The Joint Commission

Critical Access Hospital Accreditation

Organization Survey Activity Guide

2025

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What’s New for Critical Access Hospital Survey Process 2025

New or revised content for 2025 is identified by underlined text within the noted activities.

Changes effective July 1, 2025

No change for July 1, 2025

Critical Access Hospital
Organization Survey Activity Guide (SAG)

Contents

How to Use this Guide

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

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

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

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

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

For organizations being surveyed under more than one accreditation manual or for more than one service under one accreditation manual, you will receive an activity list and agenda template for each of the programs being surveyed (e.g., hospital, home care, nursing care center). Include an organization contact name and phone number for each program, as well as names or positions and phone numbers of activity participants from all the programs on these activity lists.

For multiple services being surveyed under a single accreditation program, be sure to include contact names and phone numbers from all your organization's services, for example, hospital, outpatient services, behavioral health.

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

Preparing for Surveyor Arrival

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

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

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

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

- Greeting surveyors: Identify the staff usually at the main entrance of your organization. Tell them about The Joint Commission and educate them about what to do upon the arrival of surveyors. Explain the importance of verifying any surveyor's identity by viewing their Joint Commission identification badge. This badge is a picture ID.
- Persons to notify upon surveyor arrival: Identify leaders and staff who must be notified when surveyors arrive. Create a list of names, phone numbers, or cell phone numbers. Also, include the individual who will be the surveyor's "contact person" during the survey. Identify alternate individuals if leaders and staff are unavailable.
- A location for surveyors: Ask surveyors to wait in the lobby until an organization contact person is available. Surveyors will need a location that they will call their "base" throughout the survey. This location should have a desk or table, electrical outlet, phone access**, and internet access**.
- Validation of survey: Identify who will be responsible for the validation of the survey and the identity of surveyors. Identify the steps to be taken for this process. (See Surveyor Arrival activity description for these steps.)
- Readiness Guide and Accreditation Program-specific Document List: The Guide is created for you to use as a planning tool and can be included with your survey plan. Your organization should be prepared to have the requested documents available for review by surveyors as

soon as your organization validates their identity. **If this information is not immediately available for surveyors at the Surveyor Preliminary Planning Session, they will begin the survey with an individual tracer.**

- Identifying who will provide the Safety Briefing for the surveyors
  - The purpose of the Safety Briefing is for your organization to inform surveyors about any current safety or security concerns and how Joint Commission staff should respond if your safety plans are implemented while they are on site.
  - **The briefing is informal, five minutes or less**, and should take place once the surveyors are settled in the "base" location reserved for their use throughout the survey.
  - Situations that should be covered include fire, smoke or other emergencies; workplace violence events (including active shooter scenarios); any contemporary issues the surveyors may experience during the time they are with you (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)
- Identifying who will serve as escorts for the surveyors.
- Identifying who will assist the surveyors with review of electronic records of care, if applicable to your organization; surveyors may ask to print some components of the record to facilitate tracer activity and subsequent record review.
- Identifying your organization's expectations for the on-site survey and who will share these with the survey team.

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

Readiness Guide

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

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

Survey Planning and Readiness Notes:

1. Please review the Critical Access Hospital Survey Activity List to assist you in preparing for your survey. The list includes the potential survey activities that can occur on an accreditation survey, including the suggested duration, and suggested timing for these activities. This information will allow your organization to begin identifying participants that need to be involved in the survey. The activity list includes a column for your organization to use for recording participant names, possible meeting locations, times that could conflict with participant availability, or any other notes.
2. Make available as many of the materials noted on the Critical Access Hospital Documentation Request List as possible for the Surveyor Arrival and Preliminary Planning Session.
3. Work with your surveyor(s) to confirm the best day and time for specific survey activities to take place.

Contact your Account Executive with any questions related to this information

Critical Access Hospital Accreditation Program
Requested Documentation List

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

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

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

1. Hospital license
2. CLIA Certificates
3. Organization chart
4. Name of key contact person who can assist surveyors in planning tracer selection
5. A map of the organization, if available
6. List of all sites that are eligible for survey
7. List of sites where deep or moderate sedation is in use
8. List of sites where high-level disinfection and sterilization is in use
9. List of departments/units/ areas/programs/services within the organization, if applicable
10. List of patients that includes: Name, location, age, diagnosis, and length of stay, admit date, source of admission (ED, direct admit, transfer)
11. Lists of scheduled surgeries and special procedures, for example, cardiac catheterization, endoscopy lab, electroconvulsive therapy, caesarian sections, including location of procedure and time
12. List of unapproved abbreviations
13. List of all contracted services
14. Agreement with outside blood supplier *(Applicable to Critical Access Hospitals ONLY if they operate Rehabilitation and Psychiatric Distinct Part Units)*
15. Organ Procurement Organization agreement
16. Tissue and Eye Procurement Organization agreement
17. Organ, tissue, and eye procurement policies
18. Performance improvement data from the past 12 months
19. Documentation of performance improvement projects being conducted, including the reasons for conducting the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes)
20. Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (including reasons for conducting the projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping
21. Analysis from a high-risk process
22. Environment of Care data (see Critical Access Hospital Life Safety & Environment of Care Document List and Review Tool)
23. Environment of Care Management Plans and annual evaluations
24. Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey

Critical Access Hospital Requested Documentation List …continued

25. 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
    d. Communications plan
    e. Continuity of operations & recovery plan
    f. Education and training program
    g. Exercises and testing program
    h. Emergency management program evaluation (after-action/improvement plans)
    i. Unified and integrated Emergency management program, plans, policies & procedures (if applicable)
    j. Transplant program-specific protocols (if applicable)

26. Annual infection risk assessment (i.e., identified risks for infection, contamination, and exposure that pose a risk to patients and staff)
27. Infection Control surveillance data from the past 12 months
28. Medical Staff Bylaws and Rules and Regulations (**Please Note:** If your organization has had any changes or updates to your Medical Staff Bylaws and/or Medical Staff Rules and Regulations since your last full triennial survey, please have those sections flagged for your survey team to review.)
29. Medical Executive Committee meeting minutes
30. The organization's signed and dated agreement with the QIO; in the absence of an agreement with a QIO, the organization's Utilization Review plan *(Applicable to Critical Access Hospitals ONLY if they operate Rehabilitation and Psychiatric Distinct Part Units)*
31. Governing Body minutes for the last 12 months
32. Autopsy policy *(Applicable to Critical Access Hospitals ONLY if they operate Rehabilitation and Psychiatric Distinct Part Units)*
33. Blood transfusion policy
34. Complaint/grievance policy
35. Restraint and seclusion policy
36. Waived testing policy and quality control plan
37. ORYX data – an organization should be prepared to share ORYX Performance Measurement data and/or Accelerate PI Dashboard reports.
38. Available regulatory reports (CMS, State)
39. Medication management policy *(which defines what is a complete medication order and therapeutic duplication)*
40. Abuse and neglect policy for inpatient, and ambulatory sites, if applicable
41. Fall risk assessment and policy
42. Document describing how the organization is using the CDC's Core Elements of Hospital Antibiotic Stewardship Programs
43. Organization approved antibiotic stewardship protocols (for example, policies, procedures, or order sets)
44. Antibiotic stewardship data
45. Antibiotic stewardship program reports to leadership and prescribers
46. Most recent culture of safety and quality evaluation data

Critical Access Hospital Requested Documentation List …continued

47. Environmental risk assessment identifying features in the physical environment that could be used to attempt suicide *(Applies to Critical Access Hospitals ONLY if they operate Psychiatric Distinct Part Units)*

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

Critical Access Hospital Accreditation Survey Activity List

Survey Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Organization Participants (Refer to Survey Activity Guide for more info.)
Surveyor Arrival and Preliminary Planning (includes the Safety Briefing)	30-60 minutes	1st day, upon arrival	
Opening Conference and Orientation to the Organization	30-60 minutes	1st day, as early as possible	
Individual Tracer	60-120 minutes	Individual Tracer activity occurs each day throughout the survey; the number of individuals that surveyors trace varies by organization. If travel is required to perform tracer activity (e.g., to an outpatient setting), it will be planned into this time.	
Lunch	30 minutes	At a time negotiated with the organization	
Issue Resolution **OR** Surveyor Planning / Team Meeting	30 minutes	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	30-45 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary	
Competence Assessment	30-60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Medical Staff Credentialing & Privileging	60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Emergency Management	60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Organization Quality and Performance Improvement Session	60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization.	
Leadership	60 minutes	Towards the middle or end of survey at a time negotiated with the organization	
Report Preparation	60-120 minutes	Last day of survey	
CEO Exit Briefing	15-30 minutes	Last day of survey	
Organization Exit Conference	30-45 minutes	Last day, final activity of survey	
Note: The following activities may be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.			
Interim Exit – w/ early departing surveyors & Org.	30 minutes	At the end of any day another program surveyor or Life Safety Code surveyor is departing from the survey in advance of the team	
Life Safety Code® Survey Activity			
Life Safety Code Surveyor Arrival and Preliminary Planning Session	15 minutes	LSCS survey 1st day, early	
Facility Orientation and Document Review	60 minutes 120-150 minutes	At a time negotiated with the organization	

Survey Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Organization Participants (Refer to Survey Activity Guide for more info.)
Life Safety Code® Building Assessment	2 - 5 hours per day	At a time negotiated with the organization	
Lunch	30 minutes	At a time negotiated with the organization	
Emergency Management	60 minutes	At a time negotiated with the organization. May be conducted with a Clinical surveyor.	
Report Preparation	60 minutes	Towards the end of last day of survey	
Interim Exit	30 minutes	Last activity on last day of survey	

Surveyor Arrival

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

Logistical Needs

- Identify a location where surveyors can wait for organization staff.
- Identify a location where surveyors can consider as their “base” or work-area throughout the survey.

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

Surveyor Arrival Activities

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

Surveyor Preliminary Planning Session

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

Logistical Needs

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

Surveyors need:

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

Objectives
Surveyors will:

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

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

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

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

Opening Conference

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

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

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

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

Overview
Surveyors introduce themselves and describe each component of the survey agenda. It is important for you to discuss and review your organization's expectations for the on-site survey with the surveyor(s). Questions about the on-site visit, schedule of activities, availability of documents or people and any other related topics should be raised at this time. Surveyors will also take time to review any updates to the accreditation process that may have been implemented since the organizations last full survey event.

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

Orientation to the Organization

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

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

Consider including the following individuals

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

Logistical Needs

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

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

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

Governance and operations-related topics for discussion include:

- Organization's mission, vision, goals, and strategic initiatives
- Organization structure
- Operational management structure
- Planning, resource allocation, and decision-making processes
- Information management, especially the format and maintenance of medical records
- Contracted services and performance monitoring, including telemedicine, telehealth services
- Health care errors reduction and patient safety initiatives
    - Processes in place for reporting "close calls" or "near misses"
    - Frequency with which this process is being used, analysis of data, including root cause analyses
- National Patient Safety Goal on suicide risk reduction (NPSG.15.01.01), including environmental risk assessments and mitigation plans
- The organization's patient population, including characteristics such as race, ethnicity, and language/communication needs

- Community involvement initiatives
- Leaders' roles and scope of responsibility in emergency management planning
- Utilization review process--if there is no agreement with a QIO (deemed hospitals only)
- Organization activities related to risk awareness, detection, and response as it relates to cyber emergencies
- Assessment of the organization's culture and attention to safety, including
    - Instrument being used
    - Scope of assessment
    - Response rate
    - Assessment results
    - Actions to improve results
- Organization's code of conduct and behavior for physicians and staff
- Infection prevention and control program
- Pain assessment, pain management including nonpharmacologic treatment modalities, and safe opioid prescribing, when applicable
- Patient flow, specifically, inpatient admission sources, volume and types of patients seen in the emergency department, how ED throughput is monitored, managing care of patients presenting with conditions outside the scope of services (e.g., mental health, trauma), patient boarding
- Organ, tissue, and eye donation and procurement processes; OPO identification
- Imaging services, scope, types, including fluoroscopy services, locations, safety

Additional discussion topics include:

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

Senior Leadership Role in Improving Performance discussion topics may include:

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

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

Individual Tracer Activity

Joint Commission Participants
One surveyor per individual tracer

Organization Participants
Suggested participants include staff, physicians, other licensed practitioners, and management involved in the individual's care, treatment, and services.

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

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

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

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

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

Initially, the selection of individual tracer candidates is based on organization clinical services as reported in your e-application and the general risk areas identified for the accreditation program which are listed in the Intra-Cycle Monitoring (ICM) Profile. Surveyors will also consider any organization-specific risk areas listed in the ICM Profile. As the survey progresses, the surveyors may select patients with more complex situations whose care involves multiple services.

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

- Following the course of care, treatment, or services provided to the patient from preadmission through post discharge

- Assessing the interrelationships between disciplines, departments, programs, services, or units (where applicable), and the important functions in the care, treatment or services provided
- Identifying issues that will lead to further exploration in the systems tracer or other survey activities such as Competence Assessment and Leadership Sessions

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

- Care, treatment, or services being provided to patients by clinicians, including physicians and other licensed practitioners
- The medication process (e.g., preparation, dispensing, administration, storage, control of medications)
- Infection prevention and control practices – For full details, refer to the **Infection Prevention and Control Program Assessment Tool**
- The process for planning care, treatment, or services
- The environment as it relates to the safety of patients and staff

During the individual tracer, the surveyor interviews staff about:

- Processes as they relate to the standards
- Intradepartmental and interdepartmental communication for the coordination of care, treatment, or services, for example patient hand-offs.
- The use of data in the care of patients, and for improving organization performance; their awareness and involvement in performance improvement projects
- Patient flow through the organization
- National Patient Safety Goals for example, anticoagulant therapy (NPSG.03.05.01) and suicide risk reduction (NPSG.15.01.01)
- Patient education, availability of tools and resources to assist with communication
- Orientation, education, and competency of staff
- The record-keeping systems in use for care, treatment, and services (paper, fully electronic or a combination of the two) and about any procedures they must take to protect the confidentiality and integrity of the health information they collect
    - Back-up procedures they've been instructed to use if the primary system is unavailable
    - If internet-connected health information, equipment, or devices are used in care, treatment, or service, staff may be asked to describe their access procedures (passwords, authentication, etc.), confidentiality measures, and instructions on down-time procedures
    - How they approach risk awareness, detection and/or response as it relates to potential cyber emergencies
- The education staff have been provided on antimicrobial resistance and the organization's antimicrobial stewardship program
- Pain assessment, pain management and safe opioid prescribing initiatives, when applicable, and resources made available by the organization; Prescription Drug Monitoring Database and criteria for accessing, when applicable

- Awareness of and participation in a safety culture assessment; awareness of assessment results
- Reporting near misses/close calls as well as actual errors; awareness of any organization processes to look at these occurrences
- Organization's code of conduct/behavior; reporting intimidating behavior or perceived violations of such codes
- The organization's workplace violence prevention program and any education, training, and resources they have received on workplace violence prevention, including how to report incidents
- Roles and responsibilities related to the environment of care, for example preventing, responding to, and reporting incidents
- Other topics, as applicable

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

- Organization processes that support or may be a barrier to patient care, treatment, and services
- Communications and coordination with other physicians and licensed practitioners (hospitalists, consulting physicians, primary care practitioners)
- Discharge planning, or other transitions-related resources and processes available through the organization
- Awareness of roles and responsibilities related to the environment of care, including prevention of, and response to incidents and reporting of events that occurred
- The education or information they have been provided on antimicrobial resistance and the organization's antimicrobial stewardship program
- Pain assessment, pain management and safe opioid prescribing initiatives, when applicable and resources made available by the organization; Prescription Drug Monitoring Database and criteria for accessing, when applicable
- Awareness of and participation in a safety culture assessment; awareness of assessment results
- Reporting near misses/close calls as well as actual errors; awareness of any organization processes to look at these occurrences
- Organization's code of conduct/behavior; reporting intimidating behavior or perceived violations of such codes
- The organization's workplace violence prevention program and any education, training, and resources they have received on workplace violence prevention, including how to report incidents
- Other topics, as applicable

During the individual tracer, the surveyor interviews patients, and their families about:

- Coordination and timeliness of services provided
- Education, including discharge instructions

- Response time when call bell is initiated or alarms ring, as warranted by care, treatment or services
- Perception of care, treatment, or services
- Staff observance of handwashing and verifying their identity
- Understanding of instructions (e.g., diet or movement restrictions, medications, discharge, and provider follow-up), as applicable
- Involvement in decision-making
- Informed consent prior to non-emergency procedures
- If staff involved them in their pain management plan of care, what their pain management plan of care includes (non-pharmacologic, pharmacologic or a combination of approaches)
- Discharge planning and instructions
- Patient's rights, including those regarding visitation
- Other topics as applicable

Using individual tracers for continuous evaluation

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

Selection Criteria

- Patients that allow for evaluating systems such as infection prevention and control, and safe medication practices
- Patients who move between programs/services (for example, patients scheduled for a follow-up in ambulatory care post discharge, hospital patient being discharged with home care, nursing care center residents transferred from the hospital, patients referred to another specialty provider within the same organization, patients who received radiology or laboratory services)
- Patients recently admitted
- Patients due for discharge or recently discharged
- Patients who cover multiple additional criteria listed below, such as:
    - Receiving care and treatment in the intensive care units (MICU, SICU, CVCU, etc.)
    - Admitted to the health care system through the emergency department
    - Diagnosed with cardiac arrest
    - Receiving labor and delivery services (including patients scheduled for C-section)
    - Receiving care and treatment that requires sedation and anesthesia (includes hand-off communication)
    - Receiving care and treatment on a skilled nursing or subacute care unit
    - A 23-hour admit
    - Receiving dialysis services
    - Diagnosed with a psychiatric condition, or identified as a high risk for suicide
    - Receiving pediatric care, treatment, and services
    - Receiving radiology or nuclear medicine services

- Receiving rehabilitation services
- A possible organ donor
- Receiving waived lab services
- Discharged (or retrospective review and interview of recently discharged patient)
- Receiving antibiotic medications
- Receiving opioid medications
- Diagnosed with a terminal illness
- Discharged, deceased

Program Specific Tracer – Suicide Prevention

Organization Participants
Staff and management who have been involved in the care, treatment, or services of the patient.

Logistical Needs
This focused tracer occurs during time designated for Individual Tracer Activity

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

Overview
Suicide ranks as the 10th most frequent cause of death (third most frequent in young people) in the United States. Suicide of a care recipient while in a staffed, round-the-clock care setting continues to be a frequently reported sentinel event to the Joint Commission. Identification of individuals at risk for suicide while under the care of or following discharge from a behavioral health care and human services organization or a hospital psychiatric inpatient setting is an important first step in protecting and planning the care of these at-risk individuals.

The surveyor begins by reviewing the record of the patient to attain an understanding of services provided and patient specific issues. The surveyor interviews the clinical staff working with the patient about the following issues:
- Crisis process
- Initial assessment process
- Reassessment process
- Environmental assessment for ligatures and other risks for self-harm and/or suicide
- Planning of care, treatment, or services
- Mitigation plans for patient at high-risk for suicide
- Continuum of care, treatment, or services
- Education provided to the patient and family
- Orientation, training, and competency of clinicians
- Staffing
- Information management

Program Specific Tracer – Laboratory Integration

Organization Participants
Suggested participants include laboratory and other critical access hospital staff

Logistical Needs
This focused tracer occurs during time designated for Individual Tracer Activity

Objectives
The surveyor will:

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

Overview
The surveyor traces the processes and flow of communication between the laboratory and critical access hospital units, beginning with the order for testing, and moving through physician and other licensed practitioner actions based on testing results.

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

Program Specific Tracer – Patient Flow

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

Logistical Needs
This focused tracer occurs during time designated for Individual Tracer Activity

Objectives
The surveyor will:

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

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

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

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

Organization Quality and Performance Improvement Session

Organization Participants
Suggested participants include representatives from:

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

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

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

A meeting space that can accommodate participants is recommended.

Objectives

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

Overview

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

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

    - Leadership identification and prioritization of ongoing performance monitoring and performance improvement projects
    - How data is being used to create a culture of safety.
- Evaluation of quality and performance improvement program effectiveness

Use of Data in Quality Assessment and Performance Improvement

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

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

Patient Safety-Related Data Collection, Analysis, and Monitoring

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

- If and how data is helping to create a culture of safety and quality.
- Active or recently completed **proactive risk assessment** activity (LD.03.09.01, EP 7) and identified potential process failures, and any process improvements implemented.
- Patient perception of safety and quality of care.
- Infection prevention and control data integration into the quality and performance improvement program (for example, surveillance data collection, monitoring implementation of evidence-based practices related to CLABSI, CAUTI, MDROs, and prevention of surgical site infections).
- Medication safety and quality assurance data integration into the quality and performance improvement program (for example, drug reactions, adverse drug events, controlled substance monitoring, overrides of automated dispensing systems, medication administration errors, and near misses).
- Use of root cause analysis for all serious, preventable, adverse events.

Performance Improvement Project Tracer
Using the surveyor selected performance improvement project, be prepared to discuss the following:

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

Performance Improvement Evaluation Tool

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

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

X	Assessment Item	Notes	Joint Commission Standard	HAP CoPs	CAH CoPs
	collect, aggregate, analyze/study, and report undesirable event/incident data.				
	Moderate or deep sedation adverse events		PI.01.01.01, EP5	482.21(a)(2), (e)(1)	485.635(a)(3)(v)
	Transfusion reactions (reported and confirmed)		PI.01.01.01, EP7	482.21(a)(2), (e)(1)	No CoP
	Significant medication errors		PI.01.01.01, EP12	482.21(a)(2), (e)(1)	485.635(a)(3)(v)
	Significant adverse drug reactions		PI.01.01.01, EP13	482.21(a)(2), (e)(1)	485.635(a)(3)(v)
	MRI thermal injuries		PI.01.01.01, EP 34	No CoP	No CoP
	Ferromagnetic object injuries (MRI room)		PI.01.01.01, EP 35	No CoP	No CoP
	Analysis of sentinel events		LD.03.09.01, EP 5	482.21(a)(2), (c)(2), (e)(1)	No CoP
	Proactive risk assessment (every 18 months)		LD.03.09.01, EP 7	482.21(e)(1)	No CoP
	Incident Reporting System		EC.04.01.01, EP 1	482.13(c)(2), 482.41(d)(2)	485.623(a)
	Radiation dose incidents		PI.03.01.01, EP 6	No CoP	No CoP
	Data Analyzed and Actions Taken				
	Deemed only: Medicare quality reporting data used in PI program		LD.03.02.01, EP 4 **LD.03.02.01, EP 5 CAH**	482.21(b)(1)	485.641(b)(5)
	Use of system/process failure and proactive risk assessment information		LD.03.09.01, EP 8	482.21(a)(1), (b)(2)(i), (c)(2), (e)(1)	No CoP
	Uses improvement tools or methodologies		PI.04.01.01, EP 3	No CoP	No CoP
	Analysis of data to identify patterns, trends, variation		PI.03.01.01, EP 4	482.21, 482.21(a)(2), (b)(2)(i), (e)(1)	485.641, 485.641(d)(2), 485.641(e)
	Use data to identify improvement opportunities		PI.03.01.01, EP 8	482.21, 482.21(a)(2), (b)(2)(ii), (c)(2), (e)(1)	485.641, 485.641(d)(2), 485.641(e)
	Acts on performance improvement priorities		PI.04.01.01, EP 2	482.21, (c)(3), (d)(4)	485.641(e)
	Improving Performance				
	Acts when does not achieve or sustain improvements		PI.04.01.01, EP 5	482.21, (c)(3), (d)(3)	485.641(e)
	Identifying, Prioritizing, and Planning Performance Improvement Projects				
	Deemed: PI reflects complexity of services		LD.01.03.01, EP 21	482.21	485.641(b)(1) through (b)(4), 485.641(c)
	PI is hospitalwide		LD.03.07.01, EP 1	482.21	485.641
	- Leaders set priorities for PI **- Leaders give priority to high-risk, high- volume, or problem-prone processes** **- Leaders identify frequency of data collection**		LD.03.07.01, EP 2	482.21, 482.21(c)(1)(i) – (iii) 482.21(b)(3)	485.641, 485.641(d)(1) and (d)(3)

X	Assessment Item	Notes	Joint Commission Standard	HAP CoPs	CAH CoPs
	Leaders set expectations for using data and information to achieve PI goals		LD.03.02.01, EP 1	482.21, 482.21(a)(1), (b)(2)(i)	485.641, 485.641(e)
	Leaders review plan for addressing PI priorities annually and update		PI.02.01.01, EP 2	No CoP	No CoP
	Sharing of PI Data and Information (e.g., Governing Body, Medical Staff, Patient Safety, Performance Improvement Program)				
	ICP communicates w/antibiotic stewardship and PI program		IC.04.01.01, EP 2	482.42, 482.42(c)(1)(ii) 482.42(c)(2)(iii) 482.42(c)(2)(vi)	485.640(c)(1)(ii), 485.640(c)(2)(iii), 485.640(c)(2)(vi)
	Antibiotic stewardship program communicates with ICP, leaders, and PI		MM.09.01.01, EP 12	482.42, 482.42(c)(1)(ii), 482.42(c)(3)(iii)	485.640, 485.640(c)(1)(ii), 485.640(c)(3)(iii)
	Annual reports to governance (deemed: includes PI improvement projects)		LD.03.09.01, EP 10	482.21(c)(2), (d)(1), (d)(3), (e)(1), (e)(5)	No CoP

Performance Improvement (PI) Project Tracer Checklist

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

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

Performance Monitoring and Distinct Quality Indicator Checklist

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

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

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

Special Issue Resolution

Organization Participants
None, unless otherwise requested by the survey team

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

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

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

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

Surveyor Planning/Team Meeting

Organization Participants
None

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

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

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

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

Daily Briefing

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

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

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

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

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

Competence Assessment Session

Organization Participants
Suggested participants include staff responsible for the human resources processes; orientation and education of staff; assessing staff competency. There should be someone with authority to access information contained in personal files.

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

Objectives
The surveyor will:

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

Overview
The surveyor discusses the following topics:

- Internal processes for determining compliance with policies and procedures, applicable law and regulation, and Joint Commission standards
- Methods used to determine staffing adequacy, frequency of measurement, and what has been done with the results
- Performance improvement initiatives related to competency assessment for staff
- Orientation of staff to your organization, job responsibilities, and/or clinical responsibilities
- Experience, education, and abilities assessment
- Ongoing education and training
    - Education on antibiotic resistance and antibiotic stewardship (Note: surveyors will not review human resource records or medical staff records related to antibiotic stewardship)
    - Resuscitation (for example, mock code, skills day, etc.)
    - Workplace violence prevention
- Competency assessment, maintenance, and improvement
- Competency assessment process for contracted staff, as applicable
- Other topics and issues discovered during the tracer activity

Medical Staff Credentialing and Privileging

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

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

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

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

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

Facility Orientation and Document Review – Life Safety Surveyor

Joint Commission Participants
Life Safety Surveyor

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

Logistical Needs
- Upon arrival of the surveyor, an escort will be needed to take them to the **main** fire alarm panel to verify that it is functional.
- The surveyor will meet with an organization staff member(s) to become oriented to the layout of the building. This activity is greatly facilitated if the organization has plans and drawings available that display the building fire safety features.
- Other documents needed for the Orientation activity include:
  - Policies and procedures for Interim Life Safety Measures (ILSMs)
  - Written fire response plans
  - Evaluations of fire drills conducted for the past 12 months
  - Maintenance records for fire protection and suppression equipment
  - Maintenance records for emergency power systems
  - Maintenance records for piped medical gas and vacuum systems
- A detailed list of documents along with related standards and elements of performance appears in the ***Life Safety and Environment of Care Document List and Review Tool*** found later in this guide.

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

Overview
The surveyor will:
- Assess the **main** fire alarm panel
- Become familiar with the building layout (including arrangement of smoke compartments, location of any suites, age of building additions, areas with sprinklers, areas under construction, and any equivalencies granted by the Joint Commission).

- Evaluate the effectiveness of processes for identifying and resolving *Life Safety Code® (NFPA 101-2012)* or environment of care risks (NFPA 99-2012 Health Care Facilities Code)
- Evaluate the effectiveness of processes for activities developed and implemented to protect occupants during periods when a building does not meet the applicable provisions of the *Life Safety Code® (NFPA 101-2012)* or during periods of construction
- Evaluate the effectiveness of processes for maintaining fire safety equipment and fire safety building features
- Evaluate the effectiveness of processes for maintaining and testing any emergency power system*s*
- Evaluate the effectiveness of processes for maintaining and testing any medical gas and vacuum systems
- Educate attendees on potential actions to take to address any identified *Life Safety Code® (NFPA 101-2012)* or environment of care risks (NFPA 99-2012 Health Care Facilities Code)

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

Life Safety Code® Building Assessment

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

Joint Commission Participants
Life Safety Surveyor, Clinical Surveyor in outpatient locations

Organization Participants
Suggested participants include the individual who manages organization facilities and other staff at the discretion of your organization.

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

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

Overview of Building Tour
Surveyors will:
- Assess Operating Room(s) for proper pressure relationships
- Assess required fire separations
- Assess required smoke separations (at least two)
- Assess hazardous areas, such as soiled linen rooms, trash collection rooms, and oxygen storage rooms
- Conduct an "above the ceiling" survey at each location identified above by observing the space above the ceiling to identify:
  - penetrations of smoke, fire or corridor walls
  - smoke or fire walls that are not continuous from slab-to-slab and outside wall to outside wall
  - penetrations or discontinuities of rated enclosures including hazardous areas, stairwells, chutes, shafts, and floor or roof slabs
  - corridor walls that are not slab-to-slab or do not terminate at a monolithic ceiling (if the building is fully sprinkled and the ceiling is smoke tight, the walls may terminate at the ceiling line)

    - the presence or absence of required smoke detectors or fire dampers
    - the presence or absence of required fire proofing on structural members such as columns, beams, and trusses
- Verify that fire exits per building and verify that they are continuous from the highest level they serve to the outside of the building
- Assess any kitchen grease producing cooking devices
- Assess any laundry and trash chutes (including the bottoms of any laundry and trash chutes
- Assess the condition of all emergency power systems and equipment
- Verify that there is a reliable emergency power system that supplies electricity when normal electricity is interrupted to the following areas: exit route illumination, emergency/urgent care areas, areas where electrically powered life-support equipment is used, operating rooms, and postoperative recover rooms
- Assess any medical gas and vacuum system components including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets

Documentation of Findings

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

Emergency Management Session

Joint Commission Participants
Clinical surveyor and/or Life Safety surveyor

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

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

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

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

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

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

Part 1: "Actual" emergencies or disaster incidents
The hospital describes what "real" events impacted them and how they utilized their risk assessment, emergency operations plan, policies and procedures, and the six critical areas to prepare for these events.

Be prepared to discuss:

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

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

Part 2: Emergency exercises
As part of planning and preparedness, the hospital describes what emergency exercises they recently conducted and should be based on past experiences, known risks/hazards, recent changes to their emergency operations plan, policies or procedures. These exercises should have included evaluation of one or more of the six critical areas that were used to assess responses.

Be prepared to discuss:

- One annual operations-based exercise (either a full-scale, community-based or a functional, facility-based exercise) that was conducted (or participated in), ***and***
- One other annual exercise of choice, either an operations-based *or* discussion-based exercise (tabletop, seminar, etc.) that was conducted (or participated in)

- Why these exercises were selected and how these exercises stressed (or fully tested) the emergency operations plan and response procedures and how staff and management were involved
- The exercises that were conducted at the off-site facility locations

Part 3: Training and education
The hospital describes what education and training they provided to their staff, volunteers, physicians, etc. in the past 12–36 months.

Be prepared to discuss:

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

Part 4: Evaluation, After-action and improvement plans, and review
The hospital describes the evaluation process, lessons learned, and actions taken to improve the program.

Be prepared to discuss:

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

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

In addition to the above, be prepared to discuss:

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

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

Be prepared to discuss:

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

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

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

Emergency Management Documentation Review Tool

Hospital and Critical Access Hospital

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
Emergency Management Program				
☐ Written emergency management program	All hospitals and CAHs	EM.09.01.01, EPs 1 & 3	HAP 482.15 CAH 485.625	☐ Reviewed and updated every 2 years ☐ Not reviewed and updated every 2 years
Hazard Vulnerability Analysis (HVA)				
☐ Written all-hazards HVA that include: ☐ Facility-based and community-based risk assessment ☐ Strategies for addressing events identified by the risks ☐ HVA includes All-hazards: • Natural hazards • Human-caused hazards • Technological hazards • Hazardous materials • Emerging infectious diseases	All hospitals and CAHs	EM.11.01.01, EPs 1-4 EM.17.01.01, EP 3	HAP 482.15 (a)-(a)(2) CAH 485.625 (a)-(a)(2)	☐ Reviewed and updated every 2 years ☐ Not reviewed and updated every 2 years
Emergency Operations Plan (EOP)				
☐ Written EOP that include: • Addresses patient population & persons at-risk • Type of services provided in an emergency • Continuity of operations • Delegation of authority • Leadership succession • Cooperation and collaboration with external authorities	All hospitals and CAHs	EM.12.01.01, EP 1 & EP 2 EM.13.01.01, EPs 1-4 EM.17.01.01, EP 3	HAP 482.15 (a), (a)(3) to (a)(4) CAH 485.625 (a), (a)(3) to (a)(4)	☐ Reviewed and updated every 2 years ☐ Not reviewed and updated every 2 years
Policies and Procedures				
☐ Written Policies & Procedures that include: ☐ Provision of subsistence needs for staff and patients • food, water, medical and pharmaceutical supplies ☐ Alternate sources of energy to maintain: • temperatures to protect patient health & safety & safe and sanitary storage of provisions • emergency lighting, • fire detection, extinguishing and alarm systems ☐ Sewage and waste disposal ☐ System to track location of on-duty staff and sheltered patients ☐ Safe evacuation from the hospital (needs of evacuees, staff responsibilities, transportation, evacuation location(s) ☐ Means to shelter in place ☐ System of medical documentation to preserve PHI	All hospitals and CAHs	EM.12.01.01, EPs 1, 3, 4 & 9 EM.12.02.11, EP 4 EM.17.01.01, EP 3 EM.12.02.07, EP 2 EM.12.02.01, EP 6 EM.12.02.03, EPs 1 & 2 EM.12.02.05, EP 1 IM.01.01.03, EPs 1 & 2 IM.02.01.01, EPs 1 & 4 IM.02.01.03 EPs 1 & 5	HAP 482.15 (b) to (b)(8) CAH 485.625 (b) to (b)(8)	☐ Reviewed and updated every 2 years ☐ Not reviewed and updated every 2 years

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
☐ Use of volunteers and other staffing strategies ☐ Arrangements and/or agreements with other hospitals and providers to receive patients if needed ☐ Role of the hospital in providing care and treatment at alternate care sites under an 1135 waiver				
Communications plan				
☐ Written communication plan that includes: ☐ Names & contact information for: • Staff • Entities providing services under arrangement • Patient physicians • Other hospitals • Volunteers ☐ Contact information for: • Federal, state, tribal agencies • Other sources of assistance ☐ Primary and alternate means for communicating with: • Hospital staff • Federal, state, tribal agencies ☐ Method for sharing information & medical documentation with other healthcare providers ☐ Means of providing/releasing information under 45 CFR 164.510(b)(1)(ii) ☐ Means of providing information about occupancy needs and ability to provide assistance	All hospitals and CAHs	EM.09.01.01, EP 3 EM.12.01.01, EP 1 EM.17.01.01, EP 3 EM.12.02.01, EPs 1, 3, 5 & 6 EM.12.02.05, EP 1	HAP 482.15 (c) to (c)(7) CAH 485.625 (c) to (c)(7)	☐ Reviewed and updated every 2 years ☐ Not reviewed and updated every 2 year
Education and Training Program				
☐ Written education and training program Documented education & training occurs: ☐ Initially to all new/existing staff, those providing services under contract, volunteers ☐ At least every 2 years ☐ Staff demonstrate knowledge in EM procedures ☐ Conduct training when: • When roles & responsibilities change • When significant revisions are made to P&Ps • When procedural changes are made during an event	All hospitals and CAHs	EM.15.01.01, EPs 1, 2, 3 EM.16.01.01, EP 1 EM.17.01.01, EP 3	HAP482.15 (d) to (d)(1)(v) CAH 485.625 (d) to (d)(1)(v)	☐ Reviewed and updated every 2 years ☐ Not reviewed and updated every 2 years

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
Testing Program				
☐ Two annual emergency exercises are documented and conducted as follows: ☐ Participation in one operational-based exercise (full-scale community (if avail) or a functional facility-based) ***and*** ☐ One additional exercise of choice operations-based or discussion-based ☐ Has exemption from conducting its next operations-based exercise due to a real event in which the EOP was activated	Applies to all hospitals and CAHs	EM.16.01.01, EP 2	HAP 482.15 (d)(2) to (d)(2)(ii)(C) CAH 485.625 (d)(2) to (d)(2)(ii)(C)	
Evaluation Program				
☐ Documents and reviews all emergency exercises, emergency or disaster incidents (After-action reports) ☐ Documentation, review, & update of improvement plans, actions taken, and any revisions made to plans/policies and procedures	Applies to all hospitals and CAHs	EM.17.01.01, EPs 1 & 3	HAP 482.15 (d) (2)(iii) CAH 485.625 (d)(2)(iii)	☐ Plans/policies are reviewed and updated every 2 years ☐ Plans/policies not reviewed and updated every 2 years
Emergency & standby power systems (may be incorporated with LS document review/LS building tour)				
☐ Written plan for managing essential or critical utilities during an emergency that includes: • Emergency & standby power systems • Emergency generator location • Emergency generator inspection & testing • Emergency generator fuel source	Applies to all hospitals and CAHs	EM.12.02.11, EPs 1-3 EM.12.02.09, EPs 1 & 2 EC.02.06.05, EP 1 EC.02.05.07, EPs 3-11	HAP 482.15 (e) to (f) CAH 485.625 (e) to (f)	
Unified and Integrated EM Program (if applicable)				
If hospital is part of health care system and participates in a unified and integrated emergency management program: ☐ Program accounts for the hospital's unique circumstances, patient population, and services offered ☐ Documented community-based & individual facility-based risk assessment ☐ Unified and integrated EOP ☐ Integrated P&Ps ☐ Coordinated communication plan ☐ Training and testing program ☐ Reviews and evaluates exercises and emergency events ☐ Documentation of improvement plans, actions taken, revisions to plans/policies and procedures	Applies to Hospitals and CAHs that are part of a system that has a unified and integrated EM program	EM.09.01.01 EM.11.01.01 EM.12.01.01 EM.13.01.01 EM.15.01.01 EM.16.01.01 EM.17.01.01 (every 2 years)	HAP 482.15 (f) to (f)(5) CAH 485.625 (f) to (f)(5)	☐ Written documentation ☐ No written documentation ☐ Reviewed and updated every 2 years ☐ Not reviewed and updated every 2 years

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
Transplant Program (if applicable)				
☐ Written protocols addressing duties and responsibilities of the hospital, transplant program(s), and OPO	Deemed Hospitals only	EM.09.01.01, EP 3	HAP 482.15 (g) to (g)(2)	

Leadership Session

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

Logistical Needs
The suggested duration of this session is approximately 60 minutes.

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

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

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

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

- The planning process used
- How data is used once it is collected
- Leaders' chosen improvement methodology and tools and their satisfaction with the approach and how well it is serving their needs and those of staff
- The approach used to change processes and workflow
- How information about newly implemented processes is communicated throughout your organization
- How leaders assess the culture of safety throughout the organization
- How leaders envision the performance of processes that are selected for improvement
- Leadership support and direction, including planning and resource allocation
- The degree to which the implementation is comprehensive and organization-wide
- The relationship of the function or process to patient safety and quality
- How the effective performance of the function or process is evaluated and maintained

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

- Antibiotic stewardship program, including who leads the program, leadership support of the program, and committee that oversees the program.
- Pain assessment, management, and safe opioid prescribing
- Safety culture in the organization, including
  - Assessment process/tool
  - Scope of assessment activity
  - Response rates
  - Willingness of people at all levels to discuss safety issues
  - Internal or external benchmarks
  - Board involvement in setting expectations
  - Leaders' response to safety concerns
  - Improvement projects undertaken to improve safety culture scores
- Code of conduct and behavior for physicians and staff
  - Is it the same for everyone?
  - How do staff report intimidating behavior?
  - Is your organization monitoring frequency of intimidating or disrespectful behavior occurrences?
  - Have you been able to reduce or eradicate intimidating and disrespectful behavior?
  - Discuss organization policies and procedures for dealing with intimidating behavior
- Managing near misses, close calls, actual errors
  - What is the process for staff and licensed independent practitioners to report such occurrences?
  - How often is it used? Any recent examples?
  - How does the organization determine whether actual errors, when a patient is harmed, were a system error or a person is responsible and should be held accountable?
  - Does the organization conduct root cause analyses of all near misses/close calls?
- Health care equity and the organization's efforts to reduce health care disparities, including
  - Identification of an individual to lead activities.
  - Identification of health-related social needs for the patient population served by the organization.
  - Processes to assess patients' health-related social needs, including collection of data.
  - Information the organization has gathered about community resources and support services available to the patient population being served.
  - Work planned or underway to identify health care disparities in the patient population being served.
  - Patient population health care disparities identified for initial focus and status of efforts.
  - Key stakeholders that will be receiving reports and monitoring organization progress to improve health care equity.

Surveyor Report Preparation

Organization Participants
None

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

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

CEO Exit Briefing

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

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

Objectives
Surveyors will:

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

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

Organization Exit Conference

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

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

Objectives
Surveyors will:

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

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

Surveyors will review the Summary of Survey Findings Report with participants. Discussion will include the SAFER™ matrix, Requirements for Improvement, and any patterns or trends in performance. If follow-up is required in the form of an Evidence of Standard Compliance (ESC) the surveyors explain the ESC submission process. Surveyors will direct you to information on your extranet site that explains “What Happens after Your Survey.”

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

For Critical Access Hospital Deemed Status surveys, surveyors communicate their findings relating to the Medicare Conditions of Participation. This includes describing the regulatory requirements that the organization does not meet and the findings that substantiate these deficiencies.

Guide for OPTIONAL Primary Care Medical Home (PCMH) Certification

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

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

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

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

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

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

Documents to have available:

- Performance improvement data related to:
  - Disease management outcomes
  - Patient access to care
  - Patient experience and satisfaction related to access to care, treatment, or services, and communication
  - Patient perception of the comprehensiveness, coordination, and continuity of care, treatment, or services
  - Patient perception of the continuity of care

- PCMH Self-assessment tool (completion of this tool is optional). A copy of the tool can be downloaded from The Joint Commission's website at https://www.jointcommission.org/accreditation-and-certification/certification/certifications-by-setting/hospital-certifications/primary-care-medical-home-certification/

Scope of PCMH Site Visit:

The survey will focus on evaluating the organization's provision of patient-centered care, comprehensive care, coordinated care, and superb access to care. Additionally, the survey will

include an evaluation of the organization's system-based approach to quality, that is, the commitment to quality and quality improvement through ongoing engagement in activities such as:

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

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

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

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

Critical Access Hospital Life Safety & Environment of Care Document List and Review Tool

Effective: 4/2/2024

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

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

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

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

Revisions to this document are identified by underlined text.

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

Conducted during Facility Orientation

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

STANDARD - EPs	See Legend				Document / Requirement	Yes	No	
	C	NC	NA	IOU				
LS.01.01.01					**Buildings serving patients comply w/ NFPA 101 (2012)**			
EP 1					Individual assigned to assess Life Safety Code® compliance			
EP 2					Building Assessment to determine compliance with Life Safety (LS) chapter *(frequency of assessment is defined by the hospital)*			
EP 3					Current and accurate drawings w/ fire safety features & related square footage a. Areas of building fully sprinklered (if building only partially sprinklered) b. Locations of all hazardous storage areas c. Locations of all fire-rated barriers d. Locations of all smoke-rated barriers e. Sleeping and non-sleeping suite boundaries, including size of identified suites f. Locations of designated smoke compartments g. Locations of chutes and shafts h. Any approved equivalencies or waivers	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
EP 5					Deemed Hospitals: Documentation of inspections and approvals made by state or local AHJs			
EP 7					The hospital maintains current Basic Building Information (BBI) within the Statement of Conditions (SOC).			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Yes	No	
	C	NC	NA	IOU				
EC.02.03.01					**Hospital Manages Fire Risk – Fire Response Plan**			
EP 9					The written fire response plan describes the specific roles of staff at and away from fire including: • When and how to sound and report fire alarms • How to contain smoke and fire • How to use a fire extinguisher • How to assist and relocate patients • How to evacuate to areas of refuge • How staff will cooperate with firefighting authorities Staff periodically instructed on/kept informed of duties under plan Copy of plan readily available with telephone operator or security NFPA 101-2012: 18/19.7.1; 7.2	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
COMMENTS:								

Conducted after Facility Orientation, during Document Review activity

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
EC.02.03.05					**Fire Protection and Suppression Testing and Inspection**					
EP 1					Testing for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices NFPA 72-2010: Table 14.4.5	Quarterly				
					Testing for valve supervisory switches NFPA 72-2010: Table 14.4.5	Semiannual				
					Testing for other supervisory initiating devices NFPA 72-2010: Table 14.4.5	Annually				
EP 2					Water flow devices NFPA 72-2010: Table 14.4.5 NFPA 25-2011: Table 5.1.1.2	Semiannual				

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
EC.02.03.05					**Fire Protection and Suppression Testing and Inspection**					
					Tamper switches NFPA 72-2010: Table 14.4.5	Semiannual				
EP 3					Duct, heat, smoke detectors, and manual fire alarm boxes NFPA 72-2010: Table 14.4.5; 17.14	Annually				
EP 4					Notification devices (audible & visual), and door-releasing devices NFPA 72-2010: Table 14.4.5	Annually				
EP 5					Emergency services notification transmission equipment NFPA 72-2010: Table 14.4.5	Annually				
EP 6					Electric motor-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Monthly				
					Diesel-engine-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Weekly				
EP 9					Sprinkler systems main drain tests on all risers NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1	Annually				
EP 10					Fire department connections inspected (Fire hose connections N/A) NFPA 25-2011: 13.7; Table 13.1.1.2	Quarterly				
EP 11					Fire pump(s) tested – under flow Fire pump supervisory signals for pump running and pump power loss tested NFPA 25-2011: 8.3.3; 8.3.3.4	Annually				
EP 12					Standpipe flow test every 5 years NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2	5 years				
EP 13					Kitchen suppression semi-annual testing NFPA 96-2011: 11.2	Semiannual				
EP 14					Carbon dioxide systems tested NFPA 12-2011:4.8.3.2	Annually				
					Halon systems NFPA 12A-2009: 6.1	Semiannual				
					Other special systems per National Fire Protection Association standards and manufacturers' recommendations NFPA 11-2010; NFPA 16-2011; NFPA 17-2009; NFPA 17A-2009					

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
EC.02.03.05					**Fire Protection and Suppression Testing and Inspection**					
EP 15					Portable fire extinguishers inspected monthly NFPA 10-2010: 7.2.2; 7.2.4	Monthly				
EP 16					Portable fire extinguishers maintained annually NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1	Annually				
EP 17					Fire hoses hydro tested 5 years after install; every 3 years thereafter NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6	5 years / 3 years				
EP 18					Smoke and fire dampers tested to verify full closure NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5	1 year after install				
						At least every 6 years thereafter				
EP 19					Smoke detection shutdown devices for HVAC tested NFPA 90A-2012: 6.4.1	Annually				
EP 20					All horizontal and vertical roller and slider doors tested NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2	Annually				
EP 25					Inspection and testing of door assemblies by qualified person. Does not include nonrated doors, including corridor doors to patient care rooms and smoke barrier doors. NFPA101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1	Annually				
EP 27					Elevators with firefighters' emergency operations NFPA 101-2012: 9.4.3; 9.4.6	Monthly				
EP 28					Documentation of maintenance testing and inspection activities for EPs 1-20 and 25 includes: activity name; date; inventory of devices, equipment or other items; frequency; contact info for person performing activity; NFPA standard; activity results NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4					
COMMENTS:										

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.07					**Emergency Power Systems are Maintained and Tested**			
EP 1					At least monthly performs functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5	Monthly		
EP 2					Every 12 months performs functional test of battery powered lights on the inventory required for egress and exit signs for a duration of 1 ½ hours For new construction, renovation, or modernization battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes with test results and completion dates documented NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5	Annually		
EP 3					Functional test of Level 1 SEPSS, monthly; Level 2 SEPSS, quarterly, for 5 minutes or as specified for its class Annual test at full load for 60% of full duration of its class NFPA 111-2010: 8.4	Monthly Quarterly Annually		
					Note 1: Non-SEPSS tested per manufacturer's specifications	Per Mfr.		
					Note 2: Level 1 SEPSS defined for critical areas and equipment			
					Note 3: Class defines minimum time which SEPSS is designed to operate at rated load without recharging			
EP 4					Emergency power supply system (EPSS) inspected weekly, including all associated components and batteries NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.4.1	Weekly		
EP 5					Emergency generators tested monthly for 30 continuous minutes under load (plus cool-down) NFPA 99-2012: 6.4.4.1	Monthly		

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.07					Emergency Power Systems are Maintained and Tested			
EP 6					Monthly load test for diesel-powered emergency generators conducted with dynamic load at least 30% of nameplate rating or meets mfr. recommended prime movers' exhaust gas temperature; **OR**	Monthly		
					Emergency generators tested once every 12 months using supplemental loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes for total of 1 ½ continuous hours NFPA 99-2012: 6.4.4.1	Annually		
EP 7					All automatic and manual transfer switches monthly/12 times per year with results and completion dates documented NFPA 99-2012: 6.4.4.1	Monthly		
EP 8					Fuel quality test to ASTM standards NFPA 110-2010: 8.3.8	Annually		
EP 9					Generator load test once every 36 months for 4 hours NFPA 110-2010, Chapter 8	36 Months		
EP 10					Generator 4-hour test performed at, at least 30% nameplate NFPA 110-2010, Chapter 8	36 Months		
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD		Testing Dates
	C	NC	NA	IOU			Yes	No
EC.02.05.09					Medical Gas and Vacuum Systems are Inspected and Tested			
EP 7					**Test, inspect and** maintain critical components of piped medical gas and vacuum systems, waste anesthetic gas disposal (WAGD), and support gas systems on the inventory. Inventory of critical components includes at least all source subsystems, control valves, alarms, manufactured assemblies containing	Per policy		

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
EC.02.05.09					Medical Gas and Vacuum Systems are Inspected and Tested				
					patient gases, and inlets and outlets with activities, dates and results documented No prescribed frequency; recommend risk assessment if < annual NFPA 99-2012: 5.1.14.2; 5.1.15; 5.2.14; 5.3.13				
EP 8					Location of and signage for bulk oxygen systems NFPA 99-2012: 5.1.3.5.12	On Bldg. Tour			
EP 9					Emergency oxygen supply connection NFPA 99-2012: 5.1.3.5.13	On Bldg. Tour			
EP 10					Review medical gas installation/modification/breech certification results for cross connection, purity, correct gas, and pressure NFPA 99-2012: 5.1.2; 5.1.4; 5.1.14.4.1; 5.1.14.4.6; 5.2.13	As applicable			
EP 11					Medical gas supply and zone valves are accessible and clearly labeled NFPA 99-2012: Table 5.1.11 NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11	On Bldg. Tour			
EP 12					Handling, transfer, storage, labeling, transfilling of cylinders NFPA 99-2012: 11.5.3.1; 11.6.1; 11.6.2; 11.6.5; 11.7.3	Per policy			
COMMENTS:									

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
	C	NC	NA	IOU						
EC.02.03.03					Fire Drills					
EP 1					Fire drills once per shift per quarter in health care occupancies; Quarterly in each building defined as ambulatory health care occupancy (If available,	Quarterly				

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
EC.02.03.03					**Fire Drills**					
					please provide five quarters of fire drill data) NFPA 101-2012: 18/19: 7.1.7					
EP 2					Fire drills every 12 months from date of last drill: Business Occupancies	Annually				
EP 3					When quarterly fire drills are required, ALL are unannounced • Drills held at unexpected times and under varying conditions – vary by at least one hour for each shift from quarter to quarter through four consecutive quarters • Drills include transmission of fire alarm signal and simulation of emergency fire conditions NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3	Quarterly (See fire drill matrix)				
EP 4					Staff participate in the drills according to the hospital's fire response plan	YES	NO			
EP 5					Critiques include fire safety equipment and building features, and staff response	YES	NO			
EP 7					Fire exit drills for operating rooms/surgical suites. NFPA 99-2012: 15.13.3.10.3	Annually				
EP 8					Annual emergency procedures and fire training drills for hyperbaric facilities that include recording of time to evacuate all persons from area, involves applicable staff, and focuses on prevention and simulated extinguishment and evacuation. NFPA 99-2012: 14.2.4.5.4; 14.3.1.4.5 NFPA 99-2012: B.14.2 and B.14.3	Annually				
COMMENTS:										

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

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Yes	No
EC.02.05.02					**Manages risks associated with utility systems – Water Management Program**		
EP 1					Verify individual or team responsible for oversight and implementation of the water management program		
EP 2					Review water management program to verify the following components are included: • Diagram of water supply sources, treatment systems, processing steps, control measures, and end-use points • Water risk management plan identifies areas where potentially hazardous conditions may occur ○ 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. • Plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time • Evaluation of immunocompromised patients • Monitoring protocols and acceptable ranges for control measures		
EP 3					Verify that the water management program includes documentation of the following: • Results of all monitoring activities • Corrective actions and procedures to follow if test results are outside of acceptable limits		

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Yes	No
EC.02.05.02					**Manages risks associated with utility systems – Water Management Program**		
					• Corrective actions taken when control limits are not maintained		
EP 4					Verify water management program reviewed annually and when changes have been made to the water system that add risk, new equipment or at-risk systems have been added that could generate aerosols or be source for Legionella		
COMMENTS:							

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

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
EC.02.04.03					**Medical equipment inspection, testing and maintenance**			
EP 2					All high-risk equipment. Note 1: High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment.			

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
EC.02.04.03					Medical equipment inspection, testing and maintenance			
					Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate.			
EP 3					Non-high-risk equipment identified on the medical equipment inventory			
EP 4					Conducts performance testing of and maintains all sterilizers			
EP 10					All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.			
COMMENTS: Refer to the Guidance on Use of Alternate Maintenance Activities and/or Schedules section when CAHs choose to employ alternate maintenance activities and/or schedules.								

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
EC.02.05.05					Utility system Inspection, testing and maintenance			
EP 4					High-risk utility system components on the inventory with completion date and results of activities documented Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate.			
EP 5					Infection control utility system components on the inventory with completion date and results of activities documented Note 1: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate.			
EP 6					Non-high-risk utility system components on the inventory with completion date and results of activities documented			

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
EC.02.05.05					Utility system Inspection, testing and maintenance			
EP 7					Line isolation monitors (LIM), if installed, are tested at least monthly by actuating the LIM test switch. For LIM circuits with automated self-testing, a manual test is performance at least annually. NFPA 99-2012: 6.3.2; 6.3.3; 6.3.3.3.2; 6.3.4			
COMMENTS: Refer to the Guidance on Use of Alternate Maintenance Activities and/or Schedules section when CAHs choose to employ alternate maintenance activities and/or schedules.								

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
EC.02.01.01					The hospital manages safety and security risks.			
EP 1					The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.			
EP 3					The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.			
EP 9					The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.			
EP 10					When a security incident occurs, the hospital follows its identified procedures.			
Note: EP's14 and 16 are covered by the clinical imaging tracer.								
EP 17					The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis. Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and			

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
EC.02.01.01					**The hospital manages safety and security risks.**			
					environmental design reflect best practices and conform to applicable laws and regulations.			
COMMENTS:								

STANDARD – EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
EC.01.01.01					**The hospital plans activities to minimize risks in the environment of care.**			
EPs 1-9					The hospital has a written plan for managing the following: EP-4 Environmental Safety EP-5 Security EP-6 Haz Materials EP-7 Fire Safety EP-8 Medical Equipment EP-9 Utility Systems In circumstances where the program or service is located in a business occupancy not owned by the accredited organization, the plan may only need to address how routine service and maintenance for their utility systems are obtained. Note 1: One or more persons can be assigned to manage risks associated with the management plans described in this standard. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 3: For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/ and NFPA 99-2012: 1.4.			
COMMENTS:								

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

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

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

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

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

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
EC.02.02.01					**The hospital manages risks related to hazardous materials and waste.**			
EP 1					The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. (See also MM.01.01.03, EPs 1 and 2)			
EP 3					The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures.			
EP 11					For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation.			
COMMENTS: **Note EP's 6, 7, 8, 17, and 18 are covered under clinical tracers.**								

Guidance on Use of Alternate Maintenance Activities and/or Schedules

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

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

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

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

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

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

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

A CAH may, under certain conditions, use equipment maintenance activities and frequencies that differ from those recommended by the manufacturer. CAHs that choose to employ alternate maintenance activities and/or schedules must develop, implement, and maintain a documented AEM program to minimize risks to patients and others in the CAH associated with the use of facility or medical equipment. The AEM program must be based on generally accepted standards of practice for facility or medical equipment maintenance. An example of guidelines for a medical equipment medical equipment maintenance program may be found in the American National Standards Institute/ Association for the Advancement of Medical Instrumentation document: ANSI/AAMI EQ 56:1999/ (R) 2013, Recommended Practice for a Medical Equipment Management Program. Likewise, an example of guidelines for physical plant equipment may be found in the American Society for Healthcare Engineering (ASHE) 2009 document: Maintenance Management for Health Care Facilities. There may be similar documents issued by other nationally recognized organizations which CAHs might choose to reference.

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

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

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

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

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

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

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

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

- How the equipment is used and the likely consequences of equipment failure or malfunction: would failure or malfunction of the equipment CAH-wide or in a particular setting be likely to cause harm to a patient or a staff person?
    - How serious is the harm likely to be? For example, a slightly miscalibrated scale in an adult internal medicine outpatient clinic might not present significant risk of harm. However, a miscalibrated scale in a neonatal intensive care unit could have very serious consequences for patient care.
    - How widespread is the harm likely to be? For example, are many patients exposed to the equipment, resulting in harm due to failure impacting more patients or staff? If harm would be widespread, even if the harm to each affected individual is not serious, this would be a cause for concern.
- Information, if available, on the manufacturer's equipment maintenance recommendations, including the rationale for the manufacturer's recommendations;
- Maintenance requirements of the equipment:
    - Are they simple or complex?
    - Are the manufacturer's instructions and procedures available in the CAH, and if so can the CAH explain how and why it is modifying the manufacturer's instructions?
    - If the manufacturer's instructions are not available in the CAH, how does the CAH assess whether the AEM uses appropriate maintenance strategies?
    - How readily can the CAH validate the effectiveness of AEM methods for particular equipment? For example, can the CAH explain how it ensures there is no reduction in the quality of the performance of biomedical equipment subjected to alternate maintenance methods?

- The timely availability of alternate devices or backup systems in the event of equipment failure or malfunction; and
- Incident history of identical or very similar equipment – is there documented evidence, based on the experience of the CAH (or its third party contractor), or on evidence publicly reported by credible sources outside the CAH, which:
    - Provides the number, frequency and nature of previous failures and service requests?
    - Indicates use of an AEM strategy does not result in degraded performance of the equipment?

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

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

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

- Other Federal law (for example, regulations promulgated by another Federal agency) or State law may require that facility or medical equipment maintenance, inspection and testing be performed strictly in accordance with the manufacturer's recommendations, or may establish other, more stringent maintenance requirements. In these instances, the CAH must comply with these other Federal or State requirements, but State Surveyors conducting Federal surveys assess compliance only with the CAH Conditions of Participation (CoPs).
- Other CoPs require adherence to manufacturer's recommendations and/or set specific standards which preclude their inclusion in an AEM program. For example:
    - The National Fire Protection Association Life Safety Code (LSC) requirements incorporated by reference at 42 CFR 485.623(d) have provisions that are pertinent to equipment maintenance, and compliance with these requirements are assessed on Federal surveys. Further, §485.623(d)(7)(v) requires CAHs to adhere to the manufacturer's maintenance guidelines for alcohol-based hand-rub dispensers. Compliance with these requirements is assessed on Federal surveys.
- Imaging/radiologic equipment, whether used for diagnostic or therapeutic purposes, must be maintained per manufacturer's recommendations.
- The equipment is a medical laser device. It should be noted that for medical lasers the U.S. Food and Drug Administration requires manufacturers to provide a schedule of maintenance and adequate instructions for service adjustments and service procedures to purchasers and, at cost, to any other parties requesting them.
- New equipment for which sufficient maintenance history, either based on the CAH's own or its contractor's records, or available publicly from nationally recognized sources, is not available to support a risk-based determination must not be immediately included in the AEM program. New equipment must be maintained in accordance with manufacturer recommendations until a sufficient amount of maintenance history has been acquired to determine whether the alteration of maintenance activities or frequencies would be safe. If a CAH later transitions the equipment to a risk-based maintenance regimen different than the manufacturers' recommendations, the CAH must maintain evidence that it has first evaluated the maintenance track record, risks, and tested the alternate regimen.

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

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

In developing AEM maintenance strategies, CAHs may rely upon information from a variety of sources, including, but not limited to manufacturer recommendations and other materials, nationally recognized expert associations,

and/or the CAH's (or its third party contractor's) own experience. Maintenance strategies may be applied to groups or to individual pieces of equipment.

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

Background Information on Types of Maintenance Strategies

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

Maintenance Tools

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

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

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

- The pertinent types and level of risks to patient or staff health and safety;
- Alternate maintenance activities, and the maintenance strategy and any other rationale used to determine those activities; the differences from the manufacturer's recommended maintenance activities are made explicit, unless the CAH is unable to obtain the manufacturer's maintenance recommendations, due to the age of the equipment or the manufacturer's restricting the availability of its recommendations;
- Alternate maintenance frequencies to be used, if any, and the maintenance strategy and any other rationale used to determine those frequencies. For equipment identified as presenting a very low risk to patient or staff safety, it could be acceptable to not set a particular frequency but instead indicate a less specific approach, for example, an interval range, such as "every 12 – 24 months." It could also be

acceptable to employ periodic “departmental sweeps” for such very low risk equipment, where equipment functioning is sampled and operators are polled about its functionality.

- The date when AEM program maintenance activities were performed and, if applicable, further actions required/taken; and
- Documentation of any equipment failures (not including failures due to operator error), including whether there was resulting harm to an individual. (Note: equipment failure that is due to operator error and which results in an adverse event or near miss must be documented in accordance with the QAPI CoP, as part of the CAH’s required tracking of patient safety-related incidents. However, there is no requirement to include operator failures in equipment maintenance documentation.) When the CAH has multiple identical equipment items, the documentation may be generic to that type of equipment, except that documentation of maintenance activities performed must be specific to each item of equipment.

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

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

- How equipment is evaluated to ensure there is no degradation of performance, particularly for equipment where such degradation may not be readily apparent to staff using the equipment, e.g., miscalibration.
- How incidents of equipment malfunction are investigated, including:
  - whether or not the malfunction could have been prevented, and what steps will be taken to prevent future malfunctions; and
  - how a determination is made whether or not the malfunction resulted from the use of an AEM strategy;
- The process for the removal from service of equipment determined to be unsafe or no longer suitable for its intended application; and
- The use of performance data to determine if modifications in the AEM program procedures are required.

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

- All CAH facility and medical equipment essential to the operation of the CAH, regardless of whether it is leased or owned, and regardless of whether it is maintained according to manufacturer recommendations or is in an AEM program, is expected to be listed in an inventory which includes a record of maintenance activities. For low cost/low risk essential equipment, such as housekeeping cleaning equipment, it is acceptable for the inventory to indicate under one item the number of such pieces of equipment in the CAH, e.g., “15 vacuum cleaners for cleaning patient rooms and common areas.”

- If the CAH is using an AEM program, the equipment managed through that program must be readily separately identifiable as subject to AEM. Critical equipment, whether in an AEM program or not, must also be readily identified as such.

- To facilitate effective management, a well-designed equipment inventory contains the following information for all equipment included. However, CAHs have the flexibility to demonstrate how alternative means they use are effective in enabling them to manage their equipment.
  - A unique identification number;
  - The equipment manufacturer;
  - The equipment model number;
  - The equipment serial number;
  - A description of the equipment;
  - The location of the equipment (for equipment generally kept in a fixed location);
  - The identity of the department considered to “own” the equipment;

- Identification of the service provider;
- The acceptance date; and
- Any additional information the CAH believes may be useful for proper management of the equipment.

Medical Staff-Related Standards Compliance Evaluation Guides

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

1. **Medical Staff Bylaws Review Guide**
2. **Medical Staff and Related Standards Compliance Evaluation Guide**
3. **Credentials File Review Tool**

Medical Staff Bylaws Review Guide

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

	• Clinically related activities of the department • Administrative activities of dept, unless provided by hospital • Continuing surveillance of prof perf of all in dept with privileges • Recommending to the med staff the criteria for departmental clinical privileges • Recommending clinical privileges for each member of dept • Assessing and recommending to hospital authority off-site sources of care • Integration of dept or service into primary functions of org • Coordination and integration of inter- and intra-departmental services • Development and implementation of policies and procedures • Recommendations for sufficient number of qualified and competent persons to provide care, treatment, and services • Determination of qualifications and competence of dept or service practitioners who are not licensed to practice independently • Continuous assessment and quality improvement • Maintenance of quality control programs, as appropriate • Orientation and continuing education of persons in dept or svc • Recommending space and resources needed by the dept or service
37	• Process by which med staff at each hospital are advised of their right to opt out of unified& integrated medical staff structure after a majority vote to maintain a separate medical staff for their hospital. ***N.B.: Applies to multihospital systems with unified/integrated medical staff and deemed status****
38	When MS allows an assessment in lieu of a comprehensive H&P for patients receiving specific outpatient surgical or procedural services, MS bylaws specify that the assessment is completed and documented after registration, but prior to a procedure requiring anesthesia services.

Other Medical Staff and Related Standards

Standard	EP	DESCRIPTION
EM.12.02.03	**5**	Individuals responsible for granting disaster privileges to volunteer physicians and other licensed practitioners are identified in Medical Staff bylaws, rules and regulations, or policies and procedures.
MS.02.01.01		The medical staff executive committee makes recommendations, as defined in the bylaws directly to the governing body on, at least, all the following EPs 8-12 of this Standard.
	8	Medical staff membership
	9	The organized medical staff's structure
	10	The process used to review credentials and delineate privileges
	11	The delineation of privileges for each physician and other licensed practitioner privileged through the medical staff process
	12	The executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
MS.06.01.03	**4**	The credentialing process is outlined in the medical staff bylaws*
MS.06.01.05	**11**	Completed applications for privileges are acted on within the time period specified.
MS.06.01.13	**1**	Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.
MS.10.01.01	**5**	The fair hearing process developed by the medical staff must, with the governing body, provide a mechanism to appeal adverse decisions as provided in the medical staff bylaws

*Only basic steps must be included in the Bylaws. Details may be in the Rules and Regulations or policies, as applicable.

EP 1-11 of MS.01.01.01 may be in the bylaws, but they are not required to be. While discussion of Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation and their use may be contained in the Bylaws, they are not a required part of the Bylaws of the Medical Staff.
Updated: 7/1/23

1- Credentialing Process Discussion			
YES	**NO**	**Credentialing Discussion – If no issues found in document review, begin meeting with the discussion of the credentialing process.**	
☐	☐	Ask them to discuss the credentialing process – application, processing, role of department chair, Cred Comm, Medical Executive Committee, Governing Body. Basic steps must be in bylaws ***(See also: MS Bylaws Checklist for relevant EPs of MS.01.01.01)*** Privileges are granted for a period not to exceed 3 years. Physician and other licensed practitioner is notified in writing of the decision Re: appointment, reappointment, privileges.	**MS.02.01.01 EP8, 11** **MS.06.01.03 EP4** **MS.06.01.07 EP9** **MS 06.01.09 EP1**
☐	☐	Discuss how primary source verification (PSV) is performed for licensure, training, competence. Training and competence PSV in writing for privileges requested. Licensure at initial, renewal, and request for new privileges. (PSV for competency and training only on initial appt unless new/additional privileges requested.	**MS.06.01.03 EP6**
☐	☐	Evidence of Physician and Other Licensed Practitioner ID verification (Hospital or government-issued picture ID) DEA Registration, when required by MS, hospital, or state.	**MS.06.01.03 EP5** **LD.04.01.01 EP2** *Scored only if DEA has expired*
☐	☐	Are peer recommendations considered; how are "peers" defined and, if yes, did written peer recommendations include information regarding the medical/clinical knowledge, clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism of the physician or other licensed practitioner?"	**MS.07.01.03 EP1-4**
☐	☐	When are the National Practitioner Data Bank (NPDB) queries performed: Must be at least at initial/re-appointment and whenever new privileges are requested: Is there a statement regarding practitioner's health and ability to perform the requested procedures?	**MS.06.01.05 EP7** **MS.06.01.05 EP6**
☐	☐	Is there a process for evaluation of identified red flags Re: voluntary or involuntary: licensure reductions/termination, reduced/revoked privileges, MS membership terminations, etc. at the same or previous organizations? This should be a credible process that involves MS leaders.	**MS.06.01.05 EP9**
☐	☐	Is there an expedited credentialing process? If so, are at least 2 voting Board members on the approving committee? Are there established criteria for ineligibility, and do they include an incomplete application and adverse MEC recommendation?	**MS.06.01.11 EP1** **MS.06.01.11 EP2**
☐	☐	How are criteria for granting privileges determined and approved *(does the Governing Body approve?)* Do the criteria include licensure, training, evidence of current competency, peer recommendations, and information from other organizations, when applicable?	**MS.06.01.05 EP2**
☐	☐	Temporary privileges: Time periods must be defined in bylaw ***Must be no more than 120 Days***. (See also box 3 below - file review)	**MS.06.01.13 EP1**
☐	☐	**Telemedicine:** How are these credentialed? They should all be granted privileges by the originating site but may do so in the usual way **-OR-** By contractual arrangement to accept the credentialing information from a Joint Commission Accredited or CMS certified Organization **-OR-** Joint Commission accredited or CMS Certified accept the privilege decision of distant site if all of these are met by the distant site • and the privileges to be exercised are granted: List of privileges at distant site is provided • FPPE, OPPE information is shared • Physician or other licensed practitioner is licensed in the originating site's state	**MS.13.01.01 EP1**

☐	☐	**CME**: Requires that the MS sets priorities for CME topics **EP2** Requires CME resources are related to the scope of services of the organization **EP3** State CME should be related to outcomes of PI activities **EP4** Requires documentation of CME; and **EP5** Requires CME to be considered in the credentialing process	**MS.12.01.01 EP2-5**
2- FPPE/OPPE			
YES ☐	**NO** ☐	**FPPE for all initial or New Privileges** **EP1** Implemented for all practitioners in all clinical sites and privilege specific (includes Physicians, PAs, APRNs, CRNAs, Dietitians granted privileges to write orders, pharmacists with prescriptive authority, telemedicine practitioner, etc., exercised in all settings- inpatient or outpatient-on-site or off-site within the scope of the organization's survey; is a focused direct evaluation of the requested/exercised privileges) **EP2** The process including criteria is approved by the MS (evaluation should be qualitative and not just quantitative) **EP3** The process is 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)* **EP4** Applied consistently (*follow the same process step and documentation requirements for all evaluations)*	**FPPE: MS.08.01.01** (Review CITe for interim scoring guidelines)
☐	☐	**FPPE for Cause** **EP5** Triggers should be defined clearly *(i.e.in policy)* **EP6** Decisions to initiate FPPE for cause should be based upon objective measures of current performance reflective of quality and/or safety concerns. **EP7** Criteria are developed for type of monitoring to be conducted **EP8** Measures/actions to address performance issues are defined **EP9** These measures/actions are consistently implemented	**MS.08.01.01** (Review CITe for interim scoring guidelines)
☐	☐	**OPPE:** **EP1** There is a clearly defined process: e.g. a written policy, bylaw, or Rules and Regulations. The organization determines the frequency of the data collection and review, but this may not exceed 12 months. Process includes all physicians and other licensed practitioners in all clinical sites and includes methodology of data collection and who/how the data is reviewed and acted upon. **EP2** The process requires that the data to be collected is approved by the individual departments and the MS(MEC) or just the MEC there are no departments: • Aggregate (quantitative) or trended quality metrics are encouraged - e.g., SSI rates, complications, BUT: • Qualitative or chart review data may be used • The data must be RELEVANT to the specialty or privileges granted • Review of data that occurs only when triggered by an incident is NOT acceptable • When there are situations in which there is no other way to collect data or assets, then peer recommendations may be used (*low or no volume physicians or other licensed practitioners)* • Data must be from the organization except for low volume physicians or other licensed practitioners who have available data from other accredited or CMS certified organizations. However, any data obtained must be supplemental and cannot be used in lieu of a process to attempt to capture 'local' performance data • Use of quantitative (raw) data may be used, however, it cannot be the only type of data used to evaluate performance **EP3** The data collection, review, and analysis must be used to inform the credentialing process, i.e., it must be used in the process of determining whether to continue, reduce, or otherwise modify a physician's or other licensed practitioner's privileges. This review process should be consistent and	**MS.08.01.03** (Review CITe for interim scoring guidelines)

		documented. This review process should be ongoing, i.e., - reports reviewed when they are produced - not just at the time of the 3-year reappointment.	
Other items to review/confirm related to the medical staff.			
YES ☐	**NO** ☐	Does the Medical Staff (MEC) approve the Dietary Manual for the hospital? Frequency: MS approval should be a part of the usual periodic review of the policy and whenever the manual is substantively amended.	**PC.02.02.03, EP22**
☐	☐	The Medical Staff Approval by the radiology, nuclear medicine medical director or MEC are acceptable options to approve the qualification of the radiology and nuclear medicine technical staff Frequency: MS approval should occur initially and be a part of the usual periodic review of job descriptions and qualifications or whenever there is a substantive amendment or change in these qualifications	**MS.03.01.01 EP 16,17**
☐	☐	Is there a process for education of licensed practitioners in antimicrobial stewardship? Is there a process for education of licensed practitioners in pain management and safe use of opioid medication? *(These standards require evidence of process, but does not have to be documented in individual credentialing files)*	**MM.09.01.01 EP2** **LD.04.03.13** **NPSG.06.01.01 EP4**
☐	☐	Disaster Privileges This may be addressed in document review of the Disaster Privileges policy which must comply with all EPs Note: Bylaws document review should confirm that the individuals who may grant disaster privileges is specified in the Bylaws, rules and regulations or policy and procedures.	**EM.12.02.03** **(see also:** **MS.01.01.01 EP14)**

Updated 7/1/24

Credentials File Review Tool

Practitioner info				PSV Documents						Peer Recommendations					FPPE	OPPE	Administration	
Practitioner	Specialty	Application Type	Valid Picture ID (file copy not required)	Current License	Relevant Training	Current Competence	NPDB Review	Health Status	DEA Current? (if required by medical staff)	Medical/Clinical Knowledge	Technical/Clinical Skills	Interpersonal Skills	Communication Skills	Professionalism	Was FPPE process used for new applicant or new privileges?	Was OPPE data used for recredentialing decision?	Timeliness of decision and < 2 yr term	Board approval and letter to applicant

Other Medical Staff Standards to Review		
	Yes	No
Confirm qualifications of key department leaders—name, license and board certification:		
Respiratory		
Radiology		
Nuclear Medicine		
Emergency Department		
Psychiatry (Inpatient)		
Anesthesia		
(Refer to the Medical Staff chapter for relevant standards and EPs.)		

Updated: 12.2.20

Kitchen Tracer Survey Guide – Hospital and Critical Access Hospital

Updated: 12/19/24

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

PHYSICAL ENVIRONMENT

YES	NO		YES	NO	
☐	☐	Are areas kept clean? EC.02.06.01 EP 20	☐	☐	Is the area free of any signs of **pests**? If there are pests, has the organization taken steps to address the issue? EC.02.06.01 EP 20
☐	☐	**Kitchen equipment**; is it in safe operating condition? If there is an issue, does the staff have a plan to address it? *Manufacturer's recommended periodic maintenance schedule or an acceptable Alternate Equipment Management (AEM) program should be followed.* EC.02.06.01 EP 26	☐	☐	Are **cookware/dishware/Dishes/Utensils** stored in a clean, dry location? *There is no requirement for a solid bottom shelf for storage of food or cooking equipment. Use of solid bottom shelving is **an example** of a strategy that would be used.* Clean items are managed as per local/state food code, e.g., protected from contamination, such as splash, dust or other contaminants. The HCO determines how items will be protected in accordance with food code. IC.06.01.01, EP 3
☐	☐	Is **garbage/refuse** properly disposed of? EC.02.02.01 EP 19	☐	☐	Are **wet wiping cloths** stored in an approved sanitizing solution & washed daily? IC.06.01.01, EP 3
☐	☐	Are sinks clear from items that can be contaminated from splashes? *e.g., paper-wrapped straws* IC.06.01.01, EP 3	☐	☐	Are **food carts** cleaned & sanitized *after every meal.* IC.06.01.01, EP 3
			Advanced: You can ask a question regarding pest control services that have been accomplished.		

REFRIGERATOR					
YES	NO		YES	NO	
☐	☐	**Refrigerator temps:** have they been monitored? PC.02.02.03 EP11	☐	☐	Is **uncooked food** (chicken or other meat) stored away from cooked food to prevent contamination? *e.g., not stored over cooked food* PC.02.02.03 EP 11
☐	☐	Is frequency of **temp checks & limits** (41º or lower) maintained as per policy? PC.02.02.03 EP11	☐	☐	Is **prepared food** covered & labeled with expiration date? PC.02.02.03 EP 11
☐	☐	Is there a process if the temp is inadequate? *If possible,* PC.02.02.03 EP 11 *validate the process was followed.*	☐	☐	Are **open containers** labeled with expiration date? PC.02.02.03 EP 11
☐	☐	Is **food stored** away from soiled areas & rust? PC.02.02.03 EP 11	☐	☐	Are there any **expired items**? PC.02.02.03 EP 11
			☐	☐	Is the **locking mechanism** on the door in proper working condition? EC.02.06.01 EP 26
☐	☐	Is **food stored** to allow for ventilation? PC.02.02.03 EP 11	☐	☐	Is staff aware of how to use **safety process/mechanisms** in an emergency? EC.03.01.01 EP 2

DRY STORAGE					
YES	NO		YES	NO	
☐	☐	Are there any **expired items**? PC.02.02.03 EP 11	☐	☐	Is the **area** clean, dry, & well ventilated? *This will help with humidity & prevent growth of mold/bacteria.* PC.02.02.03 EP 11
☐	☐	Are **canned goods** properly sealed? PC.02.02.03 EP 11	☐	☐	Is **food stored** away from sources of heat/light? *This helps preserve shelf life.* PC.02.02.03 EP 11
☐	☐	Does the kitchen have food storage items/plans for **disaster preparedness**? *A 96-hour stockpile isn't required for emergency operations. The kitchen should have a role in response to an event, & it should correspond with the organization's Emergency Operations Plan.* EM.12.02.09 EP 3	☐	☐	Are **food containers** stored off the floor & away from walls to allow for adequate circulation? e.g., 6" above floor, protected from splashes. *There is no requirement for a solid bottom shelf for storage of food or cooking equipment. The HCO determines how such containers will be protected from splash, etc.* ***Use of solid bottom shelving is an example of a strategy that would be used.*** PC.02.02.03 EP 11

FOOD PREP ASSESSMENT - Interview			
YES	NO		
☐	☐	**Foodborne illness:** does the organization take prevention measures? Question if cases have occurred/been resolved. IC.06.01.01, EP 4	**Advanced: Ask about ladle size & how to determine appropriate proportions.**
☐	☐	**Sick employees or those with open wounds**; is there a procedure for them? PC.02.02.03 EP6 or IC.06.01.01, EP 5	**Advanced: Conduct HAZMAT tracer for corrosive lime-a-way used for decalcifying automated dishwashers. Assess adequacy of eyewash station, PPE usage, SDS, staff knowledge, etc.**
☐	☐	**Thawing food**; is there a process? *Validate the staff is following the process during observation. Food should not be thawing at room temperature & can be thawed under cold running water or the refrigerator.* PC.02.02.03 EP 6	

FOOD PREP ASSESSMENT - Observation					
YES	NO		YES	NO	
☐	☐	**Hand hygiene during food prep**; is staff using proper practices to prevent contamination of food and food surfaces, *e.g., washing after touching face or hair* PC.02.02.03 EP 6	☐	☐	**Monitor food temp checks for hot, cold and pre-cooked items undergoing the cooling process.** *Food should be cooled to 70° within 2 hours & to 41° within 4 & total cooling time should not exceed 6 hours.* PC.02.02.03 EP 6
☐	☐	Is **hand washing facilities** separate from ones used for food prep? EC.02.06.01 EP 1	☐	☐	Review **temp logs** – did staff maintain logs for each service during food prep? Is the process for monitoring temps in alignment with food code? *Temps are usually logged at start, midpoint & end if meal service is extended. Ensure adequate process for Potentially Hazardous Foods (PHF) and Time/Temp Controlled for Safety (TCS) Foods PC.02.02.03 EP 6.*
☐	☐	**Gloves**: do staff use when appropriate to prevent contamination? *e.g., handling raw meat or ready-to-eat foods* PC.02.02.03 EP 6			
☐	☐	**Hair nets**; are all staff members wearing? PC.02.02.03 EP 6	**Final cooking temps** should be as follows: PC.02.02.03 EP 6		
☐	☐	**Cutting boards/prep surfaces**; are they cleaned and sanitized properly to avoid contamination? E.g., one for meat, one for veggies & sanitized between uses IC.06.01.01 EP 3 Does the staff use **clean utensils** with bulk foods/ice? PC.02.02.03 EP 6	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	Poultry - 165° Ground meat, ground fish, eggs - 155° Fish & other meat - 145° Precooked, cooled, then reheated - 165° Hot food hold temp - 135° or higher
☐	☐	**Evaluate dishwasher temps/chemical monitoring processes** EC.02.05.05 EP 5	☐	☐	Cold food hold temp - 41° or below

FREEZER PC.02.02.03 EP 11 for food storage					
YES	NO		YES	NO	
☐	☐	**Freezer temps**: have they been monitored?	☐	☐	Is the freezer free of any ice buildup? EC 02.06.01 EP 26
☐	☐	Is frequency of checks & temp limits maintained as per policy? *Temps should ensure that food remains solid.*	☐	☐	Are items labeled appropriately with **expiration dates?** *There should be no expired items* PC 02.02.03 EP 11
☐	☐	Is there a process if the temp is inadequate? *If possible, validate the process was followed.*	☐	☐	If there is **pre-cooked food**, is the cooling process sufficient? *See refrigerator note* above PC 02.02.03 EP 11
☐	☐	Is food stored away from soiled areas & rust?	☐	☐	Is the **locking mechanism** on the door in proper working condition? EC.02.06.01 EP 26
☐	☐	Is food stored to allow for ventilation?	☐	☐	Is there a process/mechanism in place to prevent staff from being locked in? Can the mechanism be accessed, and is it in working order? *It shouldn't be blocked or have any ice buildup.*
☐	☐	Is the freezer free from any signs of **freezer burn/food discoloration**?			
☐	☐	Are **raw foods** stored properly? *There should be no signs of them dripping on other foods.*	☐	☐	Is staff aware of how to use safety process/mechanism in emergency? EC.03.01.01 EP 2

LIFE SAFETY

YES	NO		YES	NO	
☐	☐	Is the kitchen in good repair? e.g., lack of broken floor tiles, delamination, flaking walls, etc. EC.02.06.01 EP 1	☐	☐	Are the **gaskets** intact for kitchen entry/delivery doors to prevent entry from pests? EC.02.06.01 EP 1
☐	☐	Do **sprinkler heads** have adequate **18"** clearance? *Ensure racks perpendicular to walls do not encroach 18" open space for sprinklers. NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3* LS.02.01.35 EP 6	☐	☐	**Eyewash/shower station**; if required, is it in good working order & located away from hazards? EC.02.02.01 EP 5
			☐	☐	Can staff **access eyewash station** within 10 seconds of hazardous material storage/usage area? EC 02.02.01 EP 5
Evaluate sprinkler head obstructions in BOTH refrigerators & freezers. Be wary of surface mounted fluorescent light fixtures close to sprinkler heads as this does not follow the 18" rule. *Refer to attachment for specific criteria.*			☐	☐	Has the **eyewash inspection log** been kept up to date? EC 02.02.01 EP 5
			☐	☐	**Natural gas**: does the organization use this?
☐	☐	**Soda fountain machine**: is the CO2 secured? EC 02.05.09 EP 12	☐	☐	Is a **gas valve** accessible for emergency shutoff & do staff know its location/operation? EC.02.05.05 EP 6/ EC 03.01.01 EP 2
☐	☐	Are **sewage/pipelines** free from signs of water damage? EC 02.06.01 EP 1	☐	☐	Is **emergency shutoff valve** properly labeled? EC.02.05.01 EP 9
			☐	☐	**Tethering** – Kitchen appliances are required to have restraints or tethering. NFPA 54-2012, 9.6.1.2 LS.02.01.50 EP 1
☐	☐	**Deep fat fryer**; is there a **K fire extinguisher** within 30'? *NFPA 96–2011 10.10.1; NFPA 10–2010, 6.6.1; 6.6.2* LS.02.01.35 EP 11	***Evaluate the hood system***		
			☐	☐	Is the **hood clean** with no grease buildup? *NFPA 96-2011 11.6.2* LS.2.01.30 EP 26
☐	☐	**Deep fat fryer**: is it installed with at least a 16" space between the fryer & surface flames from adjacent cooking equipment? *NFPA 96–2011 12.1.2.4* LS.02.01.30 EP 26	☐	☐	Are the **steel filter baffles** all installed with no gaps & are they in the proper direction? *NFPA 96-2011 6.2.3.1; 6.2.3.5* LS.02.01.35 EP 12
☐	☐	**K fire extinguisher placard** identifying need to activate the fixed suppression (ansul) system before using the extinguisher? *NFPA 96-2011 10.2.2* LS.02.01.35 EP 11	☐	☐	Is **grease producing equipment** located properly under the hood? *NFPA 96-2011 5.2* LS.02.01.35 EP 12
☐	☐	**Suppression system**: does staff know how to use it? *Instructions for manual operations should be conspicuously posted & reviewed by staff. NFPA 96-2011 11.1.4* EC.03.01.01 EP 1	☐	☐	Are **extinguishing heads** pointed properly toward the cooking surface? LS 02.01.35 EP 12
			☐	☐	**Electrical panels**; are they clear from obstruction? *There should be 36"* EC.02.05.05 EP 6
☐	☐	**Compressed gas cylinders**: are they properly secured? *NFPA 99-2012 11.3; 11.6.2.3* EC.02.05.09 EP 12	☐	☐	**Fire Evacuation & Relocation Plan**; is the staff knowledgeable? *NFPA 101-2012: 18/19.7.1; 7.2* EC.03.01.01 EP 2

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Imaging Document Review Guide for Healthcare Organizations

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

1. Facilities and Equipment:

- Equipment quality control (QC) and performance maintenance (PM) activities for CT, MRI, PET, and NM equipment, with the dates completed (last 12 months) (EC.02.04.01, EP 5 and 10) (EC.02.04.03, EP 16 and 18)

- CT annual equipment performance evaluation: EC.02.04.03, EP 21
  Must be documented, done by medical physicist, and include:
  - Image uniformity
  - Slice thickness accuracy
  - Alignment light accuracy
  - Table travel accuracy
  - Radiation beam width
  - High contrast resolution
  - Low contrast resolution
  - Geometric or distance accuracy
  - CT number accuracy and uniformity
  - Artifact evaluation

- MRI annual equipment performance evaluation: EC.02.04.03, EP 22
  Must be documented, done by medical physicist or MRI scientist, and include
  - Image uniformity for all coils used clinically
  - Signal to noise ratio (SNR) for all coils used clinically
  - Slice thickness accuracy
  - Slice position accuracy
  - Alignment light accuracy
  - High contrast resolution
  - Low contrast resolution
  - Geometric or distance accuracy
  - Magnetic field homogeneity
  - Artifact evaluation

- NM annual equipment performance evaluation: EC.02.04.03, EP 23
  Must be documented, done by medical physicist or nuclear medicine physicist, and include
  - Image uniformity / system uniformity
  - High contrast resolution / system spatial resolution
  - Artifact evaluation
  - Sensitivity
  - Energy resolution
  - Count rate performance

- PET annual equipment performance evaluation: EC 02.04.03, EP 24
  Must be documented, done by medical physicist or nuclear medicine physicist, and include:
  - Image uniformity / system uniformity
  - High contrast resolution / system spatial resolution
  - Low contrast resolution or detectability
  - Artifact evaluation

- Fluoroscopy annual equipment performance evaluation: EC.02.04.03, EP 34
  Must be documented, done by a medical physicist, and include:
  - Beam alignment and collimation
  - Tube potential/ kilovolt peak (kV /kVp accuracy)

- Beam filtration (half value layer)
- High contrast resolution
- Low contrast detectability
- Maximum exposure rate in all imaging modes
- Displayed air-kerma rate and cumulative air-kerma accuracy (when applicable)

 Image Acquisition Display Monitor Performance Evaluations for CT, MRI, NM, PET: EC.02.04.03, EP 25
Must be performed as part of annual equipment performance evaluations and include:
- Maximum and minimum luminance
- Luminance uniformity
- Resolution
- Spatial accuracy

Often documented in the CT, MRI, NM, PET, and Fluoro annual equipment performance evaluation

 CT Dose Verification: EC.02.04.03 EP 20
- Annual report from medical physicist on the CTDI vol for adult and pediatric brain and abdomen protocols for each diagnostic CT imaging system

 Lead Apron Assessment: EC.02.04.01, EP 2. 4, 5 and EC.02.04.03, EP 3
- Inventory and inspection for cracks, tears, integrity

2. Radiation Protection and Radiopharmaceutical Management

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

Structural Shielding:

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

3. Clinical Policies and Protocols
- Critical Tests: Written procedures or protocols, and data collected on the timeliness of reporting critical results of tests and diagnostic procedures. NPSG. 02.03.01, EP1

- CT Protocols: Protocols must be based on current standards of practice and address clinical indication, contrast administration, pediatric or adult, patient size and body habitus, expected radiation dose range. Must include input from interpreting physician, lead imaging technologist, and medical physicist and be reviewed at timeframes established by hospital. PC.01.03.01, EP 25 and 26

- Supervision of Contrast Administration: Policy or protocol defining role of licensed practitioner in direct supervision of contrast administration, including timely intervention in the event of patient emergency. Either a pharmacist reviews orders for contrast OR a licensed practitioner controls the ordering, preparation, and administration of contrast. MM.05.01.01, EP 1

- MRI Safety: Policies address: claustrophobia, noise protection, metal detection, patient emergencies while in scanner, restricting access to scanner for all people not trained in MRI safety EC.02.01.01, EP 14 and 16

4. Reporting and Performance Improvement
- Data collected on thermal injuries during MRI: PI.01.01.01, EP 34
- Data collected on incidents and injuries where ferromagnetic objects unintentionally entered MRI scan room: PI.01.01.01, EP 35
- Data collected on incidents where radiation dose (CTDIvol, DLP, SSDE) exceeded the expected range Identified in the imaging protocol: PI.03.01.01, EP 6

5. Staff Competencies

- Credential files for all diagnostic medical physicists who work with CT. HR.01.01.01, EP 33
- Credential files including certification and annual training on dose optimization for CT techs: HR.01.01.01, EP 32, and HR.01.05.03, EP 14
- Credential files including annual training for all MRI techs on safe MRI practices: HR.01.05.03, EP 25

6. Leadership
   - Documentation / Radiology Director: must be a qualified MD or DO. MS.06.01.03, EP 9
   - Documentation / Nuclear Medicine: must be a qualified MD or DO. LD 04.01.05, EP 7
   - Documentation / Radiation Safety Officer: must be designated. LD.04.01.05, EP 25
   - Documentation of Medical Staff Approval (usually at Med Exec Comm Meeting) for:
     Qualifications of radiology staff who use equipment and administer procedures: MS.03.01.01, EP16
     Nuclear Medicine Director's specifications for the qualifications, training, functions, of nuclear medicine staff: MS.03.01.01, EP 17

7. Medical Records:
   - Reports, including medical record number, documenting radiopharmaceutical dose received for 5 recent inpatients. RC.02.01.01, EP 2
   - Reports, including medical record number, documenting contrast dose and radiation dose for 5 recent inpatients. RC.02.01.01, EP 2, and PC.01.02.15, EP 5
   - Reports, including medical record number, documenting fluoroscopy radiation dose for 5 recent inpatients. PC.01.02.15, EP 13

The Joint Commission

Infection Prevention and Control Program Assessment Tool
Hospital and Critical Access Hospital

Required Documents and Data

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

Table: Elements of Compliance and Scoring Guidance

Elements of Compliance	Standard(s)/EP(s)
Infection Prevention and Control Program & Leader(s)	
1. An infection preventionist(s) or infection control professional(s) has been appointed by the hospital governing body, based on the recommendation of the medical staff and nursing leaders, and is qualified through education, training, experience, or certification.	IC.04.01.01 EP 1
2. The hospital defines the qualifications for the infection preventionist(s) or infection control professional(s), which may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).	HR.01.01.01 EP 1
3. The infection preventionist(s)/infection control professional(s) perform the following activities in collaboration with all departments, programs, and areas involved in infection prevention and control activities: a. Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines b. Documentation of the infection prevention and control program and its surveillance, prevention, and control activities c. Competency-based training and education of hospital staff on infection prevention and control policies and procedures and their application	IC.04.01.01 EP 2

Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection (HLD). (For more information on competency requirements, refer to HR.01.06.01 EPs 1, 3, 5, 6) d. The prevention and control of healthcare–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures Note: Auditing tasks may be delegated to the appropriate staff (for example, unit-based liaisons or leaders); however, if delegation occurs, the infection preventionist(s) or infection control professional(s) must be updated on the results of auditing activities e. Communication and collaboration with all components of the hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and the water management program f. Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues.	
4. The infection prevention and control program reflects the scope and complexity of the hospital's services as evidenced by the following: a. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all staff providing patient care, treatment, or services. b. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all inpatient and outpatient care locations. c. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all care, treatment, and services (for example, hemodialysis, HLD/sterilization, respiratory therapy, wound care, dietary services, and laundry services). d. The scope of surveillance is consistent with infection control standards of practice and the scope and complexity of the hospital's services. e. Policies and procedures address the special populations served by the hospital (for example, pediatric patients, patients undergoing bone marrow transplant, hemodialysis, etc.) f. New hospital locations, services, and areas (for example, new ambulatory sites) are incorporated into the infection prevention and control program activities.	IC.04.01.01 EP 5
Hospital Leadership Responsibility and Program Resources	
1. The governing body ensures that the infection prevention and control program is operational and resourced to carry out and track its activities through the following: a. Resources must be adequate to accomplish the tasks required for the infection prevention and control program. This includes the following: i. Allocating human resources to mitigate infection risks and prevent transmission of infections (for example, nursing and environmental services staffing must be adequate to carry out infection prevention and control activities). ii. Allocating material resources to mitigate infection risks and prevent transmission of infections, such as information technology, laboratory services, equipment, and supplies. iii. Allocating sufficient information resources to guide program activities, such as access to local, state, and federal public health authorities' advisories and alerts (for example, the CDC's Health Alert Network [HAN]; FDA alerts); access to manufacturers' instructions for use; access to any standards and guidelines required by applicable regulation and the guidelines and consensus standards chosen by the hospital to inform policies and procedures (for example, guidelines and standards from ASHRAE, FGI, SHEA, AAMI, AORN, APIC Text, etc.) b. The governing body is ultimately accountable for the implementation, success, and sustainability of the program activities, while the medical director, nurse executive, and administrative leaders provide additional leadership support for the program. c. Hospital policies address the roles and responsibilities for infection prevention and control program within the hospital and how the various hospital committees and departments interface with the infection prevention and control program (for example, how to report infectious/communicable disease issues to the infection prevention and control program).	IC.05.01.01 EP 1

2. The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with the hospital's quality assessment and performance improvement (QAPI) leaders, and other leaders (for example, the medical director, nurse executive, and administrative leaders) as evidenced by the following: a. The hospital's QAPI program addresses problems identified by the infection control leader(s). b. The hospital leaders, including the CEO, the medical staff leader, and the nurse executive, monitor adherence to corrective action plans, assess the effectiveness of actions taken, and verify the implementation of revised corrective actions as needed. c. The hospital's governing body, the medical staff leader, the nurse executive, and administrative leaders must ensure that staff in-service training programs address problems identified through the infection prevention and control program.	IC.05.01.01 EP 2
3. **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. 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). Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program have the following characteristics: - Structured in a manner that accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered at each hospital - 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 - A qualified individual(s) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the hospital as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff.	LD.01.03.01 EP 27
Program Policies and Procedures	
1. The hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: - Applicable law and regulation. Note: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services Conditions of Participation, the Food and Drug Administration (FDA) regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. - Manufacturers' instructions for use. - Nationally recognized evidence-based guidelines and standards of practice, including The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures.	IC.04.01.01 EP 3

Note 1: For full details on CDC 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 2: The hospital determines which evidence-based guidelines, expert recommendations, or best practices, or a combination thereof, it adopts in its policies and procedures.	
2. 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 Note: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate and low-level disinfection) to be used for the three classes of devices. - The use of EPA-registered disinfectants for noncritical devices and equipment according to the directions on the product labeling, including, but not limited to, indication, specified use-dilution, contact time, and method of application - The use of FDA-approved liquid sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with the FDA-cleared label and device manufacturers' instructions - 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 the process for the use of immediate-use steam sterilization - 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
Risk Assessment	
1. The hospital identifies risks for infection, contamination, and exposure that pose a risk to patients and staff to prioritize program activities, including the following: a. The hospital includes risks from organisms with a propensity for transmission within health care facilities based on published reports and the occurrence of clusters of patients (for example, norovirus, respiratory syncytial virus ([RSV]), influenza, measles, and organisms with antimicrobial resistance such as Carbapenem-resistant Enterobacterales ([CRE]), *Candida auris*). b. The hospital evaluates risk based on the geographical location and population it serves, for example, risk for exposure to tuberculosis (TB). c. The hospital includes community data in its risk assessment, for example, community-onset cases of muti-drug resistant organisms. d. The hospital evaluates risk based on the care, treatment, and services it provides, for example, the types of procedures, medical equipment, devices, and supplies used. e. The hospital examines the risk of potential exposure to infectious materials, blood, body fluids, secretions, or excretions to make sure PPE is appropriate and available based on the tasks performed. f. The hospital uses the information from local, state, and federal public health authorities' advisories and alerts, such as CDC' Health Alert Network (HAN) and FDA alerts, to identify infection control risks. Note: The hospital determines how it keeps current on epidemiological risks or changes.	IC.06.01.01 EP 1

2. As reflected in the water management program documentation, the hospital includes a hospital risk assessment to identify where Legionella and other opportunistic waterborne pathogens (for example, Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the hospital water system.	EC.02.05.02 EP 2
3. As part of its infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair, the hospital requires an infection control risk assessment (ICRA) to define the scope of infection risk for the project and the need for barrier measures before a project gets underway.	EC.02.06.05 EP 2
4. The hospital reviews identified risks at least annually or whenever significant changes in risk occur.	IC.06.01.01 EP 2
Surveillance	
1. The hospital performs and documents surveillance activities to prevent and control healthcare–associated infections (HAIs). Note: The hospital conducts surveillance and reporting in accordance with law and regulation, its risk assessment, and in accordance with recognized surveillance practices, such as those set forth by the CDC's National Healthcare Safety Network (NHSN).	IC.06.01.01 EP 3
2. Surveillance of infections and infection prevention and control activities is conducted on a hospitalwide basis. Note: This does not imply surveillance is always conducted in all areas and locations of the hospital. The expectation is that the hospital must have reliable sampling or other mechanisms in place to permit identifying and monitoring infections and communicable diseases occurring throughout the hospital's various locations or departments.	IC.06.01.01 EP 3
Education, Training, and Competency Assessment	
1. The hospital provides job-specific training and education on infection prevention and control. The staff's records confirm completion of education and training. Note 1: Job-specific means that education and training are consistent with or tailored to the performed roles and responsibilities. For example, environmental services staff must be trained in the methods and procedures for surface disinfection. Note 2: The training and education must include the practical applications of infection prevention and control guidelines, policies, and procedures.	HR.01.05.03 EP 1
2. The hospital provides training to staff expected to have contact with blood or other potentially infectious material on the blood borne pathogen standards upon hire, at regular intervals, and as needed.	HR.01.05.03 EP 1
3. The hospital staff receive training in the following: a. When personal protective equipment (PPE) is necessary. b. What PPE is necessary. c. How to properly don, doff, adjust, and wear PPE.	HR.01.05.03 EP 1
4. The hospital defines and assesses staff competency in infection prevention and control. Note: Competency-based training must be job-specific. For example, the staff in the sterile processing department must demonstrate competencies in the methods and procedures of sterilization, and the staff in areas that perform high-level disinfection must demonstrate competencies in the methods and procedures for high-level disinfection.	HR.01.06.01 EPs 1, 3, 5, 6
5. The hospital develops and implements education and training and assesses competencies for the staff who will implement protocols for high-consequence infectious diseases or special pathogens.	IC.07.01.01 EP 2

Note: IC.07.01.01 applies to acute hospitals; the requirements under IC.07.01.01 are not applicable to psychiatric, physical rehabilitation, surgical specialty, long term care acute hospitals or swing beds.	
Outbreak Management	
1. There is a process in place for reporting to public health authorities when the transmission of infection occurs; this process is consistent with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks.	IC.06.01.01 EP 4
2. 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 - Implementing outbreak investigation - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate.	IC.06.01.01 EP 4
Standard Precautions: Hand Hygiene Note: The hospital policies and procedures on hand hygiene are in accordance with either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines, including the following:	
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
2. Set goals for improving compliance with hand hygiene guidelines.	NPSG.07.01.01
3. Improve compliance with hand hygiene guidelines based on established goals.	NPSG.07.01.01
4. Supplies necessary for adherence to hand hygiene (such as alcohol-based hand rub, soap, water, and a sink) are readily accessible in all areas where patient care is being delivered including but not limited to patient care areas and food and medication preparation areas.	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 b. At the bedside c. Staff workstations d. Other convenient locations	IC.06.01.01 EP 3
6. Hospital 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. Hospital staff perform hand hygiene using soap and water when hands are visibly soiled (for example, blood, body fluids) or after caring for a patient with known or suspected *C. difficile* or norovirus during an outbreak.	IC.06.01.01 EP 3

Note: In all other situations, alcohol-based hand rub is preferred.	
8. Hospital staff do not wear artificial fingernails and/or extenders when having direct contact with patients in accordance with hospital policy. Note: If following the *CDC Guideline for Hand Hygiene in Health-Care Settings*: when having direct contact with patients at high risk of infection (for example, those in intensive care units or ORs). If following the *WHO Guidelines on Hand Hygiene*: when having direct contact with patients.	IC.06.01.01 EP 3
Standard Precautions: Environmental Cleaning and Disinfection Note: Environmental cleaning and disinfection is performed in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. The hospital implements routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling, including the following: a. Surfaces in the patient care environment and areas are cleaned and disinfected on a regular basis, using an EPA- registered disinfectant. Note: High-touch surfaces (for example, bed rails, over-bed table, bedside commode, lavatory surfaces in patient bathrooms) are cleaned and disinfected more frequently than minimal-touch surfaces. b. Spills of blood or other potentially infectious materials are promptly cleaned and decontaminated, using appropriate EPA-registered hospital disinfectants.	IC.06.01.01 EP 3
2. 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
3. Mop heads and cleaning cloths are laundered at least daily using appropriate laundry techniques (for example, following manufacturers' instructions when laundering microfiber items).	IC.06.01.01 EP 3
4. The hospital has established and follows a schedule for areas/equipment (for example, refrigerators, ice machines, eye wash stations, scrub sinks) to be cleaned regularly.	IC.06.01.01 EP 3
5. After a patient vacates a room and before the bed linens and towels are replaced, all potentially contaminated surfaces in the room are thoroughly cleaned and disinfected.	IC.06.01.01 EP 3
6. Undamaged hospital bed mattress covers are cleaned and disinfected according to manufacturers' instructions. Any damaged, worn, or visibly stained hospital bed mattress or mattress covers are removed from service and cleaned, disinfected, refurbished, or discarded in accordance with manufacturers' instructions and hospital procedures.	IC.06.01.01 EP 3
Standard Precautions: Injection and Sharps Safety Note: Injection practices and sharps safety and disposal are performed in accordance with The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
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. If multidose vials are used for more than one patient, medication vials do not enter the immediate patient treatment area (for example, operating room, patient room, anesthesia carts). Note: If multi-dose vials enter the immediate patient treatment area, they must be dedicated for single patient use and discarded immediately after use.	IC.06.01.01 EP 3
7. Immediately or as soon as possible after use, contaminated sharps are discarded in puncture-resistant, leakproof (on the sides and bottom) sharps containers, and sharps containers are replaced when the fill line is reached.	IC.06.01.01 EP 3
Standard Precautions: Risk Assessment with Appropriate Use of Personal Protective Equipment Note: Appropriate personal protective equipment (PPE) is used in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Staff have immediate access to PPE and are able to select, put on, remove, and dispose of PPE in a manner that protects themselves, the patient, and others.	IC.06.01.01 EP 3
2. Gloves are worn when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur. The staff change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	IC.06.01.01 EP 3
3. A gown is worn that is appropriate to the task to protect skin and prevent soiling of clothing during procedures and activities that could cause contact with blood, body fluids, secretions, or excretions.	IC.06.01.01 EP 3
4. Protective eyewear and a mask or a face shield are worn to protect the mucous membranes of the eyes, nose, and mouth during procedures and activities that could generate splashes or sprays of blood, body fluids, secretions, and excretions. Note: Masks, goggles, face shields, and combinations of each are selected according to the need anticipated by the task performed.	IC.06.01.01 EP 3
5. PPE removal and disposal: - PPE, other than respirators, are removed and discarded upon completing a task before leaving the patient's room or care area. - If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door. - Disposable gloves are removed and discarded upon completion of a task or when soiled during the process of care.	IC.06.01.01 EP 3
6. Face masks (procedure or surgical) are worn by staff who are placing a catheter or injecting materials into the epidural or subdural space (for example, during myelogram, epidural, or spinal anesthesia).	IC.06.01.01 EP 3
Standard Precautions: Minimizing Potential Exposures Preparedness for High-Consequence Infectious Diseases or Special Pathogens	
1. Respiratory hygiene and cough etiquette instructional signage or handouts are posted and tissues, masks, and hand hygiene supplies	IC.06.01.01 EP 3

available at the points of entry to minimize potential exposures to or transmission of respiratory infection. Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics	
2. The hospital has developed and implemented protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following: - Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics. - Isolate: Procedures for transmission-based precautions - Inform: Procedures for informing public health authorities and key hospital staff - Required personal protective equipment and proper donning and doffing techniques - Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls Note: See the Glossary for a definition of hierarchy of controls. - Procedures for waste management and cleaning and disinfecting patient care spaces, surfaces, and equipment Note: IC.07.01.01 applies to acute hospitals; the requirements under IC.07.01.01 are not applicable to psychiatric, physical rehabilitation, surgical specialty, long term care acute hospitals or swing beds.	IC. 07.01 01 EP 1
Standard Precautions: Reprocessing of Reusable Medical Equipment Note: Reprocessing of reusable medical equipment is performed in accordance with the Spaulding classification system, manufacturers' instructions, and hospital policies and procedures.	
1. Only devices labeled as reusable are reprocessed directly by the hospital onsite or offsite via a reprocessing vendor. If the hospital elects to reuse any devices labeled for single use by the manufacturer, these devices are reprocessed by an entity that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital has documentation from the third-party reprocessor confirming this is the case.	IC.06.01.01 EP 3
2. Manufacturers' instructions for medical devices and equipment are available to the staff performing reprocessing. The hospital may use posters or other condensed methods to provide critical information to staff performing reprocessing to ensure reprocessing consistent with the instructions for use.	IC.05.01.01 EP 1
3. Reusable non-critical medical equipment (for example, blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes) are cleaned and disinfected according to manufacturers' instructions after each use or when visibly soiled.	IC.06.01.01 EP 3
4. Hydrotherapy equipment (for example, Hubbard tanks, tubs, whirlpools, spas, birthing tanks) are drained, cleaned, and disinfected using an EPA-registered disinfectant according to manufacturers' instructions after each patient use.	IC.06.01.01 EP 3
5. Responsibility for cleaning and disinfection of reusable noncritical patient-care equipment and devices is clearly designated.	IC.06.01.01 EP 3
High-level disinfection:	
6. 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

7. 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
8. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to high- level disinfection. For instruments with lumens (for example, endoscopes), pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3
9. Manufacturers' instructions are followed for the following: a. Enzymatic cleaners or detergents b. Reusable cleaning brushes c. Chemicals used in high-level disinfection, including instructions for preparation, testing for appropriate concentration, and replacement (for example, prior to expiration) Note: The results of testing for appropriate concentration are documented to ensure minimal effective concentration of the active ingredient. d. Disinfection temperatures and length of time e. Device rinsing following high-level disinfection f. If automated reprocessing equipment is used, manufacturers' recommended connectors are used to assure that all endoscope channels are appropriately disinfected.	IC.06.01.01 EP 3
10. Devices are dried thoroughly prior to storage/reuse in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
11. After high-level disinfection, devices are stored in a manner that protects them from damage or contamination.	IC.06.01.01 EP 3
12. The hospital has a system in place to identify which endoscope was used on a patient for each procedure.	IC.06.01.01 EP 3
Sterilization:	
13. All reusable critical items are sterilized prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
14. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to sterilization. Note: For instruments with lumens, pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3
15. Enzymatic cleaner or detergent is used and discarded according to manufacturers' instructions.	IC.06.01.01 EP 3
16. Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturers' instructions) at least daily.	IC.06.01.01 EP 3
17. After pre-cleaning, items are appropriately wrapped-packaged for sterilization (for example, the package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).	IC.06.01.01 EP 3
18. The sterilization process is monitored by using a combination of mechanical, chemical, and biological indicators to ensure the effectiveness of the sterilization process. Indicators are used in accordance with the sterilizer or sterilizer accessory (pouch, casket, tray, etc.) manufacturers' instructions.	IC.06.01.01 EP 3
19. For dynamic air removal–type sterilizers (for example, prevacuum steam sterilizers), an air removal test (Bowie-Dick test) is performed each day the sterilizer is used to verify efficacy of air removal in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
20. Sterile packs are labeled with the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date.	IC.06.01.01 EP 3

21. Logs for each sterilizer cycle are current and include results from each load, in accordance with the hospital policies and procedures. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4	IC.06.01.01 EP 3
22. After sterilization, medical devices and instruments are stored so that sterility is not compromised.	IC.06.01.01 EP 3
23. Sterile packages are inspected for integrity and compromised packages are repackaged and reprocessed prior to use.	IC.06.01.01 EP 3
24. 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
25. 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
26. Staff follow hospital policies and procedures in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use. 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
Transmission-Based Precautions Note: Transmission-based precautions are applied in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. The hospital implements transmission-based precautions based on the patient's clinical presentation and likely infection diagnoses (for example, syndromes suggestive of transmissible infections such as diarrhea, meningitis, fever and rash, respiratory infection) and adjusts or discontinues precaution per policies and procedures and clinical information. Note: Implementation of transmission-based precautions may differ based on the patient care settings (inpatient, outpatient, long-term care), facility design characteristics, and the type of patient interaction.	IC.06.01.01 EP 3

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

Hemodialysis Note: Infection prevention practices during hemodialysis procedure are performed in accordance with hospital policies and procedures including the following:	
1. Staff wear appropriate PPE (gloves, gowns, face, and eye protection) and perform hand hygiene throughout the procedure.	IC.06.01.01 EP 3
2. Staff perform appropriate central line care, including preparing catheter hubs prior to accessing for hemodialysis, connecting, and disconnecting from bloodlines after the procedure.	IC.06.01.01 EP 3
3. During the priming process, blood lines do not come into contact with contaminated prime waste.	IC.06.01.01 EP 3
4. For tasks requiring aseptic technique, the staff avoid contamination of gloves and other clean/sterile items, for example avoiding touching contaminated surfaces.	IC.06.01.01 EP 3
5. Environmental surface disinfection is performed, when no patient is present, including the following: a. The dialysis station b. Priming buckets c. Reusable equipment	IC.06.01.01 EP 3
6. Disposable supplies are discarded after the patient has departed the dialysis station in accordance with the local regulated medical waste law and regulation.	IC.06.01.01 EP 3
7. The hospital adheres to the policies and procedures to determine and document the hepatitis status of a dialysis patient. Note: For the absence of policies and procedures, score IC.04.01.01 EP 3	IC.06.01.01 EP 3
8. The hospital adheres to manufacturers' instructions and hospital policies and procedures for cleaning and disinfection of the dialysis machine used for the treatment of a patient with hepatitis B. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4	IC.06.01.01 EP 3
Laundry & Linen Note: Laundry is processed in a manner consistent with law and regulation and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Soiled textiles/laundry are handled with minimum agitation to avoid contamination of air, surfaces, and persons.	IC.06.01.01 EP 3
2. Soiled laundry is contained in leak-proof bags or containers at the point of use. Note: Hamper covers are not required in patient care areas.	IC.06.01.01 EP 3
3. Healthcare textiles are protected from environmental contamination during transport and storage. Note: Textiles/linens are covered if stored in a clean area in the inpatient unit or may be uncovered if stored in a dedicated clean storage area.	IC.06.01.01 EP 3
4. The receiving area for contaminated textiles is clearly separated from clean laundry areas and is maintained at negative pressure compared with the clean areas of the laundry in accordance with FGI construction standards in effect during the time of facility construction.	EC.02.05.01 EP 16
Dietary Services/Kitchen	

Note: Practices for the prevention of foodborne infections and diseases are performed in accordance with the federal, state, and local codes, law and regulation on food operations, and hospital policies and procedures.	
1. The hospital has written policies and procedures on sanitary and hand hygiene practices for its dietary services and kitchen staff.	IC.04.01.01 EP 3
2. The hospital provides a clean and sanitary environment in food storage, preparation, serving, and dishware storage areas, consistent with law, regulation, and food sanitation code. Note: Examples may include: a. Cutting boards, prep surfaces, work areas, trays and equipment are cleaned properly to avoid contamination and sanitized between uses. b. Different cutting boards/prep surfaces are used for meat, vegetables, and other food items. c. Handwashing sinks are available. d. Sinks are clear of items that can be contaminated by splashes. e. Raw food and ingredients are prepared and stored in a manner that prevents cross contamination with other foods (for example, to avoid dripping, liquid pooling, splashing). f. Dishes and utensils are air dried and stored in a manner that prevents cross contamination. g. Food carts are sanitized after every meal. h. Wet wiping cloths are stored in an approved sanitizing solution and washed daily.	IC.06.01.01 EP 3
3. The dietary services and kitchen staff comply with hand hygiene practices.	IC.06.01.01 EP 3
4. The hospital prepares food and nutrition products using proper sanitation and temperature, including the following: a. Food service staff wear hair or beard coverings, in accordance with hospital policies and procedures, b. Food service staff adhere to hand hygiene in accordance with hospital policies and procedures. c. The hospital monitors the food's temperature for hot and cold items during meal service. d. The hospital maintains proper temperature of refrigerated or warmed foods during preparation. e. The hospital follows the proper process for thawing of foods. f. The hospital monitors final cooking temperatures.	PC.02.02.03 EP 6
5. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation: a. Food is protected from contamination during storage. b. Food storage areas such as a refrigerator, cupboards, drawers, and bins are not soiled and protected from splashes and free of odors.	PC.02.02.03 EP 11
6. The hospital manages foodborne outbreak(s) and reports outbreak(s) to public health authorities, in accordance with law and regulation and hospital policies and procedures.	IC.06.01.01 EP 4
Surgical Services Note: Surgical services are performed in accordance with hospital policies and procedures including the following:	
1. Staff perform a surgical scrub before donning sterile gloves for surgical procedures using either an antimicrobial surgical scrub agent or an FDA-approved alcohol-based antiseptic surgical hand rub. After surgical scrub, hands and arms are dried with asterile towel (if applicable), and sterile surgical gown and gloves are donned in the OR.	IC.06.01.01 EP 3
2. Staff in the surgical area adhere to aseptic and sterile technique.	IC.06.01.01 EP 3
3. Staff and visitors wear surgical attire (e.g., scrubs) and surgical caps/hoods covering all head and facial hair in semi restricted and restricted areas.	IC.06.01.01 EP 3

Note: Restricted areas include ORs, procedure rooms, and the clean core (sterile supply) area. The semi restricted areas include the peripheral support areas of the surgical suite.	
4. Surgical masks are worn fully covering the mouth and nose by all staff in restricted areas where open sterile supplies or scrubbed staff are located.	IC.06.01.01 EP 3
5. The sterile field is maintained, including the following: a. Items used within the sterile field are sterile. b. Items introduced into the sterile field are opened, dispensed, and transferred in a manner to maintain sterility. c. The sterile field is prepared in the location where it will be used and as close as possible to time of use. d. Movement in or around sterile field is done in a manner to maintain sterility.	IC.06.01.01 EP 3
6. Traffic in and out of the OR is kept to a minimum and limited to essential staff.	IC.06.01.01 EP 3
7. All horizontal surfaces (for example, furniture, surgical lights, booms, equipment) are damp dusted before the first procedure of the day using a clean, lint-free cloth and an EPA-registered hospital detergent/disinfectant.	IC.06.01.01 EP 3
8. High-touch environmental surfaces are cleaned and disinfected between patients.	IC.06.01.01 EP 3
9. ORs are terminally cleaned after the last procedure of the day (including weekends) and each 24-hour period during regular work week. Terminal cleaning includes wet-vacuuming or mopping the floor with an EPA-registered disinfectant.	IC.06.01.01 EP 3
10. Anesthesia equipment surfaces that are touched by staff while providing patient care or while handling contaminated items are cleaned and low-level disinfected between use on patients according to manufacturers' instructions.	IC.06.01.01 EP 3
11. Exterior surfaces of anesthesia equipment that are not knowingly contaminated during patient care are terminally low-level disinfected at the end of the day according to manufacturers' instructions.	IC.06.01.01 EP 3
12. Internal components of the anesthesia machine breathing circuit are cleaned per manufacturers' instructions and hospital policies and procedures.	IC.06.01.01 EP 3
13. Reusable noncritical items (for example, blood pressure cuffs, ECG leads, tourniquets, oximeter probes) are cleaned and disinfected between patients.	IC.06.01.01 EP 3

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