CEO and medical staff leaders to describe the mechanisms by which the medical staff fulfills its responsibility to be accountable for the quality of medical care in the hospital. ☐ Interview several members of the medical staff, including both practitioners who hold leadership or executive committee positions and ones who do not. Ask what their medical staff duties and responsibilities are and how they perform them. Ask them to describe how the medical staff is accountable for the quality of medical care provided to patients.
MS.14.03.01, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, in accordance with state and local laws, the following occurs: Each separately accredited hospital within a multihospital system that elects to have a unified and integrated medical staff demonstrates that the medical	**Interview** ☐ Ask hospital and medical staff leaders if the hospital is part of a multihospital system of separately certified hospitals.

staff members of each hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority, in accordance with medical staff bylaws, either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital. **§482.22(b)(4); §482.22(b)(4)(i)**	☐ If yes, ask if the hospital also shares its governing body and medical staff with one or more other separately certified hospitals in the system. ☐ If the hospital shares its governing body and medical staff with one or more separately certified hospitals in the system, ask the following questions: ☐ Does the use of the unified medical staff predate July 11, 2014? If yes, ask for documentation of the governing body's determination that use of a unified medical staff does not conflict with state or local law. ☐ Did the use of the unified medical staff start after July 11, 2014? **Interview** ☐ Ask the hospital and members of the medical staff whether there has ever been a vote on the question of opting out of using a unified medical staff. If yes, ask them to produce evidence that a majority of the practitioners holding privileges at the hospital voted against opting out. ☐ Can the hospital readily identify the medical staff members who are eligible to vote on whether to accept or to opt out of a unified medical staff? **Document Review** **General** ☐ If the unified medical staff started after July 11, 2014, verify that the hospital has documentation of the governing body's decision to elect use of a unified medical staff and of its determination that use of a unified medical staff does not conflict with state or local law. ☐ If the hospital began using a unified medical staff after July 11, 2014, verify that there is documentation that, at the time of the vote, the majority of the medical staff holding privileges at the hospital voted in accordance with medical staff bylaws to accept using a unified medical staff. ☐ Do the medical staff bylaws clearly describe a process by which a vote to opt out of using a unified medical staff may be requested and conducted?

	☐ Determine if there are restrictions or limitations on the rights of medical staff members to vote on whether to accept or opt out of a unified medical staff.
MS.14.03.01, EP 4: For hospitals that use Joint Commission accreditation for deemed status purposes: When a multihospital system has a unified and integrated medical staff, the medical staff bylaws include the following requirements: A description of the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital. **§482.22(b)(4)(ii)**	**Interview** ☐ Ask how the unified medical staff bylaws define a "majority" for the purpose of an opt-out vote of using a unified medical staff. If the bylaws require a supermajority, ask for evidence that this is consistent with the way "majority" is defined for other amendments to the bylaws. ☐ Interview several members of the medical staff to determine if they recall being notified of their right to vote by majority to opt out of using a unified medical staff. **Document Review** **General** ☐ Determine if the unified medical staff bylaws, rules, or requirements clearly describe how and when voting members holding privileges at the hospital are advised of their rights. **Personnel/Credential File** ☐ Review a sample of credentialing and privileging files of members of the medical staff for evidence of their being notified of their right to vote by majority to opt out of using a unified medical staff.
MS.14.03.01, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital. **§482.22(b)(4)(iii)**	**Interview** ☐ Ask hospital and medical staff leaders to describe the other types of hospitals in the system with which it shares a unified medical staff. How are the hospital's unique circumstances addressed? ☐ Ask leaders how the unified medical staff ensures the following: ○ Standing orders it has approved are also approved by nursing and pharmacy leaders in each separately certified hospitals. ○ Policies and procedures developed by the medical staff to minimize drug errors, if not delegated to the hospital's pharmaceutical service, take into account any unique hospital circumstances. ○ The formulary system established by the medical staff takes into account any unique hospital circumstances.

	○ The medical staff's specification of procedures and treatments requiring a properly executed informed consent reflects any unique hospital circumstances. ○ The medical staff carries out its joint responsibility with the CEO and director of nursing for ensuring that hospital-specific infection control problems identified by the hospital's infection prevention and control officer(s) are addressed in the hospital's quality assurance/performance improvement (QAPI) and training programs. ○ The medical staff fulfills its joint executive responsibilities, along with the hospital's governing body and administrative officials, for ensuring that the hospital-specific QAPI program is ongoing, defined, implemented, and maintained; addresses hospital-specific priorities for improved quality of care and patient safety; establishes clear expectations for safety in the hospital; allocates adequate resources for the hospital-specific QAPI program; and determines annually the number of distinct improvement projects conducted in the hospital. ○ Medical staff policies governing the ordering of outpatient services address any unique hospital circumstances. ○ Medical staff policies and recommendations governing which practitioners may be authorized to write orders and be responsible for the care of the patient conform to state law, including scope of practice law, for the state in which the hospital is located.
MS.14.03.01, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff establishes and implements policies and procedures and mechanisms to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are duly considered and addressed. **§482.22(b)(4)(iv)**	**Interview** ☐ Ask the hospital and medical staff leaders whether any members practicing at the hospital have raised concerns or needs. If yes, ask for documentation showing how the concern or need was considered and addressed by the unified medical staff. ☐ Ask members of the medical staff if they are aware that they can raise local concerns or needs with leaders of the unified medical staff. **Document Review** **General**

	☐ Verify that the unified medical staff has policies and procedures addressing how members can raise local concerns and needs. Do the policies and procedures cover the following: o The process for raising their local concerns and needs with the unified medical staff's leadership; o How members are informed of the process by which they can raise their local concerns and needs; o The process for referring the concerns and needs raised to the appropriate committee or other group within the medical staff for due consideration; and o The process for documenting the outcome of the medical staff's review of the concerns and needs raised.
MS.14.01.01, EP 1: The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the	**Document Review** **General** ☐ Verify that the medical staff has bylaws that comply with Conditions of Participation and state law. ☐ Verify that the bylaws describe a mechanism for ensuring enforcement of its provisions along with rules and regulations of the hospital. ☐ Verify that the medical staff enforces the bylaws. ☐ Verify that medical staff bylaws have been approved by the medical staff and governing body. ☐ Determine whether the medical staff bylaws specify the duties and scope of medical staff privileges for each category of practitioner eligible for medical staff membership or privileges. ☐ Verify that the medical staff bylaws specify the organization and structure of the medical staff and a mechanism that delineates accountability to the governing body. ☐ Verify that the bylaws describe who is responsible for regularly scheduled review and evaluation of the clinical work of medical staff members and the formation of medical staff leadership. o Are the rules and regulations clear as to acceptable standards of patient care for all diagnostic, medical, surgical, and rehabilitative services? **Document Review** **General**

hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). **§482.22(c)(1-4)**	☐ Verify that the hospital has written criteria for appointments to the medical staff and granting of medical staff privileges. ☐ Verify that the granting of medical staff membership or privileges is based on an individual practitioner meeting the medical staff's membership or privileging criteria. ☐ Verify that, at a minimum, criteria for appointment to the medical staff or granting of medical staff privileges are individual character, competence, training, experience, and judgment. ☐ Verify that the written criteria for appointment to the medical staff and granting of medical staff privileges are not dependent solely on certification, fellowship, or membership in a specialty body or society.
MS.14.01.01, EP 3: The medical staff bylaws include requirements for the following: - Medical history and physical examination for each patient as described in PC.11.02.01, EP 2 - Updated examinations of patients as described in PC.11.02.01, EP 3 - Assessments in lieu of history and physician examinations of patients as described in PC.11.02.01, EP 4 Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy. **§482.22(c)(5)(i)**	**Document Review** **General** ☐ Review medical staff bylaws to determine whether they require that a physical examination and medical history (H&P) be done for each patient no more than 30 days before or 24 hours after admission or registration by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. Verify that the bylaws require the H&P to be completed prior to surgery or a procedure requiring anesthesia services. ☐ Review the hospital's policy, if any, to determine if other qualified licensed individuals are permitted to conduct H&Ps to ensure that it is consistent with the state's scope of practice law or regulation. **Personnel/Credential File** ☐ Verify that nonphysicians who perform H&Ps within the hospital are qualified and have been credentialed and privileged in accordance with the hospital's policy. **Patient Health Record** ☐ Review a sample of inpatient and outpatient medical records that include a variety of patient populations undergoing both surgical and nonsurgical procedures to verify that the following: o There is an H&P that was completed no more than 30 days before or 24 hours after admission or registration but, in all cases, prior to surgery or a procedure requiring anesthesia services, except when an assessment is completed and documented pursuant to §482.22(c)(5)(iii).

	○ The H&P was performed by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual authorized in accordance with state law.
MS.14.01.01, EP 3: See above **§482.22(c)(5)(ii)**	**Document Review** **General** ☐ Review medical staff bylaws to ensure that they include provisions requiring that, when the H&P was completed within 30 days before admission or registration, an updated medical record entry documenting an examination for changes in the patient's condition was completed and documented in the patient's medical record within 24 hours after admission or registration. ☐ Determine whether the bylaws require that, in all cases involving surgery or a procedure requiring anesthesia services, the update to the H&P must be completed and documented prior to the surgery or procedure. **Document Review** **Patient Health Record** ☐ Review a sample of health records in which the H&P was completed within 30 days before admission or registration. Verify that an updated medical record entry documenting an examination for any changes in the patient's condition was completed and documented in the patient's health record within 24 hours after admission or registration. Verify that, in all cases involving surgery or a procedure requiring anesthesia services, the update was completed and documented prior to the surgery or procedure.
MS.14.01.01, EP 3: See above **§482.22(c)(5)(iii)**	**Document Review** **General** ☐ ~~Review medical staff bylaws to ensure that they include provisions requiring that allow for an assessment in lieu of an H&P being completed within 30 days before admission or registration, but prior to surgery or a procedure requiring anesthesia services when the patient is receiving specific outpatient surgical or procedural services.~~ ☐ Determine that there is a policy for the types of patients that do not require a comprehensive medical history and physical (or update to it) prior to specific outpatient surgical or procedural services.

	Patient Health Record ☐ Review a sample of health records in which an assessment was performed in lieu of an H&P. Verify that the type of surgery or procedure is one identified as meeting this criteria. ☐ Verify that the assessment was completed after registration but prior to surgery or a procedure requiring anesthesia services and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.
MS.16.01.01, EP 10: If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following: - Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure - Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures - Applicable state and local health and safety laws The hospital demonstrates evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: For law and regulation guidance pertaining to the medical history and physical examination at 482.22(c)(5)(iii), refer to https://www.ecfr.gov/. **§482.22(c)(5)(iv); §482.22(c)(5)(v); §482.22(c)(5)(v)(A,B,C)**	**Document Review** **General** ☐ Determine that there is a policy for the types of patients that do not require a comprehensive medical history and physical (or update to it) prior to specific outpatient surgical or procedural services. ☐ Is this policy based on the following: ○ Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure; ○ Nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures; and ○ Applicable state and local health and safety laws ☐ Review the hospital's policies and procedures regarding H&Ps to determine if they are consistent with the regulatory requirement. **Patient Health Record** ☐ Review a sample of ~~health records in which an assessment was performed in lieu of an H&P. Verify that the type of surgery or procedure is one identified as meeting this criteria.~~medical records of patients receiving outpatient surgery to determine whether evidence exists that patients who did not receive a comprehensive H&P prior to receiving outpatient surgeries and procedures met the criteria outlined in the medical staff policy. ☐ ~~Verify that the assessment was completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified~~

	~~licensed practitioner in accordance with state law and hospital policy.~~
MS.14.01.01, EP 1: The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). **§482.22(c)(6)**	**Document Review** **General** ☐ Review medical staff bylaws to ensure that they include criteria for determining the privileges to be granted to individual practitioners and the procedure for applying the criteria to individuals requesting privileges. ☐ What are the hospital's criteria for determining privileges for distant-site physicians and other licensed practitioners? If hospital's governing body has opted to have the medical staff rely on the credentialing and privileging decisions of the distant-site hospital or telemedicine entity, verify that the bylaws include a provision permitting such reliance. ☐ Verify that physicians and practitioners who provide care to patients are working within the scope of the privileges granted by the governing body.
Psychiatric Hospital	
MS.17.01.03, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inpatient psychiatric services are under the direction and supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program and who meets the training and experience	**Interview** ☐ Just prior to the end of the survey, schedule a meeting with the clinical director. By the time of this meeting, you should already have conducted required observation, interviews, and document reviews for at least a majority of the patients in the sample. Collect any

requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. The number and qualifications of doctors of medicine and osteopathy are adequate to provide essential psychiatric services. **§482.62(b)**	additional information necessary to consider in light of outcomes observed for patients, including the qualifications of the clinical director, the leadership exhibited for the scope of psychiatric/medical treatment programs needed by patients, and the rationale for medical staff coverage. If necessary, follow up on letters of complaint previously reported serious problems, discrepancies with Data Collection Medical Staff Coverage (CMS-729). **Interview:** ☐ How many staff are board certified? Fully trained? How many full-time vs. part-time specialties are represented? Is this number adequate to provide services? ☐ How are medical staff deployed? To what programs or units are they assigned? Why? ☐ How much time do physicians spend on units? Based on observations, interviews, and medical record reviews, is coverage adequate to meet the needs of sampled patients? To meet the needs of other patients observed during the survey?
MS.17.01.03, EP 6: See above **§482.62(b)(1)**	**Document Review** **General** ☐ Determine if the clinical director has one of the following: o Certification of the American Board of Psychiatry and Neurology and/or certification of the American Osteopathic Board of Neurology and Psychiatry o If no certification, evidence that the person has the training and equivalency to be admitted to the board examination o If indicated, medical school and residency training o Length of time employed at the facility o Length of time at the position **Note:** *To be admitted to American Board Examinations, the following conditions must be met:* *1. License without restrictions* *2. Graduation from a medical school approved by either the Medical Osteopathic Association or the American Medical Association.* *3. A successful completion of an approved residency training program for at least 3 years before 1988 that the America Council on Graduate Medical*

	Education (ACGME) approves. After 1988, it has to be a four-year accredited program.
MS.16.01.01, EP 8: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The clinical director, service chief, or equivalent for inpatient psychiatric services monitors and evaluates the medical staff's treatment and services for quality and appropriateness. **§482.62(b)(2)**	**Interview** ☐ The clinical director about mechanisms they use to monitor and evaluate the work of the medical staff (for example, personal interviews, quality improvement reports, incident reports). o When problems are discovered by the clinical director, how are they corrected? o Are services, notes, and reports timely? o Are medications used appropriately for the patient's diagnosis?

Hospital Medical Staff Evaluation Module Continued (Additional Joint Commission Requirements)

Joint Commission Standards / EPs	Hospital Survey Process
LD.11.02.01, EP 4: For hospitals that do not use Joint Commission accreditation for deemed status purposes: There is a single organized medical staff unless criteria are met for an exception to the single medical staff requirements.	**Interview:** □ Discuss the medical staff structure to determine if they function as a single organized medical staff unless criteria for an exception is met
MS.14.01.01 EP 4: The medical staff bylaws, rules and regulations, and policies; the governing body bylaws; and the hospital policies are compatible with each other and are compliant with law and regulation. **MS.14.01.01, EP 5:** The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body. **MS.14.01.01, EP 6:** The medical staff bylaws include the following requirements regarding the medical executive committee: - The function, size, and composition, as determined by the organized medical staff and approved by the governing body; - The authority delegated to the medical executive committee by the organized medical staff to act on the medical staff's behalf and how such authority is delegated or removed. (For more information on the role of the medical executive committee, refer to Standard MS.14.02.01.) - The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members. Note: The medical executive committee includes physicians and may include other licensed practitioners. **MS.14.01.01, EP 7:** The medical staff bylaws include the following requirements regarding the suspension or termination	**Interview** □ Discuss the process for adopting and amending the medical staff bylaws, rules and regulation, policies, and amendments. **Document Review** **General** □ Verify that medical staff bylaws, rules and regulations, and policies are compatible with each other and law and regulation □ Verify the proposed changes to bylaws, rules and regulations, and policies, and amendments are proposed directly to the governing body □ Verify 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. □ Verify the medical staff bylaws address all elements listed in MS.14.01.01, EP 6 □ Verify the medical staff bylaws include the requirements listed in MS.14.01.01, EP 7 regarding the suspension or termination of a physician's or other licensed practitioner's medical staff membership or privileges □ Verify the medical staff bylaws include requirements for the composition of the fair hearing committee

Joint Commission Standards / EPs	Hospital Survey Process
of a physician's or other licensed practitioner's medical staff membership or privileges: - Indications and process for automatic suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for summary suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges **MS.14.01.01, EP 8:** The medical staff bylaws include requirements for the composition of the fair hearing committee.	
MS.14.02.01, EP 1: The medical staff bylaws, rules, and regulations are not unilaterally amended. **MS.14.02.01, EP 2:** If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the medical executive committee. If the medical executive committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff. This element of performance applies only when the organized medical staff, with the approval of the governing body, has delegated authority over such rules, regulations, or policies to the medical executive committee. **MS.14.02.01, EP 3:** The organized medical staff has a process that is implemented to manage conflict between the medical staff and the medical executive committee on issues including but not limited to proposals to adopt a rule, regulation, or policy or an amendment thereto. This is not intended to prevent medical staff	**Interview** ☐ Discuss the process for amending medical staff bylaws, rules, and regulations ☐ Discuss how the organization manages conflict between the medical staff and the medical executive committee ☐ Discuss the process to follow when emergency amendment to rules and regulation is needed. **Documentation** **General** ☐ Review the policy for amending medical staff bylaws ☐ If applicable, review a situation in which a bylaw required urgent amendment and verify the policy was followed ☐ If applicable, review a situation in which the policy to manage conflict had been instituted.

Joint Commission Standards / EPs	Hospital Survey Process
members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication. **MS.14.02.01, EP 4**: In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the medical executive committee, if delegated to do so by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.	
MS.15.01.01, EP 1: The structure and function of the medical staff executive committee conforms to the medical staff bylaws. **MS.15.01.01, EP 2:** The chief executive officer (CEO) of the hospital or their designee attends each medical staff executive committee meeting on an ex-officio basis, with or without a vote. **MS.15.01.01, EP** 4: The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - Organized medical staff's structure	**Documentation** **General** ☐ Review structure and function of medical executive committee to verify it conforms to the medical staff bylaws ☐ Review medical staff executive committee meeting minutes to ensure the CEO or their designee attends each medical staff executive committee meeting Verify the medical staff executive committee makes recommendations on the required elements of EP 4 by reviewing meeting minutes

Joint Commission Standards / EPs	Hospital Survey Process
- Process used to review credentials and delineate privileges - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups	
MS.16.01.01, EP 2: Physician members of the organized medical staff are designated to perform the oversight activities of the organized medical staff. **MS.16.01.01, EP 3:** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **MS.16.01.01, EP 4:** The organized medical staff, through its designated mechanisms, provides leadership in activities related to patient safety. **MS.16.01.01, EP 5:** The organized medical staff provides oversight in the process of analyzing and improving patient satisfaction. **MS.16.01.01, EP 7:** The organized medical staff does the following: - Defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges - Specifies the minimal content and scope of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services, including non-inpatient services - Monitors the quality of medical histories and physical examinations	**Interview** ☐ Discuss with staff the oversight activities that the medical staff is responsible for ☐ Discuss how the medical staff ensures that licensed practioners only practice within the scope of their privileges **Document** **General** ☐ Review meeting minutes for medical staff oversight activities, including the analysis and improvement of patient satisfaction, and history and physical quality ☐ Verify that history and physical minimum content as defined by policy is present in the patient's medical record during medical record review.
MS.17.01.01, EP 1: The hospital has a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege.	**Interview** ☐ Discuss with leadership the process to determine if there is sufficient space, equipment, staffing, and financial resources available to support a new privilege

Joint Commission Standards / EPs	Hospital Survey Process
MS.17.01.01, EP 2: The hospital consistently determines the resources needed for each requested privilege.	
MS.17.03.01, EP 1: The organized medical staff develops and implements criteria for an expedited process for granting privileges. Note: To expedite initial appointments to membership and granting of privileges, reappointment to membership, or renewal or modification of privileges, the governing body may delegate the authority to render those decisions to a committee of at least two voting members of the governing body. **MS.17.03.01, EP 2:** The criteria provide that an applicant for privileges is ineligible for the expedited process if any of the following has occurred: - The applicant submits an incomplete application. - The medical staff executive committee makes a final recommendation that is adverse or has limitations. **MS.17.03.01, EP 3:** The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: - There is a current challenge or a previously successful challenge to licensure or registration. - The applicant has received an involuntary termination of medical staff membership at another hospital. - The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges. - The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.	**Interview** ☐ Discuss the process used to grant expedited privileges **Document** **General** ☐ Review the documented process to expedite granting privileges; including the criteria that would make someone ineligible for the expedited process **Credentialing File** ☐ Review a credentialing file in which the expedited process was use and verify that the process was followed ☐ If so, are at least 2 voting Board members on the approving committee?

Joint Commission Standards / EPs	Hospital Survey Process
MS.17.04.01, EP 1: Temporary privileges are granted to meet an important patient care need for a time period defined in the medical staff bylaws. **MS.17.04.01, EP 2:** When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence. **MS.17.04.01, EP 3:** Temporary privileges may be granted to applicants for new privileges while awaiting review and approval by the organized medical staff upon verification of the following: - Current licensure - Relevant training or experience - Current competence - Ability to perform the privileges requested - Other criteria required by the medical staff bylaws - A query and evaluation of the National Practitioner Data Bank (NPDB) information - A complete application - No current or previously successful challenge to licensure or registration - No subjection to involuntary termination of medical staff membership at another organization - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges **MS.17.04.01, EP 4:** All temporary privileges are granted by the chief executive officer or authorized designee.	**Interview:** ☐ Discuss process for granting temporary privileges **Documentation** **General** ☐ During medical staff bylaw review, review the temporary privilege process **Credentialing File** Review at least one of these files to determine if it meets one of the two following criteria: ☐ Temporary privileges may be granted to meet an important patient care need and may be renewed, if permitted by the bylaws. ☐ Review licensure and competency have been verified. ☐ Verify that the temporary privileges are time-limited & not to exceed 120 consecutive days

Joint Commission Standards / EPs	Hospital Survey Process
MS.17.04.01, EP 5: All temporary privileges are granted on the recommendation of the medical staff president or authorized designee. **MS.17.04.01, EP 6:** Temporary privileges for applicants for new privileges are granted for no more than 120 days.	
LD.13.03.03, EP 6: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When using the services of physicians or other licensed practitioners from a Joint Commission–accredited ambulatory care organization through a telemedicine link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.17.01.03 through MS.17.02.03.	**Documentation** □ If identified that the organization uses the services of physicians or other licensed practioners from Joint Commission – accredited ambulatory care organization, verify during credential review that the ambulatory provider uses the process described in MS.17.01.03 through MS.17.02.03
MS.18.01.01, EP 1: Recommendations from peers are obtained and evaluated for all new applicants for privileges. **MS.18.01.01, EP 2:** Upon renewal of privileges, when insufficient physician- or other licensed practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations. **MS.18.01.01, EP 3:** Peer recommendations include the following information: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism **MS.18.01.01, EP 4:** Peer recommendations are obtained from a physician or other licensed practitioner in the same professional	**Interview** □ Discuss with the organization if peer recommendations considered; If yes, how are "peers" defined. □ If allowed, discuss 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? **Documentation** **Credentialing Filed** □ Verify peer recommendation during filed review includes the information listed in EP 3

Joint Commission Standards / EPs	Hospital Survey Process
discipline as the applicant with personal knowledge of the applicant's ability to practice.	
MS.18.02.01, EP 1: The organized medical staff develops and consistently implements criteria to be used for evaluating the performance of physicians or other licensed practitioners when issues affecting the provision of safe, high quality patient care are identified. **MS.18.02.01, EP 2:** A period of focused professional practice evaluation is implemented for all initially requested privileges. **MS.18.02.01, EP 3:** The performance monitoring process is clearly defined and includes each of the following elements: - 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 **MS.18.02.01, EP 4:** The triggers that indicate the need for performance monitoring are clearly defined. Note: Triggers can be single incidents or evidence of a clinical practice trend. **MS.18.02.01, EP 5:** Criteria are developed that determine the type of monitoring to be conducted. **MS.18.02.01, EP 6:** The measures employed to resolve performance issues are clearly defined. **MS.18.02.01, EP 7:** The measures employed to resolve performance issues are consistently implemented.	**Interview** ☐ Discuss the process for implementing a period of focused professional practice evaluation for issues affecting the provisions of safe quality care or for initial privilege request **Document** **General** ☐ Review the process for conducting a focused professional practice evaluation o Is the process including criteria is approved by the MS (evaluation should be qualitative and not just quantitative)? o Is the process clearly defined *(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)* o Is the process applied consistently (*follow the same process step and documentation requirements for all evaluations)* ☐ If a for-cause FPPE: o Are the triggers clearly defined? o Are the decisions to initiate FPPE for cause based upon objective measures of current performance reflective of quality and/or safety concerns. o Is there criteria developed for type of monitoring to be conducted o Are the measures/actions to address performance issues defined? o Is there evidence these measures/actions are consistently implemented?
MS.18.02.03, EP 2: The process for the ongoing professional practice evaluation includes the type of data to be collected,	**Interview** ☐ Discuss the process for the ongoing professional practice evaluation

Joint Commission Standards / EPs	Hospital Survey Process
which is determined by individual departments and approved by the organized medical staff. **MS.18.02.03, EP 3:** The process for the ongoing professional practice evaluation includes the use of information resulting from the ongoing professional practice evaluation to determine whether to continue, limit, or revoke any existing privilege(s).	○ What types of data is collected? Who determines which data is collected? **Documentation** **Credentialing File** Review file for evidence that the ongoing professional practice evaluation includes information from the evaluation to determine to continue, limit or revoke any existing privilege(s)
MS.18.03.01 EP 1: The hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. Note: Reported concerns regarding a privileged physician's or other licensed practitioner's professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.	**Documentation** **General** ☐ Review the process for collecting, investigating, and addressing clinical practice concerns **Credentialing File** Review a file in which a concern was reported to validate the process was followed
MS.18.04.01, EP 1: The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that may differ for members and nonmembers of the medical staff. **MS.18.04.01, EP 2:** The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has a mechanism to schedule a hearing of such requests. **MS.18.04.01, EP 3:** The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has identified the procedures for the hearing to follow. **MS.18.04.01, EP 4:** The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that identifies the composition of the hearing committee as a committee that includes impartial peers. **MS.18.04.01, EP 5:** The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues	**Interview** ☐ Discuss the process for medical staff to request a fair hearing and appeal process **Documentation** ☐ Review the fair hearing process procedure that has been developed. Ensure that the following are addressed: ○ Mechanism to schedule a hearing ○ Identified procedures to follow for a fair hearing ○ Identified appropriate compositive of hearing members and includes impartial peers ○ Provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws, with the governing body.

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that, with the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws.	
MS.18.05.01, EP 1: The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses the education of physicians or other licensed practitioners and other organization staff about illness and impairment recognition issues specific to practitioners (at-risk criteria). **MS.18.05.01, EP 2:** The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses self-referral by a physician or other licensed practitioner. **MS.18.05.01, EP 3:** The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses referral by others and maintaining informant confidentiality. **MS.18.05.01, EP 4:** The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses referral of the physician or other licensed practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern. **MS.18.05.01, EP 5:** The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses maintenance of confidentiality of the physician or other licensed practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened. **MS.18.05.01, EP 6:** The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses evaluation of the credibility of a complaint, allegation, or concern.	**Interview** ☐ Discuss the process the organization follows when an individual health matter is identified or reported as concern for physicians or and other licensed practioners o What education is required about illness and impairment recognition **Documentation** **General** ☐ Review the process to identify and manage matters of individual health for physicians and other licensed practitioners. Does the process address the following: o Self-referral? o Maintaining informant confidentiality? o Referral for evaluation, diagnosis, and treatment of the condition or concern? o Maintenance of confidentiality of the physician or other licensed practitioner? o Evaluation of the credibility of the complaint or allegation? o Safety of patients until the rehabilitation is complete and periodically afterwards? o Staff leadership if patient care is unsafe? o Initiating appropriate actions when a physician or other licensed practitioner fails to complete the required rehabilitation program? ☐ Is there proof the organization implements this process when an issue or concern is brought forward?

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MS.18.05.01, EP 7: The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses monitoring the physician or other licensed practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required. **MS.18.05.01, EP 8:** The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses reporting to the organized medical staff leadership instances in which a physician or other licensed practitioner is providing unsafe treatment. **MS.18.05.01, EP 9:** The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses initiating appropriate actions when a physician or other licensed practitioner fails to complete the required rehabilitation program. **MS.18.05.01, EP 10:** The medical staff implements its process to identify and manage matters of individual health for physicians and other licensed practitioners.	
MS.19.01.01, EP 1: The organized medical staff prioritizes hospital-sponsored educational activities that relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital. **MS.19.01.01, EP 2:** Education is based on the findings of performance improvement activities. **MS.19.01.01, EP 3:** Each individual's participation in continuing education is documented. **MS.19.01.01, EP 4:** Participation in continuing education is considered in decisions about reappointment to membership on	**Documentation** **Credentialing File** ☐ Verify the physician or other licensed practitioner participated in continuing education based on performance improvement activities and this participation is considered during decisions about reappointment to membership on the medical staff or renewal or revision of individual clinical privileges

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the medical staff or renewal or revision of individual clinical privileges.	
MS.20.01.03, EP 1: The medical staff recommends which clinical services are appropriately delivered by physicians or other licensed practitioners through this medium. **MS.20.01.03, EP 2:** The clinical services offered are consistent with commonly accepted quality standards.	**Interview** ☐ Discuss how it is determined which clinical services are appropriately delivered by physicians or other licensed practitioners through telemedical link ☐ How does the organization ensure that the clinical services provided via telemedical link are consistent with accepted quality standards
Hospitals participating in a professional graduate education program(s)	
MS.16.02.01, EP 1: The organized medical staff has a defined process for supervision of each participant in the program in carrying out patient care responsibilities by a physician with appropriate clinical privileges. **MS.16.02.01, EP 2:** The organized medical staff and hospital staff receive written descriptions of the roles, responsibilities, and patient care activities of graduate education program participants. **MS.16.02.01, EP 3:** The written descriptions of the roles, responsibilities, and patient care activities of graduate education program participants 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. **MS.16.02.01, EP 4:** Organized medical staff rules and regulations and policies delineate the participants in professional education programs who may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a supervising physician. **MS.16.02.01, EP 5:** There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.	**Interview** ☐ Determine how the organization shares the written description of the roles and responsibilities, and patient care activities allowed by participants of the graduate education programs. **Documentation** **General** ☐ Review policy that defines the process for supervision by a physician, with appropriate clinical privileges, of each program participant while carrying out patient care responsibilities ☐ Review written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs ☐ Review medical staff rules and regulations and policies about which participants in professional education programs may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a supervising physician – verify in medical record review. ☐ Review the 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 ☐ **If the hospital surveyed has a professional GMEC,** Review communication to the medical staff and governing body information about: o safety and quality of patient care, treatment and services by the training program o related educational and supervisory needs of the training program ☐ **If the hospital surveyed is a community or local participating hospital or organization hospital**, review that the person(s) responsible for overseeing the

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MS.16.02.01, EP 6: There is responsibility for effective communication with the medical staff and governing body, whether training occurs at the organization that is responsible for the professional graduate education program or in a participating local or community organization or hospital, as follows: - The professional graduate medical education committee(s) (GMEC) communicates with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs. - If the graduate medical education program uses a community or local participating hospital or organization, the person(s) responsible for overseeing the participants from the program communicates to the organized medical staff and its governing body about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs. Note: The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization. **MS.16.02.01, EP 7:** There is a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the graduate medical education committee about the quality of care, treatment, and services and educational needs of the participants. **MS.16.02.01, EP 8:** Information about the quality of care, treatment, and services and educational needs is included in the communication that the graduate medical education committee has with the governing board of the sponsoring hospital. **MS.16.02.01, EP 9:** The medical staff demonstrates compliance with residency review committee citations. Note: Graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education (ACGME),	participants from the program communicate to the organized medical staff and its governing body about: ○ patient care, treatment, and services provided by the training program ○ related educational and supervisory needs of its participants in the GME programs. ☐ Verify the hospital can 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. ☐ Verify if the hospital sponsors a GME program and has a GMEC, the hospital demonstrate it specifically included information about the quality of care, treatment, and services and educational needs to the governing board by reviewing governing board minutes ☐ Review residency review committee citations

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the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the requirements in this standard; the hospital should be able to demonstrate compliance with any postgraduate education review committee citations related to this standard.	
MS.16.03.01, EP 1: The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more physicians or other licensed practitioners credentialed and privileged through the medical staff process. **MS.16.03.01, EP 2:** Information used as part of the performance improvement mechanisms, measurement, or assessment includes sentinel event data and patient safety data. **MS.16.03.01, EP 3:** The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following: - Participating in the establishment of protocols and quality metrics - Reviewing performance improvement data **MS.16.03.01, EP 4:** The organized medical staff completes patient medical records accurately, timely, and legibly. **MS.16.03.01, EP 5:** The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence.	**Interview** ☐ Discuss with medical staff leadership the process for measuring, assessing, and improving processes within the medical staff **Documentation** **General** ☐ Verify that the performance improvement plan includes sentinel event data and patient safety data ☐ Verify that medical staff is actively involved in pain assessment and management; including safe opioid prescribing ☐ Review performance improvement activities include assessment processes that are relevant to individual performance and is used in the ongoing evaluation of a physician or other licensed practioner's competence and communication of findings to appropriate staff members and the governing body.

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- Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body	

Hospital Nursing Services Evaluation Module (482.23) including Psychiatric Nursing Services. Requirements (482.62) (d)

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LD.13.03.01, EP 2: The hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides 24-hour nursing services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. **§482.23** **NPG.12.02.01, EP 4:** A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7 days a week. The hospital has a licensed practical nurse or registered nurse on duty at all times. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse is immediately available for the provision of care of any patient. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. **§482.23**	**Interview** ☐ Interview patients about the delivery of nursing services. **Document Review** **General** ☐ Review quality assurance/performance improvement (QAPI) meeting minutes to determine if the nursing services are integrated into the hospitalwide QAPI program. ☐ Verify that the hospital has an organizational chart(s) for nursing services for all locations where the hospital provides nursing services. ☐ Verify that the hospital has job descriptions for all nursing personnel, including a description for the director. ☐ Review nursing care plans, medical records, accident and investigative reports, staffing schedules (to ensure that there is a registered nurse supervising the service 24 hours a day, 7 days a week), nursing policies and procedures, and QAPI activities and reports. **Observation** ☐ Select at least one patient from every inpatient care unit. Observe the nursing care in progress to determine the adequacy of staffing and assess the delivery of care.
LD.13.03.01, EP 2: The hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides 24-hour nursing services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. **§482.23(a)** **NPG.12.02.01, EP 1:** The nurse executive, who is a licensed registered nurse, is responsible for the operation of nursing services including	**Document Review** **General** ☐ Verify that the hospital's organizational chart or plan for nursing services displays lines of authority that delegate responsibility within the department. **Credential/Personnel File Review** ☐ Review the position description for the director of nursing (DON) to determine that it delegates to the DON specific duties and responsibilities for nursing service operations.

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determining the following: - Nursing policies and procedures - Types and numbers of nursing and other staff necessary to provide nursing care for all areas of the hospital. **§482.23(a)**	☐ Verify that the DON is currently licensed in accordance with state licensure requirements. ☐ Verify that the DON is involved with or approved the development of the nursing service staffing policies and procedures. ☐ Verify that the DON approves the nursing service patient care policies and procedures.
NPG.12.02.01, EP 5: There must be an adequate number of licensed registered nurses, licensed practical (vocational) nurses, and other staff to provide nursing care to all patients, as needed. Note: There are supervisors and staff for each department or nursing unit to make certain a registered nurse is immediate availability for the care of any patient. **§482.23(b)**	**Document Review** **General** ☐ Verify that written staffing schedules correlate to the number and acuity of patients. **Patient Health Record** ☐ Review a sample of health records to determine if patient care that is to be provided by nurses is being provided as ordered. **Observation** ☐ Verify that there is an RN physically present on the premises and on duty at all times. ☐ Verify that there is supervision of personnel performance and nursing care for each department or nursing unit. To determine if there are adequate numbers of nurses to provide nursing care to all patients as needed, take into consideration the following: o Physical layout and size of the hospital o Number of patients o Intensity of illness and nursing needs o Availability of nurses' aides and orderlies and other resources for nurses (for example, housekeeping services, ward clerks) o Training and experience of personnel
LD.13.03.01, EP 2: The hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides 24-hour nursing services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. **§482.23(b)(1)** **NPG.12.02.01, EP 4:** A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7	**Document Review** **General** ☐ Review the nurse staffing schedule for a one-week period. If there are concerns regarding insufficient RN coverage, review the staffing schedules for another one-week period to determine if there is a pattern of insufficient coverage. ☐ Determine daily RN coverage for every unit of the hospital. ☐ Verify that there is at least one RN for each unit on each tour of duty, 7 days a week, 24 hours a day.

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days a week. The hospital has a licensed practical nurse or registered nurse on duty at all times. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse is immediately available for the provision of care of any patient. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. **§482.23(b)(1)**	**Note:** If the hospital has a temporary waiver of the 24-hour RN requirement in effect, refer to the SOM to determine the required verification and documentation requirements.
HR.11.01.03, EP 3: The hospital develops and implements a procedure to verify and document the following: - Credentials of staff using the primary source when licensure, certification, or registration is required by federal, state, or local law and regulation. This is done at the time of hire and at the time credentials are renewed. - Credentials of staff (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary. Note 4: The hospital determines the required qualifications for staff based on job responsibilities. **482.23(b)(2)**	**Document Review** **General** ☐ Review the nursing service licensure verification policies and procedures. Is licensure verified for each individual nursing services staff person for whom licensure is required? **Personnel/Credential File** ☐ Review hospital personnel records or records kept by the nursing service to determine that RNs, licensed practical nurses (LPNs), and other nursing personnel for whom licensure is required have current valid licenses.
NR.11.01.01, EP 4: A registered nurse supervises and evaluates the nursing care for each patient. **§482.23(b)(3)**	**Document Review** **General** ☐ Review staffing schedules and assignments to ensure that an RN is assigned to supervise and evaluate the nursing care furnished to each patient.

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PC.11.03.01, EP 1: The hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and services required to meet those goals. Note 1: Nursing staff develops and keeps current a nursing care plan, which may be a part of an interdisciplinary care plan, for each patient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals. **§482.23(b)(4)**	**Document Review** **Patient Health Record** ☐ Review a sample (approximately 6 to 12) of nursing or interdisciplinary care plans. For each plan reviewed, verify the following with respect to the nursing care component: ○ Was the plan initiated as soon as possible after admission for each patient? ○ Does the plan describe and reflect patient goals as part of the patient's nursing care assessment and, as appropriate, physiological and psychosocial factors and patient discharge planning? ○ Is the plan consistent with the medical care plan of the practitioner responsible for the care of the patient? ○ Is there evidence of reassessment of the patient's nursing care needs and response to nursing interventions and, as applicable, revisions to the plan? ○ Was the plan implemented in a timely manner?
NR.11.01.01, EP 1: A registered nurse assigns the nursing care for each patient to other nursing staff in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. **§482.23(b)(5)**	**Interview** ☐ Ask a charge nurse what considerations are necessary when making staff assignments. Answers should include but are not limited to the following: ○ Patient needs ○ Complexity of patients ○ Any special needs of individual patients ○ Competence of nursing personnel ○ Qualifications of nursing personnel ○ Education of nursing personnel ○ Experience of nursing personnel **Document Review** **General** ☐ Verify that an RN made the nursing assignments. Did the assignments take into consideration the complexity of patient care needs and the competence and specialized qualifications of the nursing staff?
NR.11.01.01, EP 2: All licensed nurses who provide services in the hospital adhere to its policies and procedures.	**Document Review** **General**

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Note: This applies to all nursing staff providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). §482.23(b)(6) **NR.11.01.01, EP 3:** The nurse executive provides for the supervision and evaluation of the clinical activities of all nursing staff in accordance with nursing policies and procedures. Note: This applies to all nursing staff who are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). §482.23(b)(6)	☐ Review the hospital's method for orienting all licensed nurses to hospital policies and procedures. The orientation should include at least the following: o Information on the hospital and unit o Emergency procedures o Nursing services policies and procedures o Safety policies and procedures. **Personnel/Credential File** ☐ Review orientation documentation to ensure that all nursing personnel are appropriately oriented prior to providing care. ☐ Confirm with the DON that the performance of all nurses is evaluated by the hospital at least once a year. If the performance evaluation is not considered confidential, review two evaluations.
NPG.12.02.01, EP 7: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has policies and procedures that establish which outpatient departments, if any, are not required to have a registered nurse present. The policies and procedures meet the following requirements: - Establish criteria that such outpatient departments need to meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and established standards of practice for the services delivered - Describe alternative staffing plans - Are approved by the director of nursing - Are reviewed at least once every three years §482.23(b)(7); §482.23(b)(7)(i), §482.23(b)(7)(ii); §482.23(b)(7)(iii); §482.23(b)(7)(iv).	**Document Review** **General** ☐ Review staffing plan for outpatient departments. ☐ If an RN is not needed for that particular outpatient department, review the alternative staffing plan that has been approved by the director of nursing and confirm that the policy has been reviewed at least once every 3 years. ☐ Review the policies and procedures for evidence that the criteria were based on the following considerations: o Types of services delivered by the department o The general level of acuity of the patients receiving care in the department o Established national standards of practice for the services being provided in the department o Patient care and safety o Responsibilities to respond to patient emergency situations ~~**Document Review**~~ ☐ ~~Validate policy and procedures for outpatient departments that do not require the presence of a registered nurse as described in §482.23(b)(7)(i) – (iv).~~
MM.16.01.01, EP 1: Drugs and biologicals are prepared and administered in accordance with the following: - Federal and state laws,	**Interview** ☐ Are staff knowledgeable about intervention protocols when patients experience adverse medication-related events?

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- The orders of the licensed practitioner or practitioners responsible for the patient's care, and - Accepted standards of practice Note 1: Drugs and biologicals are administered by, or under supervision of, nursing or other personnel when permitted by Federal and State laws and regulations (including applicable licensing requirements) and with the approved medical staff policies and procedures. Note 2: For hospitals that use Joint Commission Accreditation for deemed status purposes: Drugs and biologicals may be prepared and administered as follows: - On the orders of other practitioners not specified under 42 CFR 482.12(c) only if such practitioners are acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. - On the orders contained within preprinted and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of 42 CFR 482.24(c)(3). **§482.23(c)(1)**	☐ Interview personnel who administer medication to verify their understanding of the hospital's policies regarding timeliness of medication administration. ☐ Can staff identify time-critical and non-time-critical scheduled medications? Can they identify medications not eligible for scheduled dosing times? ☐ Can staff describe requirements for the timing of administration of time-critical and non-time-critical medications in accordance with the hospital's policies? **Document Review** **General** ☐ Verify that the hospital has policies and procedures approved by the medical staff and governing body concerning ordering of drugs and biologicals by practitioners. ☐ Verify that the hospital has policies and procedures approved by the medical staff addressing who is authorized to administer medications and that the policies and procedures are followed. ☐ Verify that nursing staff authorized to administer drugs and biologicals are practicing within their state-permitted scope of practice. ☐ Are personnel other than nursing personnel administering drugs or biologicals? If yes, determine if those personnel are administering drugs or biologicals in accordance with federal and state law and regulation, including scope of practice laws, hospital policy, and medical staff bylaws, rules, and regulations. Use the above procedures to determine compliance. ☐ Verify that the hospital has policies and procedures approved by medical staff addressing the timing of medication administration. ☐ Consistent with its policies, verify that the hospital has identified medications that meet the following criteria: o Are not eligible for scheduled dosing times o Are eligible for scheduled dosing times and are time critical o Are eligible for scheduled dosing times and are not time critical ☐ Verify that the hospital has established total windows of time that do not exceed the following: o 1 hour for time-critical scheduled medications

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	○ 2 hours for medications prescribed more frequently than daily but not more frequently than every 4 hours ○ 4 hours for medications prescribed for daily or longer administration intervals ☐ Verify that the hospital has a policy describing requirements for the administration of identified time-critical medications. Is it clear whether time-critical medications or medication types are identified as such for the entire hospital or are they specific to the unit, patient diagnosis, or clinical situation? **Patient Health Record** ☐ Review a sample of patient health records to determine if medication administration conformed to an authorized practitioner's order (that is, there is an order from an authorized practitioner, or an applicable standing order, and that the correct medication was administered to the right patient at the right dose via the correct route) and if the timing of administration complied with the hospital's policies and procedures. **Observation** ☐ Verify that procedures for the preparation of drugs and their administration to patients (medication pass) are being followed. ○ Is the patient's identity confirmed prior to medication administration? ○ Are procedures to ensure the correct medication, dose, and route followed? ○ Are drugs administered in accordance with the hospital's established policies and procedures for safe and timely medication administration? ○ Does the nurse remain with the patient until oral medication is taken? ○ Are patients assessed by nursing and/or other staff, per hospital policy, for their risk to their prescribed medications? ○ Are patients who are at higher risk and/or receiving high-alert medications monitored for adverse effects?
MM.16.01.01, EP 1: Drugs and biologicals are prepared and administered in accordance with the following: - Federal and state laws,	**Interview** ☐ Ask nursing staff if they initiate medications in accordance with standing orders.

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- The orders of the licensed practitioner or practitioners responsible for the patient's care, and - Accepted standards of practice Note 1: Drugs and biologicals are administered by, or under supervision of, nursing or other personnel when permitted by Federal and State laws and regulations (including applicable licensing requirements) and with the approved medical staff policies and procedures. Note 2: For hospitals that use Joint Commission Accreditation for deemed status purposes: Drugs and biologicals may be prepared and administered as follows: - On the orders of other practitioners not specified under 42 CFR 482.12(c) only if such practitioners are acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. - On the orders contained within preprinted and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of 42 CFR 482.24(c)(3). **§482.23(c)(1)(i); §482.23(c)(1)(ii)**	○ Are they familiar with the hospital's policies and procedures for using standing orders? ○ Are they following the policies and procedures? ☐ Request the protocol for a standing order used by nursing staff. Ask nursing staff how their practice conforms to the protocol. **Document Review** **General** ☐ Review the hospital's policy for drug and biological orders. Does it require that all administration of drugs or biologicals be based on either an applicable standing order or the order of a practitioner who is responsible for the care of the patient or otherwise authorized by hospital and medical staff policy and in accordance with state law to write orders? **Patient Health Record** ☐ Review a sample of open and closed patient medical records to verify that all orders for drugs and biologicals, with the exception of influenza and pneumococcal vaccines, are included in the patient's medical record and authenticated by a practitioner who is authorized to write orders by hospital and medical staff policy and in accordance with state law and who is responsible for the care of the patient. ○ Determine if there was an assessment of contraindications prior to administration of the vaccine(s). ☐ Ensure that all standing orders initiated by a nurse were authenticated by an authorized practitioner. ☐ Verify that all orders for drugs and biologicals contain the required elements according to **§482.23(c)(1) (ii), (c)(3) and (c)(3)(iii).** **Note:** *Although the regulation applies to both inpatient and outpatient medical records, the sample should be weighted to include more inpatient records.*
MM.16.01.01, EP 1: Drugs and biologicals are prepared and administered in accordance with the following: - Federal and state laws, - The orders of the licensed practitioner or practitioners responsible for the patient's	**See Survey Procedures for §§482.23(c)(1)**

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care, and - Accepted standards of practice Note 1: Drugs and biologicals are administered by, or under supervision of, nursing or other personnel when permitted by Federal and State laws and regulations (including applicable licensing requirements) and with the approved medical staff policies and procedures. Note 2: For hospitals that use Joint Commission Accreditation for deemed status purposes: Drugs and biologicals may be prepared and administered as follows: - On the orders of other practitioners not specified under 42 CFR 482.12(c) only if such practitioners are acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. - On the orders contained within preprinted and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of 42 CFR 482.24(c)(3). **§482.23(c)(2)** ~~**MM.16.01.01, EP 2:** Drugs and biologicals are administered by, or under supervision of, nursing or other staff in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.~~	
MM.14.01.01, EP 1: Orders for drugs and biologicals are documented and signed by any practitioner who is authorized to write orders in accordance with state law and hospital policy, medical staff bylaws, rules, and regulations. Note: Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications. **§482.23(c)(3)**	**See Survey Procedures for §482.23(c)(1)**
MM.14.01.01, EP 2: The hospital minimizes the use of verbal medication orders. **§482.23(c)(3)(i)**	**Interview** ☐ Ask direct care staff if actual practice is consistent with verbal order policies and procedures.

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	Document Review **General** ☐ Verify that the hospital has a policy or procedure to minimize the use of verbal orders. Does the policy include a requirement for read-back verification for every verbal order? **Patient Health Record** ☐ Review a sample of both open and closed patient medical records containing of verbal orders. o Were the hospital's policies and procedures for the use of verbal orders followed? o Does the number of verbal orders found in the sampled records suggest routine use, which the regulations do not permit? The number of verbal orders is not in itself evidence of noncompliance but should result in more focused analysis. For example, assess the following: ▪ Is there a pattern to the use of verbal orders? ▪ Are verbal orders used frequently for certain types of situations, and, if so, is it reasonable to assume that it is impossible or impractical for the prescribing practitioners to write/enter the orders in such situations? ▪ Do certain practitioners use verbal orders frequently?
RC.12.02.01, EP 1: Only staff authorized by hospital policies and procedures consistent with federal and state law accept and record verbal orders. **§482.23(c)(3)(ii)**	**Interview** ☐ Interview several direct care staff to determine if they are permitted to take verbal orders for drugs and biologicals and if they have been authorized to do so in accordance with hospital policy. **Document Review** **General** ☐ Determine whether the hospital has policies and procedures, consistent with federal and state law governing who is authorized to accept verbal orders. **Patient Health Record** ☐ Review open and closed patient medical records containing verbal orders for drugs and biologicals. o Verify that the orders were accepted and documented by authorized hospital personnel.

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MM.14.01.01, EP 1: Orders for drugs and biologicals are documented and signed by any practitioner who is authorized to write orders in accordance with state law and hospital policy, medical staff bylaws, rules, and regulations. Note: Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications. **§482.23(c)(3)(iii)**	**See Survey Procedures for §482.23(c)(1)**
PC.12.01.01, EP 3: The hospital administers blood transfusions and intravenous medications in accordance with state law and approved medical staff policies and procedures. **§482.23(c)(4)**	**Interview** ☐ Interview nursing staff on different units who administer IV medications and blood transfusions. Verify that they are knowledgeable about the following: o Venipuncture techniques o Safe medication administration practices, including general practices applying to all types of medications and practices concerning IV tubing and infusion pumps o Maintaining fluid and electrolyte balance o Patient assessment for risk related to IV medications and appropriate monitoring o Early detection and intervention for IV opioid-induced respiratory depression in postoperative patients o Blood transfusions, including the following: ▪ Blood components ▪ Process for verification of the right blood product for the right patient ▪ Transfusion reactions, including identification, treatment, and reporting requirements **Document Review** **Personnel/Credential File** ☐ Review the files for a sample of staff who administer blood products and IV medications for evidence that competency was assessed, and training was provided as appropriate. **Patient Health Record** ☐ Review a sample of medical records of patients who received blood transfusions or IV medications.

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	○ Are blood transfusions and IV medications administered in accordance with state law and approved medical staff policies and procedures? ○ Are blood transfusions and IV medications administered by personnel who are working within their scope of practice in accordance with state law and approved medical staff policies? **Observation** □ If able, observe blood transfusion and IV medication administration to assess staff adherence to accepted standards of practice. ○ Were safe medication administration practices used? ○ Was the transfused patient correctly identified and matched to review policies and procedures for IV medication administration and blood transfusion to the correct blood product prior to administration? ○ Was the appropriate access used for IV medications? ○ Were appropriate steps taken with regard to IV tubing and infusion pumps? ○ Are patients being monitored postinfusion for adverse reactions? □ If staff appear to not be following accepted standards of practice for patient risk assessment related to IV medications, particularly opioids, and appropriate monitoring of patients receiving IV medications and/or blood transfusions, determine if the staff address safe practices considerations.
MM.17.01.01, EP 1: The hospital develops and implements policies and procedures for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs. Note: This element of performance is also applicable to sample medications. **§482.23(c)(5)**	For adverse drug events and medication administration errors, follow the survey procedures for **§482.25(b)(6)**. Deficiencies are to be cited under both **§482.23(c)(5)** and **§482.25(b)(6)** when the drug or transfusion related to an adverse drug reaction, transfusion reaction, or medication administration error relates to a drug or transfusion administered by a nurse. **Interview** □ Interview nursing staff responsible for administering blood transfusions to verify that they are familiar with and comply with the hospital's policies. **Document Review**

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	General ☐ Verify that the hospital has a policy or procedure for internal reporting of transfusion reactions. ☐ Request any transfusion-related incident reports. o Is there evidence that the transfusion reaction was reported immediately to the practitioner responsible for the patient's care? o Was it reported to the hospital's quality assurance/performance improvement program?
MM.16.01.01, EP 3: The hospital develops and implements policies and procedures that guide the safe and accurate self-administration of medications by the patient or their caregiver or support person, where appropriate. Note 1: This applies to hospital-issued medications and the patient's own medications brought into the hospital. Note 2: The term "self-administered medication(s)" may refer to medications administered by a family member. **§482.23(c)(6)**	See Survey Procedures for **§482.23(c)(6)(i) through §482.23(c)(6)(ii)(E)**
MM.16.01.01, EP 4: If the hospital allows a patient to self-administer specific hospital-issued medications, the hospital has policies and procedures in place that address the following: - Making certain that an order is issued by a practitioner responsible for the patient's care and that it is consistent with the hospital's self-administration policy - Determining that the patient or the patient's caregiver or support person is capable of administering the specified medication(s) - Instructing the patient or the patient's caregiver or support person, where appropriate, in the safe and accurate administration of the specified medication(s) - Addressing the security of the medications for each patient Note: The term "self-administered medication(s)" may refer to medications administered by a family member. **§482.23(c)(6)(i)(A, B, C, D)** **MM.16.01.01, EP 5:** If the hospital allows a patient to self-administer medications not issued by the hospital, the hospital has policies and procedures in place that address the following:	**Interview** *For hospitals that permit self-administration of hospital-issued medications:* ☐ Ask the hospital to identify current inpatients for whom self-administration of hospital-issued medications is permitted. ☐ Interview several of these patients (or their caregivers/support persons when applicable) to verify that they received instruction on how to administer their medications ☐ Interview nurses caring for the selected patients. Ask them the following questions: o What are the applicable hospital policies and procedures for supervision of self-medication? o How do they assess a patient's (or patient's caregiver/support person's) capacity to self-administer medication. If they have concerns, how do they communicate them to the responsible practitioner? o Does the hospital permit nurses to return to nurse administration of medications in response to temporary reduction in patient capacity or absence of the patient's

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- Making certain that an order is issued by a practitioner responsible for the patient's care and that it is consistent with the hospital's self-administration policy - Determining that the patient or the patient's caregiver or support person is capable of administering the specified medication(s) - Instructing the patient or the patient's caregiver or support person, where appropriate, in the safe and accurate administration of the specified medication(s) - Addressing the security of the medications for each patient - Identifying the specified medication(s) and visually evaluating the medication(s) for integrity Note: The term "self-administered medication(s)" may refer to medications administered by a family member. **§482.23(c)(6)(ii)(A, B, C, D)** **RC.12.01.01, EP 2:** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the	caregiver/support person? If so, how do the nurses make this assessment? o How do they instruct a patient (or patient's caregiver/support person's) in medication self-administration? o How are self-administered medications? o How do they document self-administration of medications? **Document Review** **Policy/Procedure** ☐ Verify that the hospital has policies and procedures for self-administration of hospital-issued medications. o Are the staff following the policies and procedures? ☐ Verify that the policies and procedures address the following: o Limitations on medications not eligible for self-administration or patient conditions that exclude self-administration o Orders for self-administration of medication o Requirements, if any, for supervision of self-administration o Assessment of self-medication capacity o Instruction in self-medication o Security of self-administered medications o Documentation of self-administration **Patient Health Record** ☐ Review a sample of medical records for patients who self-administer medication. Verify that the records contain documentation of the following: o Order for self-administration of specific medication(s) o Nurse assessment of the patient's (or patient's caregiver/support person's) capacity to self-administer medication o Documentation of nurse instruction to the patient (or patient's caregiver/support person) in safe and appropriate techniques for self-administration of medication. o Documentation of self-administration times and doses, as reported by the patient (or patient's caregiver/support person) or directly observed by a nurse.

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patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. **§482.23(c)(6)(i)(E); §482.23(c)(6)(ii)(E)**	
NPG.12.03.01, EP 4: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services. **§482.62(d);** **HR.11.02.01, EP 2:** For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of psychiatric nursing that is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in	**Interview** ☐ Ask patients and staff if necessary treatment modalities and other services were provided in a timely manner. **Document Review** **Patient Health Record** ☐ Review a sample of patient medical records to ascertain if necessary active treatment assessments, treatments, evaluations, and activities have been conducted and documented. ☐ Review a sample of patient medical records to determine the following: o Are nursing assessments completed on all patients? o Do multidisciplinary treatment plans reflect nursing input, including specific nursing interventions for nursing problems (for example, violence toward self/others, physical/medical crises)? o Is nursing care evaluated by a registered nurse, with changes in care based on the patient's progress or lack thereof? ☐ Are intrusive techniques (for example, seclusion, restraint, electroconvulsive therapy, medical procedures) and patient incidents (for example, medication errors, patient falls, patient-to-patient and

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interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care provided. **§482.62(d); §482.62(d)(1)**	patient-to-staff injuries) monitored in accordance with hospital policy, state statutes, and safe nursing practice? ☐ **General** ☐ Review other records, such as the following, to determine the extent to which staffing levels or deployment contributed to negative patient outcomes: o Restraint and seclusion records o Incident reports o Medication error reports o Reports of patient/staff injuries ☐ Evaluate all outcome data in light of the success or failure observed during the survey relevant to each patient receiving active treatment and achieving desired outcomes of care. **Personnel/Credential File** ☐ Review the educational background and psychiatric nursing and leadership skills of the director of psychiatric nursing services. If the director has less than a master's degree in psychiatric nursing, ask to see evidence of experience and ongoing training in psychiatric nursing. **Note:** *Documented consultation from a nurse with a master's degree in psychiatric nursing constitutes ongoing training* **Observation** ☐ Observe sampled patients and others during structured sessions and in unstructured settings. Do you see behavioral evidence of a rational organization of resources? ☐ Are nursing personnel observed relating to patients in a therapeutic manner?
NPG.12.03.01, EP 4: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning	**Document Review** **General** ☐ Review the staffing plans for a sample of approximately 25% of the certified wards. **Note:** Staffing levels, including levels of nursing personnel, should be reviewed for the day(s) of the survey and evaluated based on the level of needs presented by the patients. ☐ If a problem or concern emerges, assess additional staffing patterns.

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- Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services. §482.62(d)(2) **NPG.12.03.01, EP 2:** The hospital makes certain a registered professional nurse is available 24 hours a day. §482.62(d)(2)	**Note:** *Decisions regarding the extent of additional data (number of wards and dates) to be reviewed should be based on the degree of the problem/concern. Patient needs assessment/patient acuity should be reviewed for any wards deemed necessary based on problems/concerns found in the sampling review.*

Hospital Nursing Services Evaluation Module Continued (Additional Joint Commission Requirements)

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PC.11.02.01, EP 1: The hospital conducts the patient's initial assessment within the written time frames it defines and in accordance with law and regulation. **PC.11.02.01, EP 9:** The hospital defines, in writing, the scope and content of screening, assessment, and reassessment. Patient information is collected according to these requirements. Note 1: In defining the scope and content of the information it collects, the hospital may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry. Note 2: Assessment and reassessment information includes the patient's perception of the effectiveness of, and any side effects related to, their medication(s). **PC.11.02.01, EP 10:** The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed. Note: Examples may include criteria that identify when a nutritional, functional, or pain assessment should be performed.	**Document Review** **Patient Health Record** ☐ Verify that initial assessments are completed in time frames it defines and in accordance with law and regulation ☐ Verify that screening, assessment, and reassessment is conducted according to hospital policy; including specialized, more in-depth assessments when required
PC.11.02.05, EP 1: Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes the following: - History of each substance use, including age of onset, duration, intensity, patterns of use, consequences of use, types of previous treatments, and responses to such treatment - History of mental, emotional, and behavioral problems; their co-occurrence with substance use disorders; and their treatment - History of biomedical complications associated with substance use disorders and the patient's level of awareness of the relationships between their behavioral conditions and pattern of substance use **PC.11.02.05, EP 2:** Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the	New York: Applies to Inpatient Addiction Program in general hospitals surveyed under HAP manual by SRH surveyor. See Joint Commission Survey Addendum for New York General Hospital – Inpatient Psychiatric Units

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treatment of alcoholism or other substance use disorders includes the following: - Acceptance of treatment or motivation for change, as well as recovery environment features that serve as resources or obstacles to recovery, including family members' use of alcohol or other substances - Family circumstances, including the composition of the family group and the need for their participation in the patient's care **PC.11.02.05, EP 3:** Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: - Religion and spiritual beliefs, values, and preferences - Living situation - Leisure and recreational activities - Military service history - Peer-group - Social factors - Ethnic and cultural factors - Financial status - Vocational or educational background - Legal history - Communication skills **PC.11.02.01, EP 4:** Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: - History of any physical or sexual abuse, as either the abuser or the abused - Sexual history and identification - Childhood history - Emotional and health issues - Visual-motor functioning - Self care	

Hospital Medical Record Services Evaluation Module (482.24)

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LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.24** **RC.11.01.01, EP 1:** The hospital maintains a medical record for every inpatient and outpatient in the hospital. **§482.24**	**Document Review** **General** □ Review the hospital's organizational structure and policy statements and interview the person responsible for the medical records service to determine if the service is structured appropriately to meet the needs of the hospital and its patients. **Patient Health Record** □ Review a sample of active and closed patient health records for completeness and accuracy in accordance with federal and state law, and regulation and hospital policy. **Note:** The sample should be 10 percent of the average daily census and no less than 30 records. □ Review a sample of outpatient records to determine compliance in outpatient departments, services, and locations.
LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with	**Document Review** **Patient Health Record** □ Verify that health records are promptly completed in accordance with state law and hospital policy.

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accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.24(a)** **NPG.12.01.01, EP 6:** The hospital has a medical record service that has administrative responsibility for medical records. The hospital employs adequate staff to support the prompt completion, filing, and retrieval of records. **§482.24(a)**	□ Request a sample of health records of past patients (inpatient and/or outpatient). Can the hospital promptly retrieve those records? **General** □ Review written job descriptions and staffing schedules to determine if staff is carrying out all designated responsibilities. **Observation** □ Verify that there is an established system that addresses at least the following activities of the medical records service: o Timely processing of records o Coding/indexing of records o Retrieval of records o Compiling and retrieving quality assurance activity data □ Verify that the system is reviewed and revised as needed. □ Verify that the hospital employs adequate medical record personnel who are qualified to ensure the hospital's medical records system complies with applicable law and regulation.
RC.11.01.01, EP 1: The hospital maintains a medical record for every inpatient and outpatient in the hospital. **§482.24(b)**	**Document Review** **Patient Health Record** □ Verify that a health record is maintained for each person treated or receiving care. [5]

[5] The hospital may have a separate record for both inpatients and outpatients. However, when two different systems are used, they must be appropriately cross-referenced and accessible.

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RC.11.01.01, EP 4: The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible. **§482.24(b)** **RC.11.02.01, EP 2:** The hospital uses a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. **§482.24(b)**	□ Verify that health records are accurate, completed promptly, easily retrieved, and readily accessible, as needed, in all locations where health records are maintained. **Observation** □ Determine the location(s) where health records are stored and maintained and verify that they are secure and protected from damage, flood, fire, and so on; and that access is limited to only authorized individuals □ Verify that the hospital's procedures ensure the integrity of authentication and protect the security of patient records.
RC.11.03.01, EP 1: The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical records are retained in their original or legally reproduced form for at least five years. This includes nuclear medicine reports; radiological reports, printouts, films, and scans; and other applicable image records. **§482.24(b)(1)**	**Document Review** **Patient Health Record** □ Request a sample of inpatient and outpatient health records of patients who were at the hospital in the previous 48 to 60 months. Were they promptly retrieved? Were they complete? Were they in their original or legally reproduced form? **Observation** □ Determine if health records are retained for at least 5 years, or more if required by state or local law.
IM.13.01.03, EP 1: The hospital has a system for coding and indexing medical records to make health information accessible when needed for patient care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical records system allows for timely retrieval of patient information by diagnosis and procedure. **§482.24(b)(2)**	**Interview** □ Verify that the hospital uses a coding and indexing system that permits timely retrieval of patient records by diagnosis and procedures.
IM.12.01.01, EP 1: The hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information.	**Document Review** **General**

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Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Policies and procedures also address the resident's personal records. §482.24(b)(3) **IM.12.01.01, EP 3:** The hospital develops and implements policies and procedures for the release of medical records. The policies and procedures are in accordance with law and regulation, court orders, or subpoenas. Note: Information from or copies of records may be released only to authorized individuals, and the hospital makes certain that unauthorized individuals cannot gain access to or alter patient records. §482.24(b)(3) **IM.12.01.03, EP 1:** The hospital develops and implements a written policy that addresses the security of health information, including the following: - Access and use of health information - Integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction - Intentional destruction of health information - When and by whom the removal of health information is permitted Note: Removal refers to those actions that place health information outside the hospital's control. §482.24(b)(3)	□ Verify that the hospital has policies that limit access to, and disclosure of, patient health records to permitted users and uses and that require written authorization for other disclosures. Are the policies consistent with regulatory requirements? □ Ensure that the hospital's policies and procedures stipulate that "original" health records are retained, unless their release is mandated under federal or state law, court order, or subpoena. **Patient Health Record** □ Verify that patient records, in all locations, are always secured from unauthorized access and released only as permitted by hospital policy and procedures. **Interview** Medical Records/Health Information Management staff □ About precautions taken to prevent physical or electronic altering of content previously entered into a patient health record or to prevent unauthorized disposal of patient records. □ Interview staff and ask them to demonstrate what safeguards are in place or precautions are taken to prevent unauthorized persons from gaining physical or electronic access to information in patient health records. [6]
RC.11.01.01, EP 2: The medical record includes the following: - Information needed to justify the patient's admission and continued care, treatment, and services - Information needed to support the patient's diagnosis and condition - Information about the patient's care, treatment, and services that promotes continuity of care among staff and providers Note: For hospitals that elect Joint Commission's Primary Care Medical	**Document Review** **Patient Health Record** □ Review a sample of patient health records to ensure the documentation contained within does the following: ○ Justify admission ○ Justify continued hospitalization ○ Support the diagnosis

[6] Access to electronic patient records is controlled through standard measures, such as business rules defining permitted access and passwords.

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Home option: This requirement refers to care provided by both internal and external providers. **§482.24(c)** **RC.12.01.01, EP 2:** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or	○ Describe the patient's progress ○ Describe the patient's response to medications ○ Describe the patient's response to services such as interventions, care, and treatments □ Verify that the health record contains complete information/documentation regarding evaluations, interventions, care provided, services, care plans, discharge plans, and the patient's response to those activities. □ Ensure that necessary information is included in patient records in a prompt manner so that health care staff involved in the care of the patient have access to the information necessary to monitor the patient's condition.

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impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. **§482.24(c)**	
RC.11.01.01, EP 4: The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, timed, medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible. **§482.24(c)(1)**	**Document Review** **General** □ Examine the hospital's medical records system policies and procedures to determine if required documentation is being authenticated after it is created in the patient's medical record (electronic, paper, or hybrid). **Patient Health Record** □ Review a sample of open and closed patient health records to determine the following: o All record entries are legible and written in such a way that is not likely to be misread or misinterpreted? o Orders, progress notes, nursing notes, or other entries in the medical record are complete. o All records contain sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers? o All record entries are dated, timed, and appropriately authenticated by the person who is responsible for ordering, providing, or evaluating the service provided. o All orders, including verbal orders, are written in the record and signed by the practitioner who is caring for the patient and who is authorized by hospital policy and in accordance with state law to write orders.

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	Interview Medical Records/Health Information Management staff □ How are written and electronic signatures, written initials, codes, and stamps (when such are used for authorship identification) verified? □ For electronic medical records, ask the hospital to demonstrate the security features that maintain the integrity of entries and verification of electronic signatures and authorizations.
RC.11.02.01, EP 1: All orders, including verbal orders, are dated, timed, and authenticated by the ordering physician or other licensed practitioner who is responsible for the patient's care, and who is authorized to write orders, in accordance with hospital policy, law and regulation, and medical staff bylaws, rules, and regulations. **§482.24(c)(2)**	**Document Review** **General** □ Verify that the hospital has policies and procedures requiring prompt authentication by the ordering or other practitioner [7] of all orders. □ Do the hospital's policies and procedures for verbal orders include a "read back and verify" process where the receiver of the order reads back the order to the ordering practitioner to verify its accuracy? **Patient Health Record** □ Review orders, including verbal orders, in a sample of patient health records. Have orders been dated, timed, signed and authenticated promptly by the ordering practitioner or practitioner responsible for the patient's care according to hospital policy? [3]
RC.12.01.01, EP 5: The hospital uses preprinted and electronic standing orders, order sets, and protocols for patient orders only if the the following occurs: - Orders and protocols are reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership. - Orders and protocols are consistent with nationally recognized and evidence-based guidelines. - Orders and protocols are periodically and regularly reviewed by the medical	**Document Review** **General** □ Verify that hospital policies and procedures for standing orders do the following: ○ Address the process by which a standing order is developed, approved, monitored, initiated by authorized staff, and subsequently authenticated by physicians or other practitioners responsible for the care of the patient.

[7] A practitioner other than the ordering practitioner, who is responsible for the care of the patient, may be permitted to authenticate an order under state law, hospital policy and medical staff bylaws, rules, and regulations.

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staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols.- Orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or by another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. **§482.24(c)(3)**	○ Specify the process whereby the physician or other practitioner responsible for the care of the patient acknowledges and authenticates the initiation of all standing orders after the fact, with the exception of influenza and pneumococcal vaccines. □ Verify that hospital standing order policies and procedures address a process for the identification and timely completion of any requisite updates, corrections, modifications, or revisions based on changes in nationally recognized, evidence-based guidelines. **Patient Health Record** □ Review a sample of patient health records for evidence of periodic evaluation and, if needed, modification of the standing order, including whether the order remains consistent with current evidence-based national guidelines, staff adheres to the protocol for initiation and execution, and there have been any preventable adverse events associated with the order. □ Review a sample of health records of patients for whom a nurse-initiated standing order was used. Verify that the order was documented and authenticated by a practitioner responsible for the care of the patient. **Personnel/Credential File** □ Review a sample of personnel files or other training documents for evidence of staff training on standing order's protocol. **Interview** □ Ask the hospital's medical staff and nursing and pharmacy leaders if standing orders are used. If yes, ask them to describe how a standing order is developed and monitored and their role in the process. □ Ask to see an example of one or more standing orders, including documentation on the development of the order, to look for the following: ○ Reference to the evidence-based national guidelines that support the standing order

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	○ Participation of medical staff and nursing and pharmacy leaders in the review and approval of the standing order ○ Description of the protocol to be followed when initiating the execution of the order, including description of the roles and responsibilities of various types of staff ○ Description of the process for authenticating the order's initiation by the practitioner responsible for the care of the patient or another authorized practitioner □ Interview staff providing clinical services in areas of the hospital where standing orders might be typically used and ask them if standing orders are used. [8]. ○ If they say yes, ask them to describe a typical scenario for which a standing order would be used and what they would do in that case. Does their description align with hospital protocol?
RC.12.01.01, EP 6: The medical history and physical examination or updates to the medical history and physical examination are placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. **§482.24(c)(4)(i)(A); §482.24(c)(4)(i)(B)** **RC.12.01.01, EP 7:** An assessment of the patient (in lieu of a medical history and physical examination as described in 42 CFR 482.24(c)(4)(i)(A) and (B)) is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the following conditions are met: - The patient is receiving specific outpatient surgical or procedural services. - The medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at § 482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and	~~Document Review~~ ~~General~~ ~~□ Verify that the hospital has policies and procedures for when specific patients are excluded from the required comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.~~ Patient Health Record □ Review a sample of patient health records to verify that a medical history and physical examination was completed and documented no more than 30 days before or 24 hours after a patient's admission or registration but prior to surgery or a procedure requiring anesthesia services, except for those patients who are specified as having outpatient surgeries/procedures where an assessment is performed in lieu of an H&P examination.

[8] Service areas may include, but not limited, to the emergency department, labor and delivery units, and inpatient units.

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physical examination, or any update to it, prior to specific outpatient surgical or procedural services. **§482.24(c)(4)(i)(C)** **PC.11.02.01, EP 2:** A medical history and physical examination is completed and documented no more than 30 days prior to, or within 24 hours after, registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 82.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/. **§482.24(c)(4)(i)(A)** **PC.11.02.01, EP 3:** For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/. **§482.24(c)(4)(i)(B)**	□ Ensure that the medical history and physical examination be placed in the patient's health record within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services. □ Verify that an updated examination of the patient includes the following: ○ Any changes in the patient's condition ○ That the medical history and physical examination was completed within 30 days before admission or registration □ Ensure that documentation of the updated examination was placed in the patient's health record within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services.
RC.12.01.01, EP 2: The medical record contains the following clinical information:	**Interview**

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- Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services	□ Ask patients and staff, as appropriate, to determine if patients have experienced any complications or unfavorable reactions to drugs/anesthesia. **Document Review** **Patient Health Record** □ Review a sample of patient health records to verify that the patient's admitting diagnosis is documented in each record. □ Review a sample of health records for patient complications, hospital-acquired infections, and unfavorable reactions to drugs/anesthesia. **Personnel/Credential File** □ Review a sample of health records of patients who have orders for consultative evaluations. Are the results/reports and other clinical findings of those consultative evaluations included in the record? **Observation** □ Observe any indications of patient complications, hospital-acquired infections, or unfavorable reactions to drugs/anesthesia.

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Note: Medical records are completed within 30 days following discharge, including final diagnosis. **§482.24(c)(4)(ii-iv)**	
RC.12.01.01, EP 3: The medical record contains any informed consent, when required by hospital policy or federal or state law or regulation. Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker. **§482.24(c)(4)(v)**	**Document Review** **Patient Health Record** ☐ Review a minimum of six random health records of patients who have, are undergoing, or are about to undergo a procedure or treatment that requires informed consent. Verify that each medical record contains informed consent forms. ☐ Verify that each completed informed consent form contains information for each of the elements listed below as the minimum elements of a properly executed informed consent, as well as any additional elements required by state law and/or hospital policy. o Name of the hospital where the procedure or other type of medical treatment is to take place o Name of the specific procedure or other type of medical treatment for which consent is being given o Name of the responsible practitioner who is performing the procedure or administering the medical treatment o Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative o Signature of the patient or the patient's legal representative o Date and time the informed consent form was signed by the patient or the patient's legal representative ☐ Verify that the informed consent includes notification that 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 with sedation or anesthesia ☐ Verify that there is documentation in the record that the patient was informed when practitioners other than the operating practitioner, including but not limited to, other physicians, residents, advanced

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	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 **General** □ Verify that the hospital's standard informed consent form contains the elements listed above and that it is consistent with hospital policies. If there is applicable state law, verify that the form is consistent with the requirements of that law. □ Verify that the hospital has assured that the medical staff has specified which procedures and treatments require written patient consent.
RC.12.01.01, EP 2: See above **§482.24(c)(4)(vi)**	**Document Review** **Patient Health Record** □ Review a sample of patient health records to verify that they records contain appropriate documentation of practitioners' orders, interventions, findings, assessments, records, notes, reports, and other information necessary to monitor the patient's condition, including the following: ○ All practitioner's orders (properly authenticated) ○ All nursing notes (including nursing care plans) ○ All reports of treatment (including complications and hospital-acquired infections) ○ All medication records (including unfavorable reactions to drugs) ○ All radiology reports ○ All laboratory reports ○ All vital signs ○ Any other information necessary to monitor the patient's condition □ Is this information included in patient records in a prompt manner so that health care staff involved in the care of the patient have access to the information necessary to monitor the patient's condition?
RC.12.01.01, EP 2: See above	**Document Review**

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§482.24(c)(4)(vii)	**Patient Health Record** □ Review a sample of patient health records to verify that a discharge summary is included to ensure proper continuity of care. □ Review records to verify that a final diagnosis is included in each discharge summary.
RC.12.01.01, EP 2: See above §482.24(c)(4)(viii)	**Document Review** **Patient Health Record** □ Select a sample of health records for patients who have been discharged for more than 30 days. Are the records complete? Does each record have the patient's final diagnosis?

Hospital Medical Record services Evaluation Module Continued (Additional Joint Commission Requirements)

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IM.13.01,01, EP 1: The hospital uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.	**Interview** □ Verify staff has awareness of hospital standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.
PC.11.02.07, EP 1: The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.	**Document Review** **Patient Medical Record** □ Verify that the patient's preferred language & communication needs for discussion of health care is documented and utilized during discussions
PC.12.02.01, EP 1: The hospital performs a learning needs assessment for each patient, which includes the following: - Cultural and religious beliefs - Emotional barriers - Desire and motivation to learn - Physical or cognitive limitations - Barriers to communication **PC.12.02.01, EP 2:** The hospital coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment, and services. **PC.12.02.01, EP 3:** Based on the patient's condition and assessed needs, the education and training provided to the patient by the hospital include any of the following: - An explanation of the plan for care, treatment, and services - Basic health practices and safety - Information on the safe and effective use of medications - Nutrition interventions (for example, supplements) and modified diets - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management - Information on oral health	**Document Review:** **Patient Medical Record:** □ Verify the patient received a learning needs assessment prior to providing education. □ Review education provided to the patient and determine if the patient's condition and assessed needs are addressed during their stay □ Verify the hospital evaluated the patient's understanding the education provided □ Verify the organization provided education about how to communicate concerns about the care

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- Information on the safe and effective use of medical equipment or supplies provided by the hospital - Habilitation or rehabilitation techniques to help the patient reach maximum independence - Fall reduction strategies **PC.12.02.01, EP 4:** The hospital evaluates the patient's understanding of the education and training it provided. **PC.12.02.01, EP 5:** The hospital provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.	
RC.11.01.01, EP 3: The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following: - Time and means of arrival - Indication that the patient left against medical advice, when applicable - Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services - A copy of any information made available to the provider furnishing follow-up care, treatment, or services	**Documentation Review** **Patient Medical Record** □ Verify that if a patient received urgent or immediate care, treatment or services their medical record contains all elements identified in EP 3
RC.12.01.01, EP 1: The medical record contains the following demographic information for the patient: - Name, address, and date of birth and the name of any legally authorized representative - Sex - Legal status of any patient receiving behavioral health care services - Communication needs, including preferred language for discussing health care - Race and ethnicity Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the medical record.	**Document Review:** **Patient Medical Record:** □ Verify the appropriate demographic information is collected in the medical record during record review.

Hospital Pharmaceutical Services Evaluation Module (482.25)

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NPG.12.01.01, EP 10: The hospital has a pharmacy that is directed by a registered pharmacist. If the hospital does not have a pharmacy, it has a drug storage area under competent supervision, as defined by the hospital. Note: The pharmacy or drug storage area is administered in accordance with accepted professional principles. **§ 482.25** **LD.13.01.09, EP 5:** The hospital develops and implements policies and procedures that minimizes drug errors. The medical staff develops these policies and procedures unless delegated to the pharmaceutical service. **§ 482.25**	**Interview** ☐ The leader(s) for evidence of the scope and complexity of its pharmaceutical services. ☐ The leaders(s) about how the hospital has determined that the services meet the needs of its patients. ☐ The unit nursing staff if prescribed medications are routinely available and timely. ☐ The director of pharmaceutical services about how reports of frequent delays or other problems are addressed.
MM.14.01.01, EP 3: The hospital develops and implements a written policy that defines the following: - Specific types of medication orders that it deems acceptable for use - Minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency - When indication for use is required on a medication order - Precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear - Required elements for medication titration orders, including the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes Note 1: Examples of objective clinical measures to be used to guide titration	**Interview** ☐ The director of pharmacy about how the hospital's organized pharmaceutical services responsible for the procurement, distribution, and control of all medication products used in the hospital (including medication-related devices) for inpatient and outpatient care ☐ The director of pharmacy if the hospital has a drug storage area instead of a pharmacy, does it use only drugs that are prepackaged and need no further preparation beyond that required at the point of care? ☐ The director of pharmacy and discuss how pharmacy services are integrated into its hospital-wide QAPI program ☐ Interview the director of pharmacy if the hospital conducts research involving uses investigational medications. If yes, **ask for the** policy and procedure to ensure that investigational medications are safely controlled and administered **Document Review** **General** ☐ Verify that the hospital's medical staff either has adopted pharmaceutical services policies and procedures or has delegated this task to pharmaceutical services.

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changes include blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM). Note 2: Drugs and biologicals not specifically prescribed as to time or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff. **§ 482.25(a)** **MM.11.01.01, EP 1:** Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and accepted standards of practice. Note: The hospital stores medications, including sample medications, according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. **§ 482.25(a)**	☐ Ask the pharmacy director to provide evidence that the hospital's policies and procedures are consistent with accepted professional principles. Policies must be designed to minimize drug errors (for example, high-alert medications, such as look-alike/sound-alike medications, identification of when weight-based dosing for pediatric populations is required, etc.) ☐ Ask the pharmacy director to provide evidence that the hospital's policies and procedures address key areas to prevent medication errors. ☐ Verify procedures for the use of investigational medications include, but are not limited to, the following: A written process for reviewing, approving, supervising and monitoring investigational medications specifying that when pharmacy services are provided, the pharmacy controls the storage, dispensing, labeling, and distribution of the investigational medication. **Personnel/Credential File (in the pharmacy)** ☐ Verify that staff was trained on applicable pharmaceutical policies and procedures. **Observation** ☐ Ensure that there is a process in place to monitor adherence to policies and procedures.
NPG.12.01.01, EP 11: The hospital has a full-time, part-time, or consulting pharmacist who is responsible for developing, supervising, and coordinating all pharmacy services activities. **§ 482.25(a)(1)**	**Interview** ☐ Does the hospital have a pharmacist who has been appointed to direct pharmaceutical services? ☐ Ask the pharmacy director to describe how policies and procedures related to pharmaceutical services are developed, approved, and implemented. What is their role in this process? ☐ Is there any evidence of problems within pharmaceutical services that suggest lack of supervision? ☐ If the director is a part-time employee or consultant, ask them how much time per week is spent on developing, supervising, and coordinating pharmaceutical services.

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	Document Review **General** ☐ Verify that the hospital has written criteria for the qualifications of the pharmacy director. o Is there evidence in the pharmacy director's file that they satisfy the criteria? o Is there evidence in the director's file that they meet the qualifications established by the medical staff and have been granted privileges as a pharmacist? ☐ If the hospital has a drug storage area in lieu of a pharmacy, ensure that the storage area is under competent supervision. ☐ Review the implementation of the pharmacy director's responsibilities by doing the following: o Reviewing minutes of meetings (if any) with facility staff regarding pharmaceutical services o Reviewing the job description or the written agreement to see that the responsibilities of the pharmacist are clearly defined and include development supervision and coordination of all the activities of pharmacy services o Determining whether the pharmacy director routinely evaluates the performance and competency of pharmacy personnel
NPG.12.01.01, EP 1: Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care.	**Observation** ☐ Determine if the pharmaceutical services staff is sufficient in number and training to provide quality services, including 24-hour, 7-day emergency coverage, or if there is an arrangement for emergency services, as determined by the needs of the patients and as specified by the medical staff. ☐ Determine if there are sufficient personnel to provide accurate and timely medication delivery, ensure accurate and safe medication administration, and provide appropriate clinical services, as well as the participation in continuous quality improvement programs that meet the needs of the patient population being served.

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§ 482.25(a)(2)	
MM.13.01.01, EP 1: The hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs. § 482.25(a)(3)	**Document Review** **General** - Determine if the hospital's policies and procedures minimize scheduled drug diversion. - Review records to determine if the hospital traces the movement of scheduled drugs throughout the service. - Determine if the pharmacist is responsible for determining that all drug records are in order and that an account of all scheduled drugs is maintained and periodically reconciled. **Observation** - Determine if there is a record system in place that provides information on controlled substances in a readily retrievable manner. - Determine if there is a system, delineated in policies and procedures, that tracks movement of all scheduled drugs from the point of entry into the hospital to the point of departure either through administration to the patient, destruction, or return to the manufacture. Determine if this system provides documentation on scheduled drugs in a readily retrievable manner to facilitate reconciliation of the receipt and disposition of all scheduled drugs. - Verify that the system can readily identify loss or diversion of all controlled substances in such a manner as to minimize the time frame between the actual losses or diversion to the time of detection and determination of the extent of loss or diversion.
MM.11.01.01, EP 1: Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and accepted standards of practice. Note: The hospital stores medications, including sample medications, according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. § 482.25(b)	**Interview** - The director of pharmacy or pharmacy staff how medication orders are routinely reviewed by the pharmacy before the first dose. What evidence can the hospital present that such reviews take place? - The director of pharmacy or pharmacy staff about the hospital's system for monitoring the effects of medication therapies for cases specified per hospital policy. - The director of pharmacy or pharmacy staff how the hospital retrieves and removes medications available for patient use when it has been informed of a drug recall. - Ask pharmacy staff how they address concerns, issues, or questions about any medication order and clarify with the prescribing practitioner

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	or another practitioner responsible for the care of the patient before dispensing. **Document Review** **General** ☐ Are questions regarding medication orders resolved with the prescriber? Is there a written notation of these discussions documented in the patient's medical record or pharmacy copy of the prescriber's order?
MM.15.01.01, EP 1: A pharmacist supervises all compounding, packaging, and dispensing of drugs and biologicals except in urgent situations in which a delay could harm the patient or when the product's stability is short. All compounding, packaging, and dispensing of drugs and biologicals are performed in accordance with state and federal law and regulation. **§ 482.25(b)(1)** **MM.15.01.01, EP 2:** The hospital develops and implements policies and procedures for sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation. Note: All compounded medications are prepared in accordance with the orders of a physician or other licensed practitioner. **§ 482.25(b)(1)** **MM.15.01.01, EP 3:** The hospital assesses competency of staff who conduct sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation and hospital policies. **§ 482.25(b)(1)** **MM.15.01.01, EP 4:** The hospital conducts sterile medication compounding of nonhazardous and hazardous medications within a proper environment in accordance with federal law and regulation and hospital policies. Note: Aspects of a proper environment include but are not limited to air	**Interview** ☐ Determine that only pharmacists or pharmacist-supervised personnel compound, package, and dispense drugs or biologicals in accordance with state and federal law and regulation and accepted standards of practice by doing the following: o Interviewing pharmacy and hospital staff to determine who prepares and dispenses drugs and biologicals o Observing on-site preparation and dispensing operations o Inspecting drug storage areas ☐ Ask the pharmacy director to explain the risk level(s) of the compounded sterile products (CSPs) being produced in house and/or obtained from external sources. ☐ If any CSPs are produced in the hospital: o Ask pharmacy staff for one or more examples of situations in which a beyond use date (BUD) had to be determined for a CSP based on the policy. o Ask if this function was carried out within the hospital or if it was handled by external source(s) of CSPs. o Is there evidence that the BUDs are determined consistent with the hospital's policies and procedures? o Ask staff who engage in sterile and nonsterile compounding if they knowledgeable about applicable levels of aseptic practices. ☐ Ask the pharmacy director to demonstrate how the following are accomplished to ensure that sterile compounding practices are consistent with standards for the risk level(s) of CSPs being produced for/dispensed to hospital patients:

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exchanges and pressures, ISO designations, viable testing, and cleaning/disinfecting. **§ 482.25(b)(1)** **MM.15.01.01, EP 5:** The hospital properly stores compounded sterile preparations of nonhazardous and hazardous medications and labels them with beyond-use dates in accordance with state and federal law and regulation and hospital policies. **§ 482.25(b)(1)** **MM.15.01.01, EP 6:** The hospital conducts quality assurance of compounded sterile preparations of nonhazardous and hazardous medications in accordance with state and federal law and regulation and organization policy. **§ 482.25(b)(1)** **MM.15.01.01, EP 7:** For hospitals that use Joint Commission accreditation for deemed status purposes: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals. **§ 482.25(b)(1)**	○ Verification of compounding accuracy and sterility ○ Environmental quality and controls, including environmental sampling, testing and monitoring, and cleaning and disinfection ○ Staff training and competency assessment, including but not limited to accuracy/precision in identifying and measuring ingredients, cleansing and garbing, aseptic manipulation skills, environmental quality and disinfection, appropriate work practices within and adjacent to the direct compounding area, verification/calibration of equipment, sterilization, and postproduction quality checks **Document Review** **General** ☐ Ask the pharmacy director to provide evidence that compounded medications used and/or dispensed by the hospital are being compounded consistent with standard operating procedures and quality assurance practices, ☐ If the hospital obtains compounded products from external compounding sources, verify that the external source(s) are registered with the Food and Drug Administration as outsourcing facilities. If not, ask the hospital to demonstrate that it systematically evaluates and monitors whether the outside compounding pharmacy adheres to accepted standards for safe compounding. ☐ Review the hospital's procedures for maintaining the quality of CSPs during storage, transport and dispensing. ○ Are CSPs packaged in a manner to protect package integrity and sterility? ○ How are CSP-specific requirements with respect to motion, light exposure, temperature, and potentially hazardous contents addressed? ○ How does the hospital ensure that such information is effectively conveyed to nonpharmacy health care personnel and/or to patients/caregivers, if applicable? ☐ Ensure that the hospital is systematically monitoring and tracking adherence to all of the quality assurance and staff training and competency standards described above.

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	○ Have any problems or risks been identified? ○ If so, did the hospital take effective action to protect patients, if relevant, and to effectively remedy the problem/risk? **Observation** ☐ Can the hospital demonstrate that compounded medications used and/or dispensed by the hospital are being compounded consistent with standard operating procedures and quality assurance practices?
MM.13.01.01, EP 2: The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area and locked when necessary to prevent diversion in accordance with law and regulation. Note 1: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Note 2: This element of performance is also applicable to sample medications. Note 3: Only authorized staff have access to locked areas. **§ 482.25(b)(2)(i-iii)**	**Interview** ☐ Interview staff to determine whether policies and procedures to restrict access to authorized personnel are implemented and effective. ☐ If patient self-administration of drugs and biologicals is permitted, interview patients and staff to determine whether policies and procedures are implemented and effective. **Document Review** **General** ☐ Review hospital policies and procedures governing the security of drugs and biologicals to determine if they provide for securing and locking as appropriate. ☐ Verify that the hospital has policies and procedures governing patient self-administration of drugs and biologicals. ☐ Verify that the hospital has a policy or procedure that requires Schedule II, III, IV, and V drugs to be kept in a locked storage area ☐ Verify that the hospital has a policy or procedure defining authorized personnel who are permitted access to locked areas where drugs and biologicals are stored. ☐ Verify that the hospital has a policy or procedure for limiting access to locked storage areas to authorized personnel only. **Observation** ☐ Verify that medications in various areas of the hospital are stored in a secure area and locked when appropriate. ○ Are medication storage areas periodically inspected by pharmacy staff to make sure medications are properly stored?

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	☐ Determine that security features in automatic dispensing cabinets are implemented and actively maintained (for example, access authorizations are regularly updated to reflect changes in personnel, assignments). ☐ Observe in various parts of the hospital whether Schedule II, III, IV, and V drugs are locked and stored in a secure area. ☐ Observe whether access to locked storage areas is limited to personnel authorized by the hospital's policy.
MM.13.01.01, EP 4: The hospital removes all expired, damaged, mislabeled, contaminated, or otherwise unusable medications and stores them separately from medications available for patient use. Note: This element of performance is also applicable to sample medications. **§ 482.25(b)(3)**	**Observation** ☐ Spot-check the labels of individual drug containers to verify that they conform to federal and state law and/or contain the following minimal information: o Patient's full name o Strength and quantity of the drug dispensed o Appropriate accessory and cautionary statements o Expiration date and/or, if applicable, a beyond use date (BUD) ☐ Spot-check each floor stock container to ensure labels bear the name and strength of the drug, lot and control number of equivalent, and expiration date. ☐ If the unit dose system is used, verify that each single unit dose package bears name and strength of the drug, lot and control number equivalent, expiration date, and/or, if applicable, a BUD. ☐ Inspect patient-specific and floor stock medications to identify expired, mislabeled, or unusable medications.
MM.13.01.01, EP 5: When a pharmacist is not available, only designated staff obtain drugs and biologicals from the pharmacy or storage area in accordance with policies and procedures of medical staff and pharmaceutical service, and applicable federal and state law and regulation. **§ 482.25(b)(4)**	**Document Review** **General** ☐ Determine through pharmacy records that, when the pharmacist is not available, drugs are removed from the pharmacy (drug storage area) only by a designated individual (in accordance with state law, if applicable) and only in amounts sufficient for immediate therapeutic needs. ☐ Review policies and procedures to determine who is designated to remove drugs and biologicals from the pharmacy or storage area and the amount a non-pharmacist may remove in the absence of a

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	pharmacist. The individual(s) designated should be identified by name and qualifications. - Verify that the pharmacist reviews all medication removal activity and correlates the removal with current medication orders in the patient medication profile. - Determine if the pharmacist routinely reviews the contents of the after-hours supply to determine if it is adequate to meet the after-hours needs of the hospital. **Observation** - Verify that a system is in place that accurately documents the removal of medications (type and quantity) from either the pharmacy or the after-hours supply.

MM.14.01.01, EP 3: The hospital develops and implements a written policy that defines the following:
- Specific types of medication orders that it deems acceptable for use
- Minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication
frequency
- When indication for use is required on a medication order
- Precautions for ordering medications with look-alike or sound-alike names
- Actions to take when medication orders are incomplete, illegible, or unclear
- Required elements for medication titration orders, including the medication name,
medication route, initial rate of infusion (dose/unit of time), incremental units to which
the rate or dose can be increased or decreased, how often the rate or dose can be
changed, the maximum rate or dose of infusion, and the objective clinical measure
to be used to guide changes
Note 1: Examples of objective clinical measures to be used to guide titration changes include blood pressure, Richmond Agitation–Sedation Scale
	Interview
	- Ask unit staff what happens in the case of drugs with no stop date or prescribed number of doses.
	  - Are they aware of the automatic stop policy?
	  - Can they describe how it is enforced?
	Document Review
	General
	- Review policies and procedures to determine that there is a protocol established by the medical staff to discontinue and review patients' medical records to determine compliance with the stop-order policy.

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(RASS), and the Confusion Assessment Method (CAM). Note 2: Drugs and biologicals not specifically prescribed as to time or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff. **§ 482.25(b)(5)**	
MM.17.01.01, EP 2: Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the hospital are immediately reported to the attending physician or other licensed practitioner and, as appropriate, to the hospitalwide quality assessment and performance improvement program. **§ 482.25(b)(6)** **MM.17.01.01, EP 3:** The hospital has a method (such as using established benchmarks for the size and scope of services provided by the hospital or studies on reporting rates published in peer-reviewed journals) by which to measure the effectiveness of its process for identifying and reporting medication errors and adverse drug reactions to the quality assessment and performance improvement program. **§ 482.25(b)(6)**	**Interview** ☐ Ask hospital staff what they do when they become aware of a medication error, adverse drug reaction (ADR), or drug incompatibility. ☐ Are staff aware of and do they follow the hospital's policy and procedures? ☐ Ask hospital staff how they manage drug incompatibilities. o What tools do they use in the clinical setting to minimize the risk of incompatibilities? o How is the information related to drug incompatibilities made available to the clinical staff administering IV medications (for example, posters, online tools)? o How often is the information updated to ensure accuracy? ☐ Ask hospital staff if they are aware of the hospital's policy on reporting and documentation of medication errors and adverse drug reactions. ☐ How does information regarding medication errors, adverse drug reactions, and incompatibilities get reported to the hospital quality assurance/performance improvement (QAPI) program? Ask staff to speak to the process. ☐ For QAPI reporting purposes, is the hospital's definition of an ADR and medication error based on national standards? **Document Review** **General** ☐ Does the hospital have policies and procedures that define medications errors, ADRs, and drug incompatibilities?

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	○ Do the policies and procedures address the circumstances under which they must be reported immediately to the attending physician, as well as to the hospital's QAPI program? ○ Do they address how reporting is to occur? **Observation** ☐ Are all medication errors and suspected ADRs promptly recorded in the patient's medical record, including those not subject to immediate reporting? ○ If upon review of a sample of records, a suspected ADR or medication error is identified, determine if it was reported immediately to the attending or covering physician, in accordance with the hospital's written policies and procedures. ○ If it is reported to a covering physician, determine if it was also reported to the attending physician when they became available.
MM.13.01.01, EP 3: The hospital reports abuses and losses of controlled substances, in accordance with federal and state law and regulation, to the individual responsible for the pharmacy department or service and, as appropriate, to the chief executive officer. Note: This element of performance is also applicable to sample medications. **§ 482.25(b)(7)**	**Interview** ☐ Interview pharmacy director, pharmacists, or pharmacy staff to determine their understanding of the hospital's controlled drug policies. ○ Is there a policy and procedure for handling controlled drug discrepancies? **Document Review** **General** ☐ Conduct a spot check of drug use and other inventory records to **ensure** that drugs are properly accounted for. ☐ Review reports of pharmaceutical services to determine if there are reported problems with controlled drugs and what actions have been taken to correct the situation. ○ Determine if controlled drug losses were reported to appropriate authorities, in accordance with state and federal law.

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MM.11.01.03, EP 1: Information relating to drug interactions, drug therapy, side effects, toxicology, dosage, indications for use, and routes of administration is available to the professional staff. **§ 482.25(b)(8)**	**Interview** □ If drug information is built into the hospital's electronic health records system, ask the pharmacy director how the hospital ensures that the information is accurate and up-to-date. □ Ask practitioners whether needed reference information is available to them when prescribing drugs. □ Ask nursing staff whether needed reference information is available to them when administering drugs or biologicals and when monitoring patients for effects of medication therapies. **Observation** □ Is drug information readily available to nurses and practitioners, whether in a hard-copy or electronic format?
MM.12.01.01, EP 2: The hospital maintains a formulary, including medication strength and dosage. The formulary is readily available to those involved in medication management. Note 1: Sample medications are not required to be on the formulary. Note 2: In some settings, the term "list of medications available for use" is used instead of "formulary." The terms are synonymous. **§ 482.25(b)(9)**	**Interview** □ Interview the pharmacist to determine that the medical staff has established a formulary that lists drugs that actually are available in the hospital. □ Interview the pharmacy director to determine that there is a process for creation and periodic review of a formulary system. **Observation** □ Verify that the formulary lists drugs that are available.

Hospital Radiologic Services Evaluation Module (482.26)

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LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.26; §482.26(a)** **NPG.12.01.01, EP 1:** Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services	**Interview** Ask radiology staff and leaders how the hospital: ☐ Determines diagnostic radiologic services meet the needs of its patients. ☐ Maintains or makes available diagnostic radiologic services that can be provided promptly. ☐ Maintains or makes available diagnostic radiologic services at all times to support the emergency department. *If the diagnostic radiologic services are* ***not on the same campus*** *as the hospital's emergency department, same-day surgery, inpatient locations, or other areas where services dependent on radiologic services are provided ask staff and leaders how the hospital:* ☐ Furnishes services within clinically required time frames. o Does the hospital have an arrangement with an off-site facility to furnish diagnostic services when needed? ☐ Ensures that staff **authorized to interpret diagnostic studies are ready to furnish** (either on site or through telecommunications media that permit remote review and interpretation of studies) **services within clinically required time frames.** ☐ If it is a multi-campus hospital, is able to furnish diagnostic radiologic services when needed in a clinically appropriate timeframe for each location providing inpatient, same-day surgery, and emergency services. **Document Review** **General** ☐ Written scope and complexity of the diagnostic radiological services it provides.

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- Diagnostic and therapeutic radiology services. Note 2: Emergency services staff are qualified in emergency care. **§482.26; §482.26(a)**	
PE.02.01.01, EP 4: The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) **§482.26(b)**	**Interview** □ Radiologic services staff to determine: o Familiarity with policies and procedures related to safety in general and to specific clinical protocols. o Training at appropriate intervals to on operating equipment according to manufacturer's instructions and hospital policy. o They know **how to respond to adverse events**. □ Personnel permitted to enter areas where radiologic services are provided receive required training. □ Radiologist who supervises ionizing radiologic services to determine -- o How the hospital **monitors quality and safety of radiologic services**. o How protocols for various types of ionizing radiation diagnostic or therapeutic imaging modalities are designed to minimize the amount of radiation while maximizing the yield and producing diagnostically acceptable image quality. o How adverse events are analyzed for causes and that preventive actions are taken (Cite deficiencies both here and under the applicable quality assurance/performance improvement CoP). **Document Review** **General** □ Policies, procedures, and protocols for specific radiologic services modalities that include, but are not limited to, provisions addressing the following: o For ionizing radiation services, application of the fundamental principle of As Low as Reasonably Achievable or ALARA is

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	considered an accepted standard of practice for ionizing radiation services to which hospitals must adhere.[9] ○ Written protocols designed to ensure that diagnostic studies and therapeutic procedures are routinely performed in a safe manner, utilizing parameters and specifications that are appropriate to the ordered study/procedure.[10] ○ Identification of patients at high risk for adverse events for whom the radiologic study or procedure might be contraindicated ▪ Steps to be taken, and by which personnel, if an order is written for a radiologic study or procedure for an individual identified in policies as potentially at high risk (e.g., notify the ordering physician, cancel the procedure personally, etc.). ☐ Safety protocols are reviewed periodically and, if applicable, updated with documented rationale and details for changes to technical parameters **Personnel/Credential File** ☐ Staff who perform diagnostic imaging studies or therapeutic procedures using radiologic services equipment are qualified, as applicable, and receive training that includes proper operation of equipment per manufacturer's instructions and hospital policy. **Observation** ☐ Observe one or more radiologic studies/procedures being prepped for and/or performed. Ask for the **protocol(s) for one or more studies/procedure(s)** you are going to/or did **observe** and check that they were followed.

[9] ALARA is defined by the U.S. Environmental Protection Agency (EPA) as "A principle of radiation protection philosophy that requires that exposures to ionizing radiation be kept as low as reasonably achievable, economic and social factors being taken into account. The protection from radiation exposure is ALARA when the expenditure of further resources would be unwarranted by the reduction in exposure that would be achieved." (Federal Guidance Report No. 14, Radiation Protection Guidance for Diagnostic and Interventional X-ray Procedures, p. 100, November, 2014)
[10] Developed or approved by the radiologist responsible for the radiologic services, in conjunction with other qualified radiologic services personnel (e.g., a medical physicist, radiologic technologists, patient safety officers, etc.)

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	☐ Confirm radiologic services areas are equipped with **equipment or materials to immediately respond to an adverse event**.
PE.02.01.01, EP 4: The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) **§482.26(b)(1)**	**Document Review** **General** ☐ Verify that the hospital has written policies and procedures to ensure safety from radiation hazards. The policies and procedures must address but are not limited to the following: o Clear and easily recognizable signage identifying hazardous radiation areas o Limitations on access to areas containing radiologic services equipment o Appropriate use of shielding, including the following: • Types of personal protective shielding to be used (for example, lead aprons, lead gloves, protective eyewear, thyroid shields, portable individualized lead panels, stationary barriers); under what circumstances; and for patients, including high-risk patients as identified in radiologic services policies and procedures, patient family members or support persons who may be needed to be with the patient during a study or procedure, and hospital personnel • Lead and concrete barriers built into the walls and other structures of the imaging areas • Identification and use of appropriate containers to be used for various radioactive materials, if applicable, when stored, in transport between locations within the hospital, in use, and during/after disposal **Observation** ☐ Clear and easily recognizable signage identifies hazardous radiation areas. ☐ Lead and concrete barriers have been built into the walls and other structures of the imaging areas. ☐ Limited access to areas containing radiologic services equipment. ☐ Personal shielding, supplies, and equipment maintained and routinely inspected by the hospital.

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	□ Proper shielding is applied to a patient who is undergoing a procedure using ionizing radiation. □ Staff members appropriately extricate themselves from the immediate exposure field while performing a study or procedure using ionizing radiation. □ Staff wear shielding as appropriate, per hospital policy. □ Hazardous radiation materials are clearly labeled, properly transported and stored in a safe manner in the requisite containers, and disposed of in the appropriate manner.
PE.02.01.01, EP 4: The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) **482.26(b)(2)**	**Interview** □ Ask the supervising radiologist about the following: o Staff education (for example, frequency, topics) o Processes for monitoring and trending of staff radiation exposure □ Ask staff about radiation exposure education they have received **Document Review** **General** □ Policies and procedures for conducting periodic inspections of radiology equipment □ **Inspection records (logs)** to verify periodic inspections are conducted in accordance with federal and state law and regulations and manufacturer's instructions □ **Inspection and maintenance** activities performed by **qualified individuals** □ Maintenance logs document the **calibration upon installation and after major upgrades or servicing.** □ Inspection schedule and mechanism for identifying hazards, including **accurate dosimetry** determinations with phantom patients, as applicable. □ Problems identified through testing and maintenance program are properly corrected in a timely manner and that the correction is maintained over time.
PE.02.01.01, EP 5: Radiation workers are checked periodically, using exposure meters or badge tests, for the amount of radiation exposure. **482.26(b)(3)**	**Document Review** **General** □ Policies and procedures for radiologic services

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	□ Review data on staff radiation exposure, including who documented the exposure.
PC.12.01.01, EP 1: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. **482.26(b)(4)**	**Interview** Radiologic services staff □ How they know which members of the medical staff have privileges to order radiologic services. □ What they expect to see in the order and what they do if more information is needed. **Document Review** **Patient Health Record** □ Radiologic services order
MS.17.01.03, EP 5: For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting radiologist who is a doctor of medicine or osteopathy, qualified by education and experience in radiology, supervises ionizing radiology services and interprets radiologic tests that the medical staff determine to require a radiologist's specialized knowledge. **482.26(c)**	**Document Review** **Personnel/Credential File** □ Medical staff education and experience criteria for radiologist privileges are documented □ Supervising radiologist for ionizing radiology services. **General** □ Policies and procedures for diagnostic radiology services using ionizing radiation o Identify which types of radiologic tests require interpretation by a radiologist o Identify which types of radiologic tests can be interpreted by another type of privileged practitioner o Radiologic test interpretation policies approved by the medical staff
MS.16.01.01, EP 11: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines	**Interview** □ Ask radiology services leader(s) the following:

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the qualifications of the radiology staff who use equipment and administer procedures. Note: Technologists who perform diagnostic computed tomography exams will, at a minimum, meet the requirements specified at NPG.13.01.01, EP 1. 482.26(c)(2)	○ How do you limit the use of equipment and performance of studies or procedures to only designated individuals? ○ How often do you assess staff competency and provide the training needed to keep skills current? **Document Review** **General** □ Policy for radiologic services: ○ Identifies personnel who the medical staff designate as qualified to use radiologic equipment and perform diagnostic or therapeutic studies or procedures. ○ Requires personnel to have appropriate training and to demonstrate competence in use of equipment and administration of procedures prior to being designated as qualified. **Personnel/Credential File** □ Radiology personnel records include training completion dates and evidence of satisfactory competence. **Observation** Radiologic technologists using radiologic equipment or performing studies/procedures are designated to do so
RC.12.01.01, EP 2: The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and	**Patient Health Record** Radiology reports signed by the individual who interpreted the test

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other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. **482.26(d); 482.26(d)(1)**	
RC.11.03.01, EP 1: The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical records are retained in their original or legally reproduced form for at least five years. This includes nuclear medicine reports; radiological reports, printouts, films, and scans; and other applicable image records. **482.26(d)(2); 482.26(d)(2)(i); 482.26(d)(2)(ii)**	**Interview** Radiology services leader or staff □ how many years of past radiology reports, printouts, films, scans, and other image records can be accessed. **Document Review** □ Records retention policy for radiology reports, printouts, films, scans, and other image records

Hospital Laboratory Services Evaluation Module (482.27)

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LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.27** **LD.13.03.01, EP 12:** The hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493. **§482.27**	**Document Review** ☐ Determine the total number of laboratories, the location of each laboratory, and every location where laboratory procedures are performed. ☐ Verify that the laboratory service and all laboratory locations are integrated into the hospital-wide QAPI program. ☐ If laboratory services are contracted, verify that the review of the quality of those services is integrated into the hospital-wide QAPI program.
LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope	**Interview** ☐ Leaders and determine which services are provided directly by the facility and which are provided through contractual agreements

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and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.27(a)** **LD.13.03.01, EP 12:** The hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493. **§482.27(a)**	☐ Interview lab director to view the referral laboratory's CLIA number and which specialty it is in. ☐ Interview the lab director to determine if the hospital provides laboratory services in multiple locations, verify that all laboratory services are operating under a current CLIA certificate. **Document Review** Review laboratory scope of services to confirm the services that are provided directly by the facility and which are provided through contractual agreements. The lab must be certified laboratory that meets requirements of Part 493. *Note: The CLIA certification may be accomplished by having one certificate for the entire hospital's laboratory services, by having one certificate for each laboratory, or by the hospital having a mixture. Whatever the arrangement, all laboratory services must be provided in accordance with CLIA requirements and under a current CLIA certificate, even when those laboratory services take place outside of a lab.* **Observation** ☐ Examine records in the lab and determine if the services, including emergency services, are provided in accordance with the hospital's policies.
LD.13.03.01, EP 13: Emergency laboratory services are available 24 hours a day, 7 days a week. **§482.27(a)(1)**	**Interview the lab director** ☐ Confirm emergency laboratory services are available 24 hours a day, 7 days a week (provided directly by the hospital or through on-site contracted laboratory services) ☐ Emergency lab services include collection, processing, and provision of results to meet a patient's emergency laboratory needs.

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	☐ In a hospital with multiple hospital campuses, these emergency laboratory services are available on-site 24/7 at each campus. ☐ How does the medical staff determine which laboratory services are to be immediately available to meet the patient's needs. *Note 1: The emergency laboratory services (procedures, tests, personnel) available should reflect the scope and complexity of the hospital's operation and be provided in accordance with Federal and State law, regulations and guidelines and acceptable standards of practice.* *Note 2: At a hospital with off-campus locations, the medical staff determines which laboratory services must be immediately available to meet the patient's needs. The services must be available during the hours of operation of that location.* **Interview (Individual Tracer)** ☐ Interview the emergency department staff to see if laboratory services are available to verify the 24- hour availability of emergency services and whether those services are provided when required. **Document Review** ☐ Review the written description of the emergency laboratory services. Review accession records, worksheets, and test reports to verify the 24-hour availability of services. **Observation (Individual T racer)** ☐ Observe how laboratory specimens are obtained and transported to the laboratory.
LD.13.03.01, EP 14: The hospital maintains a written description of the scope of laboratory services provided that is available to the medical staff.	**Document Review**

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§482.27(a)(2)	☐ Verify the existence of a written description of the laboratory services provided, including those furnished on a routine or STAT basis (either directly or under an arrangement with an outside facility). ☐ Verify that the description of services is accurate and current.
PC.13.01.05, EP 1: The laboratory develops and implements written policies and procedures for collecting, preserving, transporting, receiving, and reporting examination results for tissue specimens. §482.27(a)(3)	**Document Review** ☐ Verify that the laboratory has written instructions for the collection, preservation, transportation, receipt, and reporting of tissue specimen results. **Observation** ☐ Review tissue records (accession records, worksheets, and test reports) to determine if the laboratory follows the written protocol.
PC.13.01.05, EP 2: The laboratory develops and implements a written policy, approved by the medical staff and a pathologist, that establishes which tissue specimens require only a macroscopic examination, and which require both a macroscopic and microscopic examination. §482.27(a)(4)	**Document Review** ☐ Verify that the laboratory has written policies, approved by the medical staff and a pathologist, that state which tissue specimens require a macroscopic (gross) examination and which tissue specimens require both macroscopic and microscopic examination. **Observation** Verify tissue specimens are examined in accordance with the written policies. Confirm the policies are also in accordance other Federal and State laws, regulations, and guidelines.
PC.15.01.01, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements written policies and procedures, including documentation and notification procedures, addressing potentially infectious blood and blood components, consistent with Centers for Medicare & Medicaid Services requirements at 42 CFR 482.27. Note 1: The procedures for notification and documentation conform to federal, state, and local laws, including requirements for the confidentiality of medical records and other patient information. Note 2: See Glossary for the definition of potentially infectious blood and blood components.	**Interview** Interview lab staff about what they would do upon being notified of potentially infectious blood and blood components. **Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV

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§482.27(b)(1)(i-iii); §482.27(b)(2)	
LD.13.03.03, EP 5: If the hospital routinely uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement includes that the blood collecting establishment notify the hospital within the specified timeframes under the following circumstances: - Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection - Within 45 days of the test for the results of the supplemental (additional, more specific) test for HIV or HCV or other follow-up testing required by the US Food and Drug Administration -Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available §482.27(b)(3); §482.27(b)(3)(i-iii)	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV ☐ Review the written agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components.
PC.15.01.01, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification of blood that is reactive to the human immunodeficiency virus (HIV) or hepatitis C virus (HCV) screening test, the hospital determines the disposition of the blood or blood components and quarantines all previously donated blood and blood components in inventory. §482.27(b)(4)	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. This would include determining the disposition of the blood or blood components and quarantining all blood and blood components from previous donations in inventory.
PC.15.01.01, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration is negative and there are no other informative test results, the hospital may release the blood and blood components from quarantine. §482.27(b)(4)(i)	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. *Note: If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is negative, absent*

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	other informative test results, the hospital may release the blood and blood components from quarantine.
PC.15.01.01, EP 4: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration is positive, the hospital does the following: - Disposes of the blood and blood components - Notifies the transfusion recipients as set forth in 42 CFR 482.27(b)(6) **§482.27(b)(4)(ii); §482.27(b)(4)(ii)(A); §482.27(b)(4)(ii)(B)**	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. *Note: If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is positive, the hospital must dispose of the blood and blood components.*
PC.15.01.01, EP 5: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration (FDA) is indeterminate, the hospital destroys or labels prior collections of blood or blood components held in quarantine, consistent with FDA requirements 21 CFR 610.46(b)(2) and 610.47(b)(2). **§482.27(b)(4)(iii)**	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. *Note: If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital destroys, or labels prior collections of blood or blood components held in quarantine as set forth at 21 CFR 610.46(b)(2) and 610.47(b)(2).*
LD.13.01.01, EP 7: The hospital maintains the following: - Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval - A fully funded plan to transfer these records to another hospital or other entity if the hospital ceases operation for any reason **§482.27(b)(5)(i); §482.27(b)(5)(ii)**	**Interview** ☐ Interview the lab director if there is a fully funded plan to transfer these records to another hospital or other entity if the hospital ceases operation for any reason. **Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. ☐ Verify that the hospital maintains records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval.

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	Observation ☐ Ask to review records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval. Verify that the hospital maintains the records.
PC.15.01.01, EP 6: For hospitals that use Joint Commission accreditation for deemed status purposes: When potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components are administered (either directly through the hospital's own blood collecting establishment or under an agreement) or released to another entity or individual, the hospital takes the following actions: - Makes reasonable attempts to notify the patient, the attending physician or other licensed practitioner, or the physician or other licensed practitioner who ordered the blood or blood component and ask the practitioner to notify the patient, or other individuals as permitted under 42 CFR 482.27, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling - Attempts to notify to the patient, legal guardian, or relative if the practitioner is unavailable or declines to make the notification - Documents in the patient's medical record the notification or attempts to give the required notification **§482.27(b)(6)(i-iii)**	**Interview** ☐ If the hospital made reasonable attempts to notify the patient, or to notify the attending physician or the physician who ordered the blood or blood component and interview the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling. ☐ If the physician is unavailable or declines to make the notification, does the hospital make reasonable attempts to give this notification to the patient, legal guardian or relative? ☐ How does the hospital document the notification or attempts to give the required notification in the patient's medical record. **Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV.
PC.15.01.01, EP 7: If the hospital receives notification that it received potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood and blood components, the hospital makes reasonable attempts to give notification over a period of 12 weeks unless one of the following occurs: - The patient is located and notified. - The hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification timeframe to exceed 12 weeks. Note: For notifications resulting from donors tested on or after February 20, 2008 as set forth at 21 CFR 610.46 and 610.47, the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components.	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. **Note:** *For notifications resulting from donors tested on or after February 20, 2008, as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give* notification over a period of 12 weeks unless (see below) **Note:** The patient is located and notified; or

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§482.27(b)(7); §482.27(b)(7)(i); §482.27(b)(7)(ii)	**Note:** *If the hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification timeframe to exceed 12 weeks.*
PC.15.01.01, EP 8: When notifying patients who have received potentially human immune deficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components, the notification includes the following: - Oral or written information explaining the need for HIV or HCV testing and counseling, so that the patient can make an informed decision about whether to obtain HIV or HCV testing and counseling - A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose §482.27(b)(8)(i-iii)	**Interview** ☐ Lab staff to hear and see evidence of a basic explanation of the need for HIV or HCV testing and counseling. ☐ Lab staff to determine that there is enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling. ☐ Lab staff and ask to see a list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose. **Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. The notification must include the following information: (see below 482.27(b)(8)(i)) ☐
PC.15.01.01, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements written policies and procedures, including documentation and notification procedures, addressing potentially infectious blood and blood components, consistent with Centers for Medicare & Medicaid Services requirements at 42 CFR 482.27. Note 1: The procedures for notification and documentation conform to federal, state, and local laws, including requirements for the confidentiality of medical records and other patient information. Note 2: See Glossary for the definition of potentially infectious blood and blood components. §482.27(b)(9)	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. ☐ Verify that the hospital establishes policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information.
PC.15.01.01, EP 9: If a patient has received an infectious blood or blood component, the hospital notifies the specified individual(s) under the	**Interview**

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following circumstances: - A legal representative designated in accordance with state law if the patient has been adjudged incompetent by a state court - The patient or his or her legal representative or relative if the patient is competent but state law permits a legal representative or relative to receive the information on the patient's behalf - The patient's legal representative or relative if the beneficiary of the potentially human immunodeficiency virus infectious transfusion is deceased - The parents or legal guardian if the patient is a minor **§482.27(b)(10)**	□ Interview lab staff regarding notification to legal representative or relative regarding: If the patient has been adjudged incompetent by a state court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient's behalf, the physician or hospital must notify the patient or his or her legal representative or relative. For possible HIV infectious transfusion recipients that are deceased, the physician or hospital must inform the deceased patient's legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified **Document Review** □ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV.
PC.15.01.01, EP 10: The hospital complies with US Food and Drug Administration regulations pertaining to blood safety issues in the following areas: - Appropriate testing and quarantining of infectious blood and blood components - Notification and counseling of potential recipients of infectious blood and blood components Note: This applies to lookback activities only related to new blood safety issues that are identified after August 24, 2007. **§482.27(c)(1); §482.27(c)(2);**	**Document Review** □ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV For lookback activities only related to new blood safety issues that are identified after August 24, 2007: Hospitals must comply with FDA regulations as they pertain to blood safety issues in the following areas: (1) Appropriate testing and quarantining of infectious blood and blood components. (2) Notification and counseling of recipients that may have received infectious blood and blood components.

Food and Dietetic Services Evaluation Module (482.28)

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LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.28** **NPG.12.01.01, EP 7:** The hospital has dietetic services that are directed and adequately staffed by qualified personnel. Note: For hospitals that provide dietetic services through contracted services, the contracted service has a dietician who serves the hospital full-time, part-time, or on a consultant basis and acts as a liaison to hospital medical staff for recommendations on dietetic policies that affect patient care, treatment, and services. **§482.28**	**Document Review** ☐ Review food and dietetic scope of services to confirm the services are in compliance with Federal and State licensure requirements for food and dietary personnel as well as food service standards, laws and regulations.

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NPG.12.01.01, EP 8: The hospital has a full-time employee, qualified through education, training, or experience, who serves as director to oversee the daily management of food and dietetic services. **§482.28(a)(1)(i-iii)**	**Interview** ☐ Verify that the director of the food and dietetic services is a full-time employee. **Document Review** **Personnel/Credential File** ☐ Review the service director's job description to verify that it is position-specific and that responsibility and authority for the direction of the food and dietary service has been clearly delineated. ☐ Review the service director's personnel file to verify that he/she has the necessary education, experience, and training to manage the service, appropriate to the scope and complexity of food service operations.
NPG.12.01.01, EP 9: The hospital has a qualified dietitian on a full-time, part-time, or consultative basis. **482.28(a)(2)**	**Interview** ☐ If the dietitian is not full-time, determine that the number of hours spent working is appropriate to serve the nutritional needs of the patients, and that the hospital makes adequate provisions for a qualified consultant coverage when the dietitian is not available. **Document Review** **Personnel/Credential File** ☐ Review the dietitian's personnel file to determine that he/she is qualified based on education, experience, specialized training, and, if required by State law, is licensed, certified, or registered by the State.
HR.11.01.01, EP 1: The hospital's food and dietetic administrative and technical staff are competent to perform their responsibilities. **482.28(a)(3)**	**Document Review** **Personnel/Credential File** ☐ Administrative and technical staff have appropriate credentials as required and have received adequate training and are competent in their respective duties.
PC.12.01.09, EP 1: The nutritional needs of the individual patient are met in accordance with clinical practice guidelines and recognized dietary practices. Note: Diet menus meet the needs of the patients. **482.28(b)(1)**	**Interview** ☐ The dietician and confirm menus meet the nutritional needs of patients. For example, does the service rely upon Dietary Reference Intakes (DRIs), including Recommended Dietary Intakes (RDAs), in developing menus?

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	☐ The dietician and confirm the patient's nutritional needs are assessed by a dietician. Special needs are met. ☐ How are patients identified as having specialized needs monitored? **Document Review** **Patient Health Record Review** ☐ Diets/therapeutic diets are provided as ordered. **Note:** *Does the sample of patient records being reviewed include patients identified with special nutritional needs? If not, ask to see records for several such patients. Determine if there is evidence of monitoring the dietary intake and nutritional status of patients identified as having special nutritional needs.* **Observation** ☐ When observing care in inpatient units (or observation units where meals are provided) ask staff how patients are assessed for nutritional needs.
PC.12.01.01, EP 1: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. **482.28(b)(2)**	**Document Review** **Patient Health Record Review** ☐ Diet orders provided as prescribed by the practitioner(s) responsible for the care of the patient, a qualified dietitian, or qualified nutrition professional. **Personnel/Credential File** ☐ If diet orders prescribed by a dietitian or other nutrition professional, review records to verify the individual's appointment to the medical staff with diet-ordering privileges, or was granted diet-ordering privileges without being appointed to the medical staff. ☐ Ask the hospital how it determines whether the dietician/nutrition professional is qualified under state law. ☐ Review staff records to verify that dieticians/nutrition professionals demonstrate the required qualifications.
PC.12.01.09, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The dietitian and medical staff approve a therapeutic diet manual that is current and available to all medical, nursing, and food service staff.	**Document Review** ☐ The therapeutic diet manual is current (no more than 5 years old), and ~~Has been~~ approved by both the medical staff and a qualified dietitian;

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Note: For the purposes of this element of performance, current is defined as having a publication or revision date no more than five years old. **482.28(b)(3)**	☐ Is in accordance with the current national standards, such as RDA or DRI; ☐ Includes the different types of therapeutic diets routinely ordered at the hospital; **Observation** ☐ Is readily available to MD/DOs, nursing and food service personnel; and ☐ Is consistently used as guidance for ordering and preparing patient diets.

Hospital Utilization Review Evaluation Module (482.30)

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LD.13.01.03, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan that provides for review of services provided by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note: The hospital does not need to have a utilization review plan if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. **§482.30; §482.30(a)(1); §482.30(a)(2)**	*The manner and degree of noncompliance with one or more of the UR standards is considered when determining whether there is condition-level compliance or noncompliance.* **Document Review** **General** ☐ Verify that the hospital has a utilization review (UR) plan that meets regulatory requirements or has an agreement with the quality improvement organization (QIO) that provides for binding utilization review. o If there is a QIO agreement, ensure that it is signed and dated. **Note:** *It is not necessary to conduct routine surveys for compliance with the provider agreement requirement to have a QIO agreement. However, a hospital that does not satisfy the UR Conditions of Participation (CoP) through either its own program or a QIO agreement may be cited for violating the UR CoP at the condition level*
LD.13.01.03, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review committee that is either a staff committee or a group outside the hospital established by the local medical society and some or all of the hospitals in the locality or in a manner approved by the Centers for Medicare & Medicaid Services. Note: If, because of the small size of the hospital, it is impracticable to have a properly functioning staff committee, the utilization review committee is established by a group outside the hospital, as specified in 42 CFR 482.30(b)(1)(ii). **§482.30(b)(1)(i); §482.30(b)(1)(ii); §482.30(b)(1)(ii)(A,B); §482.30(b)(2)** **LD.13.01.03, EP 4:** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review committee consists of two or more licensed practitioners, and at least two of the members of the committee are doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in42 CFR 482.12(c)(1).	**Interview** ☐ Ask about the criteria for small hospitals to delegate the UR function to an outside group (for example, if it is impractical to have a staff committee). ☐ Determine if UR committee members are not financially involved in the hospital (ownership of 5 percent or greater) or participants in the development or execution of the patient's treatment plan. **Document Review** **General** ☐ Review the composition of the UR committee – does it consist of two or more practitioners who are doctors of medicine or osteopathy? ☐ Is the UR committee one of the following: o A staff committee of the institution; o A group outside of the institution; o Established by the local medical society and some or all of the hospitals in the locality; or o Established in a manner approved by CMS ☐ Verify that the hospital's governing body has delegated to the UR committee the authority and responsibility to carry out the UR function.

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Note: The committee or group's reviews are not conducted by any individual who has a direct financial interest (for example, an ownership interest) in that hospital or was professionally involved in the care of the patient whose case is being reviewed. (See also MS.16.01.03, EP 5) **§482.30(b); §482.30(b)(3); §482.30(b)(3)(i); §482.30(b)(3)(ii)**	
LD.13.01.03, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review plan provides for the review of Medicare and Medicaid patients with respect to the medical necessity of the following: - Admissions to the hospital - Duration of stays - Professional services provided, including drugs and biologicals Note 1: The hospital may perform reviews of admissions before, during, or after hospital admission. Note 2: The hospital may perform reviews on a sample basis, except for reviews of extended stay cases. **§482.30(c)(1); §482.30(c)(1)(i-iii); §482.30(c)(2); §482.30(c)(3)** **LD.13.01.03, EP 7:** For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital is paid for inpatient hospital services under the prospective payment system set forth in 42 CFR Part 412, it conducts a review of duration of stays and a review of professional services as follows: - For duration of stays, the hospital reviews only cases that it determines to be outlier cases based on extended length of stay, as described in 42 CFR 412.80(a)(1)(i). - For professional services, the hospital reviews only cases that it determines to be outlier cases based on extraordinarily high costs, as described in 42 CFR 412.80(a)(1)(ii).	**Interview** ☐ Ask if the hospital is reimbursed under the Inpatient Prospective Payment System (IPPS). **Note:** *This requirement does not apply to IPPS–excluded hospitals or units.* ☐ For hospitals reimbursed under IPPS, verify that the following are reviewed: o Duration of stay in cases reasonably assumed to be outlier cases o Professional services in cases reasonably assumed to be outlier cases **Document Review** **General** ☐ Verify that the utilization review plan provides review for Medicare and Medicaid patients with respect to the medical necessity of admissions, length of stays, and professional services provided (including medications and biologicals). ☐ Verify that the utilization review plan provides for the review of admissions performed before, at, or after hospital admission.

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§482.30(c)(4); §482.30(c)(4)(i); §482.30(c)(4)(ii)	
LD.13.01.03, EP 6: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements a process to determine if an admission or continued stay is not medically necessary. This determination is made by one of the following: - One member of the utilization review committee if the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), concur with the determination or fail to present their views when afforded the opportunity - At least two members of the utilization review committee in all other cases Note: Before determining that an admission or continued stay is not medically necessary, the utilization review committee consults the licensed practitioner(s) responsible for the patient's care and affords the practitioner(s) the opportunity to present their views. §482.30(d)(1)(i); §482.30(d)(1)(ii); §482.30(d)(2) **LD.13.01.03, EP 10:** For hospitals that use Joint Commission accreditation for deemed status purposes: If the utilization review committee determines	**Document Review** **General** ☐ Review the UR plan to determine the actions taken if admissions or continued stays that are not meeting criteria. Are they brought to the UR committee to determine the medical necessity of the admission or continued stay? ☐ Are decisions regarding medical necessity made by either of the following: o One member of the UR committee, if the practitioner(s) responsible for the patient's care concurs with the determination or fails to present their views. The practitioner must be one of those specified in §482.12(c) o At least two members of the UR committee in all cases not qualified under the above ☐ Review a sample of "medically unnecessary" decisions to verify that the physician or practitioners, as specified in §482.12(c), were informed of

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that admission to or continued stay in the hospital is not medically necessary, the committee gives written notification to the hospital, the patient, and the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), no later than 2 days after the determination. **§482.30(d)(3)**	the committees expected decision and were given an opportunity to comment. ☐ Review a sample of "medically unnecessary" cases and verify that all involved parties were notified of the decision that care was medically not necessary no later than two days following the decision.
LD.13.01.03, EP 8: For hospitals that use Joint Commission accreditation for deemed status purposes: In hospitals that are not paid under the prospective payment system, the utilization review (UR) committee periodically reviews, as specified in the UR plan, each current inpatient during a continuous period of extended duration. The scheduling of the periodic reviews may be the same for all cases or differ for different classes of cases. Note: The UR committee conducts its review no later than 7 days after the day required in the UR plan. **§482.30(e)(1); §482.30(e)(1)(i); §482.30(e)(1)(ii)** **LD.13.01.03, EP 9:** For hospitals that use Joint Commission accreditation for deemed status purposes: In hospitals paid under the prospective payment system, the utilization review (UR) committee reviews all cases where the extended length of stay exceeds the threshold criteria for the diagnosis, as described in 42 CFR 412.80 (a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis. Note: The UR committee conducts its review no later than 7 days after the day required in the UR plan. **§482.30(e)(2); §482.30(e)(3)**	**Interview** ☐ Ask if the UR committee uses a different number of days for different diagnosis or functional categories. If the committee uses a different number of days for different diagnosis or functional categories for the period of extended stay, verify that there is a written list with lengths of stay designated for each diagnosis or functional category. **Document Review** **General** ☐ Verify that the hospital's UR plan requires a periodic review of each current Medicare/Medicaid inpatient receiving hospital services of extended duration and that the review is carried out at the specified time stated in the facility's UR plan. ☐ Review minutes of the UR committee to ensure that the periodic reviews of extended stay are carried out on or before the expiration of the stated period or no later than 7 days after the day required in the hospital's plan. **Note:** *Hospitals under IPPS only need to review cases reasonably assumed to be outlier cases and extended stay that exceeds the outlier threshold for the diagnosis.*
LD.13.01.03, EP 5: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review committee reviews professional services provided to determine medical necessity and to promote the most efficient use of available health facilities and services. **§482.30(f)**	**Interview** ☐ Ask how the UR committee determines which professional services to review. **Document Review** **General**

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	☐ Review UR committee meeting minutes to ensure that the committee reviews professional services.

Hospital Physical Environment Evaluation Module (482.41)

~~Note: K tag/CoP/EP review tool is required to evaluate compliance with the Life Safety Code.~~

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
PE.01.01.01, EP 1: The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations, or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.01.01.01, EP 2:** The hospital has adequate space and facilities for the services provided, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.	**§482.41 Condition of Participation: Physical Environment** The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.	**Observation:** □ Verify that all locations of the hospital, including all campuses, satellites, provider-based activities, and inpatient and outpatient locations meet this CoP.
PE.01.01.01, EP 1: The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety	**§482.41(a) Standard: Buildings** The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner	**Observation:** □ Verify that the condition of the hospital (including all buildings at all locations) is maintained in a manner to assure the safety and well-being of

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and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations, or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.01.01.01, EP 2:** The hospital has adequate space and facilities for the services provided, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered. **PE.01.01.01, EP 3:** The hospital's premises are clean and orderly. Note: Clean and orderly means an uncluttered physical environment where patients and staff can function. This includes but is not limited to storing equipment and supplies in their proper spaces, attending to spills, and keeping areas neat.	that the safety and well-being of patients are assured.	patients, employees, and visitors (e.g., condition of ceilings, walls, floors, presence of patient hazards, etc.) ~~. in accordance with nationally recognized standards including the following:~~ ☐ ~~Management of safety hazards and risks related to age-related factors~~ ☐ ~~Implementation of security features to ensure the safety of vulnerable patients.~~ ☐ ~~Securing of access to non-clinical rooms identified as hazardous locations to prevent patient and visitor entry~~ ☐ ~~Mitigation of ligature risks in a psychiatric hospital or psychiatric unit of a hospital, including any location where patients at risk of suicide are identified~~ ☐ ~~Mitigation of potential safety hazards specific to weather on both the exterior and interior locations~~ **Document Review:** ☐ ☐ Review a copy of the most recent environmental risk assessment to determine if the hospital has identified any accessibility, age-related, security, suicide and/or weather-related risks or concerns. If environmental safety concerns have been identified in this assessment, what plans have been implemented by the hospital to ensure patient/staff safety? **Communication with Team** ☐ Refer any potential power strip use deficiencies to Life Safety Code surveyors. ☐ Any ligature risks identified in the physical environment should be evaluated with the clinical surveyors for assessment of clinical mitigation.

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PE.04.01.03, EP 1: The hospital has emergency power and lighting in the following areas, at a minimum,: - Operating rooms - Recovery rooms - Intensive care - Emergency rooms - Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.	**§482.41(a)(1)** - There must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available.	**Observation:** ☐ Verify emergency power and lighting are provided for these areas in accordance with Life Safety Code and Health Care Facilities Code
PE.04.01.03, EP 2: The hospital has a system to provide emergency gas and water supply. Note 1: The system includes making arrangements with local utility companies and others for the provision of emergency sources of water and gas. Note 2: Emergency gas includes fuels such as propane, natural gas, fuel oil, or liquefied natural gas, as well as any gases the hospital uses in the care of patients, such as oxygen, nitrogen, or nitrous oxide.	**§482.41(a)(2)** - There must be facilities for emergency gas and water supply.	**Interview:** ☐ Discuss how hospital staff determine the hospital's needs for emergency gas and water. Verify that the hospital accounts for inpatients, staff, and other individuals who come into the hospital in need of care during emergencies. ☐ Discuss with staff what the source is for emergency gas and water (quantity of supplies, availability, and how obtained) ☐ Verify that arrangements have been made with utility companies and others for the provision of emergency sources of critical utilities.
PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients	**§482.41(b) Standard: Life Safety from Fire** The hospital must ensure that the life safety from fire requirements are met.	**Observe:** ☐ ~~Use the K tag/CoP/EP Review tool~~Refer to the Building Tour Guide to evaluate compliance with the Life Safety Code.

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served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.		
PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim	**§482.41(b)** **(1) Except as otherwise provided in this section—**	**Observation:** ☐ Refer to the Building Tour Guide~~Use the K-tag/CoP/EP Review tool~~ to evaluate compliance with the Life Safety Code.

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Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA	**(i)** The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.	

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standard(s) referenced for the activity; and results of the activity.		
PE.03.01.01, EP 6: For hospitals that use Joint Commission accreditation for deemed status purposes: Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.	**§482.41(b)** **(1) Except as otherwise provided in this section—** **(ii)** Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.	**Observation:** ~~Use the K tag/CoP/EP Review tool~~Refer to the Building Tour Guide to evaluate compliance with the Life Safety Code.
PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency	**§482.41(b)(2)** In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. **Note: Waivers can only be granted by CMS**	**Refer to Joint Commission's website for additional guidance on waivers.**

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or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.		
PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety	**§482.41(b)(3)** The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals.	

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code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.		
PE.02.01.01, EP 6: The hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.	**§482.41(b)(4)** - The hospital must have procedures for the proper routine storage and prompt disposal of trash.	**Observation:** ☐ Verify that the hospital follows its process for storage and disposal of trash and medical waste. ☐ Verify through observation that staff adhere to these policies and that the hospital has appropriate storage areas, signage, containers, and documentation.
PE.03.01.01, EP 4: The hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires;	**§482.41(b)(5)** - The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires;	**Interview:** ☐ Interview staff to verify their knowledge of their responsibilities during a fire

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protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities.	protection of patients, personnel and guests; evacuation; and cooperation with fire-fighting authorities.	**Document Review:** ☐ Review the hospital's fire control plan to verify that the plan includes the required elements of the Life Safety Code and state law.
PE.03.01.01, EP 5: The hospital maintains written evidence of regular inspection and approval by state or local fire control agencies.	**§482.41(b)(6)** - The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.	**Document Review:** ☐ Review copies of inspection and approval reports from state or local fire control agencies and verify the facility has written evidence of regular inspections and maintains necessary approvals.
PE.03.01.01, EP 7: When the hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.	**§482.41(b)(7)** - A hospital may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.	**Observation:** ☐ Verify that ABHR dispensers are installed in accordance with Life Safety Code requirements ~~(see K tag/CoP/EP Review tool)~~ and maintained in accordance with manufacturer recommendations or established policies and procedures. ☐ Determine whether ABR dispensers are adequately protected against inappropriate access.
PE.03.01.01, EP 8: When a sprinkler system is shut down for more than 10 hours, the hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service or the hospital establishes a fire watch until the system is back in service.	**§482.41(b)(8)** When a sprinkler system is shut down for more than 10 hours, the hospital must: (i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or (ii) Establish a fire watch until the system is back in service.	**Interview:** ☐ Discuss with facilities staff how they would handle a situation where a sprinkler system is shut down for more than 10 hours. ☐ Determine if the sprinkler system has been out of service for more than 10 hours, and if so, confirm that an evacuation or a fire watch was in effect until the system was back in service.
PE.03.01.01, EP 9: Buildings have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016, the sill	**§482.41(b)(9)** Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches above the floor. Windows in atrium	**Observation:** ☐ ~~Use the K tag/CoP/EP Review tool to evaluate compliance with the outside window or door requirements.~~ Identify patient sleeping rooms intended to be occupied for more than 24 hours.

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height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.	walls are considered outside windows for the purposes of this requirement. (i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. (ii) The sill height in special nursing care areas of new occupancies must not exceed 60 inches.	Confirm these rooms have an outside window or outside door. If the building was constructed after July 5, 2016, confirm the outside window sill is 36 inches or less above the floor. In newly constructed special nursing areas, confirm the outside window is 60 inches or less above the floor.
PE.04.01.01, EP 1: The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. ~~Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of~~	**§482.41(c) Standard: Building Safety** Except as otherwise provided in this section, the hospital must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5 and TIA 12–6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospital. (2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the hospital, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.	**Document Review:** ☐ Review plans, policies and procedures, and documentation to determine compliance with Health Care Facilities Code requirements. **Observation:** ☐ ~~Use the K-tag/CoP/EP Review tool~~Refer to the Building Tour Guide to evaluate compliance with the Health Care Facilities Code.

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~~person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.~~		
PE.01.01.01, EP 1: The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations, or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.01.01.01, EP 2:** The hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.	**§482.41(d) Standard: Facilities** The hospital must maintain adequate facilities for its services.	**Document Review:** - Review the facility's water supply and distribution system to ensure that the water quality is acceptable for its intended use (drinking water, irrigation water, lab water, etc.). Review the facility water quality monitoring and, as appropriate, treatment system. **Observation:** - Observe the facility layout and determine if the patient's needs are met. Toilets, sinks, specialized equipment, etc. should be accessible.
PE.01.01.01, EP 1: The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients.	**§482.41(d)(1)** - Diagnostic and therapeutic facilities must be located for the safety of patients.	**Observation:** - When conducting patient tracers or the building tour, determine that x-ray, physical therapy, and other specialized services are provided in areas

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Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations, or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.		appropriate for the service provided. When specialized services are provided outside of designated locations (e.g., at the bedside), ensure the safety of patients, visitors, and staff is maintained.
PE.04.01.01, EP 2: The hospital maintains essential equipment in safe operating condition. Note 1: For fire/smoke detection, alarm, and extinguishing system testing: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. Note 2: For all other equipment: Inspection, testing, and maintenance activities are documented in accordance with manufacturer's recommendations or established alternative equipment	**§482.41(d)(2)** - Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.	**Interview:** Interview personnel in charge of facility, supplies, and equipment maintenance to determine: □ If supplies are maintained to ensure an acceptable level of safety and quality □ If supplies are stored as recommended by the manufacturer □ If supplies are stored in such as manner as not to endanger patient safety □ If the hospital has identified equipment that is essential for both regular operations and in an emergency situation. □ If the hospital has made adequate provisions to ensure the availability of those and equipment when needed. Interview equipment users on units/departments to determine: □ If equipment failures are occurring and causing problems for patient health or safety. **Document Review:**

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maintenance (AEM) activities and frequencies defined in the AEM program. **PE.04.01.01, EP 5:** The hospital maintains supplies to ensure an acceptable level of safety and quality. Note: Supplies are stored in a manner to ensure the safety of the stored supplies and to not violate fire codes or otherwise endanger patients. **PE.04.01.05, EP 1:** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **PE.04.01.05, EP 2:** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water)		Review equipment inventory to verify the following: ☐ The inventory is complete and includes equipment required to meet patient needs regardless of ownership. ☐ The hospital has available manufacturer's recommendations (e.g., manufacturer's operation and maintenance manual, standards, studies, guidance, recall information, service records, etc.). ☐ Critical equipment is readily identified ☐ If AEM program is used, equipment in the program is readily identified Review equipment maintenance documentation to verify the following: ☐ All equipment is inspected and tested for performance and safety before initial use and after major repairs or upgrades ☐ All equipment is inspected, tested, and maintained to ensure its safety, availability and reliability in accordance with established maintenance activities based on manufacturer's recommendations or alternative equipment maintenance program Review documentation to verify: ☐ Individual(s) responsible for overseeing the development, implementation, and management of equipment maintenance programs and activities (including contractors) are qualified. Examples include training certificates or certifications. **If the hospital is following the manufacturer-recommended equipment maintenance activities and frequencies:** **Document Review:** In addition to reviewing maintenance records on equipment observed while inspecting various hospital

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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. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. (See also IC.04.01.01, EP 2) **PE.04.01.05, EP 3:** The individual or team responsible for the water management program manages the following: - Documenting results of all monitoring activities - Corrective actions and procedures to		locations for multiple compliance assessment purposes, select a sample of equipment from the hospital's equipment inventory to determine whether the hospital is following the manufacturer's recommendations. Critical equipment which poses a higher risk to patient safety if it were to fail, such as ventilators, defibrillators, robotic surgery devices, etc. should make up the sample majority. For the sample selected, determine if: ☐ ~~The hospital has available manufacturer's recommendations (e.g., manufacturer's operation and maintenance manual, standards, studies, guidance, recall information, service records, etc.).~~ ☐ Maintenance is being performed in accordance with manufacturer's recommendations **If a hospital is using an AEM for some equipment:** **Document Review:** ☐ Verify that the hospital's inventory does not include equipment ineligible for AEM, for example, any diagnostic imaging or therapeutic radiologic equipment? ☐ Verify for each type of equipment subject to the AEM program, that there is documentation indicating: o The pertinent types and level of risks to patient or staff health and safety o Alternate maintenance activities, and the maintenance strategy and any other rationale used to determine those activities o Alternate maintenance frequencies to be used, if any, and the maintenance strategy and any other rationale used to determine those frequencies

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follow if a test result outside of acceptable limits is obtained, including when a probable or confirmed waterborne pathogen(s) indicates action is necessary - Documenting corrective actions taken when control limits are not maintained Note: See PE.07.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues. **PE.04.01.05, EP 4:** The individual or team responsible for the water management program reviews the program annually and when the following occurs: - Changes have been made to the water system that would add additional risk. - New equipment or an at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building. Note 1: Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing protocols are at the discretion of the hospital unless required by law or regulation. Note 2: Refer to ASHRAE Standard 188-2018 “Legionellosis: Risk Management for Building Water Systems” and the Centers for Disease Control and Prevention Toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings" for guidance on creating a water management plan. For additional guidance,		○ The date when AEM program maintenance activities were performed and, if applicable, further actions required/taken ○ If any equipment failures (not including failures due to operator error) occurred, including whether there was resulting harm to an individual. ☐ Verify the hospital has policies and procedures which address the effectiveness of its AEM program. ☐ Verify the hospital is evaluating the safety and effectiveness of the AEM program. ☐ If there is equipment on the inventory the hospital has identified as having such a very low level of risk that it has determined it can use a broad interval range or departmental “sweeps,” ask the hospital for the evidence used to make this determination. Does it seem reasonable? **Interview:** Select a sample of equipment in the AEM program. The majority of the sample must include critical equipment which poses a higher risk to patient safety if it were to fail, such as ventilators, defibrillators, robotic surgery devices, etc. For the sample selected: ☐ Ask the responsible personnel to explain how the decision was made to place the equipment in an AEM program. Does the methodology used consider risk factors and make use of available evidence? ☐ Ask the responsible personnel to describe the methodology for applying maintenance strategies and determining alternative maintenance activities or frequencies for the sampled equipment. Can they readily provide an explanation and point to sources of information (accepted standards of

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consult ANSI/ASHRAE Guideline 12-2020 "Managing the Risk of Legionellosis Associated with Building Water Systems."		practice for facility or medical equipment) they relied upon? - Determine if maintenance is being performed in accordance with the maintenance activities and frequencies defined in the AEM program in accordance with established policies and procedures - Verify the hospital is evaluating the safety and effectiveness of the AEM maintenance activities for this equipment and taking corrective actions when needed.
PE.01.01.01, EP 2: The hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.	**§482.41(d)(3)** - The extent and complexity of facilities must be determined by the services offered.	**Observation:** - Verify through observation that the physical facilities are large enough and properly equipped for the scope of services provided and the number of patients served. Appropriate size of facility should be based on state rules and regulations and the current FGI guidelines.
PE.04.01.01, EP 3: The hospital has proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.	**§482.41(d)(4)** - There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.	**Observation:** - Verify that food and medication preparation areas are well lit - Verify the hospital is in compliance with ventilation requirements - Verify that food products are stored under appropriate conditions based on nationally accepted sources - Verify pharmaceuticals are stored in accordance with manufacturer's recommendations **Document Review:**

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		☐ Review monitoring records for temperature to make certain that appropriate levels are maintained ☐ Review temperature, humidity, and airflow maintenance records for operating rooms and associated ancillary rooms to ensure acceptable parameters are being maintained. If monitoring determines that temperature, humidity, or airflow levels were not within acceptable parameters, confirm corrective actions were performed in a timely manner to achieve acceptable levels. Corrective actions must be documented. o Note: ASHRAE 170-2008 and other acceptable standards allow for modifications to temperature and humidity in certain circumstances: ♣ Temperatures may be changed to outside normal requirements if required for patient treatment, procedures, or physician request per Note O in ASHRAE 170-2008. If these variances are allowed, organizations must document their allowance and ensure temperature will return to design requirements after completion of a procedure. ♣ Humidity levels may be permitted to be reduced from 30% to 20% in operating rooms, if organizations determine that equipment and supplies in operating rooms are safe to be utilized in this reduced humidity environment. This evidence will be documented. ☐
PE.04.01.01, EP 1: The hospital meets the applicable provisions and proceeds in	**§482.41(e) through (e)(1)(xi)**	**PE.04.01.01, EP 1 (482.41(e)(1)(vii) through (e)(1)(xi))**

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accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. ~~Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.~~ **PE.03.01.01, EP 3:** The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies,	The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federalregulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011. (ii) TIA 12–2 to NFPA 99, issued August 11, 2011. (iii) TIA 12–3 to NFPA 99, issued August 9, 2012. (iv) TIA 12–4 to NFPA 99, issued March 7, 2013. (v) TIA 12–5 to NFPA 99, issued August 1, 2013. (vi) TIA 12–6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;	**PE.03.01.01, EP 3 (482.41(e)(1)(i) through (e)(1)(vi))**

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regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.	(viii) TIA 12–1 to NFPA 101, issued August 11, 2011. (ix) TIA 12–2 to NFPA 101, issued October 30, 2012. (x) TIA 12–3 to NFPA 101, issued October 22, 2013. (xi) TIA 12–4 to NFPA 101, issued October 22, 2013.	

Hospital Infection Prevention and Control and Antibiotic Stewardship Programs Evaluation Module (482.42)

Note: The interview with the infection preventionist(s)/infection control professional(s) and document review for the infection prevention and control program occur during a targeted session on Survey Day 1 (the timing of the session can be negotiated with the organization based on key staff availability). Observations of infection control–related systems and activities are evaluated throughout the survey of all organization settings by all surveyors.

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IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - 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 water management program - Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues 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. (For more information on competency requirements, refer to HR.11.04.01, EP 1). **§482.42**	**Document Review** ☐ Review the infection prevention and control and antibiotic stewardship program documents for evidence of the following: ○ The hospital has an active, hospitalwide program for surveillance, prevention, and control of health care–associated infections and other infectious diseases based on national standards of practice and best practices. ○ The infection prevention and control program is working collaboratively with the hospital QAPI program to address issues identified in the infection control program. ○ The hospital has an active hospital-wide program for the optimization of antibiotic use through stewardship based on national standards of practice and best practices. ○ The hospital is working collaboratively between antibiotic stewardship and hospital QAPI when antibiotic use issues are identified.

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IC.04.01.01, EP 3: 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. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation. b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (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. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's 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. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html. Note 3: The hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures. **§482.42** **IC.04.01.01, EP 5:** The infection prevention and control program reflects the scope and complexity of the hospital services provided by addressing all locations, patient populations, and staff. **§482.42**	

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IC.05.01.01, EP 1: The hospital's governing body is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities. Note: To make certain that systems are in place and operational to support the program, the governing body provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. §482.42 **IC.05.01.01, EP 2:** The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders). §482.42 **IC.06.01.01, EP 3:** The hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the hospital. §482.42 **MM.18.01.01, EP 1:** The antibiotic stewardship program reflects the scope and complexity of the hospital services provided. §482.42 **MM.18.01.01, EP 3:** The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation of a hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics - All documentation, written or electronic, of antibiotic stewardship activities - Communication and collaboration with the medical staff, nursing, and pharmacy leadership, as well as with the hospital's infection prevention and control and QAPI	

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programs, on antibiotic use issues - Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures **§482.42** **PE.04.01.01, EP 1:** The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. **§482.42**	
HR.11.02.01, EP 1: The hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments (CLIA), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are	**Interview** ☐ Interview the infection preventionist(s)/infection professional(s) to determine whether resources are adequate to accomplish the tasks required for the infection prevention and control program. ☐ Interview the hospital leaders about the criteria the hospital uses to determine whether the resource allocation to the IPC program matches the determined needs. **Document Review** **Personnel/Credential File** ☐ Review the personnel file of the infection preventionist(s)/infection control professional(s) to determine whether they are qualified through professional education, training, experience, or certification to oversee IPC program. ☐ Verify that the individual(s) was appointed by the hospital's governing body based on recommendations by medical and nursing staff leaders.

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provided by the hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. §482.42(a)(1) **NPG.12.01.01, EP 12:** The hospital's governing body, based on the recommendation of the medical staff and nursing leaders, appoints an infection preventionist(s) or infection control professional(s) qualified through education, training, experience, or certification in infection prevention to be responsible for the infection prevention and control program. §482.42(a)(1)	
IC.04.01.01, EP 3: 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. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation. b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (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. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne Pathogens	**Document Review** **General** ☐ Review policies and procedures for infection prevention and control to ensure that the hospital is employing methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other health care settings. **Observation** ☐ Determine if the IPC program is being applied throughout the hospital to both inpatient and outpatient settings.

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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. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html. Note 3: The hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures. **§482.42(a)(2)** **IC.04.01.01, EP 4:** The hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: - Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions - Use of disinfectants registered by the Environmental Protection Agency 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 - Use of FDA–approved liquid chemical sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with FDA–cleared label and device manufacturers' instructions - 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 - Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment - Criteria and process for the use of immediate-use steam sterilization	

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- 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 Note 1: 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-level disinfection, and low-level disinfection) to be used for the three classes of devices. Note 2: 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. **§482.42(a)(2)**	
IC.06.01.01, EP 3: The hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the hospital. **§482.42(a)(3)** **IC.06.01.01, EP 4:** The hospital implements its policies and procedures for infectious disease outbreaks, including the following: - Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities - Reporting an outbreak in accordance with state and local public health authorities' requirements - Investigating an outbreak - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate **§482.42(a)(3)** **IC.06.01.01, EP 5:** The hospital implements policies and procedures to minimize the risk of communicable disease exposure and acquisition among its staff, in	**Document Review** ☐ Review documentation of surveillance activities, including the measures selected for monitoring, collection, and analysis. Based on the review, determine whether the surveillance program employes methods to permit identifying and monitoring infections and communicable diseases throughout various locations or departments. ☐ Review the water management program documentation related to the hospital risk assessment and water quality monitoring. ☐ Verify that the hospital has policies and procedures for the detection, investigation, and control of outbreaks that are consistent with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks. **Observation** ☐ Observe the hospital for the sanitary condition of its environments of care, noting the cleanliness of patient rooms, floors, horizontal surfaces, patient equipment, air inlets, mechanical rooms, food service activities, treatment and procedure areas, surgical areas, central supply, storage areas, and medication preparation areas.

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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 §482.42(a)(3) **PE.01.01.01, EP 1:** The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. §482.42(a)(3) **PE.04.01.05, EP 1:** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. §482.42(a)(3) **PE.04.01.05, EP 2:** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to	

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identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) 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. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. **§482.42(a)(3)**	
IC.04.01.01, EP 5: The infection prevention and control program reflects the scope and complexity of the hospital services provided by addressing all locations, patient populations, and staff. **§482.42(a)(4)**	**Interview** ☐ Interview hospital staff in various locations or areas on collection of infection and communicable disease data and actions to reduce the risks of infections. **Document review** ☐ Determine whether the infection control and prevention program is hospital-wide and program-specific in gathering and assessing infection and communicable disease data and in taking steps to reduce the risks of infections. ☐ Review documentation of surveillance activities to determine whether active surveillance is suitable to the scope and complexity of the hospital's services and the population served.
MM.18.01.01, EP 2: The hospital demonstrates that an individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership.	**Interview** ☐ Determine whether the antibiotic stewardship leader(s): ○ Was appointed by the governing body based on recommendations from medical staff and pharmacy leaders

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§482.42(b)(1)	and has the responsibility for the antibiotic stewardship program. o ~~Is a physician and/or pharmacist.~~ ☐ Ask the leader(s) about their qualifications to oversee the antibiotic stewardship program. o **Note:** ~~*Training and/or certification may be obtained through organizations such as the specialty boards in adult or pediatric infectious diseases offered for physicians by the American Board of Internal Medicine (for internists), the American Board of Pediatrics (for pediatricians), and the Society for Infectious Disease Pharmacists (for pharmacists).*~~ If board members are present, ask how they are involved in decisions about antibiotic stewardship leader(s). **Document Review** **General** ☐ Determine whether the leader(s) of antibiotic stewardship: o Was appointed by the governing body based on recommendations by medical staff and pharmacy leaders and has the responsibility for the antibiotic stewardship program. o Has developed and implemented the hospital's antibiotic stewardship policies. **Note:** *Antibiotic stewardship policies should address the roles and responsibilities for antibiotic stewardship and use within the hospital, how the various hospital committees and departments interface with the antibiotic stewardship program, and how to optimize antibiotic use.* ☐ Review the criteria the hospital used to determine the resources necessary to operate effectively and ensure the resource allocation matches the determined needs. **Personnel/Credential File** ☐ Review the personnel file of the antibiotic stewardship leader(s) to determine whether they are qualified through ongoing education, training, experience, or certification to oversee the antibiotic stewardship program.

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	~~**Note:** *Training and/or certification may be obtained through organizations such as the specialty boards in adult or pediatric infectious diseases offered for physicians by the American Board of Internal Medicine (for internists), the American Board of Pediatrics (for pediatricians), and the Society for Infectious Disease Pharmacists (for pharmacists).*~~
MM.18.01.01, EP 5: The hospitalwide antibiotic stewardship program: - Demonstrates coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services. - Documents the evidence-based use of antibiotics in all departments and services of the hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use. **§482.42(b)(2)(i-iii)**	**Interview** ☐ Verify with staff who prescribe antibiotics that the hospital implements and maintains an active and hospitalwide antibiotic stewardship program as an effective means to improve the hospital's antibiotic-prescribing practices. ☐ Ask staff who prescribe antibiotics how the hospital promotes the evidence-based use of antibiotics to reduce the incidence of adverse consequences of inappropriate antibiotic use, including but not limited to adverse drug events, CDIs, and the growth of antibiotic resistance in the hospital overall. **Document Review** **General** ☐ Review antibiotic stewardship policies and procedures for evidence of a process for the coordination of all components of the hospital related to antibiotic use and resistance, including but not limited to the antibiotic stewardship program, the infection prevention and control program, the quality assurance/performance improvement program, the medical staff, nursing services, and pharmacy services. ☐ Confirm that the hospital develops and implements antibiotic stewardship interventions to address issues identified through its assessment activities and then monitors the effectiveness of interventions through further data collection and analysis. ☐ Verify that the hospital promotes evidence-based use of antibiotics to reduce the incidence of adverse consequences of inappropriate antibiotic use, including but not limited to treatment failures, *C. difficile* infections (CDIs), and growth of antibiotic resistance in the hospital overall. ☐ Verify that the hospital's antibiotic use is consistent with their documented evidence-based, hospitalwide antibiotic stewardship program recommendations.

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	☐ Review documentation of improvements and/or sustainment of improvements through the use of the evidence-based, hospitalwide antibiotic stewardship program recommendations. ☐ Confirm that the antibiotic stewardship program is updated with any advancing evidence-based improvements in antibiotic-prescribing practices.
MM.18.01.01, EP 6: The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use. **§482.42(b)(3)**	**Interview** ☐ Ask staff who prescribe antibiotics about the nationally recognized guidelines that have been implemented as part of the hospitalwide antibiotic stewardship program. **Document Review** **General** ☐ Verify that nationally recognized guidelines have been implemented for the evidence-based, hospitalwide antibiotic stewardship program. ☐ Verify that core elements of best practices have been included within the hospitalwide antibiotic stewardship program, including hospital leadership commitment, accountability, pharmacy expertise, tracking, reporting, education, and appropriate interventions or actions being taken to improve antibiotic use to reduce adverse events, prevent emergence of resistance, and ensure better outcomes for patients in this setting. **Note:** *See the Centers for Disease Control and Prevention's Core Elements of Antibiotic Stewardship at https://www.cdc.gov/antibiotic-use/coreelements/index.html for more information. Examples of other organizations with nationally recognized antibiotic stewardship guidelines and/or recommendations include but are not limited to the Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, the American Society for Health System Pharmacists, and the Society for Infectious Disease Pharmacists.*
MM.18.01.01, EP 1: The antibiotic stewardship program reflects the scope and complexity of the hospital services provided. **§482.42(b)(4)**	**Document Review** **General** ☐ Review the parameters of the antibiotic stewardship program to determine whether it is suitable to the scope and complexity of the hospital's services.

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IC.05.01.01, EP 1: The hospital's governing body is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities. Note: To make certain that systems are in place and operational to support the program, the governing body provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **§482.42(c)(1)(i)** **MM.18.01.01, EP 7:** The governing body ensures that systems are in place and operational for the tracking of all antibiotic use activities in order to demonstrate the implementation, success, and sustainability of such activities. **§482.42(c)(1)(i)**	**Document Review** **General** ☐ Review the hospital policies and governing body meeting minutes for record of support for the infection control and antibiotic stewardship programs. ☐ Verify that the hospital policies are being followed for the tracking of all infection surveillance, prevention and control, and the monitoring of hospital antibiotic use activities.
IC.05.01.01, EP 2: The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders). **§482.42(c)(1)(ii)** **MM.18.01.01, EP 4:** The governing body, or responsible individual, ensures all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the hospital's QAPI leadership. **§482.42(c)(1)(ii)**	**Interview** ☐ Interview program leaders to confirm that the hospital's infection control program and antibiotic stewardship program are being coordinated with their QAPI leadership, medical staff, nursing services, and pharmacy services. **Document Review** ☐ Determine whether infection control and antibiotic use problems identified are reported to the hospital's leadership. Verify that hospital leadership takes steps to ensure that corrective actions are implemented and successful. ☐ Determine whether the hospital's QAPI program and staff in-service training programs address problems identified by the hospital's infection control program and antibiotic stewardship programs.
IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its	**Document Review** ☐ Verify that the hospital's infection prevention and control program, including its hospital-wide infection surveillance, prevention, and control policies and procedures, is consistent with nationally recognized standards.

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surveillance, prevention, and control activities - Competency-based training and education of hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - 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 water management program - Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues 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. (For more information on competency requirements, refer to HR.11.04.01, EP 1). **§482.42(c)(2)(i)**	
IC.04.01.01, EP 2 See above **§482.42(c)(2)(ii)**	**Document Review** ☐ Verify that the hospital's infection preventionist(s) and/or infection prevention and control professional(s) is documenting, in written or electronic form, the IPC program and its surveillance, prevention, and control activities.
IC.04.01.01, EP 2 See above **§482.42(c)(2)(iii)**	**Document Review** ☐ Verify that the hospital's infection preventionist(s) and/or infection control professional(s) is communicating and collaborating with the hospital's QAPI program on all infection prevention and control issues.
IC.04.01.01, EP 2 See above **§482.42(c)(2)(iv)**	**Document Review** ☐ Review the hospital's policies and procedures on training and educating staff to confirm that the hospital's infection

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HR.11.03.01, EP 1: Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented. **§482.42(c)(2)(iv)** **HR.11.04.01, EP 1:** Staff competence is initially assessed and documented as part of orientation and once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. **§482.42(c)(2)(iv)**	preventionist(s) and/or infection control professional(s) training and education of hospital personnel and staff is competency based **Personnel/Credential File** ☐ Review a sample of personnel files to verify that training on the practical applications of infection prevention and control guidelines was completed and required competencies were met.
IC.04.01.01, EP 2 See above **§482.42(c)(2)(v); §482.42(c)(2)(vi)**	**Document Review** ☐ Verify that the hospital's infection preventionist(s) and/or infection prevention and control professional(s) has an active role in auditing the adherence to infection prevention and control policies and procedures by hospital personnel. ☐ Verify that the hospital's infection preventionist(s) and/or infection prevention and control professional(s) is communicating and collaborating with the antibiotic stewardship program.
MM.18.01.01, EP 3: The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation of a hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics - All documentation, written or electronic, of antibiotic stewardship activities - Communication and collaboration with the medical staff, nursing, and pharmacy leadership, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Competency-based training and education for hospital personnel and staff, including medical staff and, as applicable, personnel providing contract services in the hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures **§482.42(c)(3)(i)-(iv)**	**Interview** ☐ Ask the leader(s) to describe their responsibilities for the antibiotic stewardship program. ☐ Ask the leader about: o The basis for the hospital's program o Record-keeping of program activities and antibiotic-use issues o Communication and collaboration with other hospital departments and programs o Training and education of hospital personnel and staff **Document Review** Ask the program leader(s) to see: ☐ Documentation of the program's activities (meeting minutes, reports to leadership, of any other evidence) ☐ Examples of how the program communicates and collaborates with other hospital departments and programs

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	☐ Examples of the training and education being provided, including orientation, in-service, refresher courses and the curriculum that is covered.
LD.11.01.01, EP 10: For hospitals that use Joint Commission accreditation for deemed status purposes: 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. 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 do the following: - Account for each member hospital's unique circumstances and any significant differences in patient populations and services offered - 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 - Have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed - Designate a qualified individual(s) at the hospital with expertise in infection prevention and control and in antibiotic stewardship 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 Note: For hospitals that use Joint Commission accreditation for deemed status purposes: 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). **§482.42(d)**	**General** ☐ Assess the manner and degree of noncompliance with the standards within this condition to determine whether there is condition-level noncompliance. ***If the hospital is part of a hospital system that has a unified and integrated infection prevention and control and antibiotic stewardship programs:*** **Document Review** ☐ Review the infection prevention and control antibiotic stewardship program and identify unified infection prevention and control and antibiotic stewardship policies and activities and how these take into account the hospitals' population and services offered. ☐ Review the infection prevention and control and antibiotic stewardship programs and identify unified infection prevention and control and antibiotic stewardship policies and procedures and identify how each separately certified hospital's unique needs and areas of concern have been considered in the development of those policies and procedures. ☐ Review the QAPI program and identify unified QAPI elements that are unique to a particular hospital. ☐ Identify the process for which these unique elements are integrated into the QAPI program. ☐ Review governing body policies for evidence that a qualified individual(s) has/have been designated as responsible for communicating with the unified infection prevention program and antibiotic stewardship program, for implementing and maintaining policies and procedures governing the infection

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	prevention and control and antibiotic stewardship programs, and training of hospital staff. □ Review documentation that the designated individual(s) communicate(s) with the unified program leadership related to issues with infection prevention and antibiotic stewardship. □ Review hospital training documents related to education in infection prevention and antibiotic stewardship as evidence of training of hospital staff.

Hospital Discharge Planning Evaluation Module (482.43)

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PC.14.01.01, EP 1: The hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the hospital to post-discharge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes. **§482.43** **PC.14.01.01, EP 4:** The patient, the patient's caregiver(s) or support person(s), physicians, other licensed practitioners, clinical psychologists, and staff who are involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. The patient and their caregiver(s) or support person(s) are included as active partners when planning for post-discharge care. Note 1: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand and includes the items described in 42 CFR 483.15(c)(5). The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly. The hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **§482.43**	**Document Review** **General** ☐ Review the hospital's discharge planning process to determine if it focuses on the patient's goals and treatment preferences and includes the patient and their caregivers/support person. **Patient Health Record** ☐ Is the patient's discharge plan consistent with their goals? ☐ Is it evident in the plan that the patient and their caregiver/support person ~~was~~were included? ☐ Verify that the discharge plan includes a safe transition from the hospital to discharge destination. **Interview** ☐ Ask the patient/family/caregiver and hospital staff how they were involved in the discharge planning process
PC.14.01.01, EP 2: The hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. **§482.43(a)**	**Document Review** **General**

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PC.14.01.01, EP 5: The hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person. **§482.43(a)**	☐ Review the discharge planning ~~process~~ policies and procedures ~~which patients receive a discharge planning evaluation?~~ ☐ Does the discharge planning process indicate how the hospital identifies patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning? (Some hospitals complete a discharge planning evaluation on all patients, which meets the intent) ☐ ~~When is the discharge planning evaluation done?~~ Verify that patients are screened in a timely manner so that discharge planning process is completed before the patient's discharge. **Patient Health Record** ☐ Review a sample of medical records for those identified as likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning – was there an evaluation done?
PC.14.01.01, EP 5: The hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person. **§482.43(a)(1)**	**Document Review** **General** ☐ Review discharge planning process – when is discharge planning evaluation completed? Does it provide adequate time to ensure that post-hospital arrangements are made? **Patient Health Record** ☐ Review closed medical record of patient who required arrangements for post-hospital care – is there evidence that discharge was delayed due to lack of a timely discharge planning evaluation?
PC.14.01.01, EP 3: As part of the discharge planning evaluation, the hospital evaluates the patient's need for appropriate posthospital services, including but not limited to hospice care services, extended care services, home health services, and non–health care services and community-based care providers.	**Document Review** **Patient Health Record** ☐ Review sample of medical records of patients who have received a discharge planning evaluation. Does it include:

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The hospital also evaluates the availability of the appropriate services and the patient's access to those services as part of the discharge planning evaluation. §482.43(a)(2)	○ An evaluation of a patient's likely need for post-hospital services including but not limited to hospice care, post-hospital extended care, home health, and non-health care services and community-based care providers ○ A determination of the availability of the appropriate services ○ A determination of the patient's access to those services (the hospital may make referrals on behalf of the patient).
PC.14.01.01, EP 6: The hospital discusses the results of the discharge planning evaluation with the patient or their representative, including any reevaluations performed and any arrangements made. §482.43(a)(3) **RC.12.01.01, EP 2:** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation	**Interview** ☐ Ask the patient if the results of the discharge planning evaluation were discussed with them and if they understand their discharge plan. **Document Review** **Patient Health Record** ☐ Review a sample of medical records of patients who have received a discharge planning evaluation to determine if there is documentation that the evaluation was completed and ~~the evaluation was discussed with the patient or caregiver/support person.~~evidence of how the evaluation was used in developing an appropriate discharge plan.

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of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. **§482.43(a)(3)**	
PC.14.01.01, EP 5: The hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person. **§482.43(a)(4)**	**Documentation Review** **General** ☐ Review discharge planning process to determine if it states a discharge plan is arranged at the request of the patient's physician. ☐ Review hospital policy for how the hospital will develop and implement a discharge plan when a patient does not meet the screening criteria for evaluation but is otherwise requested by a physician.
PC.14.01.01, EP 5: See above **§482.43(a)(5)**	**Documentation Review** **General**

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	☐ Review discharge planning process to determine if it specifies that discharge planning evaluations and discharge plans must be developed by or under supervision of a registered nurse, social worker, or other appropriately qualified personnel. **Patient Health Record** ☐ Review a sample of medical records for patients who have had a discharge planning evaluation or discharge plan created – was it completed by (or under the supervision of) a registered nurse, social worker, or other qualified personnel?
PC.14.01.01, EP 1: The hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the hospital to post-discharge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes. **§482.43(a)(6)**	**Documentation Review** **General** ☐ Review the discharge planning process – does it require a regular re-evaluation of the patient's condition to identify if modifications are needed to the discharge plan? **Patient Health Record** ☐ Review a sample of medical records that have a discharge plan – are the patients re-evaluated at the frequency the discharge planning process indicated?
PC.14.01.01, EP 14: The hospital assesses its discharge planning process on a regular basis, as defined by the hospital. The assessment includes an ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient post-discharge needs. **§482.43(a)(7)**	**Documentation Review** **General** ☐ Review the discharge planning process – does it indicate that there is a periodic review of a representative sample of discharge plans at regular intervals of time, as per hospital policy, including those patients who were readmitted within 30 days of a previous ~~admission~~discharge? ☐ Ask to see the log of cases that were reviewed to verify a representative sample of discharge plans are being reviewed. Does the sample include cases of patients who were readmitted within 30 days of a previous admission? ☐ For those cases of patients who were readmitted within 30 days, are the discharge plans being reviewed for appropriateness to determine if the plan met the patient's post-discharge needs?

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PC.14.01.01, EP 7: The hospital assists the patient, their family, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency, skilled nursing facility, inpatient rehabilitation facility, and long term care hospital data on quality measures and resource-use measures. The hospital makes certain that the post-acute care data on quality measures and resource-use measures is relevant and applicable to the patient's goals of care and treatment preferences. **§482.43(a)(8)**	**Documentation Review** **General** ☐ Review the discharge planning process – how are patients/families/representatives made aware of post-acute providers? **Patient Health Record** ☐ Review a sample of medical records of patients who required post-acute care providers – was data on quality measures shared with the patient/family/caregiver? Was the data shared relevant to the patient's goals? **Interview** ☐ Ask staff what data is shared with patients when they are choosing a post-acute care provider? How is the data shared? ☐ Ask patients who are selecting a post-acute care provider what data was shared with them? How was it shared?
PC.14.02.03, EP 1: The hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - The patient's current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge **§482.43(b)**	**Interview** ☐ ~~Are~~Discuss with staff ~~who are responsible for discharge planning evaluation correctly following the hospital's policies and procedures?~~the process for providing all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences to appropriate post-acute care providers, suppliers, facilities, etc. ☐ ~~Ask staff if there is a process to ensure that, once the necessary postdischarge services for a patient have been determined, those services or comparable solutions are available.~~ ☐ ~~Verify that hospital staff has knowledge of community resources to assist in arranging services.~~ ☐ ~~How do staff determine if a patient requires community based services or transfer to another facility? How do they determine that the post-acute provider can meet the patient's needs?~~

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	~~Interview patients and their representatives about their discharge planning evaluation. If they were not aware they could request an evaluation, can the hospital provide evidence that they received notice of their right for one?~~ ~~Ask the patient or patient's representative if the results of the discharge planning evaluation were discussed with them.~~ ~~If the hospital does not require a discharge planning evaluation for all inpatients:~~ ~~Does the hospital have a standard process for notifying the patient, their representative, and their physician that they may request a discharge planning evaluation and that the hospital will conduct an evaluation upon request?~~ ~~Can discharge planning and unit nursing staff describe the process for a patient or their representative to request a discharge planning evaluation?~~ ~~Interview attending physicians to see if they are aware that they can request a discharge planning evaluation. If they are not aware, can the hospital provide evidence of how they inform the medical staff about this?~~ **Document Review** **General** Review the discharge planning process – what information is shared with post-acute care providers? Does it include all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care and treatment preferences at the time of discharge? ~~Review the discharge planning process to determine when discharge planning evaluations are completed so they do not contribute to delays in discharge.~~ **Patient Health Record** Review a sample of medical records of patients who required post-acute care services – **was all of the information** shared with the

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	provider/practitioner responsible for the patient's follow-up or ancillary care? ☐ ~~Discharge planning evaluation activities are evident for patients identified as requiring a discharge planning evaluation.~~ ☐ ~~Review a sample of medical records to determine if the discharge planning evaluation documents the goals and preferences of the patient (or the patient's representatives) for postdischarge placement and care.~~ ☐ ~~Review the discharge planning evaluation for the following:~~ ○ ~~Does the evaluation include assessment of the patient's capacity for self-care or ability to be cared for by others in the environment?~~ ○ ~~Does the evaluation consider what the patient's care needs will be immediately upon discharge and whether those needs are expected to remain constant or lessen over time?~~ ○ ~~If the patient was admitted from their private residence, does the assessment include whether the patient is capable of addressing their care needs through self-care?~~ ○ ~~Does the evaluation include assessment of whether the patient will require specialized medical equipment or permanent physical modification to the home and the feasibility of acquiring equipment or the required modifications?~~ ○ ~~If the patient is unable to provide some or all of their self-care, does the evaluation address whether family or friends are available and willing to provide (or be trained to provide) the required care?~~ ☐ ~~Review a sample of medical records to determine if the discharge planning evaluation was completed on a timely basis to allow for appropriate arrangements to be made for posthospital care and to avoid delays in discharge.~~

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	~~Determine when the discharge planning evaluation was initiated. If the evaluation was not begun within 24 hours of the request or identification of the need for an evaluation, ask why.~~ ~~Is there a pattern of delayed start or completion of the evaluation? If so, is the delay due to circumstances beyond the hospital's control (for example, inability to reach the beneficiary's support person(s), continuing changes in the patient's condition) and/or is the delay due to the hospital's failure to develop timely discharge planning evaluations?~~ ~~Review a sample of medical records to determine if the discharge planning evaluation results were discussed with the patient or the patient's representative. If the patient rejects the results of the evaluation, is this documented in the record?~~ ~~Review a sample of medical records to determine if the discharge planning evaluation results are included in the health record.~~
PC.14.01.01, EP 15: The hospital has written policies and procedures for transferring patients under its care (inclusive of inpatient services) to the appropriate level of care (including to another hospital) as needed to meet the needs of the patient. The hospital also provides annual training to relevant staff regarding the hospital policies and procedures for transferring patients under its care.	CMS guidance pending
PC.14.01.01, EP 8: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's discharge plan includes a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides (as defined by the home health agency or in the case of a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, in the geographic area requested by the patient). The hospital documents in the medical record that this list was presented to the patient or the patient's representative. Note 1: Home health agencies must request to be listed by the hospital. Note 2: This list is only presented to patients for whom home health care, posthospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed.	**Interview** Ask patients who require one of these organizations or facilities if they were given a list of these organizations/facilities in their area from which to choose. Interview staff members involved with the discharge planning process. Ask them to describe how patient preferences are taken into account in the selection of post-hospital HHA or SNF services. **Document Review** **Patient Health Record** Review a sample of medical records of patients who required home care, skilled nursing facility, inpatient rehabilitation, or long-term care hospital services to determine if they were provided a list of these organizations/facilities in the geographic area which they reside.

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§482.43(d)(1)	○ Is there documentation of a list of multiple HHAs or SNFs being provided (including electronically) to the patient? If not, is there documentation for an acceptable rationale for providing only one option, e.g., the patient's home is included in the service area of only one Medicare-participating HHA that requested to be included in the hospital lists, or there is only one Medicare-participating SNF in the area preferred by the patient? ○ Ask to see examples of lists of HHAs and SNFs provided to patients prior to discharge.
PC.14.01.01, EP 8: See above §482.43(d)(1)(i)	**Document Review** **Patient Health Record** ☐ Review a sample of medical records – are lists of home health care and post-hospital extended care services provided only to those patients as indicated?
PC.14.01.01, EP 9: For hospitals that use Joint Commission accreditation for deemed status purposes: For patients enrolled in managed care organizations, the hospital makes patients aware of the need to verify with their managed care organization which practitioners, providers, or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers, or certified suppliers are in the network of the patient's managed care organization, it shares this information with the patient or the patient's representative. §482.43(d)(1)(ii)	~~**Document Review**~~ ~~**Patient Health Record**~~ ~~☐ Review a sample of medical records for those patients enrolled in managed care organizations – has the patient been made aware of the need to verify with their managed care organizations which providers or suppliers are in network?~~ **Interview** ☐ Ask the discharge planners or staff who register patients if the hospital has information regarding which providers or suppliers are in network, is that information provided to patients? ☐ Interview a patient: has the patient been made aware of the need to verify with their managed care organizations which providers or suppliers are in network?
PC.14.01.01, EP 8: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's discharge plan includes a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or	**Document Review** **Patient Record**

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long-term care hospitals that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides (as defined by the home health agency or in the case of a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, in the geographic area requested by the patient). The hospital documents in the medical record that this list was presented to the patient or the patient's representative. Note 1: Home health agencies must request to be listed by the hospital. Note 2: This list is only presented to patients for whom home health care, posthospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed. **§482.43(d)(1)(iii)**	☐ Is there documentation in the patient's record that the list was given to the patient or their representative?
PC.14.01.01, EP 10: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of postdischarge services and, when possible, respects the patient's or their representative's goals of care and treatment preferences, as well as other preferences when they are expressed. The hospital does not limit the qualified providers or suppliers that are available to the patient. **§482.43(d)(2)**	**Document Review** **General** ☐ Review the discharge planning policy – does it say that the patient/patient's representative is informed of their freedom to choose among Medicare participating providers? **Interview** ☐ Ask staff how they inform patients/representatives of their freedom to choose providers? ☐ Ask patients – were they informed of their freedom to choose among Medicare participating providers? ☐ Ask patients if the hospital arranged for their referral/transfer to a home care organization or skilled nursing facility reflecting their preferences. If not, did the hospital explain why their choice was not feasible?
PC.14.01.01, EP 11: For hospitals that use Joint Commission accreditation for deemed status purposes: The discharge plan identifies any home health agency or skilled nursing facility in which the hospital has a disclosable financial interest, and any home health agency or skilled nursing facility that has a disclosable financial interest in a hospital. Note: Disclosure of financial interest is determined in accordance with the	**Interview** ☐ Ask ~~discharge planning staff – how patients are informed about disclosable financial interests and any home care or skilled nursing facility disclosable interests (are home care or skilled nursing facility owned by same entity as the hospital?).~~the hospital if it has any disclosable financial interests in any home care or skilled nursing facility on its lists, or if a home care or skilled nursing facility has a

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provisions in 42 CFR 420, subpart C and section 1861 of the Social Security Act (42 U.S.C. 1395x). §482.43(d)(3)	disclosable financial interest in the hospital. If yes, is this stated clearly on the lists? If applicable, were patients made aware of disclosable financial interests?

Hospital Organ, Tissue, and Eye Procurement Evaluation Module (482.45)

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	§482.45(a) Standard: Organ Procurement Responsibilities **Document Review** ☐ Organ procurement policies and procedures that address the hospital responsibilities, including: o Timely notification of OPO or third party designated by the OPO of individuals whose death is imminent or who have died in the hospital.
TS.11.01.01, EP 1: The hospital develops and implements written policies and procedures that include the following: - A written agreement with an organ procurement organization (OPO) that includes that hospital notifying, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes. - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family to discuss potential organ, tissue, or eye donations Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes; The hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single	**Interview** ☐ Interview the staff to verify that they are aware of the policies and procedures for organ, tissue, and eye procurement. **Document Review** ☐ Review the written agreement with the OPO to verify that it addresses all required information. See below. • Written agreement with an Organ Procurement Organization (OPO), designated under 42 CFR Part 486 that at a minimum addresses the following: o The criteria for referral, including the referral of all individuals whose death is imminent or who have died in the hospital. o Includes a definition of "imminent death;" o Includes a definition of "timely notification;" o Addresses the OPO's responsibility to determine medical suitability for organ donation. o Specifies how the tissue and/or eye bank will be notified about potential donors using notification protocols developed by the OPO in consultation with the hospital-designated tissue and eye bank(s); o Provides for notification of each individual death in a timely manner to the OPO (or designated third party) in accordance with the terms of the agreement. o Ensures that the designated requestor training program offered by the OPO has been developed in cooperation with the tissue bank and eye bank designated by the hospital.

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agreement with an OPO that provides services for organ, tissue, and eye; or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https: //n.neurology.org/content/early/2023/09/13 /WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines /Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC. **§482.45(a)(1)**	○ Permits the OPO, tissue bank, and eye bank access to the hospital's death record information according to a designated schedule, e.g., monthly, or quarterly. ○ Includes that the hospital is not required to perform credentialing reviews for, or grant privileges to, members of organ recovery teams as long as the OPO sends only "qualified, trained individuals" to perform organ recovery; and ○ The interventions the hospital will utilize to maintain potential organ donor patients so that the patient organs remain viable. ☐ Verify that the governing body has approved the organ procurement policies. **Patient Record** ☐ Review a sample of death records to verify that the hospital has implemented its organ procurement policies. **QAPI** ☐ Verify that the organ, tissue, and eye donation program is integrated into the QA program.
TS.11.01.01, EP 1: See above **§482.45(a)(2)**	**Document Review** ☐ Verify that the hospital has an agreement with at least one tissue bank and one eye bank that specifies criteria for referral of all potential tissue and eye donors, or an agreement with an OPO that specifies the tissue bank and eye bank to which referrals will be made. The agreement should also acknowledge that it is the OPO's responsibility to determine medical suitability for tissue and eye donation unless the hospital has an alternative agreement with a different tissue and/or eye bank.
TS.11.01.01, EP 1: See above **§482.45(a)(3)**	**Interview** ☐ Does the hospital have QAPI mechanisms in place to ensure that the families of all potential donors are informed of their options to donate organs, tissues, or eyes, or to decline to donate? **Document Review**

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	☐ Verify that the hospital ensures that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, including the option to decline to donate. **Interview** ☐ How does the hospital ensure that only OPO, tissue bank, or eye bank staff or designated requestors are approaching families to ask them to donate? **Document Review** ☐ Review training schedules and personnel files to verify that all designated requestors have completed the required training.
TS.11.01.01, EP 1: See above **§482.45(a)(4)**	**Interview** ☐ Interview a hospital-designated requestor regarding approaches to donation requests. **Document Review** ☐ Review the designated requestor training program to verify that it addresses the use of discretion. ☐ Review the hospital's complaint file for any relevant complaints.
TS.11.01.01, EP 2: The hospital develops and implements policies and procedures for working with the organ procurement organization (OPO) and tissue and eye banks to do the following: - Review death records in order to improve identification of potential donors - Maintain potential donors while the necessary testing and placement of potential donated organs, tissues, and eyes takes place in order to maximize the viability of donor organs for transplant - Educate staff about issues surrounding donation **§482.45(a)(5)**	**Interview** ☐ How does the hospital ensure that all appropriate staff has attended an educational program regarding donation issues and how to work with the OPO, tissue bank, and eye bank? **Document Review** ☐ Review in-service training schedules and attendance sheets **Credential/Personnel File** ☐ Appropriate hospital staff, including all patient care staff, must be trained on donation issues. The training program must be developed in cooperation with the OPO, tissue bank and eye bank, and should include, at a minimum: o Consent process; o Importance of using discretion and sensitivity when approaching families; o Role of the designated requestor;

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	○ Transplantation and donation, including pediatrics, if appropriate; ○ Quality improvement activities; and ○ Role of the organ procurement organization. ☐ Training should be conducted with new employees annually, whenever there are policy/procedure changes, or when problems are determined through the hospital's QAPI program. ☐ Those hospital staff who may have to contact or work with the OPO, tissue bank and eye bank staff must have appropriate training on donation issues including their duties and roles. ☐ Determine by review, what policies and procedures are in place to ensure that potential donors are identified and declared dead by an appropriate practitioner within an acceptable timeframe. ☐ Verify that there are policies and procedures in place to ensure the coordination between facility staff and OPO staff in maintaining the potential donor.
TS.11.01.01, EP 1: The hospital develops and implements written policies and procedures that include the following: - A written agreement with an organ procurement organization (OPO) that includes that hospital notifying, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes. - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in	**Document Review** ☐ Verify by review, one year of reports submitted by the facility to the OPTN, the Scientific Registry, the OPOs, and any data submitted to the Department per request of the Secretary.

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collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family to discuss potential organ, tissue, or eye donations Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes; The hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye; or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https: //n.neurology.org/content/early/2023/09/13 /WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines /Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC. **§482.45(b)(2);** **TS.12.01.01, EP 1:** The hospital performing organ transplants belongs to and abides by the rules of the Organ Procurement and Transplantation Network (OPTN) established under section 372 of the Public Health Service (PHS) Act. Note: The term "rules of the OPTN" means those rules provided for in regulations issued by the Secretary of the US Department of Health & Human Services in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of	

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compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this paragraph, unless the Secretary has given the OPTN formal notice that the Secretary approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing. §482.45(b)(1) **TS.12.01.01, EP 2:** If requested, the hospital provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry of Transplant Recipients (SRTR), the hospital's designated organ procurement organization (OPO), and, when requested by the Office of the Secretary, directly to the US Department of Health & Human Services§482.45(b)(3)	

Hospital Organ, Tissue, and Eye Procurement Evaluation Module Continued (Additional Joint Commission Requirement)

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TS.11.01.01, EP 3: The individual designated by the hospital documents that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor.	**Document Review:** **Patient Medical Record:** ☐ Verify that the patient or families to be or not to be an organ, tissue, or eye donor is documented in the medical record when appropriate.

Hospital Surgical Services Evaluation Module (482.51)

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LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.51** **LD.13.03.01, EP 10:** If the hospital provides outpatient surgical services, the services are consistent with the quality of inpatient surgical care **§482.51**	**Observation** ☐ Inspect all inpatient and outpatient operating rooms/suites. Request the use of proper PPE for the inspection. ☐ Determine if surgical services are provided in accordance with acceptable standards of practice, including but not limited to: o Access to surgical and recovery area, including traffic flow pattern(s) o Adherence to aseptic and sterile techniques, including cleaning between cases and appropriate terminal cleaning o Appropriate utilization of PPE for type of surgical case(s) performed o Equipment maintenance by the hospital's biomedical equipment program and in accordance with federal and state law, regulations, guidelines, and manufacturer's recommendations o Equipment availability for rapid and routine sterilization of OR equipment and materials o Packaging, handling, labeling, and storage of sterilized materials o Monitoring of temperature and humidity o Integration of surgical services into the hospitalwide quality assurance/performance improvement program
LD.13.03.01, EP 1: See above **§482.51(a)** **LD.13.03.01, EP 11:** The surgical services are consistent with the resources available. **§482.51(a)**	**Document Review** **General** ☐ Review the hospital's organizational chart displaying the relationship of operating room services to other services and confirm that the chart indicates lines of authority and delegation of responsibility within the department or service.

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	☐ Review the staffing plan to ensure leadership has provided the appropriate types and number of staff to provide surgical services
NPG.12.01.01, EP 13: The surgical services include but are not limited to the following staff: - An experienced registered nurse or doctor of medicine or osteopathy who supervises the operating rooms - Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) who serve as scrub nurses, if under the supervision of a registered nurse - Qualified registered nurses who perform circulating duties in the operating room Note: In accordance with applicable state laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies. **§482.51(a)(1)**	**Interview** ☐ Verify that a registered nurse or physician is responsible for supervising the operating rooms. **Document Review** **Personnel/Credential File** ☐ Request a copy of the supervisor's position description to verify that it specifies qualifications, duties, and responsibilities of the position. ☐ Verify that the supervisor is experienced and competent in the management of surgical services.
NPG.12.01.01, EP 13: See above **§482.51(a)(2)**	**Document Review** **General** ☐ Validate the availability of a registered nurse by requesting and reviewing a staffing schedule for the operating room. ☐ Review staffing schedules to determine adequacy of coverage by staff and RN supervisor
NPG.12.01.01, EP 13: See above **§482.51(a)(3)**	**Document Review** **General** o Review the staffing schedule to make certain that the circulating nurse is an RN. o Verify that RNs, LPNs, and surgical technologists are working in accordance with applicable state law and medical-staff approved policies and procedures. **Interview** ☐ For hospitals that utilize LPNs and STs to assist with circulating duties, inquire as to the process for RN supervisor response in emergency situations

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MS.17.02.01, EP 6: The hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine **§482.51(a)(4)** **MS.17.02.01, EP 7:** The surgical service maintains a current roster listing each practitioner's surgical privileges. Note: The roster may be in paper or electronic format. **§482.51(a)(4)** **MS.17.02.03, EP 1:** Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services. **§482.51(a)(4)**	**Document Review** **General** ☐ Review the roster of practitioners to ensure it specifies the surgical privileges of each practitioner ☐ Review the medical staff bylaws for criteria that determine the privileges to be granted to an individual practitioner ☐ If the hospital utilizes RN First Assistants, surgical PA, or other non-MD/DO surgical assistants, review the criteria, qualifications and a credentialing process to grant specific privileges to individual practitioners **Personnel/Credential File (Medical Staff Credential File Review Activity)** ☐ Verify surgical privileges in accordance with the competencies of each practitioner. ☐ Verify practitioner competency appraisal as established by the hospital's QAPI program and credentialing process in accordance with scope of practice and other State laws and regulations. **Interview** ☐ Ask to see where the surgical roster(s) are kept including: ☐ A current roster with each practitioner's specific privileges o A current list of surgeons with suspended or restricted surgical privileges o Discuss the process for individuals requesting surgical privileges **Observation** ☐ Ask to see where the surgical roster(s) are kept including: o A current roster with each practitioner's specific privileges o A current list of surgeons with suspended or restricted surgical privileges
LD.13.01.09, EP 6: The hospital develops and implements surgical care policies and procedures that maintain high standards for medical practice and patient care. **§482.51(b)**	**Document Review** **General** ☐ Review policies and procedures that pertain to surgical services to determine whether they address the elements specified in §482.51(b)

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LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.51(b)** **LD.13.03.01, EP 11:** The surgical services are consistent with the resources available. **§482.51(b)**	☐ If the hospital uses alcohol-based skin preparations in anesthetizing locations, review the policies and procedures in place to minimize the risk of surgical fires. **Interview** ☐ Ask surgical services staff how their work adheres to applicable policies and procedures
PC.11.02.01, EP 2: A medical history and physical examination is completed and documented no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment	**Document Review** **Patient Health Record** ☐ During record review, verify a complete history and physical (H&P) and an update if applicable, is present in the medical record prior to a surgical procedure requiring anesthesia services, even if that surgery or procedure occurs less than 24 hours after admission or registration.

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is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/. **§482.51(b)(1)(i)**	Note: A complete H&P is required in the medical record of all patients except in emergences and under §482.51(b)(1)(iii) and as determined by medical staff policy. ☐ Verify that the history and physical meets the following requirements in accordance the requirements of 42 CFR 482.2 (c)(5)
PC.11.02.01, EP 3: For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/. **§482.51(b)(1)(ii)**	**Document Review** **Patient Health Record** ☐ During record review, determine whether an updated medical history and physical exam was conducted, including any change in patient condition, and documented in a timely manner, except for those patients who are specified as not requiring a comprehensive history and physical for specific outpatient surgeries and procedures. ☐ Determine whether the H&P update was conducted in accordance with the requirements of 42 CFR 482.22(c)(5). ☐ Determine whether the records of patients who did not have a timely H&P updated indicate that the surgery or procedure was conducted on an emergency basis. ~~☐ verify that an updated physical exam is completed and documented within 24 hours after admission or registration when the medical history and physical exam are completed within 30 days before admission or registration except in circumstances provided in §482.43(b)(1)(iii).~~
PC.11.02.01, EP 4: When the medical staff allows an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the patient assessment is completed and documented after registration but prior to the surgery or procedure requiring anesthesia services. Note: For further regulatory guidance at 42 CFR 482.24(c)(4)(i)(A) and (B), 482.51(b)(1)(i) and (ii), and 482.22(c)(5)(v), refer to https://www.ecfr.gov/. **§482.51(b)(1)(iii)**	**Document Review** **General** ☐ Review policies developed by the medical staff ~~state~~ that identify, in accordance with 482.22(c)(5)(v), specific patients that do not require a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services. Patient health record ☐ Review a sample of medical records of patients receiving outpatient surgery to determine whether

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	evidence exists that pre-surgical assessments and updates have been completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services except in the case of emergencies.
RC.12.01.01, EP 3: The medical record contains any informed consent, when required by hospital policy or federal or state law or regulation. Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker. **§482.51(b)(2)**	**Interview** □ Ask medical staff if they understand which procedures are considered surgery and, thus, are those that require a properly executed informed consent form. □ Discuss with staff the policies and procedures that are being followed related to informed consent process (including 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 an invasive procedure □ Interview two or three postsurgical patients or their representatives, as appropriate, to assess satisfaction with the informed consent discussion prior to their surgery. **Document Review** **General** □ Review the hospital's policies and procedures pertaining to informed consent, including circumstances when a surgery would be considered an emergency and thus not require that an informed consent form be placed in the medical record prior to surgery. □ Review the hospital's policies for 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) **Patient Health Record**

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	☐ Review a minimum of six medical records of surgical patients that did not receive emergency surgery to verify that the informed consent is present in the medical record prior to surgery, except in the case of emergency surgery. When possible, review medical records of patients who are about to undergo surgery, or who are in a surgical recovery area.
PC.12.01.05, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: At a minimum, operating room suites have the following equipment available: - Call-in system (process to communicate with or summon staff outside of the operating room when needed) - Cardiac monitor - Resuscitator (hand-held or mechanical device that provides positive airway pressure) - Defibrillator - Aspirator (hand-held or mechanical device used to suction out fluids or secretions) - Tracheotomy set **§482.51(b)(3)**	**Observation** ☐ Determine if the operating room suite has the following items available: o On-call system o Cardiac monitor o Resuscitator o Defibrillator o Aspirator (suction equipment) o Tracheotomy set (cricothyroidotomy set is not a substitute) ☐ Verify that all equipment is working and, as applicable, in compliance with the hospital's biomedical equipment inspection, testing, and maintenance program.
PC.13.01.03, EP 5: The hospital has adequate provisions for immediate postoperative care. **§482.51(b)(4)**	**Observation** ☐ Verify that the hospital has provisions for postoperative care. ☐ Observe care provided to patients in a postanesthesia care unit(PACU) to determine if patients are monitored and assessed appropriately prior to transfer or discharge (in the case of same-day surgery patients) from the PACU. ☐ Does the hospital have a system for identifying and addressing the monitoring needs of postoperative patients transferred from the PACU to other areas of the hospital? **Interview** ☐ Ask staff in the PACU and in units who receive patients from the PACU how the needs of postoperative patients for vigilant monitoring is addressed when the patients are transferred from the PACU to other areas of the hospital.

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RC.12.01.03, EP 1: The hospital has a complete and up-to-date operating room register or equivalent record that includes the following: - Patient's name - Patient's hospital identification number - Date of operation - Inclusive or total time of operation - Name of surgeon and any assistants - Name of nursing staff - Type of anesthesia used and name of person administering it - Operation performed - Pre- and postoperative diagnosis - Age of patient **§482.51(b)(5)**	**Document Review** **General** ☐ Examine the operating room register or equivalent record that lists all surgery performed by surgery services to ensure that it includes items specified in §482.51(b)(5).
RC.12.01.03, EP 2: An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following: - Name and hospital identification number of the patient - Date and times of the surgery - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) - Preoperative and postoperative diagnosis - Name of the specific surgical procedure(s) performed - Type of anesthesia administered - Complications, if any - Description of techniques, findings, and tissues removed or altered - Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any - Any estimated blood loss Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a	**Document Review** **General** ☐ Review a minimum sample of six medical health records of patients who had a surgical encounter to make certain ensure that they contain a surgical report that was dated and signed by the responsible surgeon and includes the information specified in §482.51(b)(6).

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time frame defined by the hospital. Note 2: If the physician or other licensed practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care. §482.51(b)(6)	

Hospital Anesthesia Services Evaluation Module (482.52)

Joint Commission Standards / EPs	Hospital Survey Process
LD.13.01.07, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services when provided: - Anesthesia - Nuclear medicine - Respiratory care Note 1: The anesthesia service is responsible for all anesthesia administered in the hospital. Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis. **§482.52** **LD.13.03.01, EP 1** The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.52**	**Document Review** **General** ☐ Organizational chart for anesthesia services. ☐ Anesthesia services policies and procedures. o Do they apply in all hospital locations where anesthesia services are provided? o Do they indicate the necessary qualifications that each clinical practitioner must possess to administer anesthesia as well as moderate sedation or other forms of analgesia? o Do they address what clinical applications are considered to involve analgesia, in particular moderate sedation, rather than anesthesia, based on identifiable national guidelines? o What are the national guidelines that they are following and how is that documented? ☐ Does the hospital have a system by which adverse events related to the administration of anesthesia and analgesia, including moderate sedation, are tracked and acted on? **Personnel/Credential File** ☐ Determine that a doctor of medicine or osteopathy has the authority and responsibility for directing all anesthesia services throughout the hospital. ☐ Look for evidence in the director's file of their appointment privileges and qualifications, consistent with the criteria adopted by the hospital's governing body. Review the position description. o Confirm that the director's responsibilities include at least the following: ▪ Planning, directing, and supervising all activities of the service. ▪ Evaluating the quality and appropriateness of the anesthesia services provided to patients as part of the hospital's quality assurance/performance improvement program.

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LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **482.52(a)** **PC.13.01.01, EP 1:** For hospitals that use Joint Commission accreditation for deemed status purposes: General anesthesia, regional anesthesia and monitored anesthesia, including deep sedation/analgesia, is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR	**Document Review** **Personnel/Credential File** ☐ Review the qualifications of individuals authorized to administer general anesthesia, regional anesthesia, and monitored anesthesia, including deep sedation/analgesia, to determine if they satisfy the requirements at §482.52(a) and (c). This includes o Director of Anesthesia o Physician who administers anesthesia but not Anesthesiologist o Dentist, Oral Surgeon, or Podiatrist who administers anesthesia under state law o Certified Reg Nurse Anesthetist o Anesthesiologist's assistant ☐ Determine that there is documentation of current licensure and, as applicable, current certification for all persons administering anesthesia. ☐ Review the qualifications of individuals authorized to furnish other anesthesia services to determine if they are consistent with the hospital's anesthesia services policies.

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410.69(b), supervised by the operating practitioner, except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist who is immediately available if needed Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law or, if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor attests that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. **482.52(a)(1-5)**	
PC.13.01.01, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: General anesthesia, regional anesthesia and monitored anesthesia, including deep sedation/analgesia, is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law	**Document Review** **Personnel/Credential File** □ Review the qualifications of individuals authorized to administer general anesthesia, regional anesthesia, and monitored anesthesia, including deep sedation/analgesia, to determine if they satisfy the requirements at §482.52(a) and (c).

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- A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b), supervised by the operating practitioner except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist who is immediately available if needed Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law or, if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) anesthesiologist assistant. Note 3: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor attests that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. **§482.52(c)(1); §482.52(c)(2)**	□ Determine that there is documentation of current licensure and, as applicable, current certification for all persons administering anesthesia. □ Review the qualifications of individuals authorized to furnish other anesthesia services to determine if they are consistent with the hospital's anesthesia services policies. **General** □ Determine if the state is an "opt-out state" and therefore permits CRNAs to administer anesthesia without supervision in accordance with 482.52(c). □ Review the hospital's policies and procedures governing supervision of assistants to certified registered nurse anesthetists (CRNAs) and anesthesiologist and determine whether they comply with regulatory requirements.
LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in	**Document Review** **General** □ Review the policies developed on anesthesia procedures determine they address at a minimum:

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accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.52(b)** **PC.13.01.03, EP 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements policies and procedures for anesthesia that include the delineation of preanesthesia and postanesthesia responsibilities. The policies require the following for each patient: - A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in 42 CFR 482.52(a), within 48 hours prior to surgery or a procedure requiring anesthesia services. - An intraoperative anesthesia record. - A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in 42 CFR 482.52(a), no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery is completed in accordance with state law and hospital policies	○ How the hospital's anesthesia services needs will be met; ○ Delivery of anesthesia services consistent with recognized standards for anesthesia care. A well-designed anesthesia services policy would address issues such as: ▪ Patient consent; ▪ Infection control measures; ▪ Safety practices in all anesthetizing areas; ▪ Protocol for supportive life functions, e.g., cardiac and respiratory emergencies; ▪ Reporting requirements; ▪ Documentation requirements; ▪ Equipment requirements, as well as the monitoring, inspection, testing, and maintenance of anesthesia equipment in the hospital's biomedical equipment program. ○ Delineation of pre- and post-anesthesia staff responsibilities

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and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care. **§482.52(b)**	
PC.13.01.03, EP 2: See above **§482.52(b)(1)**	**Document Review** **Patient Health Record** □ Review a sample of inpatient and outpatient health records for patients who had surgery or a procedure requiring anesthesia. Determine if each patient o Had a preanesthesia evaluation by a practitioner qualified to administer anesthesia. o Preanesthesia evaluation included at least the elements that must be performed within the 48-hour timeframe as follows: ▪ Review of the medical history, including anesthesia, drug and allergy history; and ▪ Interview, if possible given the patient's condition, and examination of the patient. Elements that must be reviewed and updated as necessary within 48 hours, but which may also have been performed during or within 30 days prior to the 48-hour time period, in preparation for the procedure: ▪ Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk). ▪ Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access). ▪ Additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation). ▪ Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's

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	representative) of the risks and benefits of the delivery of anesthesia. o Determine that the preanesthesia evaluation was updated, completed, and documented within 48 hours prior to the delivery of the first dose of medication(s) given for the purpose of inducing anesthesia for surgery or a procedure requiring anesthesia services.
PC.13.01.03, EP 2: See above **§482.52(b)(2)**	**Document Review** **Patient Health Record** □ Review a sample of health records for patients who had surgery or a procedure requiring anesthesia to determine that each patient has an intraoperative anesthesia record that includes the following elements: o Name and hospital identification number of the patient; o Name(s) of practitioner(s) who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner; o Name, dosage, route and time of administration of drugs and anesthesia agents; o Techniques(s) used and patient position(s), including the insertion/use of any intravascular or airway devices; o Name and amounts of IV fluids, including blood or blood products if applicable; o Timed-based documentation of vital signs as well as oxygenation and ventilation parameters; and o Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.
PC.13.01.03, EP 2: See above **482.52(b)(3)**	**Document Review** **Patient Health Record** Review a sample of medical records for patients who had surgery or a procedure requiring general, regional, or monitored anesthesia to determine if □ A postanesthesia evaluation was completed for each patient.

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	○ Was the evaluation conducted by a practitioner who is qualified to administer anesthesia? ○ Was the evaluation completed and documented within 48 hours after the surgery or procedure? ○ Were the elements of an adequate postanesthesia evaluation documented in the medical record: ▪ Respiratory function, including respiratory rate, airway patency, and oxygen saturation; ▪ Cardiovascular function, including pulse rate and blood pressure; ▪ Mental status; ▪ Temperature; ▪ Pain; ▪ Nausea and vomiting; and ▪ Postoperative hydration.

Hospital Anesthesia Services Evaluation Module (Additional Joint Commission Requirements)

Joint Commission Standards/EPs	Hospital Survey Process
PC.13.01.03, EP 1: Before operative or other high-risk procedures are initiated or before anesthesia is administered, the hospital conducts a preanesthesia patient assessment. **PC.13.01.03, EP 4:** Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered, the hospital provides the patient with preprocedural education, according to the plan for care. **PC.13.01.03, EP 6:** A qualified physician or other licensed practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified individual, patients are discharged according to criteria approved by clinical leaders.	**Document Review:** **Patient Medical Record:** ☐ Verify that a patient assessment is conducted prior to the patient receiving anesthesia ☐ Verify that the patient received education about their plan of care prior to anesthesia being administered ☐ Verify that a qualified physician or other licensed practitioner discharged the patient from the recovery area. In absence of a qualified individual, verify the patient was discharged according to the criteria approved by clinical leaders

Hospital Nuclear Medicine Services Evaluation Module (482.53)

Joint Commission Standards / EPs	Hospital Survey Process
LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.53**	**Interview** ☐ If nuclear medicine services are offered, determine the type(s) of services provided and the location where each service is provided. ☐ Can the director of nuclear medicine services demonstrate how the hospital ensures that the services are provided in accordance with acceptable standards of practice? ☐ Can the director point to accepted guidelines or state or other federal law that support the hospital's nuclear medicine policies and procedures? ☐ Can the director explain how the hospital's policies, procedures, and protocols are consistent with **ALARA** principles? **Document Review** **Policy/Procedure Review** ☐ nuclear medicine policies and procedures that take into consideration classes of patients who may be at higher risk for over-exposure, as well as the radiation exposure of staff when preparing, storing, transporting, administering and disposing of radioactive materials. **QAPI Review** ☐ the hospital's nuclear medicine services must be integrated into its hospital- wide Quality Assessment and Performance Improvement (QAPI) program, as required by §482.21. Consistent with these requirements, the hospital must monitor the quality and safety of nuclear medicine services **Observation** ☐ Observe one or more nuclear medicine studies to determine whether staff follows the hospital's protocols for that study. After the observation, ask staff to show you the applicable protocol and explain how they complied with it.

Joint Commission Standards / EPs	Hospital Survey Process
LD.13.01.07, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services when provided: - Anesthesia - Nuclear medicine - Respiratory care Note 1: The anesthesia service is responsible for all anesthesia administered in the hospital. Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis. **§482.53(a)(1)** **LD.13.03.01, EP 1:** See above **§482.53(a)** **MS.16.01.01, EP 12:** For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff. **§482.53(a)(2)**	**Document Review** **General** □ Determine whether the scope of the nuclear medicine services offered is specified in writing. □ Determine whether there are nuclear medicine policies developed by the director of nuclear medicine that govern the provision of these services in every part of the hospital offering nuclear medicine services. **Personnel/Credential File** ☐ Verify that the hospital has a written description of the qualifications of the nuclear medicine services director. o Review the service director's file to verify that they are an MD or a DO and have the necessary education, experience, and specialized training in nuclear medicine, per the hospital's written policies ☐ Ensure that the hospital has specified, in writing, the qualifications, training, functions, and responsibilities of each category of personnel used by the hospital, whether personnel are employees or contractors, in the delivery of nuclear medicine services. o The written specifications must be developed by the nuclear medicine services director and approved by the hospital's medical staff. o Qualifications include, at a minimum, job title, education, experience, specialized training, and licensure/certification, consistent with any applicable federal and state law. The specifications must also address ongoing training for personnel. o Review personnel files for a sample of nuclear medicine staff to determine if they meet the prescribed qualifications and have received ongoing training as required in the hospital's policies and procedures.
LD.13.03.01, EP 9: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital provides nuclear medicine services, and nuclear medicine staff perform laboratory tests, the services meet the applicable requirements for laboratory services specified in 42 CFR 482.27.	**Interview** □ Ask the hospital to demonstrate how it limits access to radioactive materials at all times.

Joint Commission Standards / EPs	Hospital Survey Process
§482.53(b)(3) **MM.15.01.01, EP 7:** For hospitals that use Joint Commission accreditation for deemed status purposes: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals. §482.53(b)(1) **PE.02.01.01, EP 4:** The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) §482.53(b); §482.53(b)(2)	☐ Determine if staff use their dosimeters according to manufacturer's instructions, particularly in the appropriate placement of the dosimeter on the body, as indicated on the dosimeter. ☐ Ask responsible staff to demonstrate how they ensure the safe transport of radioactive materials in the hospital. ☐ Ask responsible staff to determine whether the appropriate container for protection devices (for example, lead for gamma emitters) are being used for storage and administration of radioactive materials. ☐ Ask staff to show the policy for disposal methods for radioactive waste or unused material and to explain how they ensure that these procedures are followed. ☐ If radiopharmaceuticals are prepared in-house, determine that the preparation is performed by, or supervised by, a registered pharmacist or MD/DO. ☐ Ask the supervising pharmacist or MD/DO how technicians who prepare radiopharmaceuticals are supervised. Are supervision policies based on the recommendations of the Society of Nuclear Medicine and Molecular Imaging? If not, what is the basis for the supervision policies? ☐ Ask what policies and procedures the hospital uses to ensure proper preparation. ☐ Ask what guidelines the hospital relies on for radio pharmaceutical preparation. **Document Review** **General** ☐ Verify that radioactive materials are prepared, labeled, used, transported, stored, and disposed of in accordance with hospital policies that are based on acceptable standards of practice. ☐ Verify that the hospital maintains accurate records of the receipt, distribution, and disposal of radioactive materials, including radiopharmaceuticals. ☐ If radiopharmaceuticals are obtained from an outside source, verify that the receipt and storage are appropriately tracked. ☐ Verify that the hospital has policies regarding the supervision of nuclear medicine personnel and the in-house preparation of radio pharmaceuticals.

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	Personnel/Credential File
	- Review personnel records of pharmacists, MDs/DOs, and nuclear medicine personnel involved in the preparation and supervision of radiopharmaceuticals to verify that they have required qualifications per state law and hospital policy.
	
	Observation
	- If the hospital prepares radiopharmaceuticals on-site, observe the preparation to verify that proper safety precautions are used to protect staff from excess radiation and, once prepared, are stored in appropriate containers.
	- Verify that a clear, recognizable label for nuclear material is appropriately displayed in all relevant areas throughout the hospital and on all radioactive materials.
	- Verify that safety precautions are followed in the operations of the nuclear medicine service and that personnel and patients maintain and wear appropriate body shielding (for example, lead aprons, lead gloves, thyroid shields), when appropriate.
	- Observe a staff member deliver a nuclear medicine procedure to a patient, paying attention to adherence to hospital safety protocols during the delivery of the radiopharmaceutical.
	- Verify that radioactive materials, including radioactive waste, have appropriate storage and disposal.
	- Determine how the hospital disposes of unneeded radio nuclides and radio pharmaceuticals.
	  - Are these methods in accordance with federal and state law, regulation, and guidelines?
	  - Are the methods described in hospital policy?
	- Ensure that any laboratory tests performed in connection with nuclear medicine services comply with procedures for the laboratory services Condition of Participation.

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PE.04.01.01, EP 4: The hospital maintains equipment and supplies appropriate for the types of nuclear medicine services offered. The equipment is maintained for safe operation and efficient performance. **§482.53(c); §482.53(c)(1)** **PE.05.01.01, EP 1:** At least annually, a diagnostic medical physicist or nuclear medicine physicist inspects, tests, and calibrates all nuclear medicine (NM) imaging equipment. The results, along with recommendations for correcting any problems identified, are documented. These activities are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: - Image uniformity/system uniformity - High-contrast resolution/system spatial resolution - Sensitivity - Energy resolution - Count-rate performance - Artifact evaluation Note 1: The following test is recommended, but not required: Low-contrast resolution or detectability for non-planar acquisitions. Note 2: The medical physicist or nuclear medicine physicist is accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or nuclear medicine physicist. (For more information, refer to HR.11.01.03, EPs 1 and 2; HR.11.02.01, EP 2) **§482.53(c)(2)**	**Interview** ☐ Ask nuclear medicine services staff who operate equipment what they would do if they suspected a malfunction. Does the hospital have a policy to address this and are staff familiar with it? **Document Review** **General** ☐ Does the hospital have documentation that indicates that the equipment and supplies it uses in nuclear medicine services are appropriate for use with radioactive materials? ☐ Review equipment maintenance records. Verify that equipment is tested, calibrated, and otherwise maintained at least annually, following the manufacturer's recommended procedures. ☐ Verify that, if the manufacturer requires more frequent than annual testing and maintenance, the hospital adheres to the manufacturer's prescribed schedule. **Personnel/Credential File** ☐ Can the hospital demonstrate how personnel, whether employees or contractors, who inspect, test, calibrate, and maintain nuclear medicine services equipment are qualified to do so? **Observe** ☐ Have staff demonstrate how the equipment is maintained for quality assurance in patient care.
MM.13.01.01, EP 6: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains records of the receipt and distribution of radiopharmaceuticals. **§482.53(d)(3)**	**Interview** ☐ Ask the hospital to demonstrate how it maintains accurate records of the receipt and distribution of radiopharmaceuticals at all locations throughout the hospital.

Joint Commission Standards / EPs	Hospital Survey Process
PC.12.01.01, EP 1: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. **§482.53(d)(4)** **RC.11.01.01, EP 4:** The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, timed, medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible. **§482.53(d); §482.53(d)(2)** **RC.11.03.01, EP 1:** The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical records are retained in their original or legally reproduced form for at least five years. This includes nuclear medicine reports; radiological reports, printouts, films, and scans; and other applicable image records. **§482.53(d)(1)**	☐ Ask what the hospital's policy is for frequency of review of the records. Is there evidence that the hospital complies with its policy? ☐ Ask the hospital to explain how it addresses discrepancies in the records. ○ What actions does it take to determine whether there are errors in the records versus unaccounted loss of materials? ○ If applicable, what further actions does it take to locate unaccounted radioactive materials? ○ If applicable, what further actions does it take to prevent future recordkeeping errors? **Document Review** **General** ☐ Verify that copies of nuclear medicine reports are maintained for at least 5 years. ☐ Verify that reports of nuclear medicine interpretations are signed and dated only by the practitioner who interpreted the study's results, as authorized by the medical staff to perform these interpretations. ☐ Verify that nuclear medicine services are ordered only by practitioners who have privileges to do so or, for outpatient services when authorized and consistent with the provisions of §482.54, by other practitioners authorized to do so by the medical staff, consistent with federal and state law.

Joint Commission Standards / EPs	Hospital Survey Process
RC.12.01.01, EP 2: The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications	

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dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. **§482.53(d)**	

Outpatient Services Evaluation Module (482.54)

Joint Commission Standards / EPs	Hospital Survey Process
LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.54**	**Document Review:** ☐ Review hospital's scope of services (see survey procedures for 482.54 (a)(1)
LD.13.03.01, EP 5: If the hospital provides outpatient services, the services are integrated with inpatient services. **482.54(a)**	**Interview:** ☐ Director of outpatient services to understand scope and complexity of services provided and organization of the service(s) ☐ Director of outpatient services and staff about established procedures and communication methods to facilitate continuity of care ☐ Verify that outpatient services are integrated into hospital wide QAPI program (A-1081) **Document Review:** ☐ Review the hospital scope of services

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	☐ Policies to assure the integration of outpatient services, including an established method of communication between outpatient service departments to corresponding inpatient services. **Patient Health Record Review:** ☐ Review 1-2 outpatient medical records of patients who were admitted to acute care to confirm that pertinent information from the outpatient record has been included in the inpatient record. **Observation:** ☐ For each outpatient location visited, observe for staffing, equipment, and supplies to support the scope and complexity of services provided at each location. Services provided are in accordance with acceptable standards of practice
LD.13.01.07, EP 2: The hospital assigns one or more individuals who are responsible for outpatient services. **482.54(b)(1)** **NPG.12.01.01, EP 1:** Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services. Note 2: Emergency services staff are qualified in emergency care. **482.54(b)(2)**	**Interview** ☐ Identify the individual(s) responsible for providing direction for outpatient services. **Document review** ☐ Policies and procedures to determine the person's responsibility. **Personnel file review** ☐ Review the job description and personnel file of the individual(s) responsible for a selection of outpatient services to ensure qualifications are in accordance with State law, acceptable standards of practice and hospital policy to direct the service for which they are responsible. **Observation:** ☐ Visit several on- and off-campus locations where hospital outpatient services are provided. ☐ Based on scope and complexity of the services being offered, there is sufficient staff/personnel with the appropriate

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	education, experience, certifications, current licensure where appropriate, and competencies for assigned responsibilities.
PC.12.01.01, EP 2: Any physician or other licensed practitioner who orders outpatient services meets the following conditions: - Responsible for the care of the patient - Licensed in the state where they provide care to the patient - Acting within their scope of practice under state law - Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services Note: This applies to physicians or other licensed practitioners who are appointed to the hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria. **482.54(c)(1-4)**	**Interview and patient health records review** ☐ Outpatient services must be ordered by a physician or other licensed practitioner who orders outpatient services meets the following conditions: ☐ Is responsible for the care of the patient ☐ Is licensed in the state where they provide care to the patient ☐ Is acting within his or her scope of practice under state law ☐ Is authorized in accordance with state law and medical staff policies approved by the governing body to order the applicable outpatient services
LD.13.03.01, EP 1: See above **Standard-level Tag for §482.54**	**Interview** ☐ Verify that equipment, staff and facilities are adequate to provide the outpatient services offered at each location are in accordance with acceptable standards of practice. ☐ Verify that outpatient services at all locations are in compliance with the hospital CoP. ☐ Determine locations and type(s) of outpatient services provided. **Document Review** ☐ Verify that the hospital's outpatient services are integrated into its hospitalwide QAPI program.

Hospital Emergency Services Evaluation Module (482.55)

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LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.55** **LD.13.03.01, EP 7:** If the hospital provides emergency services, the services meet the needs of its patients in accordance with accepted standards of practice, are organized under the direction of a qualified member of the medical staff, and are integrated with other departments of the hospital. **§482.55**	**Interview** **General** ☐ Ask staff how the hospital meets the emergency needs of its patients in accordance with acceptable standards of practice and as per applicable law and regulation.

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LD.13.03.01, EP 1: See above **§482.55(a)(1)** **LD.13.03.01, EP 7:** See above **§482.55(a)(1)**	**Interview** ☐ Leaders about emergency services, including who leads these services, and the medical staff's criteria for this position. **Document Review** **General** ☐ Verify that emergency services are organized under the direction of a qualified member of the medical staff. Note: *A single emergency services director must be identified and be responsible for the hospital's emergency services.* ☐ Has the medical staff established criteria for the qualifications of the emergency services director in accordance with state law and acceptable standards of practice?
LD.13.03.01, EP 1: See above **§482.55(a)(2)** **LD.13.03.01, EP 7:** See above **§482.55(a)(2)**	**Interview** ☐ Ask emergency services staff how the hospital's other departments provide emergency patients the care and services needed within safe and appropriate times (for example, emergency surgery, on-call staff response times, lab turnaround times for critical patients) **Document Review** **General** ☐ Verify that there are established procedures for emergency services provided at the hospital and that they are integrated with other hospital services, such as laboratory, radiology, and operating services, etc. to provide continuity of care. Note: *For hospitals that offer urgent care services on the hospital campus or in provider-based clinics in the communities they serve, verify that there are established procedures and integration in those locations.*
MS.16.01.01, EP 9: If the hospital provides emergency services, the medical staff establishes and is continually responsible for the policies and procedures governing emergency medical care.	**Document Review** **General**

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§482.55(a)(3)	☐ Verify that policies and procedures for emergency medical services (including triage of patients) are established, evaluated, and updated on an ongoing basis. Note: *The emergency service or emergency department policies must be current and revised as necessary based on the ongoing monitoring conducted by the medical staff and the emergency service or department QAPI activities.*
LD.13.01.07, EP 1: The hospital's emergency services are supervised by a qualified member of the medical staff. §482.55(b)(1)	**Document Review** **General** ☐ Verify that the hospital's medical staff has established criteria for the qualifications a medical staff member must possess to be granted privileges for supervising the provision of emergency care services. ☐ Verify that a qualified member of the medical staff is designated to supervise emergency care services. Note: *The role of the emergency services supervisor must include expectations for the supervisor to be in the hospital and immediately available, when needed, to provide direction and/or direct care during the ED's operating hours.* Note: *Qualifications include necessary education, experience, and specialized training, consistent with state law and acceptable standards of practice.*
NPG.12.01.01, EP 1: Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services.	**Document Review** **General** ☐ Review emergency services policies and procedures for the following: ○ The categories and numbers of MD/DOs, specialists, RNs, EMTs, and emergency department support staff needed to meet its anticipated emergency needs. ○ Medical staff criteria that is in accordance with state law and regulation and acceptable standards of practice delineating the qualifications required for each category of emergency services staff (for example, emergency physicians, specialist MDs/DOs, RNs, EMTs, midlevel practitioners).

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Note 2: Emergency services staff are qualified in emergency care. §482.55(b)(2)	○ The needs anticipated by the facility are specific to the assigned duties for emergency care staff. ○ Clear chain of command. **Interview** ☐ Ask leaders and emergency services director how they determine the categories and numbers of MDs/DOs, specialists, RNs, EMTs, and ED support staff the hospital needs to meet its anticipated emergency care services needs. ☐ Ask staff to verify how the hospital conducts periodic assessments of its emergency needs to anticipate the policies, procedures, staffing, training, and other resources that may be required to address likely demands. ☐ Based on their level of participation in emergency care, ask staff to describe how they maintain knowledge of the following: ○ Parenteral administration of electrolytes, fluids, blood, and blood components ○ Care and management of injuries to extremities and the central nervous system ○ Prevention of contamination and cross infection
LD.13.03.01, EP 20 In accordance with the complexity and scope of services offered, the hospital has adequate provisions and protocols to meet the emergency needs of patients. §482.55(c)	CMS guidance pending
LD.13.03.01, EP 21 In accordance with the complexity and scope of services offered, the hospital protocols are consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate postdelivery care. §482.55(c)(1)	~~CMS guidance pending~~ Ref: QSO-26-07-Hospitals/CAHs, March 27, 2026 To assess compliance with this regulation, surveyors should focus on the following key elements: 1) Identify if the protocol contains the required elements in the regulation. 2) Identify if the protocols are implemented as intended to meet the emergency needs of patients, as required. 3) Identify if the facility had adequate provisions to meet the emergency needs of patients, as required. If any of these three elements are not met, that would constitute noncompliance.

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	• To assess compliance with key element number 1: Review the protocols to verify the hospital has written emergency protocols for: medical emergencies (e.g., stroke, cardiac arrest), surgical emergencies (e.g., trauma, hemorrhage), obstetrical emergencies and complications (e.g., eclampsia, shoulder dystocia), and immediate post-delivery care (e.g., neonatal resuscitation). • Review the protocols to ensure they identify the condition or emergency type addressed and reflect the most current version of the nationally recognized standard or evidence-based guideline used (e.g., ACOG, ACEP, AHA). • Verify that protocols are regularly reviewed and updated according to hospital policy to reflect the current evidence-based guideline or standard of practice and have been formally approved by the governing body and medical staff. • Interview a sample of clinical staff (e.g., ED nurses, providers, OB staff) to assess their awareness of the emergency protocols and their ability to access protocols during emergencies (paper, electronic, binder, etc.). To assess compliance with key elements numbers 2 and 3: • If available, review a sample of five (5) patient records involving emergency care (medical, surgical, obstetrical) and include any adverse events. Review the hospital's evidence for the use of appropriate protocols during the emergency, documentation of why a protocol was or was not followed, and the rationale. o Review the medical record of these patients to determine: ▪ Was the facility's emergency protocol followed (key element #2)? ▪ Did the facility have adequate provisions to meet the emergency needs of patients (key element #3). For example, were there delays in the provision of services that led to a decline in condition or adverse events? o Interview clinical staff to explain how the protocol was implemented in the emergency and do the actions of the staff documented in the medical record align with the established protocol. Page 9 of 11 ***Surveyors should avoid evaluating clinical judgment; focus on documentation and protocol alignment.
LD.13.03.01, EP 22 In accordance with the complexity and scope of services offered, the hospital has provisions that include	~~CMS guidance pending~~ Ref: QSO-26-07-Hospitals/CAHs, March 27, 2026 • Observe emergency care areas (ED, OB/triage, trauma room, nursery) for:

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equipment, supplies, and medication used in treating emergency cases. Such provisions are kept at the hospital and readily available for treating emergency cases to meet the needs of patients. The available provisions include the following: • Drugs, blood and blood products, and biologicals commonly used in lifesaving procedures • Equipment and supplies commonly used in life-saving procedures • A call-in system for each patient in each emergency services treatment area **§482.55(c)(2); §482.55(c)(2)(i-iii)**	o Availability of required emergency equipment, supplies and medications in accordance with hospital protocols. o Emergency kits (e.g., OB hemorrhage carts, neonatal resuscitation stations) are clearly labeled, stocked, and accessible. o Medications are not expired. o Equipment is inspected and maintained per policy. • Ask clinical staff to demonstrate or explain: o Use of specific emergency equipment (e.g., suction, defibrillator, neonatal warmer). o Step-by-step response to an emergency condition using the applicable protocol (e.g., postpartum hemorrhage). o The process for escalation and transfer, if the emergency exceeds hospital capabilities. • If equipment, supplies, or related items are unavailable, non-functional, or staff cannot demonstrate or explain their use in an emergency, the hospital cannot meet the patient's emergency needs. Provisions require equipment, supplies, and personnel to address patients' needs during emergencies. The absence of any of these components constitutes noncompliance. • Verify the call-in system used by the hospital, is functioning properly and patients always have access to the system in a manner that meets their needs. In the event the call-in system is not functional, what process does the hospital have in place to ensure that patients can call for help when needed? If there is not a functional call-in system or the hospital does not have a process in place to ensure that each patient can call for help when needed, there is non-compliance.
HR.11.03.01, EP 2 Applicable staff, as identified by the hospital, are trained annually on the protocols and provisions implemented for emergency services readiness. Note 1: The hospital must document in staff personnel records that the annual training was successfully completed. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Protocols and	CMS guidance pending

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provisions implemented for emergency services readiness are pursuant to 42 CFR 482.55(c). **§482.55(c)(3); §482.55(c)(3)(ii)**	
HR.11.03.01, EP 3 For hospitals that use Joint Commission Accreditation for deemed status purposes: The governing body identifies and documents which staff must complete the annual emergency services readiness protocols and provisions training. **§482.55(c)(3)(i)**	CMS guidance pending
HR.11.03.01, EP 4 The hospital is able to demonstrate staff knowledge on the topics implemented for emergency services readiness protocols and provisions. **§482.55(c)(3)(iii)**	CMS guidance pending
HR.11.03.01, EP 5 The hospital uses findings from its quality assessment and performance improvement (QAPI) program to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Quality assessment and performance improvement findings are used as required at 42 CFR 482.21. **§482.55(c)(3)(iv)**	CMS guidance pending

Hospital Rehabilitation Services Evaluation Module (482.56)

Joint Commission Standards / EPs	Hospital Survey Process
PC.12.01.01, EP 4: If the hospital provides rehabilitation, physical therapy, occupational therapy, speech-language pathology, or audiology services, the services are organized and provided in accordance with national accepted standards of practice. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The provision of rehabilitation services is in accordance with 42 CFR 409.17. **§482.56**	**Interview** □ What types of rehabilitation services are provided at the hospital. **Document Review** **General** □ Review the hospital's policies and procedures to verify that the scope of rehabilitation services offered is defined in writing. □ If services are provided under an arrangement, review policies and contracts. □ For each service, determine that adequate types and numbers of qualified staff are available to ensure safe and efficient provision of treatment. □ Determine if the hospital's rehabilitation services are integrated into its hospital wide quality assurance/performance improvement program.
PC.12.01.01, EP 4: See above **§482.56(a)**	**Document Review** **General** □ Review the hospital's policies and procedures to verify that the scope of rehabilitation services offered is defined in writing. □ For each service, determine that adequate types and numbers of qualified staff are available to ensure safe and efficient provision of treatment in accordance with acceptable standards of practice. **Patient Health Record** □ Review a sample of medical records to verify that a qualified professional evaluates the patient and initiates each treatment episode. **Personnel/Credential File (HR File Review/Competency Activity)** □ Review a sample of personnel files to verify current licensure, certifications, and ongoing training, consistent with applicable state law. **Interview**

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	□ Ask leadership to describe how services are provided (single discipline department vs. multidiscipline department) and to delineate the established lines of authority and responsibility
HR.11.02.01, EP 3: The director of rehabilitation services has the knowledge, experience, and capabilities to supervise and administer the services. **§482.56(a)(1)**	**Document Review** **Personnel/Credential File (HR File Review/Competency Activity)** □ Verify that each service is accountable to an individual who directs the overall operation of that service. □ Review the service director's position description to verify that they have been granted the authority and responsibility for operation of the service, consistent with hospital policies, state law, and accepted standards of practice. □ If the director does not work full time, review timesheets to determine if the number of hours spent working is appropriate to the scope of services provided. □ Review the director's personnel file to determine that they have the necessary education, experience, and specialized training to properly supervise and administer the service. This includes maintaining current licensure and certifications as required by state law. **Interview** □ Ask the director if they have the necessary knowledge, experience, and capabilities to properly supervise and administer the service.
HR.11.02.01, EP 1: The hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments, under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6. Note 3: For hospitals that use Joint Commission accreditation for	**Document Review** **Personnel/Credential File (HR File Review/Competency Activity)** □ Review the staff's personnel file to determine that they have the necessary education, experience, and specialized training to properly supervise and administer the service. This includes maintaining current licensure and certifications as required by state law.

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deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **§482.56(a)(2)**	
PC.12.01.01, EP 1 Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. **§482.56(b)**	**Document Review** **Patient Health Record** □ Review a sample of medical records of patients receiving rehabilitation services. • Who wrote the orders for the rehabilitation services? • Is the practitioner responsible for the care of the patient privileged to write orders for rehabilitation services? • Does the practitioner meet hospital medical staff policy criteria to order services, as well as state law for ordering rehabilitation services? **Interview** □ Does the hospital permit acceptance of orders from outside practitioners who do not practice at the hospital? If so, evaluate for compliance with §482.54(c).

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RC.12.01.01, EP 2: The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course	**Document Review** **Patient Health Record** □ Review a sample of medical records of patients who received rehabilitation services. Verify that the rehabilitation service orders are legible, complete, dated, timed, and authenticated and meet all other medical record requirements specified at §482.24.

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of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. §482.56(b)(1)	
PC.12.01.01, EP 4: If the hospital provides rehabilitation, physical therapy, occupational therapy, speech-language pathology, or audiology services, the services are organized and provided in accordance with national accepted standards of practice. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The provision of rehabilitation services is in accordance with 42 CFR 409.17. §482.56(b)(2)	Interview □ What national standards of rehabilitation practice provide the basis for its rehabilitation services. Review supporting documentation Document Review Patient Health Record □ Review a sample of health records of patients who received rehabilitation services. Determine whether the required care plan was developed and implemented. Personnel/Credential File □ Review a sample of employee personnel files to verify that rehabilitation service providers (that is, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, and/or speech-language pathologists) have the necessary education, experience, training, and documented competencies to provide rehabilitation services.

Hospital Respiratory Care Services Evaluation Module (482.57)

Joint Commission Standards / EPs	Hospital Survey Process
LD.13.03.01, EP 1: The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital. **§482.57**	**Interview** □ Ask if the hospital provides any degree of respiratory care services. **Document Review** **General** □ Determine that the type and amount of respiratory care provided meets the needs of the patients and is delivered in accordance with acceptable standards of practice. □ Determine if the hospital's respiratory services are integrated into its hospitalwide quality assurance/performance improvement program.
LD.13.03.01, EP 1: See above **§482.57(a)**	**Document Review** **General** □ Review the hospital's organizational chart to determine the relationship of respiratory care services to other services provided by the hospital. □ Review the hospital policies and procedures to verify that the scope of diagnostic and/or therapeutic respiratory care services provided is defined in writing.
LD.13.01.07, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services when provided: - Anesthesia	**Interview** □ Interview respiratory care staff regarding the role and oversight activities conducted by the director. **Document Review**

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- Nuclear medicine - Respiratory care Note 1: The anesthesia service is responsible for all anesthesia administered in the hospital. Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis. **§482.57(a)(1)**	**Personnel/Credential File** □ Verify that a respiratory care services director has been appointed and that they have fixed lines of authority and delegated responsibility for operation of the service. □Review the service director's credentialing file to determine that they are an MD or a DO and have the necessary education, experience, and specialized training to supervise and administer the service properly.
NPG.12.01.01, EP 1: Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services. Note 2: Emergency services staff are qualified in emergency care. **§482.57(a)(2)**	**Interview** □ Interview respiratory care staff regarding services provided, schedules, and availability of staff throughout the day and week to determine if the number and type of staff available is appropriate to the volume and types of treatments furnished. If needed, review staffing and on-call schedules. **Document Review** **Personnel/Credential File** □ Review a sample of personnel files for respiratory care staff to determine that they meet the qualifications specified by the medical staff, consistent with state law.
LD.13.01.09, EP 7: If respiratory care services are provided, services are delivered in accordance with policies and procedures approved by the medical staff. **482.57(b)**	**Document Review** **General** □ Review the hospital's policies that are developed and approved by the medical staff for the provision of respiratory care services.
HR.11.02.01, EP 1: The hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments (CLIA), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-	**Document Review** □ Review treatment logs, job descriptions of respiratory care staff, and policies and procedures to determine the following: □ Duties and responsibilities of staff □ Qualifications and education required, including licensure, consistent with state law □ Specialized training or experience needed to perform specific duties

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idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **§482.57(b)(1)**	
LD.13.03.01, EP 15: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital provides respiratory care services and respiratory care staff perform blood gasses or other clinical laboratory tests, the applicable requirements for laboratory services specified in 42 CFR 482.27 are met **§482.57(b)(2)**	**Interview** □ Ask if blood gases or other clinical laboratory tests are performed in the respiratory care unit.
PC.12.01.01, EP 1: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed	**Interview** □Ask the respiratory therapist(s) if the hospital permits acceptance of orders from outside practitioners who do not practice at the hospital? If so, evaluate for compliance with §482.54(c). **Document Review** **Patient Health Record** □ Review a sample of health records of patients receiving respiratory care services. □ Determine who wrote the orders for respiratory care services

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status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. 482.57(b)(3)	□ Determine if the practitioner responsible for the care of the patient privileged to write orders for respiratory care services? **Personnel/Credential File** □ Verify the practitioner meet hospital medical staff policy criteria to order services, as well as state law for ordering respiratory care services □ Verify that the practitioner responsible for the care of the patient is privileged to write orders for respiratory care services
RC.12.01.01, EP 2: The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient	**Document Review** **Patient Health Record** □ Review a sample of patient medical records for patients who received respiratory care services. Determine whether the respiratory care services orders are legible, complete, dated, timed, and authenticated and meet all other medical record requirements as specified at §484.24.

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- Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. §482.57(b)(4)	

Obstetrical Services Evaluation Module (482.59)

Joint Commission Standards / EPs	Hospital Survey Process
LD.13.03.01, EP 1 The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the hospital.	CMS guidance pending
LD.13.03.01, EP 1 (See above)	CMS guidance pending
LD.13.01.07, EP 4 If obstetrical services are provided, hospital labor and delivery rooms/suites (including labor rooms; delivery rooms, including rooms for operative delivery; and post-partum/recovery rooms whether combined or separate) are supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a doctor of medicine or osteopathy.	CMS guidance pending

Obstetrical Services Evaluation Module (482.59)

MS.17.02.01, EP 10 If obstetrical services are provided, obstetrical privileges are delineated for all practitioners providing obstetrical care in accordance with the competencies of each practitioner. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Obstetrical privileges are delineated in accordance with 42 CFR 482.22(c).	CMS guidance pending
LD.13.03.01, EP 23 If obstetrical services are provided, obstetrical services are consistent with the needs and resources of the hospital. Policies governing obstetrical care are designed to assure the achievement and maintenance of high standards of medical practice and patient care and safety.	CMS guidance pending
PC.12.01.05, EP 2 If obstetrical services are provided, the following equipment is kept at the hospital and is readily available for treating obstetrical cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered: call-in-system, cardiac monitor, and fetal doppler or monitor.	CMS guidance pending
LD.13.03.01, EP 24 If obstetrical services are provided, the hospital has adequate provisions and protocols, consistent with nationally recognized and evidence-based guidelines, for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified as part of the quality assessment and performance improvement (QAPI) program. Provisions include equipment, supplies, and medication used in treating emergency cases. Such provisions are kept in the hospital and are readily available for treating emergency cases. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: See 42 CFR 482.21 for QAPI program requirements. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The equipment addressed at this EP is in addition to the equipment required at 42 CFR 482.59(b)(1).	CMS guidance pending

Hospital Special Provisions Applying to Psychiatric Hospitals Evaluation Module (482.60)

Joint Commission Standards / EPs	Hospital Survey Process
	§482.60-Special Provisions Applying to Psychiatric Hospitals – Interview ☐ If the psychiatric hospital provides outpatient psychiatric services, verify with staff that the services are provided by or under the direction of a medical doctor or doctor of osteopathy (MD/DO). Note 1: If the psychiatric hospital provides any outpatient services, the services must comply with the hospital outpatient services CoP at §482.54 (Tags A-1076 through A-1081). The hospital outpatient services CoP at §482.54 requires that all outpatient services "must be organized and integrated with inpatient services." Note 2: Psychiatric hospitals are required to meet the hospital CoPs at §482.1 through §482.23 and §482.25 through §482.57, as well as the special CoPs for psychiatric hospitals at §482.60, §482.61 and §482.62.
NPG.12.03.01, EP 1: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital does the following: - Is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons. - Meets the Medicare Conditions of Participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57. - Meets the staffing requirements specified in 42 CFR 482.62. §482.60(a)	~~The hospital will be deemed to meet standard (a), If it meets standards (c) and (d).~~ ~~§482.60(c) Maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries as specified in §482.61; and~~ ~~*and*~~ ~~§482.60(d) Meet the staffing requirements specified in §482.62.~~ ~~See Survey Procedure for §482.61 and §482.62.~~ ☐ Interview members of the governing body or medical staff to ensure the psychiatric hospital is supervised by a MD or DO. ☐ Interview staff to determine supervisory authority. ☐ Interview staff and review medical records of current and past patients to determine if the psychiatric hospital is primarily engaged in providing psychiatric services for diagnosing and treating mentally ill persons.

NPG.12.03.01, EP 1: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital does the following: - Is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons. - Meets the Medicare Conditions of Participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57. - Meets the staffing requirements specified in 42 CFR 482.62. **§482.60(b)**	Follow the survey procedures for §§ 482.1 through 482.23 and §§ 482.25 through 482.57
RC.11.01.01, EP 5: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61. **§482.60(c)**	Refer to interpretive guidelines under §482.61 for details on the clinical record requirements for psychiatric hospitals.
NPG.12.03.01, EP 1: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital does the following: - Is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons. - Meets the Medicare Conditions of Participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57. - Meets the staffing requirements specified in 42 CFR 482.62. **§482.60(d)**	Refer to interpretive guidelines under §482.62 for detail on the special staff requirements for psychiatric hospitals.

Psychiatric Hospitals Special Medical Record Requirements Evaluation Module (482.61)

Joint Commission Standards / EPs	Hospital Survey Process
RC.11.01.01, EP 5: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61. **§482.61**	**Interview** ☐ Interview staff and patients to validate the care/services identified within the patient health record. **Document Review** **Patient Health Record** ☐ Verify the patient health record contains the status of the patient, the degree of severity of mental illness, plan for interventions, the patient's response to interventions, intensity of treatment, and how interventions impacted patient outcomes. ☐ Verify that records are accurate, complete, and legible. **Observation** ☐ Verify the care/services being provided to patients within the active environment are consistent with the documentation in patients' health records.
RC.11.01.01, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The medical record contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, a record of a complete neurological examination recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic	**Document Review** **Patient Health Record** ☐ Review patient health records to validate care/services related to psychiatric conditions for which the patient is hospitalized. For inpatient and outpatient records, v~~V~~erify that the psychiatric components of the record are present and available to those staff involved in the treatment and care of the patient.

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efforts - Discharge summary of the patient's hospitalization that includes recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge **§482.61(a)**	
RC.11.01.01, EP 6: See above **§482.61(a)(1)**	**Interview** Interview staff to understand the terminology they use in defining "legal status." **Document Review** **Patient Health Record** ☐ Review patient health records to verify they include the patient's legal status. [11] ☐ Review a sample of medical records to verify that documentation required by state law or court order is present. If the inpatient admission or outpatient treatment is involuntary, verify documentation that the psychiatric hospital has submitted a court hearing notification. ☐ If evaluation and recertification is required by the State, determine that legal documentation supporting ~~this~~ the patient's legal status is present in the patient health record. ☐ Verify that changes in legal status are recorded in the patient health record with the date of change, and the person determining the change in status is present and is properly identified in the record.
RC.11.01.01, EP 6: See above **§482.61(a)(2)**	**Document Review** **Patient Health Record** ☐ Verify that the patient record contains an admitting diagnosis, the diagnosis of intercurrent nonpsychiatric diseases, [12] and the

[11] Legal Status is defined in the State statutes and dictates the circumstances under which the patient was admitted and/or is being treated - i.e., voluntary, involuntary, committed by court, evaluation and recertification are in accordance with state requirements.

[12] Attention should be paid to physical examination notes, including known medical conditions, even allergies and recent exposure to infections, illness, or substance abuse, and to available laboratory or test reports which identify abnormal findings to see that these are reflected by appropriate diagnosis. Diagnostic categories should include physical illness when present.

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	psychiatric diagnosis. In the absence of a diagnosis verify there is documented justification for the omission. ☐ Review the patient health record to determine if o Abnormal physical examination findings and/or laboratory findings justified by further diagnostic testing and/or development of an intercurrent diagnosis, and, if so, was such done? o An identified physical illness requires immediate treatment, is the treatment being given? o An identified physical illness is likely to impact on the patient's eventual outcome. To what extent has this potential impact been addressed by the team?
RC.11.01.01, EP 6: See above **§482.61(a)(3)**	**Document Review** **Patient Health Record** ☐ Verify that the reason for the patient's admission is documented in the health record and includes who provided the information and any supporting factors such as: o The patient's description of problems, stresses, situations experienced prior to hospitalization and whether they still exist. o An informants direct or indirect knowledge of the patient's behavior. o Staff's knowledge of the patient's pattern of behavior. What made hospitalization necessary? o Changes/events in the patient's environment (death, separations of significant others) which contributed to the need for hospitalization. If relevant, has staff explored how these changes/events will impact the patient's treatment and have they been addressed by the treatment team? o An interruption or change in the patient's medication. o Review the health record for the patient's response to the

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	admission
RC.11.01.01, EP 6: See above **§482.61(a)(4)**	**Document Review** **Patient Health Record** ☐ Review a sample of patient health records to ~~determine~~ verify that a ~~psychosocial history/~~social service assessment has been completed ~~on all patients and that it~~ and includes the following components: o A description of home plans (which may include a description of household members, pre-hospital residence or homelessness, and expected discharge location, etc.); o A description of family attitudes; o A social history for the patient; and, o A list of community resource contacts. ☐ Review reports of interviews, which indicate whether the patient participated in the assessment and collection of data for treatment and discharge planning. ☐ If the record indicates a lack of patient participation, check to see that the staff documented reason(s) for the lack of patient participation. ☐ If the record indicates that someone other than the patient provided information for the social services assessment, verify the identity of the individual and document their relationship with the patient. ☐ Interview the social worker or individual in charge of performing the social services assessment to verify that the patient, the patient's family member, and/or patient representative was involved in constructing the patient's discharge plan. ☐ Verify that initial recommendations for community resource contacts have been documented. ☐ For patients who were determined as incapable of managing their care or making self-care decisions, verify that a representative is appropriately appointed and identified in the record to help the patient with making discharge-planning decisions. Check the record to verify

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	that there is appropriate documentation for individuals who have power of attorney to make treatment decisions for the patient. ~~A. *Factual and Historical Information*~~ ~~1. Specific reasons for the patient's admission or readmission;~~ ~~2. A description of the patient's past and present biopsychosocial functioning;~~ ~~3. Family and marital history, dynamics, and patient's relationships with family and significant others;~~ ~~4. Pertinent religious and cultural factors;~~ ~~5. History of physical, sexual and emotional abuse;~~ ~~6. Significant aspects of psychiatric, medical, and substance abuse history and treatment as presented by family members and significant others;~~ ~~7. Educational, vocational, employment, and military service history;~~ ~~8. Identification of community resources including previously used treatment sources;~~ ~~9. Identification of present environmental and financial needs.~~ ~~B. *Social Evaluation*~~ ~~1. Patient strength and deficits;~~ ~~2. High risk psychosocial issues requiring early treatment planning and intervention - i.e., unattended child(ren) in home; prior noncompliance to specific treatment and/ or discharge interventions; and potential obstacles to present treatment and discharge planning.~~ ~~C. *Conclusions and Recommendations* Assessment of Sections A and B shall result in the development of (C) recommendations related to the following areas:~~ ~~1. Anticipated necessary steps for discharge to occur;~~ ~~2. High risk patient and/or family psychosocial issues requiring early treatment planning and immediate intervention regardless of the patient's length of stay;~~ ~~3. Specific community resources/ support systems for utilization in discharge planning - i.e., housing, living arrangements, financial aid, and aftercare treatment sources;~~

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	~~4. Anticipated social work role(s) in treatment and discharge planning.~~ ☐ ~~Does the psychosocial history/assessment indicate:~~ ○ ~~Clear identification of the informants(s) and sources of information?~~ ○ ~~Whether information is considered reliable?~~ ○ ~~Patient participation to the extent possible in provision of data relative to treatment and discharge planning?~~ ○ ~~Integration of significant data including identified high risk psychosocial issues (problems) into the treatment plan?~~ ○ ~~How does the hospital ensure the information is reliable?~~
RC.11.01.01, EP 6: See above **§482.61(a)(5)** **PC.11.02.03, EP 1:** The assessment for patients who receive treatment for emotional and behavioral disorders includes the following, based on their age and needs: - Psychiatric evaluation - Psychological assessments, including intellectual, projective, neuropsychological, and personality testing - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.11.02.01, EP 2) **§482.61(a)(5)**	**Document Review** **Patient Health Record** ☐ ~~Verify that a history and physical examination, sufficient to discover all structural, functional, systemic and metabolic disorders, was performed upon admission.~~ ☐ ~~Is there evidence that a "screening" neurological examination was done and recorded at the time of the physical examination?~~ ☐ ~~Was the neurological screening or history indicative of possible involvement (tremors, paralysis, motor weakness or muscle atrophy, severe headaches, seizures, head trauma?~~ ☐ ~~Did the presence of an abnormal physical finding or laboratory finding justify the need for further diagnostic testing, or for the development of an intercurrent diagnosis? If the finding justified further follow-up in either situation, was such follow-up done?~~ ☐ ~~If indicated, was a complete, comprehensive neurological exam ordered, completed and recorded in the medical record in a timely manner?~~ ☐ Review the sample of patient records and verify that, when the history and physical examination indicates, a neurological examination was completed and documented at the time the admission history and physical examination was completed.

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	☐ If no neurological examination is present in the medical record, is there documentation from the practitioner who completed the history and physical examination that states a neurological examination was not indicated? ☐ Verify that neurological function screening/examination was done (when indicated) and recorded at the time of the admission physical examination, and that a complete, comprehensive neurological exam was ordered, completed and recorded in the medical record in a timely manner.
PC.11.02.03, EP 2: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: - Medical history - Record of mental status - Description of the onset of illness and the circumstances leading to admission - Description of attitudes and behavior - Estimation of intellectual functioning, memory functioning, and orientation - Inventory of the patient's assets in descriptive, not interpretative, fashion **§482.61(b)(1-7)**	**§482.61(b)** **Document Review** General □ Review hospital policies and procedures for completing the psychiatric evaluations. If utilized, verify non-physician practitioners are privileged to complete part or all of the psychiatric evaluation. **Patient Health Record** ○ Review a sample of patient ~~health~~ records ~~to determine if~~ and verify that ~~each patient received~~ a psychiatric evaluation ~~that contains the necessary information to justify the diagnosis and planned treatment including:~~ has been completed and documented for each patient. ○ If there is a change in psychiatric diagnosis or if a new diagnosis is added, verify that the change in diagnosis is supported by documentation of the patient's condition or the current symptoms the patient exhibits. The rationale for changing the diagnosis must be documented. ~~○ The patient's chief complaints and/or reaction to hospitalization, recorded in patient's own words where possible.~~ ~~○ Why is the patient in the hospital? Was it his/her idea? (Does he/she feel ill/disturbed/frightened?)~~ ~~○ Is the patient in the hospital against his/her will? Who decided to hospitalize/why?~~

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	○ Past history of any psychiatric problems and treatment, including prior precipitating factors, diagnosis, course and treatment. ○ Has the patient been chronically ill? ○ Continuously/repeatedly? How severely has the past illness/treatment interfered with the patient's development and/or adjustment? ○ Are there persistent symptoms/signs/behaviors that must be addressed and treated in order to favorably impact on the future psychiatric course? ○ What medications or supports helped him/her improve in the past? ○ Are the same resources available to impact on the patient's treatment during this episode? ○ Past family, educational, vocational, occupational and social history. ○ To what extent, if any, is there a presence or absence of familial predisposition? ○ What is the patient's educational level? Was he/she a good student? Is he/she still interested in learning? ○ What jobs has the patient held? For how long? Is he/she now employed/unemployed? For how long? Has he/she ever worked? ○ How does the patient get along with people? As a child, did he/she have friends? Does he/she have friends now? ○ Within the psychiatric evaluation does one find the specific signs and symptoms, and other factors, that justify the diagnosis? ○ Review a sample of patient health records to determine if patients received a psychiatric evaluation within 60 hours of admission. ☐ Review a sample of patient health records to determine if patient psychiatric evaluations include a non-psychiatric medical history that includes the following: ○ Relevant past surgery

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	~~o Past medical conditions and disabilities especially those of a chronic nature~~ ~~o How these have contributed to the patient's psychiatric condition~~ ~~o Are any of these conditions still present to any significant degree? Are they likely to impact on the patient's recovery/remission? Should they be addressed immediately?~~ ~~o Does the facility have the capability to intervene? If not, how is the need to be met?~~ ~~Review a sample of patient health records to determine that patients psychiatric evaluations include a record of mental status.~~ ~~o Does the mental status evaluation describe the appearance and behavior, emotional response, verbalization, thought content, and cognition of the patient as reported by the patient and observed by the examiner at the time of the examination. S*hould include patient specific supportive information.*~~ ~~Review a sample of patient health records to determine that patient psychiatric evaluations include the onset of illness and the circumstances leading to admission. Does the documentation include:~~ ~~o How long has the patient been ill? Was it a gradual or sudden onset? Is this a recurrence?~~ ~~o What were the precipitating factors? What happened?~~ ~~o What symptoms, signs, behaviors made this hospitalization necessary?~~ ~~o What treatment has the patient already received before coming to the hospital?~~ ~~o Any medication the patient received?~~ ~~o Patient psychiatric evaluations describe attitudes and behavior.~~[13]

[13] The problem statement should describe behavior(s) which require change in order for the patient to function in a less restrictive setting. The identified problems may also include behavioral or relationship difficulties with significant others which require active treatment in order to facilitate a successful discharge.

Joint Commission Standards / EPs	Hospital Survey Process
	~~o Patient psychiatric evaluations estimate intellectual functioning, memory functioning and orientation; and~~ ~~o Patient psychiatric evaluations include an inventory of the patient's assets [14] in descriptive, not interpretive fashion.~~ §482.61(b)(1) Document Review General □ Review hospital policy to ensure that psychiatric evaluations are required to be completed within 60 hours of admission. Patient Health Record ☐ Review a sample of open and closed patient records and verify that the psychiatric evaluation was completed within 60 hours of admission. §482.61(b)(2) Document Review Patient Health Record □ Review a sample of patient records and verify that the psychiatric evaluation includes a medical history which includes medication allergies, co-morbid conditions, other intellectual changes, etc. §482.61(b)(3) Interview □ Interview patients and family members or others significantly involved with the patient to determine if the patient's mental status is accurately reflected in the record.

[14] Assets (strengths) are personal attributes i.e., knowledge, interests, skills, aptitudes, personal experiences, education, talents and employment status, which may be useful in developing a meaningful treatment plan. For purposes of the regulation, words such as "youth," "pretty," "Social Security income," and "has a car" do not represent assets.

Joint Commission Standards / EPs	Hospital Survey Process
	Document Review Patient Health Record □ Review a sample of patient records and verify that the patient's mental status is described in the psychiatric evaluation and documented in the medical record. Ensure the mental status describes such specific examples as the patient's appearance and behavior, emotional response to interventions and other situations, verbalization ability, cognition, etc. **§482.61(b)(4)** Document Review Patient Health Record □ Review a sample of patient records and verify that the record contains information regarding the onset of the patient's illness and the precipitating circumstances that lead to the current admission or outpatient visit. □ Review a sample of medical records to verify that identified problems are documented and are indicated as related to the patient's need for admission and treatment or outpatient treatment. **§482.61(b)(5)** Interview: ☐ Interview patients and family members or others significantly involved with the patient to determine the patient's attitudes and behaviors are accurately reflected in the record. Document Review Patient Health Record □ Review the psychiatric evaluations in the sample of medical records and verify that they contain a description of the patient's attitudes and behaviors.

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	§482.61(b)(6) Document Review Patient Health Record □ Review the sample of medical records and verify specifics of the patient's mental status exam are recorded; such as, the patient's appearance and behavior, emotional response to interventions and other situations, verbalization ability, cognition, etc. §482.61(b)(7) Interview: ☐ Interview patients and family members or others significantly involved with the patient to determine the patient's strengths as personal attributes such as, the patient's personal interests, skills, talents, etc. are included in the record. Document Review Patient Health Record □ Review the sample of medical records to verify the psychiatric evaluation includes an inventory of the patient's assets in descriptive form as personal attributes and not in an interpretive fashion.
PC.11.03.01, EP 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient has an individual comprehensive treatment plan that is based on an inventory of the patient's strengths and disabilities. The written plan includes the following: - Substantiated diagnosis - Short-term and long-range goals - Specific treatment modalities utilized - Responsibilities of each member of the treatment team - Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out	**Interview:** □ Interviews with patients, families, treatment staff and others involved directly or indirectly with active treatment. Verify that the patients, families, or caregivers participated in the development of the treatment plans. □ Ask staff to describe how they develop treatment plans and comply with the hospital's policy for treatment plan development. **Document Review** **Patient Health Record**

Joint Commission Standards / EPs	Hospital Survey Process
§482.61(c)(1)	☐ Verify that patients have an individualized, comprehensive treatment plan. [15] ☐ Review the treatment plan to determine that it is individualized and the patient's particular strengths and psychiatric disabilities are documented. ~~☐ that is developed by the patient and treatment team using:~~ ~~○ Information gained from assessing/evaluating the patient~~ ~~○ Information contained in the psychiatric evaluation and in the assessments/diagnostic data collected by the total treatment team.~~ ~~○ Assessment summaries formulated by team members of various disciplines. The treatment team identifies which patient disabilities will be treated during hospitalization.~~ ~~○ Patient strengths (must be identified). (See also §482.61(b)(7).)~~ ~~☐ Verify that there is evidence of a periodic review of the patient's response and progress towards goals. The review intervals are determined by the hospital, however, consideration must be given to the type of psychiatric program(s) under review to determine the timeframe for treatment plan review.~~ [16] ~~○ If the patient has made progress toward meeting goals, or if there is a lack of progress, the review must justify: (1) continuing with the current goals and approaches; or (2) revising the treatment plan to increase the possibility of a successful treatment outcome.~~ ~~**Document Review:**~~ ~~General~~

[15] Treatment planning depends on several variables; whether the admission is limited to crisis intervention, short-term treatment or long-term treatment. The briefer the hospital stay the fewer disciplines may be involved in the patient's treatment. There must be evidence of periodic review of the patient's response and progress toward meeting planned goals.

[16] The hospital's review system must be sufficiently responsive to ensure the treatment plan is reviewed: whenever a goal(s) has been accomplished; when a patient is regressing; when a patient is failing to progress; or when a patient requires a new treatment goal.

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	~~How is the facility ensuring the patient's treatment plans are being reviewed by the team and how does it monitor the attendance of all relevant participants at the treatment plan team meetings?~~ ~~Review any meeting attendance logs. Who is monitoring consistent attendance?~~ ~~Are the patient's observed behaviors consistent with the problems and strengths identified in the plan or update?~~ ~~Have the views which the patient communicated to the surveyor regarding problems which require treatment during hospitalization and plans for discharge, been incorporated in the plan or update?~~ ~~**Observation:**~~ ~~*Determination of compliance regarding treatment plans is accomplished by the surveyor using the following methods, and to the extent possible, the following order:*~~ ~~Observation of the patient and staff at planned therapies/meetings.~~ ~~Reviews of scheduled treatment programs (individual, group, family meetings, therapeutic activities, therapeutic procedures).~~ ~~Attendance at multidisciplinary treatment planning meetings.~~
PC.11.03.01, EP 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient has an individual comprehensive treatment plan that is based on an inventory of the patient's strengths and disabilities. The written plan includes the following: - Substantiated diagnosis - Short-term and long-range goals - Specific treatment modalities utilized - Responsibilities of each member of the treatment team - Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out	Document Review Patient Health Record Verify that the written treatment plan includes a substantiated diagnosis. 18F18F17 o What specific problems will be treated during the patient's hospitalization? o Are physical problems identified and included in the treatment plan if they require treatment, or interfere with treatment, during the patient's hospitalization?

[17] Does the treatment plan identify and precisely describe problem behaviors rather than generalized statements i.e., "paranoid," "aggressive," "depressed?" or generic terminology i.e., "alteration in thought process," "ineffective coping," "alteration in mood?"

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§482.61(c)(1)(i)	☐ Verify identified physical problems and other health conditions are included as a part of the substantiated psychiatric diagnosis if they require treatment or interfere with treatment during the patient's hospitalization. ☐ When a psychiatric evaluation results in a new diagnosis or additional psychiatric diagnosis, verify that the treatment or intervention recommendation is added to the comprehensive treatment plan. Review the treatment plan to verify that the diagnosis is addressed.
PC.11.03.01, EP 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient has an individual comprehensive treatment plan that is based on an inventory of the patient's strengths and disabilities. The written plan includes the following: - Substantiated diagnosis - Short-term and long-range goals - Specific treatment modalities utilized - Responsibilities of each member of the treatment team - Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out §482.61(c)(1)(ii)	**Document Review** **Patient Health Record** ☐ Verify that the written treatment plan includes short-term and long range goals. o How do treatment plan goals relate to the problems being treated? o Do goals indicate the outcomes to be achieved by the patient? o Are the goals written in a way that allow changes in the patient's behavior to be measured? o If not apparent, what criteria do staff use to measure success? o How relevant are the treatment plan goals to the patient's condition? o Do short and long-range goals have specific dates for expected achievement?
PC.11.03.01, EP 3: See above §482.61(c)(1)(iii)	**Document Review** **Patient Health Record**

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	☐ ~~Do the pieces of the treatment plan work together to achieve the greatest possible gain for the patient?~~ Verify that the interventions or treatments, such as medication therapy, documented in the patient's treatment plan are supported by the psychiatric evaluation or other comprehensive assessment. Any change in treatment must be justified by assessment of the patient's response to the treatment or a documented change in the patient's condition. **Observation** *Observation of staff implementing treatment, both in structured and non-structured settings, is a major criterion to determine whether active treatment is being provided in accordance with planned treatment.* ☐ Verify that the written treatment plan includes the specific treatment modalities utilized. o Are qualified staff observed following the methods, approaches and staff intervention as stated? o Are observed treatment methods, approaches and interventions from all disciplines included in the plan? o ~~Does the hospital integrate its activities, therapies, treatments, and patient routines to work for the patient's therapeutic interest first~~ o ~~Do the disciplines present at observed treatment planning meetings represent all of the patient's needs?~~ o ~~If the patient attends treatment planning, how do the staff prepare the patient to participate? If the patient does not attend do staff provide a reason.~~ o ~~Is there a process to enable staff to reach a consensus regarding how treatment will be carried out?~~ o ~~Is the patient included in the decision making, whenever possible?~~ o ~~Are the final decisions regarding treatment approaches defined clearly by the end of the discussion?~~ o ~~How does the patient get to know his/her treatment regime?~~

Joint Commission Standards / EPs	Hospital Survey Process
	~~o How does the treatment team encourage the patient to accept responsibility for engaging in the treatment regime, rather than accepting it passively?~~ **Interview:** ~~Can staff explain the focus of the treatment modality they have provided?~~ Interview staff to determine if modalities are determined for specific needs of individual patients. Interview patients and family members or others significantly involved with the patient to determine if the patient is offered specific, individualized treatment modalities. ~~Can patients discuss their treatment regime and how it was developed?~~
PC.11.03.01, EP 3: See above **§482.61(c)(1)(iv)**	**Interview** ~~Are the patients able to name the staff responsible for implementing their treatment? Is this information consistent with the treatment plan?~~ Document Review Patient Health Record Verify that the individualized treatment plan includes the responsibilities of each member of the treatment team. Verify treatment and interventions include the discipline assigned to take responsibility for the treatment and that the treatment is being completed by an individual either by name and title or by their title within that discipline. ~~Observation~~ ~~Are staff who are designated in the treatment plan observed carrying out treatment activities and therapies?~~
PC.11.03.01, EP 3: See above **§482.61(c)(1)(v)**	**Document Review** **Patient Health Record** Do the treatment notes ~~relative~~ relate to the treatment plan?

Joint Commission Standards / EPs	Hospital Survey Process
	☐ Do the notes indicate how staff is carrying out the treatment plan? ☐ Do the notes include the patient's response to interventions? ☐ Verify the appropriate qualified personnel completed the progress and treatment notes. ☐ Verify that the patient's participation and responses to the treatment and rehabilitative activities are documented.
RC.11.01.01, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The medical record contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge §482.61(c)(2)	**Interview** **Patient Interview** ~~☐ Does the patient know his/her diagnosis?~~ ~~☐ What did the patient contribute to the formulation of the treatment plan? Goals of treatment?~~ ~~☐ If the patient receives medication, does the patient understand the reason for the medication?~~ ~~○ The name of the medication?~~ ~~○ The dose prescribed?~~ ~~○ The time of administration?~~ ~~○ The desired effects?~~ ~~○ The potential side effects?~~ ~~○ If medication is changed, is there a rationale for the change?~~ ☐ Interview the patient, family member or others significantly involved with the patient, and the staff to determine if a patient is actively involved in assigned treatment. ~~**Document Review**~~ ~~**General**~~ ~~☐ Verify that the hospital has policies and procedures that address the following areas:~~ ~~○ Informed consent~~ ~~○ Confidentiality, privacy, and security~~ ~~○ Therapeutic use of restrictions, such as visitors, mail, and phone calls.~~

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	~~o Seclusion and restraint (must address patient protection and safety while in a restricted setting).~~ **Patient Health Record** ~~Review the patient record to verify that the patient was educated about their medications, intended effects, and potential side effects.~~ ~~Does the record indicate that the patient is a danger to self or others? If so, what did the staff do to care for the patient in the current environment before progressing to a more restrictive setting?~~ ~~Are staff members recording their observations relative to the patient's response to the treatment modalities, including medication?~~ ~~Is there evidence that the patient was afforded the opportunity to participate in his/her plan of care?~~ ~~What progress has the patient made? Has the patient achieved his/her optimal level of functioning? If not, why? Are these reasons/barriers reflected in the current treatment plan? Do treatment and progress notes support these insights?~~ ~~Does the observed status of the patient in the various treatment modalities correspond to the progress note reports of status?~~ ~~Do all treatment team members document their observations and interventions so that the information is available to the entire team?~~ ~~If a restrictive procedure is used (e.g., restraint and/or seclusion), is there evidence that attempts were made systematically to treat the patient in the least restrictive manner?~~ Review a sample of medical records and verify staff members are recording their interventions and therapeutic efforts in such a way that the interventions and therapeutic efforts are included. Verify documentation of treatment progress is written as an objective description of observed or monitored behaviors of the patient in response to the treatment modalities, including medication. Review the progress notes to determine if progress or lack thereof has been documented. Verify that all treatment team members document their observations and interventions so that the information is available and accessible to the entire team.

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	☐ Is there evidence that the rights of the patient were protected while in the restrictive setting in accordance with Federal and State law and accepted standards of practice? **Observation** Look for evidence that each patient's rights are being addressed and protected
RC.12.01.01, EP 4: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Progress notes are documented in accordance with applicable state scope-of-practice laws and hospital policies by the following qualified practitioners: - Doctor(s) of medicine or osteopathy or other licensed practitioner(s) who is responsible for the care of the patient - Nurse(s) - Social worker(s) or social service staff involved in the care of the patient - When appropriate, others significantly involved in the patient's active treatment modalities The patient's condition determines the frequency of progress notes, but they must be recorded at least weekly for the first 2 months and at least once a month thereafter. The progress notes must contain recommendations for revisions in the treatment plan as indicated, as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan. **§482.61(d)**	**Document Review** **Patient Health Record** ☐ Verify that Medicare patients are under the care of a MD/DO, psychologist(s), or other licensed independent practitioners responsible for the care of the patient. ☐ Review progress notes authored by physicians, psychologists, nurses, social workers, and others significantly involved in active treatment modalities. o Do the progress notes provide a clear picture of the patient's progress or lack thereof? Do the physicians, nurses, social workers, and other care providers make recommendations for further care? ☐ Verify that the progress notes contain the following: o A precise assessment of the patient's progress in accordance with the original or revised treatment plan. o A chronological picture of the patient's progress or lack of progress towards attaining short and long-range goals outlined in the individual treatment plan o Goals of the treatment plan o Evaluation of aftercare/discharge plans o Documentation substantiating changes/revisions in the treatment plan and subsequent assessment of the patient's responses and progress o Recommendations for revisions in the treatment plan ☐ What is the frequency of progress notes in relation to the condition of the patient? o Verify that progress notes are recorded at least weekly for the first 2 months and at least once a month thereafter.

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	Observation ☐ Is there a correlation between the patient care observed and what is described in the progress notes?
RC.11.01.01, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The medical record contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization, recommendations from appropriate services concerning follow-up or aftercare, ~~as well as~~and a brief summary of the patient's condition on discharge **§482.61(e)**	**Document Review** **Patient Health Record** Review a sample of patient health records for patients that have been discharged ☐ To verify a discharge summary is included. Verify that the summary includes: ☐ Review a sample of medical records of discharged patients and verify that the records contain a discharge summary ☐ Verify that the discharge summary includes the following: o Outcome of treatment and procedures o Disposition of the case o Provisions for follow-up care ☐ Review a sample of medical records and verify the discharge summary follow-up recommendations were included in the discharge summary. ☐ Review the discharge plan to verify that it identifies appropriate aftercare for follow-up treatment. ☐ Verify that discharge related documents are made available to the patient, patient's representative, community treatment source and/or any other aftercare service provider, as appropriate, who may need the record for continuity of care. ☐ Verify that the aftercare plan was communicated to the posthospital treatment entity, when indicated. ☐ Review the discharge summary to determine if it contains a plan for follow-up psychiatric care, medical/physical treatment and the medication regimen as applicable. ☐ Review a sample of medical records and verify the discharge

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	summary contains information on the status of the patient's condition on the day of discharge. ~~o A summary of the patient's condition on discharge.~~ ~~o Description of services and supports appropriate to the patient's needs and that will be effect on the day of discharge.~~ ~~o Recommendations from appropriate services concerning follow-up or aftercare.~~ ~~o A description of arrangements with treatment and other community resources for the provision of follow-up services.~~ ~~o A plan outlining psychiatric, medical/physical treatment and the medication regimen as applicable.~~ ~~o Specific appointment date(s) and names and addresses of the service provider(s).~~ ~~o Description of community housing/living arrangement.~~ ~~o Economic/financial status or plan, i.e., supplemental security income benefits.~~ ~~o Recreational and leisure resources; and A complete description of the involvement of family and significant others with the patient after discharge.~~ ~~To determine if the patient health record includes:~~ ~~o Verification of appointment sources, dates and addresses. This includes a contact person name, specific appointment date and time for the initial follow-up visit~~ ~~o Documentation that the patient was involved in discharge and aftercare planning process.~~ ~~o Documentation indicating the participation of multidisciplinary staff in discharge planning process.~~

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	~~o Evidence that contact with the post hospital treatment entity included communication of treatment recommendations (including information regarding the patient's medications)~~ ~~o Indication that discharge related documents were made available to the patient, family, community treatment source and/or any other appropriate sources.~~ o A recapitulation of the patient's hospitalization, which is a summary of the circumstances and rationale for admission, and a synopsis of accomplishments achieved as reflected through the treatment plan. This summary includes the reason(s) for admission, treatment, goals achieved during hospitalization, a baseline of the psychiatric, physical and social functioning of the patient at the time of discharge, and evidence of the patient, family, and/or significant other's response to the treatment interventions.
IM.13.01.05, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates that its electronic health records system's (or other electronic administrative system's) notification capacity is fully operational and is used in accordance with applicable state and federal laws and regulations for the exchange of patient health information. **§482.61(f)(1)** **IM.13.01.05, EP 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates that its electronic health records system (or other electronic administrative system) sends notifications that include, at a minimum, the patient's name, treating licensed practitioner's name, and sending institution's name. **§482.61(f)(2)**	**Interview** ☐ Ask health information management staff if the hospital's electronic health records system notification features are operational. o What type of information is being exchanged and with who? o Are staff able to disable the notification features to meet the patient's expressed privacy preferences?

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IM.13.01.05, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: - The patient's emergency department registration - The patient's inpatient admission **§482.61(f)(3); §482.61(f)(3)(i); §482.61(f)(3)(ii)** **IM.13.01.05, EP 4:** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the hospital's emergency department or inpatient services. **§482.61(f)(4); §482.61(f)(4)(i); §482.61(f)(4)(ii)** **IM.13.01.05, EP 5:** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post-acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: - Patient's established primary care licensed practitioner - Patient's established primary care practice group or entity - Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care	

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Note: The term “reasonable effort” means that a hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which a hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with a hospital system’s capabilities. **§482.61(f)(5); §482.61(f)(5)(i-iii)**	

Hospital Special Staff Requirements for Psychiatric Hospitals Evaluation Module (482.62)

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NPG.12.03.01, EP 4: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services **§482.62**	**Observation** ☐ Observe sampled patients and others during structured sessions and in unstructured settings to ensure behavioral evidence of a rational organization of resources. ☐ Observe the structure of units to ensure adequate programming is provided by various interdisciplinary staff, i.e., therapeutic groups, social work therapy, recreational therapy, or occupational therapy. **Interview** ☐ Interview patients and staff to determine whether necessary treatment modalities and other services are being provided in a timely manner. ☐ Interview staff to determine if the number, type, and utilization of staff available is appropriate to the volume and acuity of patients in order to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning. **Document Review** **General** ☐ Review the nursing assignments. Verify that the assignments take into consideration the complexity of patient's care needs and the competence and specialized qualifications of the nursing staff. ☐ Review incident logs to determine if staffing may have played a part in any recorded incidents. ☐ Review observation logs to ensure rounds are being conducted in real time, and if not, determine if lack of staff may be contributing to this failure. ☐ If necessary, review video monitoring to determine if rounds are being conducted and recorded in real time. If not, determine if lack of staff may be contributing to this failure. ~~**Patient Health Record**~~ ~~☐ Review a sample of patient health records to determine if necessary active treatment assessments, treatments, evaluations, and activities have been conducted and documented.~~ ~~☐ Review other records, such as restraint and seclusion records, incident reports, medication error reports, and reports of patient/staff injuries, to determine the extent to which staffing levels or deployment contributed to negative patient outcomes.~~

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	~~Evaluate all outcome data in light of the success or failure observed during the survey relevant to each patient receiving active treatment and achieving desired outcomes of care.~~ ~~**Note:** Evaluating outcome data is the primary basis for assessing the adequacy of the hospital's staffing under this special condition.~~
NPG.12.03.01, EP 4: See above **§482.62(a)(1)**	**Interview** Interview professional staff, technical staff, and consultative staff regarding services provided, schedules, and availability of staff throughout the day and week to determine that the number and type of staff available is appropriate to the volume and types of treatments furnished. If needed, review staffing and on-call schedules. **Observation** Verify that there is adequate staff to complete the admission workups (assessment, diagnostic data gathering) in a timely manner. **Document Review** **Personnel/Credential File** Review a sample of personnel files for professional, technical, and consultative staff to determine that the personnel meet the qualifications specified by the hospital policy, consistent with state law, to perform discipline-specific evaluations. **Patient Health Record** Review a sample of patient health records to determine that the personnel meet the qualifications specified by the hospital policy, consistent with state law, to perform discipline-specific evaluations.~~ensure that there is continuing evaluation of the patient's progress and response to treatment.~~ ~~Are evaluations delayed or missing?~~
NPG.12.03.01, EP 4: See above **§482.62(a)(2)**	~~**Observation**~~ ~~Observe a treatment team meeting. Is there sufficient discipline participation to ensure that the treatment plan meets the patient's individualized needs?~~ ~~**Interview**~~ ~~What problems prevent staff members from attending treatment meetings?~~

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	~~Do they relate to staffing?~~ **Document Review** ~~**Patient Health Record**~~ ~~Review a sample of patient health records to determine if the continuing evaluation of the patient's progress is missing or delayed to the extent that it is not useful to the treatment team for the purpose of planning individualized treatment.~~ Review a sample of medical records and verify there is an individualized, comprehensive treatment plan that addresses the specific psychiatric needs of each patient. Review the individualized, comprehensive psychiatric treatment plan to ensure it is, in fact, individualized and comprehensive. If the treatment plans are absent, lacking information, or reveal delayed implementation to the extent that they are not useful to the treatment team for the purpose of planning individualized treatment: o Verify there is sufficient interdisciplinary staff participation at the treatment team meeting, to assure formulation of a comprehensive treatment plan that meets the patient's individualized needs. o Interview staff to determine what issues prevent staff members from attending treatment meetings, and if those issues are related to inadequate staffing.
NPG.12.03.01, EP 4: See above **§482.62(a)(3)**	**Observation** Through observation, interviews, and record reviews, determine if patients receive active treatment. o Is the distribution of staff consistent with particular patient needs? o Is appropriate staffing sufficient to carry out treatment plans? o Does the patient attend therapies that are relevant to the identified problems that brought them to the hospital? o Are staff absences and/or vacancies preventing the patient from receiving active treatment? o Are patients not attending therapeutic activities off the unit because there is no staff to escort them? o Are therapeutic groups not available on the unit for patients who are not able to go off the unit? ~~o Are patients observed not engaged in activities while staff attend to administrative tasks?~~

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	○ Are active treatment sessions or activities exclusively carried out at discrete time intervals? Or is active treatment implemented as the patient's needs emerge during the course of the day? ~~Document Review~~ ~~General~~ ☐ ~~Review quality assurance data to determine if there is a pattern of serious incidents occurring on particular shifts and/or days of the week.~~ ☐ ~~Is there a consistent, observable pattern of evidence that hospital staff provide, reinforce, and otherwise implement measures to achieve active treatment objectives?~~ ~~Interview~~ ☐ ~~Ask patients to describe their treatment modalities.~~ ☐ ~~Ask patients if they believe the treatment being provided is helpful.~~ ☐ ~~Interview patients if the content and scheduling of activities are directly related to their treatment objectives or if the content and scheduling are generalized, nontherapeutic "time fillers"?~~ ☐ ~~Ask staff to describe how treatment interventions relate to patients' treatment objectives.~~ ☐ ~~At any point in time, for any of the observed patient's experiences in the hospital, is the thrust of the patient's treatment plan observable during staff and/or patient interactions?~~
NPG.12.03.01, EP 4: See above **§482.62(a)(4)**	**Interview** ☐ ~~Ask patients if they participate in the discharge planning process. If not, why?~~ ☐ ~~Interview staff to determine if they are aware of the discharge plans for the patients they are working with?~~ ☐ Are staff aware of how, when, and whom to notify of changes in the patient's clinical condition that might warrant a change in the discharge planning process? ☐ Ask staff about any discharge planning delays. If delays are identified, ask staff about adequate staffing to complete necessary tasks. **Document Review** ~~Personnel/Credential File~~

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	~~Do record review and interviews indicate that all relevant staff have participated in discharge planning?~~ **Patient Health Record** Review a sample of cases to determine if the discharge planning evaluation documents the patient's goals and preferences for post-discharge placement and care. Are the results of the discharge planning evaluation documented in the medical record?
MS.17.01.03, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inpatient psychiatric services are under the direction and supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program and who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. The number and qualifications of doctors of medicine and osteopathy are adequate to provide essential psychiatric services. **§482.62(b)**	**Document Review** **General** ~~Just prior to the end of the survey, schedule a meeting with the clinical director. By the time of this meeting, the surveyor should already have conducted required observation, interviews and record reviews for at least a majority of the patients in the sample. Collect any additional information that is necessary to consider in light of outcomes observed for patients, including the following:~~ ~~Qualifications of the clinical director~~ ~~Leadership exhibited for the scope of psychiatric/medical treatment programs needed by patients~~ ~~Rationale for medical staffing coverage~~ ~~If necessary, follow up on letters of complaint, previously reported serious problems, and/or discrepancies with Data Collection Medical Staff Coverage (CMS 729).~~ Verify that a single MD/DO who is a psychiatrist is responsible for supervising inpatient psychiatric services. Review the credentialing file of the clinical director to verify qualifications and the leadership exhibited for the scope of psychiatric treatment programs needed by patients. Request and review evidence to verify that the clinical director plays an integral part in supervising the planning, evaluation, and revision of policies, procedures, and activities that affect the safety, quality, and compliance related to inpatient psychiatric treatment or services. Review medical staff meeting documents, QAPI, and related committee notes to verify the supervision and leadership activities of the clinical director. ~~**Interview with Clinical Director**~~ ~~**General**~~

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	~~How many staff are board certified? Fully trained?~~ ~~How many full time/part time specialties are represented?~~ ~~How are medical staff deployed?~~ ~~To what programs/units are they assigned? Why?~~ ~~How much time do physicians spend on the units?~~ ~~Based on observations, interviews, and medical record reviews, is coverage adequate to meet the needs of sampled patients?~~ ~~To meet the needs of other patients observed during the survey?~~
MS.17.01.03, EP 6: See above **§482.62(b)(1)**	**Document Review** **Personnel/Credential File (Medical Staff Credentialing Activity)** Review the clinical director's personnel (credentialing) file for evidence that the director is board certified or eligible for board certification. Additionally, look for evidence of completion of a psychiatric residency program approved by the American Board of Psychiatry and Neurology and/or the American Osteopathic Board of Psychiatry. ~~Review the clinical director's personnel folder or ask the clinical director if they have one of the following:~~ ~~o Certification of the American Board of Psychiatry and Neurology and/or certification of the American Osteopathic Board of Neurology and Psychiatry~~ ~~o If no certification, evidence that the person took the Boards would satisfy that the person had the training and equivalency to be admitted to the board examination.~~ ~~o If indicated, medical school and residency training~~ ~~o Length of time they have been employed at the facility~~ ~~o Length of time they have been at their position~~ ~~o To be admitted to the American Board Examinations the following conditions must be met:~~ ~~o 1. License without restrictions~~ ~~o 2. Graduation from a medical school approved by either the Medical Osteopathic Association or the American Medical Association~~ ~~o 3. A successful completion of an approved residency training program for at least 3 years before 1988 that the America Council on Graduate Medical Education (ACGME) approves. After 1988, it has to be a four year accredited program.~~

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MS.16.01.01, EP 8: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The clinical director, service chief, or equivalent for inpatient psychiatric services monitors and evaluates the medical staff's treatment and services for quality and appropriateness. §482.62(b)(2)	**Interview** ☐ Interview the clinical director and ask him/her to describe their role and involvement in the credentialing and privileging process. ☐ Ask the clinical director to describe the process for ongoing review of the medical staff. **Document Review** **General** ☐ Verify mechanisms the director uses to monitor and evaluate the work of the medical staff (for example, personal interviews, quality improvement reports, incident reports). ☐ When problems are discovered by the clinical director, determine how they corrected. ☐ ~~Verify that services, notes, and reports are timely.~~ ☐ ~~Ensure that medications are used appropriately for each patient's diagnosis?~~ ☐ Review medical staff meeting minutes and/or Governing Body meeting minutes to verify the clinical director's involvement in oversight and evaluation of the medical staff. ☐ Review the mechanisms utilized, as reported by the clinical director, to ensure the quality and appropriateness of psychiatric services and treatment are monitored.
NPG.12.03.01, EP 5: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Doctors of medicine or osteopathy and other appropriate professional staff are available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital has an agreement with an outside source for these services to ensure that they are immediately available, or the hospital establishes an agreement for transferring patients to a general hospital that participates in the Medicare program. §482.62(c)	**Interview** ☐ Interview staff to determine how the hospital meets the medical/surgical/diagnostic needs of its patients. ☐ Interview patients who have required medical/surgical/diagnostic needs to determine adequacy and quality of treatment. ☐ Interview hospital staff at various locations. Ask them to describe how they respond to emergencies and minor injuries or illnesses. **Document Review** ☐ How did the hospital meet the medical/surgical/diagnostic needs represented by each patient in the sample? Were these done timely? Appropriately? ☐ ~~If contracts are not current or available, how are these services provided for the patient, if needed?~~

Joint Commission Standards / EPs	Hospital Survey Process
	~~Is there evidence of negative outcomes as a result of these arrangements?~~ ~~Are reports from other services such as pharmacy, radiology, and clinical laboratory timely?~~ ~~Appropriate?~~ Review the medical, surgical, and diagnostic services provided by the hospital during the interview with the clinical director. If the medical and surgical services are provided by outside sources or another hospital, discuss the contract or agreement with the clinical director to determine the kind and extent of services provided. Ask the clinical director for copies of the agreements to verify the hospital has agreements in place. For medical and surgical diagnostic and treatment services that are beyond the capabilities of the hospital, verify the hospital has an agreement with an outside source of these services to ensure they are immediately available or with a local Medicare participating hospital for transferring patients.
See Nursing Services 482.23 **HR.11.02.01, EP 2:** For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of psychiatric nursing that is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care provided. **§482.62(d); §482.62(d)(1)** **NPG.12.03.01, EP 4:** For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients	**Interview** Ask staff about the orientation and continuing education they receive. Listen for responses that might indicate individualized treatment interventions are addressed. Ask staff who provides the required leadership and supervision for the psychiatric nursing department. Speak with the Director of Nursing about o Their educational background and psychiatric nursing and leadership skills. *If the DON has less than a Master's Degree in Psychiatric Nursing, expect to hear/see evidence of experience and ongoing training in psychiatric nursing.* o Implementation of continuous quality improvement programs o Provision of orientation, in-service, and continuing education programs for nursing personnel, especially in the areas of psychiatric nursing, nursing process, prevention and management of violence, CPR and Universal Precautions.

Joint Commission Standards / EPs	Hospital Survey Process
- Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services **§482.62(d);**	○ The mechanism in place to monitor and evaluate the nursing care furnished by nursing staff as part of a quality improvement program or another program which would evaluate care. ○ The development and review of nursing service policies and procedures. ○ Approval of the nursing service policies and procedures. ○ The on-going and continuing education for psychiatric nurses and mental health care staff. **Document Review** **General** ☐ Check the outlines/content of orientation programs and ongoing continuing education programs for Licensed Practical Nurses and mental health workers to determine if they stress individualized treatment interventions. ☐ Review staffing schedules and staffing assignments to determine if the staffing numbers are adequate to meet the nursing care demands, taking into consideration the following: ○ Number of patients, ○ Patient acuity, ○ Availability of RNs, LPNs, NAs, and mental health aides. **Patient Health Record** Review the selected sample of patient health records to determine if: ☐ Nursing assessments are completed on all patients? ☐ Multidisciplinary treatment plans reflect nursing input which include specific nursing interventions for nursing problems (e.g. violence toward self/others, physical/medical crises)? ☐ Nursing care is evaluated by an R.N., with changes in the care based on the patient's progress or lack thereof? ☐ Nursing services are being provided in accordance with safe, acceptable standards of nursing practice. ~~**Observation**~~

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	~~Are intrusive techniques (e.g. seclusion, restraint, electroconvulsive therapy (ECT), and/or medical procedures) and patient incidents (e.g. medication errors, patient falls, patient to patient and patient to staff injuries) monitored in accordance with hospital policy, State statutes and safe nursing practice?~~ ~~Are nursing personnel observed relating to patients in a therapeutic manner?~~ Are nursing services being provided in accordance with safe, acceptable standards of nursing practice?
NPG.12.03.01, EP 4: See above **§482.62(d)(2)** **NPG.12.03.01, EP 2**: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes certain a registered professional nurse is available 24 hours a day. **§482.62(d)(2)**	**Interview** Interview patients and family members or significant others involved in the patient's care for information relative to the delivery of nursing services. Interview staff to determine adequacy of nursing staffing. Determine if there is immediate availability of an RN 24 hours a day **Document Review** **General** Determine that there are written staffing schedules which correlate to the number and acuity of patients. Verify that there is supervision of personnel performance and nursing care for each department or nursing unit. To determine if there are adequate numbers of nurses to provide nursing care to all patients as needed, take into consideration: o Physical layout and size of the hospital; o Number of patients; o Acuity of illness and nursing needs; o Availability of NAs and mental health workers and other resources for nurses; o Training and experience of personnel. **Observation** The nursing staffing patterns should be reviewed on a sample of approximately 25% of the certified wards. The staffing, including levels of nursing personnel, should be reviewed for the day(s) of the survey and evaluated based on the level of needs presented by the patients. Review additional staffing patterns if a problem or concern is identified. Base decisions regarding extent of additional data (number of

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	wards and dates) to review on the degree of problem/concern. Review patient need assessment/patient acuity for any wards as deemed necessary based on problems/concerns found in the sampling review. □ Select at least one patient from every inpatient care unit. Observe the nursing care in progress to determine the adequacy of staffing and to assess who is providing care to ensure the delivery of care is provided by staff who are functioning within their scope of practice. Other sources of information to use in the evaluation of the nursing services are: nursing care plans, medical records, patients, family members, accident and investigative reports, staffing schedules, nursing policies and procedures, and QAPI activities and reports.
LD.13.03.01, EP 18: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities to meet the needs of its patients. Note: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. **§482.62(e)**	**Interview** Ask the ~~service clinical leaders about~~ clinical director about the following: □ How psychological service staffing needs are determined. How many of the various types of mental health professionals are on staff and staffed each shift? □ Do the psychological services' staff participate in interdisciplinary treatment planning? □ If additional resources are needed, what plans are in place to secure those services? □ The types of psychological services and programs that are provided and how they meet the needs of the patient population. ~~□ The number of full time, part time, and consulting psychologists available. How do they determine that this number is adequate to provide necessary services to patients.~~ ~~□ The types of psychological services offered for example, assessments, therapy.~~ ~~□ How does the hospital or Psychological Service Department determine whether or not: it meets the needs of patients? Its services are underutilized or over utilized?~~ ~~□ Why have psychological services staff been deployed in the manner that they have?~~ **Document Review**

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	General ☐ Review the psychological services staffing; is there sufficient staff to address each patient's psychological needs? Do the psychological services staff have the appropriate qualifications for the task they are asked to perform? ~~**Observation**~~ ☐ ~~Did the patients in the sample have a need for psychological services or testing? Were they provided in a timely manner and with sufficient intensity?~~ ☐ ~~Did any of the patients in the sample indicate a need for psychological services, but none were requested?~~ ☐ ~~Do certain groups of patients receive testing routinely? Dementia? Children? Adolescents? Why?~~ ☐ ~~Once tests are performed, are results reported in sufficient time to be integrated in the patient's active treatment and treatment plan?~~
NPG.12.03.01, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of social services who monitors and evaluates the quality and appropriateness of social services. Note: Social services are provided in accordance with accepted standards of practice and established policies and procedures. **§482.62(f)** **HR.11.02.01, EP 5**: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The director of social services has a master's degree from an accredited school of social work or is qualified by education and experience in the social services needs of the mentally ill. Note: If the director does not hold a master's degree in social work, at least one staff member has this qualification. **§482.62(f)(1)**	**§482.62(f)** **Interview** ☐ Ask the director ~~about their qualifications, experience, and scope of duties within the position.~~to describe how they determine the social service needs of the patient population served. ☐ During interviews, ask the director of social services to demonstrate or provide evidence of how they monitor and evaluate quality and appropriateness of services furnished. Is there a policy for auditing the services furnished? How is information gathered through the auditing process shared with social services staff? Is there an established quality improvement program to monitor these services? ☐ Ask the social services director how he/she delegates responsibility within the department. ☐ Determine if the director of social services is involved with the development of and approval of the social services policies and procedures.

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PC.14.01.01, EP 4: The patient, the patient's caregiver(s) or support person(s), physicians, other licensed practitioners, clinical psychologists, and staff who are involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. The patient and their caregiver(s) or support person(s) are included as active partners when planning for postdischarge care. Note 1: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly. The hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **§482.62(f)(2)**	☐ Ask the director of social services as well as social services staff to demonstrate how the social services, furnished to patients, are consistent with nationally recognized standards of practice. Is there documentation that the hospital has developed social services policies and procedures based on accepted standards of practice? ☐ ~~If a MSW staff member, other than the director, is performing any of these duties, what are the staff member's experience and scope of duties performed? Why were these duties delegated?~~ ☐ ~~To what extent is the director's knowledge of the social work needs of the various wards? Why has the social work staff and services provided throughout the hospital been deployed in the manner it has?~~ ☐ ~~How does the director periodically audit the quality of social work services furnished? What are the outcomes of audits conducted? What percentage of psychosocial assessments was completed and available in written form at the time of the interdisciplinary treatment plan? How does the patient's social needs as addressed by the social worker in the psychosocial assessment compare against the goals developed in the interdisciplinary treatment plan?~~ Ask social work staff to demonstrate how they provide social services to patients in accordance with the hospital's policies and procedures. ☐ ~~If they are routinely involved in providing services to the patient that are identified in the treatment plan.~~ ☐ ~~If they have provided active treatment in accordance with the patient's treatment plan.~~ ☐ ~~To what extent they provide discharge planning services to the patient in the way of: supportive individual, couple, family, or group therapy focused on discharge goals of the patient? Carrying out a liaison role with community resource providers?~~ ☐ ~~If they have assured that adequate information is provided to post-hospital patient service providers.~~ **Interview patients**

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	☐ Determine if social services staff is providing adequate treatment which is individualized and comprehensive. **Document Review** ~~**General**~~ ☐ ~~The duties, functions, and responsibilities of the director of social services/social work should be clearly delineated and documented in the facility's policies and procedures. If the director is not MSW qualified and at least one staff member is MSW qualified, verify the duties, functions, and responsibilities of the MSW.~~ **Patient Health Record** ☐ Determine if social services are furnished to both inpatients and outpatients. ☐ Verify that social services staff have provided treatment in accordance with the patients' individualized, comprehensive treatment plans. **Observation** ☐ Observe treatment team meetings. Social services should play an active role in the treatment team and participate in the meetings. §482.62(f)(1) **Document Review** **Personnel/Credential File** ☐ Review personnel record for the Director of Social Work to determine whether he/she has a MSW from an accredited school of social work or is qualified by education and experience in the social services needs of the mentally ill. ☐ If the director of social services does not have a MSW from an accredited school of social work, determine if there is another social service professional on staff with a MSW from an accredited school of social work. §482.62(f)(2)

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	Interview ☐ Interview social work staff and ask them to describe discharge planning processes including how patients are provided options for continuity of care after discharge. ☐ Interview patients and ask them to describe how social services staff are working with them to plan their discharge; verify the patient is involved in the discharge planning decision making through interviewing the patient and medical record documentation. ☐ Ask social worker to provide documentation of how they develop mechanisms for exchange of appropriate information with organizations outside the hospital. ☐ Determine whether social work staff act as the liaison between the patient and community resource providers. **Document Review** **General** Review the hospital's policy to determine the role(s) of social services staff. **Patient Health Record** ☐ Verify when the social worker had contact with patient, patient representative and significant others; e.g., occurred during admission or soon after admission. ☐ Verify social services participation in the assessment, development and implementation of the discharge plan including the arrangement of follow-up care. ☐ Verify the extent to which social work staff prepare patients for post-hospitalization treatment and outpatient services. ☐ Verify documentation that social work staff provided appropriate information to sources outside the hospital who will provide aftercare, such as post-hospital patient service providers, community agencies, the patient, family members, and anyone else significantly involved with the patient who will provide care after hospitalization.

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	Observation □ Observe treatment plan meetings to assess how social workers participate in the development of a discharge plan.
LD.13.03.01, EP 18: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities to meet the needs of its patients. Note: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. **§482.62(g)** ~~**LD.14.03.01, EP 21:**~~ **LD.13.03.01, EP 18** See above **§482.62(g)(1)** **NPG.12.03.01, EP 3:** The number of qualified therapists, support personnel, and consultants available is adequate to provide therapeutic activities consistent with each patient's active treatment. **§482.62(g)(2)**	**Interview** Ask the Therapeutic Activities Director about □ Their qualifications, experience, duties and responsibilities of the Therapeutic Activities Director and discipline supervisor(s). □ How the program is organized. □ ~~Why therapeutic activities staff has been deployed in the manner they have.~~ □ Ask the person responsible for directing therapeutic activities: o To describe how patients are informed of therapeutic activities available o To describe the types of therapeutic activities offered, and o To describe how the activities are appropriate to meet the needs and interests of the patient. Ask staff about: □ Activities provided and the availability of staff throughout the day and week to determine that the numbers and types of staff available is appropriate to provide therapeutic activities consistent with each patient's treatment plan. □ How they determine the therapeutic needs of patients and how they are meeting those needs. □ Verify there are mechanisms in place to provide therapeutic activities during periods when certain activities are not available at the facility, yet needed. **Document Review** **General** □ Review the hospital's written criteria for determining qualification of therapeutic staff.

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	☐ Review personnel files to verify the qualifications of the therapeutic activities staff are documented. **Patient Health Record** ☐ Review a sample of medical records to determine if patient care that is to be provided by therapeutic activity staff is being provided as ordered. **Observation** ☐ Is there evidence to support that the hospital has adequate staffing to provide therapeutic activities to each patient? ☐ ~~Is there evidence that sampled patients and staff are familiar with the goals and staff interventions described in the patient's treatment plan? Are these observed interventions being carried out? What is the patient's response? Are these interventions and activities of sufficient frequency and intensity to achieve maximum therapeutic benefit?~~ ☐ ~~Did the patients in the sample have a need for any therapeutic activities? Were their needs met?~~ ☐ ~~Did any of the patients in the sample indicate a need for therapeutic activities, but none were considered?~~ ☐ ~~What kinds of services are provided to the patient population?~~ ☐ ~~Are activity areas/sites accessible and available to meet the patient's individual needs? Are the facilities and resources adequate to enable implementation of goals set in the patient's treatment plan?~~ ☐ ~~Does the program utilize available community resources to provide opportunities for socialization, leisure, and therapeutic and/or rehabilitation activities for patients who can participate outside the hospital setting?~~ ☐ ~~Are current activity schedules clearly posted for patient and staff reference and use? Are the scheduled activities related to the particular patient area and specific treatment needs of patients?~~ ☐ ~~Are patient needs met consistently at all times including evenings and weekends?~~

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	☐ ~~If a large number of patients are assigned to the same therapeutic activity, do patients have individualized goals within their treatment plans?~~

Hospital Swing Beds Evaluation Module (482.58)

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	Condition of Participation: §482.58 **Special requirements for hospital providers of long-term care services ("swing-beds")** **CMS RO makes the determination whether the hospital has satisfied the eligibility criteria and awards approval of swing-bed status.** The eligibility criteria at 42 CFR 482.58(a) requires: • The hospital has a Medicare provider agreement; • An initial applicant hospital may seek swing-bed approval. If the applicant hospital meets all Federal requirements for participation, including those for swing-bed approval, the applicant hospital's approval for swing-bed services will be effective with the effective date of the hospital's Medicare participation agreement **Survey Procedures (Use Appendix PP to survey) and score to existing TJC EPs mapped to 482.58 and the identified skilled nursing facility requirements contained in subpart B of part 483)** ☐ There must be discharge orders from acute care hospital inpatient services and subsequent admission orders for swing-bed services, the same as if the patient had been transferred to a separately certified skilled nursing facility. ☐ The same clinical record may be used for a swing-bed patient, but it must include discharge orders from acute care hospital inpatient services and admission orders to swing-bed services, and the swing-bed services (which may be SNF or NF level services) must be clearly delineated within the clinical record. ☐ An on-site survey must be conducted and the hospital must meet all the requirements of 42 CFR 482.58 before the hospital can obtain swing bed approval. ☐ Surveyors assess the manner and degree of non-compliance with the swing bed standards in determining whether there is condition-level compliance or standard-level non-compliance.
	§482.58 (a) Eligibility. **Observation** ☐ Verify that the hospital has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care units.

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	Note: *A hospital licensed for more than 100 beds may be eligible for swing-bed approval if it uses and staffs for fewer than 100 beds.* o Count the beds in each nursing unit. Do not count beds in recovery rooms, intensive care units, operating rooms, newborn nurseries, or stretchers in emergency departments. However, do count the beds within rehabilitation and psychiatric units that are excluded from the inpatient prospective payment system (IPPS).
IM.12.01.01, EP 1 and 2 §482.58(b)(1) LD.13.02.01,EP 2 and 3 §482.58(b)(1) PC.11.03.01, EP 2 §482.58(b)(1) RI.11.01.01, EP 1, 5 and 8 §482.58(b)(1) RI.12.01.01, EP 1,3,4 and 6 §482.58(b)(1) RI.11.02.01, EP 1 §482.58(b)(1) RI.13.01.03, EP 1,2 and 3 §482.58(b)(1)	Interview/Patient Health Record ☐ Surveyors must check whether there has been a delegation of resident rights or designation of a resident representative. ☐ Surveyors must also determine, through interview and record reviews, whether or not the resident's delegation of rights has been followed by facility staff. ☐ Determine through interview and record review if the resident has been found to be legally incompetent by a court in accordance with state law. If yes: ☐ Verify the appropriate legal documentation for a court-appointed resident representative is present in the resident's medical record. ☐ Review court orders or other legal documentation to determine the extent of the court appointed resident representative's authority to make decision on behalf of the resident and any limitations on that authority that may have been ordered by the court. ☐ Determine if the court-appointed representative is making decisions for the resident beyond the scope of the resident representative's decision-making authority and the facility is relying on that authority as the basis of a practice (e.g., health care treatment, managing resident funds, discharge decision). If so, a deficiency may be cited under this regulation. ☐ Determine if the resident was involved in care planning activities and able to make choices, to the extent possible. ☐ Observe resident care and daily activities (e.g., participation in activities) for adherence to resident's or court-appointed resident representative's goals, choices, and preferences. Even when there is a court-appointed resident representative, the facility should seek to understand the resident's goals,

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	choices, and preferences and have honored them to the extent legally possible. **If no:** □ Determine how decisions are being made for the resident. Does the resident maintain all of his/her rights, even if he/she has designated a representative to assist with decision-making unless a court has limited those rights under state law, and only to the extent that has been specified by a court under state law? Has the resident designated a resident representative and is facility staff respecting the authority of this designate surrogate decision-maker to act on behalf of the resident? □ Are all residents informed of their plan of care or treatment in the most understandable manner possible, and given an opportunity to voice their views? Autonomy is also expressed through gestures and actions and this also should be recognized. Residents even without capacity or declared incompetent may be able to express their needs and desires. □ Determine whether same-sex spouses are treated in the same manner as an opposite-sex spouse in all states and territories. □ If the resident has delegated a resident representative, verify the appropriate documentation is present in the resident's medical record. During **observations, interviews, and record reviews**, surveyors must: □ Interview the resident, and/or his or her representative to determine the level of participation in care planning. □ Identify ways staff involve residents and/or their representative(s) in care planning. □ Determine if care plan meetings are scheduled to accommodate residents and/or their representative. □ Determine how facility staff addressed questions or concerns raised by a resident or his or her representative, including if they are addressed at times when it would be beneficial to the resident, such as when they are expressing concerns or raising questions. □ Determine if the resident and representative were unable to participate, did facility staff consult them in advance about care and treatment changes. □ Interview staff to determine how they inform residents or their representative of their rights and incorporate their personal preferences, choices, and goals into their care plan.

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	☐ When the resident request is something that facility staff feels would place the individual at risk (i.e., the resident chooses not to use the walker, recommended by therapy), is there a process in place to examine the risk/benefit and guide decision-making? ☐ Review the resident's medical record to determine if facility staff included an assessment of the resident's strengths and needs and whether these, as well as the resident's personal and cultural preferences, were incorporated when developing his or her care plan. ☐ Determine how facility staff observes and responds to the non-verbal communication of a resident who is unable to verbalize preferences (i.e., if the resident spits out food, is this considered to be a choice and alternative meal options offered). **Interview** ☐ Through interviews with facility staff and residents and/or their representatives, determine how residents or their representative are informed of and are supported in: o His or her right to choose a physician; o How to contact their physician and other primary care professionals responsible for their care; o His or her options to choose an alternate physician or other primary care professional. ☐ If his or her physician is unable or not willing to provide necessary care and services, determine if facility staff worked with the resident to choose another physician. ☐ If facility staff refused to allow a resident to retain his or her personal possession(s), determine if such a restriction was appropriate due to insufficient space, protection of health and safety, and maintaining other resident rights, and whether the reason for the restriction was communicated to the resident. ☐ Through interviews with residents, their representative, family members, visitors and others as permitted under this requirement, determine if they

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	know that they are able to visit 24-hours a day, subject to a resident's choice and reasonable restrictions as defined above. ☐ Review the facility's written visitation policy and procedures to determine whether they support the resident's right to visitors and whether they explain those situations where visitors may be restricted due to clinical or safety concerns. ☐ If a concern is identified, interview facility staff to determine how they ensure 24-hour or immediate access as permitted under these requirements ☐ Ask residents about mail service both incoming and outgoing. ☐ Interview the resident, resident's representative and facility staff to determine if: o Residents are informed in a manner they understand of their right to request or refuse treatment; o A resident has an advance directive and if staff are aware of what this directive states; o A resident does not have an advance directive and, if so, how the resident was informed of his or her right to develop one and was the resident provided assistance in doing so; and o Staff periodically assess a resident's decision-making capacity, how often and how and by whom is this done. ☐ During interviews with residents, their representatives, visitors or families determine if their privacy has been honored by facility staff. ☐ Interview the representative of the Office of the State Long-Term Care Ombudsman who serves residents of the facility, to determine if the facility allows him/her to examine the resident's records with the permission of the resident or resident representative or as otherwise authorized by State law. **Patient Health Record** ☐ Review the resident's medical record to determine if: o The resident has an advance directive and a copy is located in the medical record; and o The facility has policies and procedures to implement advance directives.

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	Observation ☐ Observe for situations where facility staff may not be honoring the resident's privacy, including during visits, treatment, or leaving medical records out for public view. ☐ Are there signs regarding care information posted in view in residents' rooms? If these are observed, determine if such signs are there by resident or resident representative direction. If so, these signs are allowable. ☐ Is personal resident information communicated in a way that protects the confidentiality of the information and the dignity of residents? ☐ If concerns are found, interview staff regarding facility policy or procedures regarding protecting resident privacy and confidentiality.
PC.14.01.01, EP 4,12 and 13 **§482.58(b)(2)** **PC.14.01.03, EP 1** **§482.58(b)(2)** **RC.12.03.01, EP 1-4** **§482.58(b)(2)**	**Interview** ☐ Determine whether a transfer or discharge is resident- or facility-initiated. The determination that a transfer or discharge is facility-initiated does not equate to noncompliance if the requirements in this regulatory section are met. ☐ Were the resident's needed/requested possessions transferred with the resident to the new location? Ask resident or his or her representative if they understand why the transfer or discharge occurred. **Document Review** **General** ☐ Review the facility's notice before transfer which must include all the following elements at the time notice is provided: o The specific reason for the transfer or discharge, including the basis under §§483.15(c)(1)(i)(A)-(F); o The effective date of the transfer or discharge; o The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged; o An explanation of the right to appeal the transfer or discharge to the State;

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	○ The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests; ○ Information on how to obtain an appeal form; ○ Information on obtaining assistance in completing and submitting the appeal hearing request; and ○ The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. ○ For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice must include the name, mailing and e-mail addresses and phone number of the state agency responsible for the protection and advocacy for these populations. **Patient Health Record** □ For resident-initiated discharges, the medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care. Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated. □ If a surveyor has concerns about whether a resident-initiated transfer or discharge was actually a facility-initiated transfer or discharge, the surveyor should investigate further through interviews and record review. □ Review nursing notes and any other relevant documentation to see if appropriate orientation and preparation of the resident prior to transfer and discharge has occurred. □ Through record review and interviews, determine if the resident received sufficient preparation prior to transfer or discharge, and if they understood the information provided to them. □ Was the facility's notice before transfer provided at least 30 days prior to the transfer or discharge of the resident.

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HR.11.02.01, EP 4 **§482.58(b)(3)** **PC.13.02.01, EP 1 and 2** **§482.58(b)(3)** **RI.13.01.01, EP 1-5** **§482.58(b)(3)**	**Interview** ☐ Ask residents about the facility and how they are treated by staff, other residents, or visitors. ☐ Ask family members or legal representatives that are present if they have any concerns about how a resident is being treated. ☐ Ask staff about the orientation and training they receive in recognizing signs that a resident may have experienced some form of abuse or neglect. ☐ Ask staff if the facility uses any form of restraints. If they are used, ask about the policy and procedure that governs use. ☐ Interview the staff member responsible for quality assurance activities to determine what type of data is collected to monitor use of restraints or seclusion. Determine who receives and evaluates this data and is responsible for taking action to reduce the use of such measures. **Document Review** **General** ☐ Review facility policies and procedures on the following; o Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. o Investigation of any such allegations. o Response to allegations of abuse, neglect, exploitation, or mistreatment. ☐ Review the facility's screening policies for new hires to determine the criteria, such as being found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law or have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property, that would automatically exclude a candidate from employment. **Patient Health Record** ☐ Review patient health records of a sample of residents who experience some form of restraints to determine the amount of time the restraint was used, and if and when re-evaluation of the need for restraints occurred. **Observation** ☐ Observe whether staff members make remarks and behave in a manner that may indicate concerns with staff treatment of residents.

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PC.14.02.01, EP 2 §482.58(b)(4) Social services	Interview - Ask leaders and clinical staff about the medically-related social services that are available to residents. - Ask staff how they determine a resident is in need of medically-related social services. Document Review Patient Health Record - Review a sample of resident records to determine if medically-related social services are provided for each resident.
~~PC.14.02.01, EP 2~~ ~~§482.58(b)(4) Patient activities~~	~~Interview~~ - ~~Ask facility staff about the activities program for residents. Determine if the program is based on resident assessments, care plans and preferences.~~ - ~~Ask the leader activities program leader about their qualifications and experience.~~ - ~~Ask a sample of residents about the activities and if they are meeting their interests.~~ ~~Document Review~~ ~~General~~ - ~~Review the facility's ongoing program to support residents in their choice of group, individual, and independent activities.~~ - ~~If there is a calendar or list of activities available review this schedule and arrange to view a group activity that is taking place.~~ - ~~Determine the basis for the activity offerings including comparing them to what residents expressed during interview and what is reflected in sampled resident health records documentation.~~ ~~Personnel/Credential Files~~ ~~Review the personnel file of the activities director to verify their qualifications, experience and certification or eligibility for certification.~~ ~~Patient Health Record~~ ~~Review a sample of resident health records to determine from the comprehensive assessments and care plans, and preferences of each resident to determine.~~

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	~~Observation~~ ~~Observe residents engaged in activities while tracing through the facility.~~
RC.12.03.01, EP 5 : For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When the hospital anticipates the discharge of a resident, the discharge summary includes but is not limited to the following: - A summary of the resident's stay that includes at a minimum the resident's diagnosis, course of illness/treatment or therapy, and pertinent laboratory, radiology, and consultation results - A final summary of the resident's status to include items in 42 CFR 483.20 (b)(1) at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. - Reconciliation of all predischarge medications with the resident's postdischarge medications (both prescribed and over-the-counter). - A postdischarge plan of care, which will assist the resident to adjust to his or her new living environment, that is developed with the participation of the resident and, with the resident's consent, the resident representative(s). The postdischarge plan of care indicates where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any postdischarge medical and nonmedical services **§482.58(b)(5)**	**Interview** ☐ If there is a resident ready for discharge to home, ask them or their representative if they were given written discharge instructions that were conveyed in a language and manner they understood. **Document Review** **Patient Health Record** ☐ Review a sample of resident discharge summaries to determine that they include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another. ☐ Items required to be in the final summary of the resident's status are: ○ • Identification and demographic information; ○ • Customary routine; ○ • Cognitive patterns; ○ • Communication; ○ • Vision; ○ • Mood and Behavior patterns; ○ • Psychosocial well-being; ○ • Physical functioning and structural problems; ○ • Continence; ○ • Disease diagnoses and health conditions; ○ • Dental and nutritional status ○ • Skin condition; ○ • Activity pursuit; ○ • Medications; ○ • Special treatments and procedures; ○ • Discharge planning (as evidenced by most recent discharge care plan); ○ • Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and

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	○ • Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts. ☐ In addition to the above, pursuant to §483.15(c)(2)(iii), the facility (transferring nursing home) must convey the following information to the receiving provider when a resident is discharged (or transferred) from that facility: ○ • Contact information of the practitioner (at the transferring nursing home) responsible for the care of the resident; ○ • Resident representative information, if applicable, including contact information; ○ • Advance directive information; ○ • All special instructions or precautions for ongoing care, as appropriate; ○ • Comprehensive care plan goals; and ○ • All other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. ☐ Determine the medical record identifies the receiving facilities for which or physicians/practitioners to whom the discharge summary is provided. ☐ For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident representative. ○ Discharge instructions and accompanying prescriptions provided to the resident and if applicable, the resident representative must accurately reflect the reconciled medication list in the discharge summary. ☐ Review the post-discharge plan of care to determine if it was developed with the participation of the Interdisciplinary team and the resident and, with the resident's consent, the resident's representative.
~~PC.14.02.01, EP 2~~	~~See §482.58(b)(4).~~ ~~Document Review~~ ~~Personnel/Credentials File~~ ~~Review the personnel/credentials file of the social worker to determine they meet the required qualifications/experience.~~
HR.11.02.01, EP 1 §482.58(b)(6)	During **observations, interviews, and record reviews**, surveyors will determine the following:

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PC.12.01.01, EP 1 §482.58(b)(6) PC.14.02.01, EP 8 §482.58(b)(6)	☐ For residents with a Level II determination and recommendations, has the facility incorporated the determination and recommendations into the resident's assessment and care plan? ☐ How does the facility identify residents with newly evident or possible serious mental disorder, ID or a related condition? ☐ If a resident was identified with newly evident or possible serious MD, ID or a related condition, did the facility refer the resident to the appropriate state-designated authority for review? ☐ Is there evidence that the facility provides the next care setting with the resident's PASARR Level II recommendations when a resident with MD or ID transitions to another care setting? ☐ Has the facility arranged for the resident to receive specialized services through off-site visits, if appropriate, to meet the resident's needs as identified in the resident's PASARR Level II recommendations?
PC.14.02.01, EP 3-7 §482.58(b)(7)	Interview ☐ Interview the resident and/or resident representative to determine if any concerns have been promptly addressed to the resident's or the resident representative's satisfaction. Determine if the facility provided the assistance to obtain dental services needed or requested by the resident or resident representative and whether the facility assisted the resident with arranging transportation to the dental appointment. ☐ If there is a concern related to missing or damaged dentures, determine if the facility provided the assistance to obtain dental services needed or requested by the resident or resident representative and whether the facility assisted the resident with arranging transportation to the dental appointment. Document Review General ☐ Review the facility's policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility Patient Health Record ☐ Review a resident's record for identification of the resident's dental needs and the resident's responsiveness to dental services.

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	Observation ☐ Observe the resident to determine if his or her dental status is consistent with the comprehensive assessment or if the resident exhibited signs of dental health concerns that may not have been identified.

Hospital Emergency Management Evaluation Module (482.15)

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EM.09.01.01, EP 1: The hospital has a written comprehensive emergency management program that utilizes an all-hazards approach. The program includes, but is not limited to, the following: - Leadership structure and program accountability - Hazard vulnerability analysis - Mitigation and preparedness activities - Emergency operations plan and policies and procedures - Education and training - Exercises and testing - Continuity of operations plan - Disaster recovery - Program evaluation **§482.15** **EM.09.01.01, EP 3:** The hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations. **§482.15**	**Interview** □ Ask leaders to describe the hospital's emergency preparedness program. □ Ask leaders to describe how the hospital used an all-hazards approach when developing its program. **Document Review** **General** □ Verify that the hospital has a written policy on its emergency preparedness program. ***Note:*** *CMS does not require any particular system for meeting the requirements. It is up to each hospital to be able to demonstrate in writing its emergency preparedness program.*
EM.12.01.01, EP 1: The hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **§482.15(a)** **EM.17.01.01, EP 3:** The hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the	**Interview** □ Ask hospital leaders to identify the hazards (for example, natural, humanmade, facility, geographic) that were identified in the hospital's risk assessment and how the risk assessment was conducted. **Document Review** **General** □ Verify that the hospital has an emergency preparedness plan that is reviewed and updated at least every 2 years and the plan contains all the required elements that includes: ▪ Hazard vulnerability analysis ▪ Emergency operation plan and policies and procedures ▪ Communications plan ▪ Continuity of operations ▪ Education and training ▪ Exercises and testing ▪ Program evaluation (after-action/improvement plans) ▪ Unified and integrated EM program (if applicable) **Note:** *Ask for documentation of the date of the last review and updates that were made to the plan based on the review.*

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following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program **§482.15(a)**	
EM.11.01.01, EP 1: The hospital conducts a facility-based hazard vulnerability analysis (HVA) using an all-hazards approach that includes the following: - Hazards that are likely to impact the hospital's geographic region, community, facility, and patient population - A community-based risk assessment (such as those developed by external emergency management agencies) - Separate HVAs for its other accredited facilities if they significantly differ from the main site The findings are documented. Note: A separate HVA is only required if the accredited facilities are in different geographic locations, experience different hazards or threats, or the patient population and services offered are unique to this facility. **§482.15(a)(1)** **EM.11.01.01, EP 2:** The hospital's hazard vulnerability analysis includes the following: - Natural hazards (such as flooding, wildfires) - Human-caused hazards (such as bomb threats or cyber/information technology crimes) - Technological hazards (such as utility or information technology outages) - Hazardous materials (such as radiological, nuclear, chemical) - Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses) **§482.15(a)(1)**	**Interview** □ Ask hospital leaders which hazards (for example, natural, humanmade, facility, geographic) were included in the hospital's risk assessment, why they were included, and how the risk assessment was conducted. **Document Review** **General** □ Ask to see written documentation on the hospital's risk assessments and associated strategies. ▪ Verify that the risk assessment is based on the hospital and the community. ▪ Ensure that the risk assessment takes an all-hazards approach specific to the geographic location of the hospital and encompasses potential hazards, such as emerging infectious diseases. **Note:** *Surveyors are not expected to analyze a hospital's risk assessment to determine whether the identified risks are appropriate. Surveyors may consider the geographic location and review the remaining standards to determine that the hospital has addressed the hazards within their risk assessment through their policies and procedures.*

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EM.11.01.01, EP 3: The hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the hospital and its ability to provide services. The findings are documented. **§482.15(a)(2)** **EM.11.01.01, EP 4:** The hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the hospital and helps reduce disruption of essential services or functions. **§482.15(a)(2)**	
EM.12.01.01, EP 2: The hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence. **§482.15(a)(3)** **EM.13.01.01, EP 1:** The hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance leaders, and other department leaders as determined by the hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption.	**Interview** □ Ask leaders to describe the following: ▪ The hospital's patient populations that would be at risk during an emergency event ▪ Services that the hospital would be able to provide during an emergency and any plans to address services needed that cannot be provided by the hospital during an emergency as part of continuity of operations and services ▪ How the hospital plans to continue operations during an emergency ▪ How the hospital delegates authority and implements succession plans □ Ask leaders if the hospital has delegations and succession plans that use roles and responsibilities instead of staff names (for example, Safety Officer = Emergency Department Charge Nurse or Pharmacy Department Lead), identify an individual who would be designated in one of the roles and ask them to describe their role based on the hospital's emergency preparedness program. **Document Review** **General** □ Verify that the written emergency plan includes the following: ▪ Addresses the patient population, including, but not limited to, persons at-risk

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§482.15(a)(3) **EM.13.01.01, EP 2:** The hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. §482.15(a)(3) **EM.13.01.01, EP 3:** The hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties. §482.15(a)(3) **EM.13.01.01, EP 4:** The hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority. §482.15(a)(3)	▪ The type of services the hospital has the ability to provide in an emergency ▪ Continuity of operations, including delegations of authority and succession plans
EM.12.01.01, EP 6: The hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident. §482.15(a)(4)	**Interview** □ Ask hospital leaders to describe their process for ensuring cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials during a disaster or emergency situation.

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EM.12.01.01, EP 1: The hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **§482.15(b)** **EM.17.01.01, EP 3:** The hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program **§482.15(b)**	**Document Review** **General** □ Verify that the hospital has written emergency preparedness policies and procedures that are based on the emergency plan. ▪ Ensure that the policies and procedures were developed with a facility- and community-based risk assessment and communication plan, using an all-hazards approach. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years*.
EM.12.01.01, EP 4: The emergency operations plan includes written procedures for how the hospital will provide essential needs for its staff, volunteers, and patients, whether they shelter in place or evacuate, that includes, but is not limited to, the following: - Food and other nutritional supplies - Medications and related supplies - Medical/surgical supplies	**Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include: ▪ Provision of subsistence needs, including but not limited to food, water, and pharmaceutical supplies for patients and staff ▪ Alternate sources of energy, including emergency power necessary to maintain the following:

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- Medical oxygen and supplies - Potable or bottled water **§482.15(b)(1)(i); §482.15(b)(1)(ii)** **EM.12.02.11, EP 4:** The hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the hospital considers partial or full evacuation or closure. **§482.15(b)(1)(ii)(A,B,C,D)** **PE.03.01.01, EP 4:** The hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities. **§482.15(b)(1)(ii)(C)**	• Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions • Emergency lighting • Fire detection, extinguishing, and alarm systems • Sewage and waste disposal **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.02.07, EP 2: The hospital's plan for safety and security measures includes a system to track the location of its on-duty staff and volunteers and patients when sheltered in place, relocated, or evacuated. If on-duty staff and volunteers and patients are relocated during an emergency, the hospital documents the specific name and location of the receiving facility or evacuation location. Note: Examples of systems used for tracking purposes include the use of established technology or tracking systems or taking head counts at defined intervals. **§482.15(b)(2)**	**Interview** □ Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff. **Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include a tracking system to be used during emergencies that includes: ▪ A system to track the location of on-duty staff and sheltered patients in the hospital's care during an emergency. ▪ If on-duty staff and sheltered patients are relocated during the emergency, the hospital must document the specific name and location of the receiving facility or other location. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*

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EM.12.01.01, EP 3: The hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the hospital includes consideration of care, treatment, and service needs of evacuees, staff responsibilities, and transportation. **§482.15(b)(3)** **EM.12.02.01, EP 5:** The hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the hospital plans to communicate with - Testing the functionality of the hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems. **§482.15(b)(3)**	**Interview** □ Ask staff to describe how they would handle a situation in which a patient refused to evacuate **Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include safe evacuation from the hospital, including the following: ▪ Consideration of care and treatment needs of evacuees ▪ Staff responsibilities ▪ Transportation ▪ Identification of evacuation location(s) ▪ Primary and alternate means of communication with external sources of assistance **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.01.01, EP 3: The hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the hospital includes consideration of care, treatment, and service needs of evacuees, staff responsibilities, and transportation. **§482.15(b)(4)**	**Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include how the hospital will provide a means to shelter in place for patients, staff, and volunteers who on remain in the hospital. □ Verify that the hospital's policies and procedures for sheltering in place align with its emergency plan and risk assessment. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
IM.11.01.01, EP 1: The hospital develops and implements policies and procedures regarding medical documentation and patient information during emergencies and other interruptions to information management systems, including security and availability of patient records to support	**Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include a medical record documentation system that preserves patient

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continuity of care. Note: These policies and procedures are based on the emergency plan, risk assessment, and emergency communication plan and are reviewed and updated at least every 2 years. §482.15(b)(5)	information, protects confidentiality of patient information, and secures and maintains the availability of records. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.02.03, EP 1: The hospital develops a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. The plan includes the following: - Methods for contacting off-duty staff - Acquisition of staff from its other health care facilities - Use of volunteer staffing, such as staffing agencies, health care coalition support, and those deployed as part of the disaster medical assistance teams Note: If the hospital determines that it will never use volunteers during disasters, this is documented in its plan. §482.15(b)(6) **EM.12.02.03, EP 2:** The hospital's staffing plan addresses the management of all staff and volunteers as follows: - Reporting processes - Roles and responsibilities for essential functions - Integration of staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities §482.15(b)(6)	**Interview** □ Ask hospital leaders to explain their staffing strategies. ▪ Do they use volunteers? ▪ Do they have other emergency staffing strategies if no volunteers are used? **Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include: ▪ Use of volunteers and other emergency staffing strategies during an emergency ▪ Addressing surge needs during an emergency **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.02.05, EP 1: The hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care. §482.15(b)(7)	**Interview** □ Ask hospital leaders to explain the arrangements in place for transportation in the event of an evacuation. **Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include written arrangements and/or agreements the hospital has with other facilities to receive patients in the event the hospital is not able to care for them during an emergency. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*

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EM.12.01.01, EP 7: The hospital must develop and implement emergency preparedness policies and procedures that address the role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Note 1: This element of performance is applicable only to hospitals that receive Medicare, Medicaid, or Children's Health Insurance Program reimbursement. Note 2: For more information on 1135 waivers, visit https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidatedmedicareffsemergencyqsas.pdf. §482.15(b)(8)	**Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include the hospital's role in providing care and treatment at alternate care sites under an 1135 waiver. **Note:** *This policy and procedure requirement does not require a hospital to have an 1135 waiver on hand at the time of the survey, as such waivers are established or granted by CMS only during a declared emergency period. Section 1135 waivers by nature are time limited.* **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.09.01.01, EP 3: The hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations. §482.15(b)(8) **EM.12.01.01, EP 1:** The hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records §482.15(b)(8)	**Interview** □ Ask hospital leaders or the designee responsible for the emergency program to explain how they collaborate with federal, state, and local officials to ensure their communication plan complies with federal, state and local requirements. **Document Review** **General** □ Verify that the hospital has a written emergency preparedness communication plan, that complies with Federal, State and local laws. **Note:** *The communication plan must be reviewed and updated at least every 2 years.*

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EM.17.01.01, EP 3: The hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program §482.15(b)(8)	
EM.12.02.01, EP 1: The hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident. §482.15(c)(1)	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes names and contact information for staff, entities under arrangement, physicians, other hospitals and CAHs, and volunteers **Note:** *Hospitals that use electronic data storage should be able to provide evidence of data backup with hard copies or by demonstrating the ability to reproduce contact lists or access these data during emergencies.* **Note:** *The communication plan and contact information must be reviewed and updated at least every 2 years.*
EM.12.02.01, EP 1: The hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes contact information for federal, state, tribal, regional, and local emergency preparedness officials and other sources of assistance.

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- Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident. **§482.15(c)(2)**	□ Verify that the hospital has contact information for the State Survey Agency and/or public health departments. **Note:** *The communication plan and contact information must be reviewed and updated at least every 2 years.*
EM.12.02.01, EP 5: The hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the hospital plans to communicate with - Testing the functionality of the hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems. **§482.15(c)(3)**	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes primary and alternate means for communicating with facility staff and federal, state, tribal, regional, and local emergency management agencies. **Note:** *Hospitals have the discretion to use alternate communication systems that best meet their needs.* **Note:** *The communication plan must be reviewed and updated at least every 2 years.* □ Verify that the hospital's communication plan includes the types of communication equipment and/or communication systems that will be used for primary and alternate means of communicating. **Note:** *Hospitals may use pagers, cell phones, radio transceivers (that is, walkie-talkies), and various other radio devices (such as Ham Radio systems, as well as satellite telephone communications systems. However, those in rural or remote areas may have difficulty using some communications systems, which should be outlined with their risk assessment.* □ Verify that the hospital's communication plan includes procedures for when and how alternate communication methods will be used and who uses them. **Observation**

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	□ Ask to see the communications equipment or communication systems listed in the plan
EM.12.02.05, EP 1: The hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care. **§482.15(c)(4);** **EM.12.02.01, EP 4:** In the event of an emergency or evacuation, the hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the care of the patient - Disaster relief organizations and relevant authorities - Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4). **§482.15(c)(4); §482.15(c)(5); §482.15(c)(6)**	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes a method for sharing information and medical documentation for patients under its care, as necessary, with other health providers to maintain the continuity of care. □ Verify that the hospital has policies and procedures addressing the means it will use to release patient information, including the general condition and location of patients. **Note:** *The communication plan must be reviewed and updated at least every 2 years.*
EM.12.02.01, EP 3: The hospital's communication plan describes how the hospital will communicate with and report information about its organizational needs, available occupancy, and ability to provide assistance to relevant authorities. Note: Examples of hospital needs include shortages in personal protective equipment, staffing shortages, evacuation or transfer of patients, and temporary loss of part or all organization function. **§482.15(c)(7)**	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes a means of providing information about the hospital's needs and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or a designee. □ Verify that the hospital's communication plan includes a means of providing information about its occupancy. **Note:** *The communication plan must be reviewed and updated at least every 2 years.*
EM.15.01.01, EP 1: The hospital has a written education and training program in emergency management that is based on the hospital's prioritized risks identified as part of its hazard vulnerability analysis,	**Document Review** **General**

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emergency operations plan, communications plan, and policies and procedures. Note: If the hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs. §482.15(d) **EM.16.01.01, EP 1:** The hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following: - Likely emergencies or disaster scenarios - EOP and policies and procedures - After-action reports (AAR) and improvement plans - Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures to assess how prepared the hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. §482.15(d) **EM.17.01.01, EP 3:** The hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program §482.15(d)	□ Verify that the hospital has a written training and testing program that is based on the hospital's risk assessment, has incorporated its policies and procedures, as well as its communication plan within training required for staff. **Note:** *Refer to the hospital's risk assessment when determining if the training and testing program reflects the risks and hazards identified within the hospital's program.* **Note:** *Training and testing program must be reviewed and updated at least every 2 years.*

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EM.15.01.01, EP 2: The hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that is consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required. **§482.15(d)(1)(i); §482.15(d)(1)(iii); §482.15(d)(1)(iv)** **EM.15.01.01, EP 3:** The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that is consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program. **§482.15(d)(1)(ii); §482.15(d)(1)(iii); §482.15(d)(1)(iv); §482.15(d)(1)(v)**	**Interview** □ Ask various staff about the hospital's initial and subsequent (at least every 2 years) training courses to verify staff knowledge of emergency procedures. **Document Review** **General** □ Verify that the hospital's training program provides initial and subsequent (at least every 2 years) emergency preparedness training that is consistent with staff roles during an emergency and is based on the hospital's risk assessment, policies, and procedures, as well as the communication plan. **Note:** *Training is intended for all new and existing staff, individuals providing services under arrangement, and volunteers. It is up to the hospital to decide what level of training each staff member will be required to complete based on an individual's involvement or expected role during an emergency.* **Personnel/Credential File** □ Review a sample of staff training files to verify that staff have received initial and subsequent (at least every 2 years) emergency preparedness training. **Note:** *For ease of demonstrating compliance that the hospital has updated its training program at least every 2 years, hospitals should retain, at a minimum, the past 2 cycles (generally 4 years) of emergency training documentation for both training and exercises.*

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EM.16.01.01, EP 2: The hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises. **§482.15(d)(2); §482.15(d)(2)(i); §482.15(d)(2)(i) (A,B) §482.15(d)(2)(ii) (A,B,C)** **EM.17.01.01, EP 1:** The multidisciplinary committee that oversees the emergency management program reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews after-action reports (AARs), identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented. Note 1: The review and evaluation addresses the effectiveness of its	**Interview** □ Ask hospital leaders to describe the participation of managers and staff during scheduled exercises. **Document Review** **General** □ Verify that the hospital has conducted at least 2 annual exercises to test the emergency plan. The hospital is required to conduct a minimum of 2 exercises per year as follows: ▪ One annual exercise must be a full-scale community- or facility-based functional exercise. ▪ The other annual exercise can be of choice, which may be a full-scale community based or a facility-based functional exercise, or the exercise may be a mock drill, tabletop exercise, or workshop. **Note:** *If the hospital experiences a real emergency that requires activation of its emergency plan, the hospital is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.* □ Ask to see documentation of the exercises conducted by the hospital which may include but is not limited to the exercise plan, the after-action report, and any additional documentation used by the hospital to support the exercise. **Note:** *Hospitals are to retain, at a minimum, the past 2 cycles (generally 2 years for inpatient providers) of emergency testing exercise documentation.* □ Ask to see documentation of the hospital's efforts to identify a full-scale community-based exercise if it did not participate in one (that is, date, staff and agencies contacted, and reasons for the inability to participate). □ Verify documentation of the hospital's analysis and response to the annual exercises and how the hospital updated its emergency program based on this analysis.

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emergency response procedure, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients. Note 2: An AAR provides a detailed critical summary or analysis of a planned exercise or actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **§482.15(d)(2)(iii)** **EM.17.01.01, EP 3:** The hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program **§482.15(d)(2)(iii)**	
EM.12.02.09, EP 1: The hospital's plan for managing its resources and assets describes in writing how it will document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets during and after an emergency or disaster incident: - Medications and related supplies - Medical/surgical supplies - Medical gases including oxygen and supplies - Potable or bottled water and nutrition - Non-potable water - Laboratory equipment and supplies - Personal protective equipment - Fuel for operations - Equipment and nonmedical supplies to sustain operations Note: The hospital should be aware of the resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency or disaster incident.	**Document Review** **General** □ Verify that the hospital has the required emergency and standby power systems to meet the requirements of its emergency plan and corresponding policies and procedures. □ Verify that the hospital's emergency plan for "shelter in place" and evacuation plans include its emergency power supply systems or plans to maintain safe operations while sheltering in place. □ Verify that hospitals under construction or with existing buildings being renovated have a written plan to relocate the emergency power supply system (EPSS) by the time construction is completed. □ Verify that hospitals with permanently attached generators evaluate and maintain their on-site fuel source in accordance with NFPA 110 and have a

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482.15(e)(3) **EM.12.02.09, EP 2:** The hospital's plan for managing its resources and assets describes in writing how it will obtain, allocate, mobilize, replenish, and conserve its resources and assets during and after an emergency or disaster incident, including the following: - If part of a health care system, coordinating within the system to request resources - Coordinating with local supply chains or vendors - Coordinating with local, state, or federal agencies for additional resources - Coordinating with regional health care coalitions for additional resources - Managing donations (such as food, water, equipment, materials) Note: High priority should be given to resources that are known to deplete quickly and are extremely competitive to acquire and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications). 482.15(e)(3) **EM.12.02.11, EP 1:** The hospital's plan for managing utilities describes in writing the utility systems that it considers as essential or critical to provide care, treatment, and services. Note: Essential or critical utilities to consider may include systems for electrical distribution; emergency power; vertical and horizontal transport; heating, ventilation, and air conditioning; plumbing and steam boilers; medical gas; medical/surgical vacuum; and network or communication systems. §482.15(e) **EM.12.02.11, EP 2:** The hospital's plan for managing utilities describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident. §482.15(e); 482.15(e)(3)	plan for how to keep the generator operational during an emergency, unless they plan to evacuate.

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EM.12.02.11, EP 3: The hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators. **§482.15(e); 482.15(e)(3)** **PE.03.01.01, EP 3:** The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. **§482.15(e)(1)** **PE.04.01.01, EP 1:** The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do	

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not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. **§482.15(e)(1)** **PE.04.01.03, EP 3:** The hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements. Note: The hospital implements the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. **§482.15(e)(1); 482.15(e)(2)**	
EM.09.01.01, EP 2: If the hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified hospital's unique circumstances, patient population, and services offered - Each separately certified hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach	**Interview** □ If the hospital has opted to participate in its health care system's unified and integrated emergency preparedness program, ask hospital leaders to describe how the program is updated based on changes within the health care system, such as when facilities enter or leave the system. **Document Review** **General** □ Verify whether the hospital has opted to be part of its health care system's unified and integrated emergency preparedness program. Note: *This is optional for separately certified hospitals.* □ If the hospital has opted to participate in its health care system's unified and integrated emergency preparedness program, ask to see documentation of its inclusion in the program.

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- Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program **§482.15(f)(1); §482.15(f)(2); §482.15(f)(3); §482.15(f)(4)** **EM.11.01.01, EP 3:** The hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the hospital and its ability to provide services. The findings are documented. **§482.15(f)(4)** **EM.11.01.01, EP 4:** The hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the hospital and helps reduce disruption of essential services or functions. **§482.15(f)(4)** **EM.12.01.01, EP 2:** The hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence. **§482.15(f)(4)** **EM.12.01.01, EP 6:** The hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support	▪ Verify that the hospital was actively involved in the development of the unified emergency preparedness program. ▪ Verify that the hospital was actively involved in the review of program requirements and updates. ▪ Ask to see a copy of the integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program).

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and resources and to provide an integrated response during an emergency or disaster incident. §482.15(f)(4) **EM.13.01.01, EP 1:** The hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance leaders, and other department leaders as determined by the hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption. §482.15(f)(4) **EM.13.01.01, EP 2:** The hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. §482.15(f)(4) **EM.13.01.01, EP 3:** The hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties. §482.15(f)(4)	

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EM.13.01.01, EP 4: The hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority. §482.15(f)(4)	