Office Based Surgery Accreditation

Organization
Survey Activity Guide

2026

Issue Date: December 2025

What’s New for Office Based Surgery Survey Process 2026

No changes for January 2026.

Office Based Surgery (OBS)
Organization Survey Activity Guide (SAG)

Contents

How to Use this Guide

Joint Commission's Survey Activity Guide for office-based surgery practices is available on your organization's *Joint Commission Connect* extranet site.

This guide contains:

- Information to help you prepare for survey.
- A description of each survey activity that includes an overview of the session, logistical information, suggested participants, and standards related topics that will be covered
- Requested documentation list
- A sample agenda for an Office Based Surgery survey

A template agenda with a schedule of onsite survey activities is posted to your organization's *Joint Commission Connect* extranet site once your application for accreditation is reviewed and processed by your account executive. When the agenda is available, please review the material and think about the people you might involve in the survey. There is an activity list in this guide that includes a column in which you can record participant names or positions next to each of the sessions. Identifying key participants (and their phone numbers) for each session, including back-ups, is important. Consider including possible meeting locations and surveyor workspace in your planning documents. Review the descriptions in this Survey Activity Guide to learn about what will occur during the activity/session.

The template agenda and activity list include suggested duration and scheduling guidelines for each of the sessions. The surveyor will adjust the duration of activities as needed to complete the required evaluation and objectives. On the first day of survey, there will be an opportunity for you to work with the surveyor to prepare an agenda for the visit that will fit with your day-to-day operations.

If you have any questions about the survey, please contact your Account Executive. If you are unsure of your Account Executive's name or phone number, call Joint Commission at 630-792-3007 for assistance.

Preparing for Surveyor Arrival

Overview
The practice will receive a short notice, **seven-business day advance notice,** is given to Office-Based Surgery practices for most surveys. If this is the practice's initial accreditation survey a 30-day advance notice is provided.

Planning in advance for the surveyor's arrival helps staff be better prepared for the survey. Practice leaders and staff can review the survey agenda template in advance of the onsite visit and be prepared to discuss the schedule for the survey day with the surveyor upon arrival. Based on practice activity, the surveyor may begin with observing patient care, treatment, and services and postpone review of documentation until later.

Preparing for Survey

Prepare a plan for staff to follow when the surveyor arrives. The plan should include:

- Greeting surveyor(s): Identify the staff usually at the main entrance of your practice. Tell them about Joint Commission and what to do when the surveyor arrives. Explain the importance of verifying any surveyor's identity by checking his or her Joint Commission picture identification badge. Also log into your *Joint Commission Connect* extranet site to validate the surveyor's identity when possible.
- Who to notify: Identify leaders and staff to notify when the surveyor arrives, including the individual who will be the surveyor's "contact person" during the survey. Identify alternate individuals in the event that leaders and staff are unavailable. Create a list of their names and telephone numbers.
- A work location for the surveyor: Ask surveyors to wait in the lobby until an organization contact person is available. The surveyor will need a location that they will call their "base" throughout the survey. This location should have an electrical outlet, phone access, and internet access.
- Validation of survey: Identify who will handle the validation of the survey and the identity of the surveyor. Identify the steps to be taken for this process. (See Surveyor Arrival Session for these steps.)
- The Survey Readiness Guide a helpful survey planning tool (See page 8).
- Requested Documentation: A selection of documents are found on the Office Based Surgery Requested Documentation list in this guide. Practice staff can identify where the documents will be found, electronically or on paper, in advance of the survey so they can easily display them upon surveyor request.
- Identifying who will provide the Safety Briefing for the surveyor(s)
    - The purpose of the Safety Briefing is for your practice to inform the surveyor 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 is 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

may experience during the time they are with you (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)

- Staff: Identify staff who will accompany the surveyor during the survey.
- Expectations for the survey: Identify your practice's expectations for the onsite survey and who will share these with the surveyor.

Survey Readiness Guide

Actions to take when the surveyor(s) arrives	Responsible Staff	Comments:
Greet surveyor(s)		
Check your *Joint Commission Connect* extranet site for notification of survey event		Be sure to designate someone to access your organization's *Joint Commission Connect* extranet site.
Verify identity of the surveyor(s)		Check the picture ID to ensure that they are from Joint Commission. Also log into your *Joint Commission Connect* extranet site to validate the surveyor's identity, when possible.
Determine where they will meet with your team		Location:

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

The Requested Documentation list and Survey Activities list appears on the pages that follow. Please review them to assist you in preparing for your survey. The Survey Activities list includes the potential survey activities that can occur on an accreditation survey, including the suggested duration, and suggested timing for these activities. This information will allow your practice to begin identifying participants that need to be involved in the survey. The Survey Activities list includes a column for your practice to use for recording participant names, possible meeting locations, times that could conflict with participant availability, or any other notes. Please work with your surveyor to confirm the best day and/or time(s) for specific survey activities to take place. Contact your Account Executive with any questions related to this information.

Office Based Surgery Requested Documentation

The practice can find information about the survey on the Joint Commission extranet site by accessing www.jointcommission.org.

- On the home page, scroll down to the **Connect With Us** section and click on "Joint Commission Connect."
- An organization login and password are required.
- The following information will be available:
    a. Confirmation of unannounced Joint Commission event authorizing the presence of the surveyors.
    b. Surveyor name, picture, and biographical sketch.
    c. A copy of the survey agenda.

As an Office-Based Surgery practice, you will need the following information and documents available for the surveyor to review during the Preliminary Planning Session or a time agreed upon by the surveyor and practice leaders and staff.

The 12-month reference in the following items is not applicable to practices undergoing an initial accreditation survey.

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

Item No.	Items	Comments/ Notes
	Any reports or lists of patient appointment schedules or surgery schedules for each day of the survey	
	Name and extension of key contacts who can assist surveyors in planning tracer selection	
	A list of contracted services (patient care contracts only)	
	Most recent culture of safety and quality evaluation data	
	Risks for infection, contamination, and exposure that pose a risk to patients and staff that are identified by the practice annually	
	Environment of Care management plans	
	Performance / Quality Improvement Data from the past 12 months	
	Prioritized Potential Emergencies (Hazard Vulnerability Analysis)	
	Emergency Operations Plan and supporting policies and procedures	

Office Based Surgery Accreditation Survey Activities

Activity Name	Suggested Activity Duration*	Scheduling Guidelines	Notes
Surveyor Arrival and Preliminary Planning, includes the Safety Briefing	30-45 minutes	1st day, upon arrival. The surveyor and practice leaders and staff should delay the planning and document review activity if patient care observation opportunities are only available early in the day.	
Opening Conference	15 minutes	1st day, as early as possible. The surveyor and practice leaders and staff should delay the planning and document review activity if patient care observation opportunities are only available early in the day.	
Orientation to Your Organization	30-45 minutes	1st day, as early as possible. The surveyor and practice leaders and staff should delay the planning and document review activity if patient care observation opportunities are only available early in the day.	
Individual Tracer	60-120 minutes	Individual Tracer activity occurs throughout the survey; the number of individuals who surveyors trace varies by practice.	
Lunch	30 minutes	At a time negotiated with the practice.	
Environment of Care and Emergency Management	45-60 minutes	After some individual tracer activity has occurred at a time negotiated with the practice leaders and staff.	
Competence Assessment and Credentialing & Privileging	45-60 minutes	After some individual tracer activity has occurred at a time negotiated with the practice leaders and staff.	
System Tracer – Data Management	45-60 minutes	After some individual tracer activity has occurred at a time negotiated with the practice leaders and staff. Will include some discussion of infection control and medication management topics.	
Surveyor Report Preparation	60-90 minutes	Last day of survey	
CEO Exit Briefing and Organization Exit Conference	30 minutes	Last day, final activity of survey	
Activities scheduled only on a multi-day survey			
Issue Resolution OR Surveyor Planning/Team Meeting	30 minutes	End of each day except last; can be scheduled at other times as necessary.	
Daily Briefing	15-30 minutes	Only occurs on multi-day surveys. Start of each survey day except the first day; can be scheduled at other times as necessary.	

*Please note: Surveyors will adjust the schedule and duration of activities as needed to complete the required evaluation and activity objectives.

DURING THE SURVEY

Surveyor Arrival and Preliminary Planning Session

Participants
Suggested participants include the practice's accreditation contact or survey coordinator and other leaders and staff identified in pre-survey planning. that will provide the Safety Briefing to surveyors, if different than the.

Duration
The surveyor(s) will arrive between 7:45-8:00 a.m. unless business hours, as reflected in the survey application, indicate that your practice opens at a later time. The suggested duration of the preliminary planning session is approximately 30 to 60 minutes, with more time added as needed to complete required evaluation activities.

Surveyor Arrival Activities
- Notify key practice leaders and staff, identified in the pre-survey planning, of the surveyor's arrival.
- Validate that the survey is legitimate by accessing your *Joint Commission Connect* extranet site. A staff member in your practice with a login and password to your *Joint Commission Connect* extranet website will follow through with this by:
    - Accessing Joint Commission's website at www.jointcommission.org
    - Under 'Action Center,' log in *Joint Commission Connect* extranet site
    - Enter a login and password
    - If you cannot access your *Joint Commission Connect* extranet site to validate the survey or surveyors, call your Account Executive

  Your practice's *Joint Commission Connect* extranet site contains the following information:
    - Confirmation of Joint Commission event authorizing the presence of the surveyor.
    - Surveyor name, picture, and biographical sketch
    - Copy of the survey agenda
- If you have not already downloaded a copy of your survey agenda, do so at this time.
- Begin gathering and presenting documents as identified on the Requested Documentation list.

Overview
The surveyor will need a workspace they can use as their "base" for the duration of the survey. This area should have a desk/table, internet access**,** and access to an electrical outlet. The surveyor will need the name and phone number of a key contact person to assist them in planning for the survey and their tracer selections.

After the surveyor identification has been verified, they will immediately begin planning for tracer activity by talking with leaders and staff and reviewing the documents you provide them (refer to the Requested Documentation list on the preceding pages). If patient care, treatment, and services observation opportunities are only available early in the day, they will begin individual tracer activity. Document review will be conducted later.

The practice is requested to provide surveyors with a Safety Briefing (informal, no more than five minutes) sometime during this activity. The purpose of this briefing is to inform the surveyors of any

current practice safety or security concerns and how Joint Commission staff should respond if your safety plans are implemented while they are on site. Situations to cover include:

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

Opening Conference

Participants
Suggested participants include members of the governing body (in single owner practices, this may be the surgeon or CEO) and senior leadership for example, practice manager, administrator, quality coordinator). Attendees should be able to address leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your practice's mission and strategic objectives. Leaders of the medical staff should also take part, when applicable.

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

Overview
During this session, the surveyor(s) will:

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

The surveyor will introduce themselves and describe each component of the survey agenda. It is important for you to discuss and review your practice's expectations for the onsite survey with the surveyor. Questions about the onsite visit, schedule of activities, availability of documents or people, and any other related topics should be raised at this time.

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

Orientation to the Organization

Participants
Suggested participants include members of the governing body (in single owner practices, this may be the surgeon or CEO) and senior leadership for example, practice manager, administrator, quality coordinator). Attendees should be able to address leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your practice's mission and strategic objectives.

Duration
The suggested duration of this session is approximately 30-45 minutes, with more time added as needed to complete required evaluation activities.

Overview
During this session, the surveyor becomes acquainted with your practice. They learn how your practice is governed and operated and explore your performance improvement process. There is no need to prepare a formal presentation. This session is an interactive discussion and may be combined with the Opening Conference.

Governance and operations-related topics for discussion include:

- Practice's mission, vision, goals, and strategic initiatives
- Practice structure
- Operational management structure
- Information management, including the format and maintenance of medical records
- Contracted services and performance monitoring of contracted services
- Patient safety initiatives
- Assessing the practice's culture of safety and attention to safety
- Practice leader(s) involvement in safety issues
- National Patient Safety Goals
- Community involvement
- Leader's role in emergency management planning
- Practice activities related to risk awareness, detection and response as it relates to cyber emergencies
- Cleaning, disinfection, and sterilization processes (Are these performed onsite or off-site?)
- As applicable to the practice's services: Pain assessment, pain management and safe opioid prescribing
- **For providers of imaging services, including fluoroscopy:** scope, types, locations, and safety

Discussion topics include:

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

Senior Leadership role in improving performance discussion topics may include:

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

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

Individual Tracer Activity

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

Duration
The suggested duration of individual tracer activity blocks of time varies but typically is 60-120 minutes, with more time added as needed to complete required evaluation activities.

Overview
During tracers, the surveyor will evaluate your practice's compliance with standards as they relate to the care, treatment, or services provided to patients.

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

Initially, the selection of individual tracer candidates is based on your practice's clinical services as reported in your e-application and the general risk areas identified for the accreditation program which are listed in the Intra-Cycle Monitoring (ICM) Profile. The surveyor will also consider any practice-specific risk areas listed in the ICM Profile.

The individual tracer begins where the patient and his/her record of care are located. The surveyor starts the tracer by reviewing a record of care with the staff person responsible for the individual's care, treatment, or services. The surveyor then continues the tracer by:

- Following the course of care, treatment, or services provided to the patient from entry to the practice through the end of the episode of care.
- Assessing the interrelationships between disciplines, departments, services as applicable to the practice and identifying issues that will lead to further exploration in other survey activities such as Environment of Care and Emergency Management and Data Management.

The surveyor is attentive to protecting patient confidentiality and privacy and they will seek the assistance of your staff in this effort. The surveyor may use multiple patient records during an individual tracer. The record helps the surveyor follow the care, treatment, or services provided by the practice to the patient.

The surveyor may arrive in a setting and need to wait for staff to become available. If this happens, the surveyor will use this time to evaluate environment of care issues or observe the care, treatment, or services that are being provided to patients.

The surveyor will try to minimize multiple visits to the same location, although they will need to follow the patient to the areas where services were provided.

During the individual tracer, the surveyor will observe the following at a minimum:

- Care, treatment, or services being provided to patients by clinicians, including physicians
- The medication process (e.g., preparation, dispensing, administration, storage, control of medications)

- Infection control issues (e.g., techniques for hand hygiene, sterilization of equipment, disinfection, and environmental cleaning)
- The process for planning care, treatment or services
- The environment as it relates to the safety of patients and staff
- Surveyors will ask to review your policy on pre-surgical assessments. The policy needs to address:
  - The timeframe for completing histories and physicals
  - Patient-specific factors, such as age, diagnosis, type and number of same-day procedures, comorbidities, and type of anesthesia
  - Intradepartmental and interdepartmental communication

During the individual tracer, the surveyor will interview staff about:

- Communication for the coordination of care, treatment, or services. (e.g., hand offs)
- The use of data in the care of patients, and for improving practice performance; their awareness and involvement in performance improvement projects
- National Patient Safety Goals
- Patient education
- Orientation, education, and competency of staff
- The information systems they use for care, treatment and services (paper, fully electronic or a combination of the two) and about any procedures they must take to protect the confidentiality and integrity of the health information they collect
  - Back up procedures they've been instructed to use if the primary system is unavailable
  - If internet-connected health information, equipment, or devices are used in care, treatment, or service, staff may be asked to describe their access procedures (passwords, authentication, etc.), confidentiality measures, and instructions on down-time procedures
  - How they approach risk awareness, detection and/or response as it relates to potential cyber emergencies
- As applicable to the practice's services: Pain assessment, pain management and safe opioid prescribing initiatives and resources made available by the practice; Prescription Drug Monitoring Database and criteria for accessing
- Other issues

During the individual tracer, the surveyor(s) will speak with available physicians and other licensed practitioners about:

- Practice processes that support or may be a barrier to patient care, treatment, or services
- Communications and coordination with other licensed practitioners (hospitalists, consulting physicians, primary care practitioners)
- As applicable to the practice's services: Pain assessment, pain management and safe opioid prescribing initiatives and resources made available by the practice; Prescription Drug Monitoring Database and criteria for accessing
- Discharge planning, or other transitions-related resources and processes available through the practice.
- Awareness of roles and responsibilities related to the Environment of Care, including prevention of, and response to incidents and reporting of events that occurred

During the individual tracer, the surveyor(s) will interview patients and their families about:

- Coordination and timeliness of services provided
- Education, including discharge instructions
- Response time when a call bell is initiated or alarms ring, as warranted by care, treatment, or services
- Perception of care, treatment, or services
- Staff observance of hand-washing and verifying patient's identity
- Understanding of instructions (e.g., diet or movement restrictions, medications, discharge, and provider follow-up), as applicable
- As applicable to the practice's services: How staff involved them in their pain management plan of care, what their pain management plan of care includes (non-pharmacologic, pharmacologic or a combination of approaches)
- Rights of patients
- Other issues

Special Issue Resolution

Participants
As requested by the surveyor

Duration
This activity only takes place as necessary. The suggested duration is approximately 30 minutes and scheduled toward the end of each day, except the last, for surveyors to conduct either Special Issue Resolution or engage in Surveyor Planning activity. The surveyor will inform the practice contact person what activity will take place, with more time added as needed to complete required evaluation activities.

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

- The review of certain policies and procedures
- The review of additional patient records to validate findings
- Discussions with staff to obtain additional information or clarification
- Review of staff and credentials files
- Review of data, such as performance improvement results
- Other issues requiring more discussion

The surveyor will inform your practice's contact person about any documentation needed, any staff who they would like to speak with, or locations they want to visit.

Surveyor Planning

Participants
None

Duration
The suggested duration for this session is 30 minutes.

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

Before leaving the practice, the surveyor(s) will return all documents to the survey coordinator or contact person. If the surveyor has not returned documents, your staff is encouraged to ask the surveyor for them prior to their departure.

Daily Briefing

Participants
Suggested participants include representative(s) from governance, the CEO/Administrator or Executive Director, the Joint Commission accreditation contact, and other key contact individuals identified by staff.

Duration
The suggested duration for this session is approximately 15 to 30 minutes, beginning on Day 2.

Overview
During this session, the surveyor(s) will briefly summarize the survey activities completed the previous day and communicate observations according to standards areas that may or may not lead to findings. Surveyor(s) may ask to hold a daily briefing before concluding activity on the first day, depending on circumstances. If a surveyor cannot participate in this session because he or she is surveying at a remote location, you may be asked for assistance with setting up a conference call to include all surveyors and appropriate staff.

The surveyor(s) will make general comments regarding significant issues from the previous day, note potential non-compliance, and emphasize performance patterns or trends of concern that could lead to findings of non-compliance. The surveyor(s) will allow you the opportunity to provide information that they may have missed or that they requested during the previous survey day. You may also present surveyors with information related to corrective actions being implemented for any issues of non-compliance. Surveyor(s) will still record the observations and findings but will include a statement that corrective actions were implemented by the practice during the onsite survey.

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

Competence Assessment and Credentialing & Privileging

Participants
Suggested participants include staff responsible for the human resources processes; orientation and education of staff; assessing staff competency; assessing physician and other licensed practitioner competency.

Duration
The suggested duration for this session is 30-45 minutes, with more time added as needed to complete required evaluation activities.

Overview
During this session, the surveyor will:

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

Inform the surveyor of your process for maintaining competency records. The review of files is not the primary focus of this session; however, the surveyor verifies process-related information through documentation in staff or credential files. The surveyor identifies specific staff, physicians, or other licensed practitioners whose files they would like to review.

The surveyor discusses the following topics:

- Internal processes for determining compliance with policies and procedures, applicable law and regulation, and Joint Commission standards.
- Orientation of staff, physicians, and other licensed practitioners to your practice, and/or job responsibilities.
- Competency assessment, maintenance, and improvement.
- Competency assessment process for contracted staff, as applicable.
- Process for granting of privileges to physicians and other licensed practitioners.
- Other topics and issues discovered during the tracer activity.

Environment of Care and Emergency Management Session

Participants

Suggested participants include leaders and other individuals familiar with the management of the environment of care (EC) and emergency management (EM) within your practice. This may include the safety officer, security management coordinator, facility manager, building utility systems manager, IT representative, and the person responsible for emergency management.

Logistics

In preparation for the EC discussion, the surveyor will evaluate written documentation of the following:

- Preventive maintenance of essential mechanical, electrical, and patient care equipment following manufacturer's recommendations
- Annual evaluation of the EC management plans (as required by the services provided)
- Performance of fire drills and fire response activity
- Safety data analysis and actions taken by the practice
- EC multidisciplinary team meeting minutes for the previous 12 months

In preparation for the EM discussion, the surveyor will evaluate written documentation of the following and make certain that the documents have been updated and reviewed at least every two years:

- Hazard vulnerability analysis
- Emergency operation plan and policies and procedures
- Communications plan
- Education and training
- Testing (exercises/drills)
- Program evaluation (after-action/improvement plans)

Objective

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

Overview

The duration of this session is **45 minutes** depending on the type of practice, services provided and facilities, and will consist of two parts: Environment of care and emergency management discussion and an environment of care tracer, as needed.

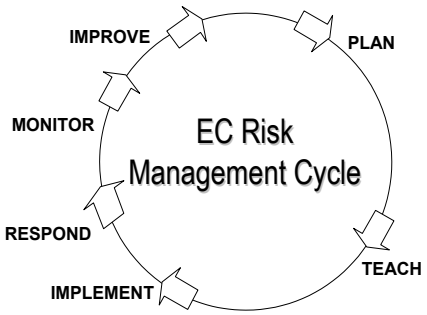
During the first part of the session, there is a group discussion that takes approximately 70% of this session. The surveyor will discuss with practice representatives the environment of care, including high-risk areas such as life sustaining medical equipment and fire prevention activities relevant to the services and care setting..

The surveyor will also discuss the practice's recent emergency management activities that have occurred in the past 12–36 months. The EM discussion is broken into four distinct discussion topics as described

below and the practice staff should be prepared to discuss the application and use of the emergency operations plan and policies and procedures during an emergency (real or simulated).

In the remaining time (approximately 30%) is spent as the surveyor observes and evaluates your practice's performance in managing a particular risk or management process in the environment of care. The management process or risk selected for observation is based on the environment of care documents reviewed, and observations and discussions that take place during tracer activity.

Environment of care discussion – Be prepared to discuss how the various environment of care risk categories,[1] and construction activities, when applicable, are addressed in each of the following six management processes.



Plan

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

Teach

- How has your practice communicated roles and responsibilities for staff and volunteers, if applicable.

Implement

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

Respond

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

Monitor

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

Improve

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

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

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

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

Emergency management discussion

During this portion of the discussion, the practice should be prepared to discuss the following.

Part 1: "Actual" emergencies or disaster incidents

The practice describes what "actual" events impacted them and how they utilized their risk assessment, emergency operations plan, policies, and procedures to prepare for these events.

Be prepared to discuss:

- Recent emergencies or disaster incidents that have occurred in the past 12-36 months in which the emergency operations plan was activated.
- What services you were you able to provide during the event(s) (as applicable)
- How the recent events were identified, and risk prioritized as part of the risk assessment (hazard vulnerability analysis)
- The communication methods that were used to notify staff, patient, and others about the event(s)
- How staffing was managed to meet patient care needs and if any additional staffing (such as volunteers, etc.) was used/needed during the recent event(s) (as applicable)

Part 2: Emergency exercises

As part of planning and preparedness, the practice describes what emergency exercises they recently conducted as they should be based on past experiences, known risks/hazards, recent changes to their emergency operations plan, policies, or procedures. These exercises should be comprehensive enough to gain a realistic understanding of the practice's readiness for a real emergency or disaster incident.

Be prepared to:

Describe the one (1) required annual exercise conducted.

- Did the practice conduct at least one emergency management exercise?

  Note: The annual exercise may be either an operations-based (full-scale or functional) or a discussion-based exercise (such as a mock drill, tabletop, seminar, or workshop)
- Why was the exercise selected?
- Provide documentation of the exercise conducted.

Part 3: Education and training

The practice describes what education and training they provided to their staff in the past 12–36 months.

Be prepared to discuss:

- The education and training that was provided to staff (new and existing)
- The validation used to assess staff knowledge of emergency response procedures

Part 4: Evaluation, after-action and improvement plans, and review

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

Be prepared to discuss:

- As a result of recent events and/or exercises, were any gaps identified in the emergency operations plan or policies or procedures?
- What lessons were learned? What was identified as opportunities for improvement based on recent events and/or exercises? How were they incorporated into revised plans, policies, and procedures?

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

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

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

The surveyor observes and evaluates your practice's performance in managing the selected environment of care risk. He or she observes implementation of those particular management processes determined to be potentially vulnerable or trace a particular risk(s) in one or more of the environment of care risk categories your practice manages. The surveyor

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

If the risk can be encountered at different locations within your practice environment (e.g., a hazardous material or waste), the surveyor will evaluate it in these locations.

Data Management Session

Participants
Suggested participants include the staff member(s) responsible for the quality monitoring and performance improvement work of the practice, practice leaders**.**

Duration
The suggested duration for this activity is 30-45 minutes, with more time added as needed to complete required evaluation activities.

Overview
During this session, the surveyor will learn about how your practice uses data to evaluate the safety and quality of care being provided to patients. They will also assess your practice's performance improvement processes including the management and use of data.

The surveyor will review your practice's data and performance improvement projects during planning activity, if possible, in preparation for discussing the following topics:

- How your practice identifies and prioritizes measurement and performance improvement projects
- How you make sure that all data is collected as planned, and that it is accurate and reliable
- How data is aggregated, analyzed, and turned into useful information
- How data is used on an ongoing basis and how it is used in periodic performance monitoring and project-based activities
- Any improvement methodology or tools being used in performance improvement initiatives

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

- Infection prevention and control –Monitoring staff adherence to hand hygiene.
- Medication management – process for reporting errors, system breakdowns, near misses, monitoring overrides of automated dispensing systems.
- As applicable to the practice's services: Pain assessment, pain management and safe opioid use.
- National Patient Safety Goal data
- Performance monitoring of contracted (patient care) services, if applicable
- Other federal or state required reports
- Incident/error reporting

Surveyor Report Preparation

Participants
Surveyor

Duration
The suggested duration of this session is approximately 60-90 minutes. The surveyor needs a space that includes a desk or table, power outlet, and internet access.

Overview
During this time, the surveyor will compile, analyze, and organize the data collected during the survey. The surveyor will use this information to develop a Summary of Survey Findings Report that includes your practice's Requirements for Improvement (RFI). This report will summarize your practice's compliance with the standards. The surveyor(s) will provide you with the opportunity to present additional information at the beginning of this session if there are any outstanding surveyor(s) requests or further evidence to present from the last day of survey activity. The surveyor may also ask practice representatives for additional information during this session.

CEO Exit Briefing

Please note this session may not occur if the CEO/Administrator prefers to deliver the Summary of Survey Findings Report privately to their practice.

Participants
Suggested participants include the Chief Executive Officer (CEO) and/or practice administrator, if available.

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

Overview
During this session, the surveyor(s) will:

- Review the Summary of Survey Findings Report with the practice leaders.
- Discuss any patterns or trends in performance revealed.
- Determine if the practice leaders want to have an Organization Exit Conference or prefer to deliver the Summary of Survey Findings Report privately to their staff.

Organization Exit Conference

Please note this session may not occur if the CEO/Administrator prefers to deliver the Summary of Survey Findings report privately to the practice.

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

Duration
The suggested duration of this session is approximately 30 minutes. This session immediately follows the CEO Exit Briefing.

Overview
A Summary of Survey Findings Report will be sent to your *Joint Commission Connect* extranet site. You should print copies for all exit conference participants, if desired.

During this session, the surveyor 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. The surveyor will provide information about the clarification process.

Post-survey follow-up may be required in the form of an Evidence of Standard Compliance (ESC). The surveyor will explain the ESC submission process.

After Your Joint Commission Survey

Your on-site survey is an important part of the accreditation decision-making process. During the on-site survey, your survey team uses the tracer methodology and other survey techniques to identify and document areas of noncompliance with Joint Commission standards. The summary of survey findings report provided to you at the conclusion of your on-site survey is confidential and does not contain an accreditation decision. Your final accreditation decision is not reached until the conclusion of the post-survey activities described in this document.

Post-Survey Activities

- Before the exit conference, the surveyor will post a preliminary summary of survey findings report. This preliminary report will appear under the "Notification of Scheduled Events" section of your *Joint Commission Connect* extranet site. Your practice will have access and can print copies in preparation for the exit conference.
  Note: The "Notification of Scheduled Events" section has a time restriction and the preliminary report will only remain available until midnight of the day the survey has been completed.

- At the exit conference, the surveyor will review the preliminary findings identified during the survey. The surveyor does not recommend and is not able to predict your practice's accreditation decision. The accreditation decision is not made until all of your practice's post-survey activities are completed.

- Your practice's summary of survey findings report may require further review by staff at Joint Commission's Central Office.
  - Reports that meet a decision rule that automatically trigger a Preliminary Denial of Accreditation or Accreditation with Follow-up Survey decision are always stopped for further review.
  - Reports may be reviewed by the Standards Interpretation Group if there is a unique issue, such as possible noncompliance with an Accreditation Participation Requirement, or an unusual question or circumstance that could not be resolved during the survey.

- Based on the review, staff may recommend a decision of Accreditation with Follow-up Survey or Preliminary Denial of Accreditation. Senior leadership in the Division of Accreditation and Certification Operations must review and approve the recommendation. Your practice will be provided detailed instructions outlining next steps in the accreditation process.

- Following the completion of the review, your practice's final summary of survey findings report will be posted under the "Official Documents" or the "Survey Process" tab under "Accreditation Report and Letter" on your organization's *Joint Commission Connect* extranet site. Your practice will receive an automated e-mail once this report is available.

- The summary of survey findings report will indicate which findings require an Evidence of Standards Compliance (ESC) submission within 60 days. The ESC form will be available under the Survey Process TAB in the "Post-Survey" section of your organization's *Joint Commission Connect* extranet site. Please refer to the ESC Instructions document when completing the ESC reports. The ESC Instructions are accessible by clicking on the Evidence of Standards Compliance link.

- Upon the approval of your practice's ESC, your accreditation decision is posted to your *Joint Commission Connect* extranet site and your practice will appear as an accredited organization when searched for on Joint Commission's website). *Note: Your practice's CEO and primary accreditation contact will receive an automated email notification.*

Resources

- The *Joint Commission Connect* extranet site can be accessed using a login and password (www.jointcommission.org). Please refer to the following information under the "Post-Survey" section:

- Evidence of Standards Compliance
- Publicity Kit
- Evaluations
- Certificates

➢ Your Account Executive is available to assist you with any questions that you may have about the post-survey process.

SAMPLE SURVEY AGENDA

Office Based Surgery
One Surveyor, One Day

Time	Activity
8:00 – 8:30 a.m.	Surveyor Arrival and Preliminary Planning Session
8:30 – 9:00 a.m.	Opening Conference and Orientation to Organization
9:00 – 9:30 a.m.	
9:30 – 10:00 a.m.	Individual Tracer Activity
10:00 – 10:30 a.m.	
10:30 – 11:00 a.m.	
11:00 – 11:30 a.m.	
11:30 – 11:45 p.m.	
11:45 – 12:00 p.m.	Competence Assessment and Credentialing/Privileging
12:00 – 12:30 p.m.	
12:30 – 1:00 p.m.	Surveyor Lunch
1:00 – 1:30 p.m.	Environment of Care and Emergency Management Session
1:30 – 1:45 p.m.	
1:45 – 2:00 pm.	Data Management Session
2:00 – 2:30 p.m.	
2:30 – 3:00 p.m.	Surveyor Report Preparation
3:00 – 3:30 p.m.	
3:30 – 4:00 p.m.	
4:00 – 4:30 p.m.	CEO Exit Briefing and Organization Exit Conference

OTHER SURVEY TOOLS & INFORMATION

Imaging Document Review Guide for Healthcare Organizations

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

1. Facilities and Equipment:

    - Fluoroscopy annual equipment performance evaluation: EC.02.04.03, EP 34
      Must be documented, done by a medical physicist, and include:
        - Beam alignment and collimation
        - Tube potential/ kilovolt peak (kV /kVp accuracy)
        - Beam filtration (half value layer)
        - High contrast resolution
        - Low contrast detectability
        - Maximum exposure rate in all imaging modes
        - Displayed air-kerma rate and cumulative air-kerma accuracy (when applicable)

    - Lead Apron Assessment: EC.02.04.01, EP 4 and EC.02.04.03, EP 3
        - Inventory and inspection for cracks, tears, integrity

2. Radiation Protection and Radiopharmaceutical Management
   Radiation Protection and Radiopharmaceutical Management
        - Documentation of dosimetry monitoring at least quarterly by the radiation safety officer or physicist: EC.02.02.01, EP 17

3. Leadership
    - Documentation / Radiation Safety Officer: must be designated. LD.04.01.05, EP 25

4. Medical Records:
    - Reports, including medical record number, documenting radiopharmaceutical dose received for recent patients. RC.02.01.01, EP 2
    - Reports, including medical record number, documenting contrast dose and radiation dose for recent patients. RC.02.01.01, EP 2
    - Reports, including medical record number, documenting fluoroscopy radiation dose for recent patients. PC.01.02.15, EP 13

Infection Prevention and Control Program Assessment Tool for the Office Based Surgery Program

Note 1: This tool is based on *Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings* and *Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care* guidance from the Centers for Disease Control and Prevention (CDC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC).

Note 2. *For practices that perform high-level disinfection and sterilization procedures onsite:* See Section 2 below.

Required Documents

- Assessment of infection risks
  Note: Performed at least annually, the format is determined by the practice.
- Infection prevention and control policies and procedures that guide program activities and methods (in electronic or paper form)
- Action plan(s) for any identified infection control issues

Section 1

Table 1: Elements of Compliance and Scoring Guidance

Elements of Compliance	Standard(s)/EP(s)
Infection Prevention and Control Program	
1. The practice's infection prevention and control program is under the direction of a designated and qualified professional) who has training in infection control. Note: If the practice is part of a system that has a unified infection prevention and control program, the designated infection control professional at the system level may be responsible for the practice's program. The unified infection prevention and control program takes into account the unique circumstances and any significant differences in patient populations and services offered at each practice. Examples of education and training may include in-person or online courses or training from recognized entities (state public health, CDC), professional associations and societies (for example, ADA, AAMI, AORN, APIC, SHEA, IDSA, etc.), or colleges and universities.	IC.04.01.01 EP 1
2. The practice's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing, controlling, and investigating infections and communicable diseases. The policies and procedures are in accordance with applicable law and regulation, nationally recognized evidence-based guidelines, and standards of practice, including the use of standard precautions. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Food and Drug Administration (FDA) regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: Standard precautions include hand hygiene, environmental cleaning and disinfection, injection and medication safety, use of personal protective equipment (PPE), minimizing potential exposures, and reprocessing of reusable medical equipment or devices. For full details on standard precautions, refer to the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html.	IC.04.01.01 EP 3

3. ***For practices that perform high-level disinfection and sterilization procedures <u>onsite</u>***	**See Section 2**
4. ***For practices that use <u>offsite</u> high-level disinfection and sterilization services:*** The practice defines procedures in accordance with the manufacturers' instructions for initial equipment reprocessing, for example, pre-cleaning at the point of use and transporting of items, that occur before equipment is transferred to the offsite facility for high-level disinfection and sterilization.	IC.04.01.01 EP 10
5. To prioritize the infection prevention and control program's activities and determine what resources are necessary for the program, the practice identifies risks for infection, contamination, and exposure that pose a risk to patients and staff based on the following: a. Its population served b. Care, treatment, and services it provides c. Relevant infection control issues identified by the local, state, or federal public health authorities that could impact the practice Note: Risks may include organisms with a propensity for transmission within health care facilities based on published reports (for example, norovirus, respiratory syncytial virus [RSV], influenza, COVID-19).	IC.06.01.01 EP 1
6. The practice reviews identified risks at least annually or whenever significant changes in risk occur (for example, in response to local infectious diseases outbreaks).	IC.06.01.01 EP 2
7. The practice develops and implements action plans when infection control issues arise, including nonadherence with infection control policies and procedures. Note: The practice evaluates and revises its action plan as needed. (See also LD.03.07.01 EP 2; PI.01.01.01 EP 2; PI.03.01.01 EPs 4,8)	IC.06.01.01 EP 6
8. The practice provides job-specific infection prevention and control education to staff. Note: Job-specific means that education and training are consistent with or tailored to the performed roles and responsibilities. For example, environmental services staff must be trained in the methods and procedures for surface disinfection.	HR.01.05.03 EP 1
9. The practice provides training to staff expected to have contact with blood or other potentially infectious material on the blood borne pathogen standards upon hire, at regular intervals, and as needed.	HR.01.04.01 EP 1 HR.01.05.03 EP 1
10. The practice staff receive training in the following: a. When personal protective equipment (PPE) is necessary b. What PPE is necessary c. How to properly don, doff, adjust, and wear PPE	HR.01.04.01 EP 1 HR.01.05.03 EP 1
11. Staff competence in infection control is assessed and documented once every three years, or more frequently as required by practice policy or in accordance with law and regulation. Note: Competence refers to observable and measurable knowledge, skills, and abilities. Practices have the flexibility to define what staff competencies are needed to ensure correct practical application of practice infection prevention and control policies and procedures.	HR.01.06.01 EP 6
Standard Precautions: Hand Hygiene	
1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines.	NPSG.07.01.01 EP 1
2. Set goals for improving compliance with hand hygiene guidelines.	NPSG.07.01.01 EP 2

3. Improve compliance with hand hygiene guidelines based on established goals.	NPSG.07.01.01 EP 3
4. Supplies necessary for adherence to hand hygiene (such as alcohol-based hand rub, soap, water, and a sink) are readily accessible in all areas where patient care is being delivered.	IC.06.01.01 EP 3
5. Alcohol-based hand rub is readily accessible and placed in appropriate locations where it can be accessed by the staff, patients, and visitors. The locations may include the following: a. Entrances to patient rooms or care areas b. At the bedside c. Staff workstations	IC.06.01.01 EP 3
6. Staff use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (for example, placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal	IC.06.01.01 EP 3
7. Staff perform hand hygiene using soap and water when hands are visibly soiled (for example, blood, body fluids) or after caring for a patient with known or suspected *C. difficile* or norovirus during an outbreak. Note: In all other situations, alcohol-based hand rub is preferred.	IC.06.01.01 EP 3
Standard Precautions: Environmental Cleaning and Disinfection	
1. The practice has written policies and procedures for routine and targeted cleaning and disinfection of environmental surfaces, including identification of responsible staff.	IC.04.01.01 EP 3
2. The practice implements routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling, including the following: a. Surfaces in the patient care environment and areas are cleaned and disinfected on a regular basis, using an EPA-registered disinfectant. b. Spills of blood or other potentially infectious materials are promptly cleaned and decontaminated, using appropriate EPA-registered disinfectants.	IC.06.01.01 EP 3
3. Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturers' instructions (for example, dilution, storage, shelf-life, contact time).	IC.06.01.01 EP 3
Standard Precautions: Injection and Sharps Safety	
1. Injections are prepared using aseptic technique in an area that has been cleaned and separated from potential sources of contamination (for example, visible blood, body fluids, sinks or other water sources).	IC.06.01.01 EP 3
2. Single-dose or single-use vials, ampules, bags or bottles of parenteral solution, fluid infusion or administration sets (for example, intravenous tubing) are used for one patient only.	IC.06.01.01 EP 3
3. Diaphragms of medication vials are disinfected before inserting a device into the vial.	IC.06.01.01 EP 3

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

1. Practice: a. Posts signs at entrances with instructions to patients with symptoms of respiratory infection to: i. Inform staff or a healthcare provider of symptoms of a respiratory infection when they first register for care, and ii. Practice Respiratory Hygiene/Cough Etiquette (cover their mouths/noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been covered with respiratory secretions).	IC.06.01.01 EP 3
b. Provides tissues and no-touch receptacles for disposal of tissues. c. Provides resources for performing hand hygiene in or near waiting areas.	
Standard Precautions: Reprocessing of Non-Critical Reusable Medical Equipment **Note: For reprocessing of critical and semi-critical equipment, see Section 3.**	
1. Reusable non-critical medical equipment (for example, blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes) are cleaned and disinfected according to manufacturers' instructions after each use or when visibly soiled.	IC.06.01.01 EP 3
2. Responsibility for cleaning and disinfection of reusable noncritical patient-care equipment and devices is clearly designated.	IC.06.01.01 EP 3
Linen	
1. Staff handle, store, process, and transport linens in accordance with local or state regulations.	IC.06.01.01 EP 8
2. Soiled textiles/laundry are handled with minimum agitation to avoid contamination of air, surfaces, and persons.	IC.06.01.01 EP 8
3. Clean textiles/linens are covered if stored in a clean area or may be uncovered if stored in a dedicated clean storage area.	IC.06.01.01 EP 8
Operating Room	
1. The practice adheres to infection control practices for surgical infection prevention including: a. Adherence to preoperative surgical scrub and hand hygiene b. Appropriate use of surgical attire and drapes c. Adherence to aseptic technique and sterile field d. Minimization of traffic in the operating room e. Adherence to cleaning and disinfection of environmental surfaces f. Terminal cleaning of operating rooms after last procedure of the day	IC.06.01.01 EP 3
2. The practice follows proper ventilation requirements in surgical suites.	EC.02.05.01 EP 7

Section 2: For Practices that Perform High-Level Disinfection and Sterilization Procedures Onsite

Categories of Medical Devices:

• **Critical items** (e.g., surgical instruments) are objects that enter sterile tissue or the vascular system and must be sterile prior to use (see Sterilization Section).

• **Semi-critical items** (e.g., endoscopes for upper endoscopy and colonoscopy, vaginal probes) are objects that contact mucous membranes or non-intact skin and require, at

a minimum, high-level disinfection prior to reuse (see High-level Disinfection Section).

• **Non-critical items** (e.g., blood pressure cuffs) are objects that may come in contact with intact skin but not mucous membranes and should undergo cleaning and low- or intermediate-level disinfection depending on the nature and degree of contamination.

• **Single-use devices (SUDs)** are labeled by the manufacturer for a single use and do not have reprocessing instructions. They may not be reprocessed for reuse except by entities which have complied with FDA regulatory requirements and have received FDA clearance to reprocess specific SUDs.

Table 2. Reprocessing of Critical and Semi-Critical Reusable Medical Devices

Elements of Compliance	Standard(s)/EP(s)
1. Only devices labeled as reusable are reprocessed directly by the practice onsite or offsite via a reprocessing vendor. If the practice elects to reuse any devices labeled for single use by the manufacturer, these devices are reprocessed by an entity that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The practice has documentation from the third-party reprocessor confirming this is the case.	IC.06.01.01 EP 3
2. For practices that perform high-level disinfection and sterilization procedures onsite: The practice's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: a. Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions Note: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate disinfection, and low-level disinfection) to be used for the three classes of devices. b. 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 the FDA–cleared label and device manufacturers' instructions c. 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 d. Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment e. Criteria and the process for the use of immediate-use steam sterilization f. 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: 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.	IC.04.01.01 EP 4
3. Manufacturers' instructions for medical devices and equipment are available to the staff performing reprocessing. The practice may use posters or other condensed methods to provide critical information to staff performing reprocessing to ensure reprocessing consistent with the instructions for use.	IC.06.01.01 EP 3
High-level Disinfection:	
1. All reusable semi-critical items receive at least high-level disinfection prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
2. Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
3. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to high- level disinfection. For instruments with lumens (for example, endoscopes), pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3

4. Manufacturers' instructions are followed for the following: a. Enzymatic cleaners or detergents b. Reusable cleaning brushes c. Chemicals used in high-level disinfection, including instructions for preparation, testing for appropriate concentration, and replacement (for example, prior to expiration) Note: The results of testing for appropriate concentration are documented to ensure minimal effective concentration of the active ingredient. d. Disinfection temperatures and length of time e. Device rinsing following high-level disinfection f. If automated reprocessing equipment is used, manufacturers' recommended connectors are used to assure that all endoscope channels are appropriately disinfected.	IC.06.01.01 EP 3
5. Devices are dried thoroughly prior to storage/reuse in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
6. After high-level disinfection, devices are stored in a manner that protects them from damage or contamination.	IC.06.01.01 EP 3
7. The practice has a system in place to identify which endoscope was used on a patient for each procedure.	IC.06.01.01 EP 3
Sterilization:	
8. All reusable critical items are sterilized prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
9. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to sterilization. Note: For instruments with lumens, pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3
10. Enzymatic cleaner or detergent is used and discarded according to manufacturers' instructions.	IC.06.01.01 EP 3
11. Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturers' instructions) at least daily.	IC.06.01.01 EP 3
12. After pre-cleaning, items are appropriately wrapped-packaged for sterilization (for example, the package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).	IC.06.01.01 EP 3
13. The sterilization process is monitored by using a combination of mechanical, chemical, and biological indicators to ensure the effectiveness of the sterilization process. Indicators are used in accordance with the sterilizer or sterilizer accessory (pouch, casket, tray, etc.) manufacturers' instructions.	IC.06.01.01 EP 3
14. For dynamic air removal–type sterilizers (for example, prevacuum steam sterilizers), an air removal test (Bowie-Dick test) is performed each day the sterilizer is used to verify efficacy of air removal in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
15. Sterile packs are labeled with the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date.	IC.06.01.01 EP 3
16. Logs for each sterilizer cycle are current and include results from each load, in accordance with practice policies and procedures. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4	IC.06.01.01 EP 3
17. After sterilization, medical devices and instruments are stored so that sterility is not compromised.	IC.06.01.01 EP 3
18. Sterile packages are inspected for integrity and compromised packages are repackaged and reprocessed prior to use.	IC.06.01.01 EP 3

19. If immediate-use* steam sterilization (IUSS) is performed, all of the following criteria are met: a. Work practices ensure proper cleaning and decontamination, inspection, and arrangement of the instruments into the recommended sterilizing trays or other containment devices before sterilization. b. Once clean, the item is placed within a container intended for immediate use. c. The sterilizer cycle and parameters used are selected according to the manufacturers' instructions for use for the device, container, and sterilizer. d. The sterilizer function is monitored with mechanical monitors and chemical and biologic indicators that are validated for use with the sterilization cycle and in accordance with the device and sterilizer manufacturers' instructions. e. The processed item must be transferred immediately*, using aseptic technique, from the sterilizer to the actual point of use, the sterile field in an ongoing surgical procedure. *"Immediate use" is defined as the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic transfer to the sterile field. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another.	IC.06.01.01 EP 3
20. Immediate-use steam sterilization is not performed on the following devices: a. Implants (except in documented emergency situations when no other option is available) Note: If IUSS must be used for an implantable device, the name of the patient/patient's unique identifier and any other information needed to accurately link the instrument processed using IUSS back to the patient must be recorded. b. Post-procedure decontamination of instruments used on patients who may have Creutzfeldt-Jakob disease or similar disorders c. Devices that have not been validated with the specific cycle employed d. Single-use devices that are sold sterile	IC.06.01.01 EP 3
21. Staff follow practice policies and procedures in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use. Note: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4.	IC.06.01.01 EP 3