Ambulatory Care Accreditation

Organization
Survey Activity Guide

September 2026

Issue Date: August 24, 2026

Summary of Changes

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

Changes listed below are effective: September 1, 2026

For ASC Deemed Status Surveys: Compliance with CfC §416.42 for Surgical Services was added under individual tracer activity. See page 23 for further information.

Ambulatory Care (AHC)
Organization Survey Activity Guide (SAG)

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How to Use this Guide

Joint Commission's Survey Activity Guide for ambulatory care organizations is available on your organization's *Joint Commission Connect* extranet site.

This guide contains:

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

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

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

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

Organizations surveyed under more than one accreditation manual or that have more than one service under one accreditation manual, will receive an activity list and agenda template for each of the programs being surveyed (e.g., behavioral, home care, laboratory).

For multiple services surveyed under a single accreditation program, be sure to include contact names and phone numbers from all your organization's services. For example, Ambulatory Care might have the following services: Ambulatory Surgery Centers, Diagnostic Imaging Services, Diagnostic Sleep Centers, or Urgent Care.

Also identify names or positions and phone numbers of activity participants from all the programs on these activity lists.

This Survey Activity Guide is created for small and large organizations. Some organizations will have one surveyor while others will have multiple surveyors. **For Ambulatory Surgical Centers using Joint Commission for deeming purposes, this will include a clinician(s) and Life Safety Code surveyor.** 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 Joint Commission at 630-792-3007 for assistance.

PRIOR TO THE SURVEY

Preparing for Surveyor Arrival

Applicability
Applies to Ambulatory Health Care programs.

Overview

The surveyor(s) arrive unannounced or with short notice for most surveys. Exceptions to the unannounced survey process include:

- Initial accreditation surveys that are not a Deemed Status survey (30-day advance notice)
- Early Survey Option – 1st and 2nd surveys that are not a Deemed Status survey (30-day advance notice)
- Intra-cycle Monitoring (ICM) Option 2 and Option 3 surveys

Exceptions to the unannounced survey process may change at any time. Changes are published in Joint Commission's newsletter *Perspectives*.

A seven-business day advance notice is given for the following Ambulatory Care Accreditation Program re-survey types:

- Very small Ambulatory as defined in the Accreditation Process section of the accreditation manuals (short notice)
- Department of Defense facilities
- Bureau of Prisons facilities and contracted prison facilities
- Immigration facilities
- Office-Based Surgery practices
- Telehealth Services
- Sleep Centers
- Ambulatory surgery centers that are not using accreditation for deemed status purposes
- Surgery/anesthesia services
- Medical/dental services
- Specified diagnostic/therapeutic services
- Mobile diagnostic services.

Please Note: Organizations offering procedures/services from more than one of the above service types (for example, surgery/anesthesia + medical/dental + telehealth) are **not** eligible for a short notice survey.

Planning in advance for the surveyor's arrival helps staff be better prepared for 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 that can be found on the Survey Document Lists for each accreditation program in the pages that follow. If these documents are not available when the surveyors arrive, they immediately begin to evaluate the care, treatment, or services provided to one of your patients served through an individual tracer.

Preparing for Survey

Prepare a plan for staff to follow when surveyor(s) arrive. The plan should include:

- Greeting surveyor(s): Identify the staff usually at the main entrance of your organization. Tell them about Joint Commission and what to do when the surveyor(s) arrive. Explain the importance of verifying any surveyor's identity by checking his or her Joint Commission picture identification badge. Also log into your *Joint Commission Connect* extranet site to validate the surveyor's identity when possible.

- Who to notify: Identify leaders and staff to notify when surveyors arrive, including the individual who will be the surveyor's "contact person" during the survey. Identify alternate individuals in the event that leaders and staff are unavailable. Create a list of their names and telephone numbers.

- A location for surveyor(s): Ask surveyors to wait in the lobby until an organization contact person is available. Surveyor(s) will need a location that they will call their

"base" throughout the survey. This location should have an electrical outlet, phone access, and internet access.

- Validation of survey: Identify who will be responsible for the validation of the survey and the identity of surveyors. Identify the steps to be taken for this process. (See Surveyor Arrival Session for these steps.)
- The Survey Readiness Guide is a tool that helps you plan the survey (See page 8).
- Document Lists: Your organization should be prepared to have documents available for the surveyor(s) 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 surveyor(s)
  - 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)
- Staff: Identify staff who will accompany the surveyors during the survey.
- Expectations for the survey: Identify your organization's expectations for the on-site survey and who will share these with the surveyor(s)

Survey Readiness Guide

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

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

The Survey Document List and Survey Activities list appears on the pages that follow. Please review them to assist you in preparing for your survey. The Survey Activities list includes the potential survey activities that can occur on an accreditation survey, including the suggested duration, and suggested timing for these activities. This information will allow your organization to begin identifying participants that need to be involved in the survey. The Survey Activities 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. Please work with your surveyor(s) to confirm the best day(s) and/or time(s) for specific survey activities to take place. Contact your Account Executive with any questions related to this information.

Survey Document List

As an Ambulatory Care organization, you will need to have the following documentation available for the surveyor(s) to review (depending on the type of survey or setting) during the Surveyor Arrival and Preliminary Planning Session.

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

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

Item No.	Items	Comments/ Notes
1	Performance / Quality Improvement Data from the past 12 months	
2	Infection Control surveillance data from the past 12 months	
3	Infection Control Plan	
4	Environment of Care management plans and annual evaluations	
5	Meeting minutes about Environment of Care topics for the 12-months prior to survey, if applicable	
6	Organization chart	
7	A map of the organization, if available	
8	List of all sites that are eligible for survey	
9	List of locations where services are provided, including anesthetizing locations	
10	List of locations where high-level disinfection and sterilization is in use	
11	Any reports or lists of patient appointment schedules or surgery schedules for each day of the survey	
12	A list of contracted services	
13	Name and extension of key contacts who can assist surveyors in planning tracer selection	
14	Most recent culture of safety and quality evaluation data	
For Ambulatory Surgery Centers (ASC) Deemed Status Surveys:		
15	List of surgeries from the past six months	
16	List of cases in the past 12-months, if any, where the patient was transferred to a hospital or the patient died **(Note: The 12-month time frame for this data applies to all ASC organizations seeking deemed status, whether undergoing a Joint Commission initial survey or resurvey.)**	

17	Documents related to the infection control program (e.g., description, policy, procedures, surveillance data)	
18	Infection Control Surveyor Worksheet	
19	Policy on Pre-surgical Assessments	
	See also the Ambulatory Surgical Center (ASC) Life Safety and Environment of Care Document List and Review Tool ASC_LS_EC_Document_List for more required documentation.	
Documents Related to CMS Emergency Management Final Rule applies to Deemed Ambulatory Surgical Centers, Rural Health Clinics, and Federally Qualified Health Centers Note: Document formats may vary, and many of the documents listed below may be included in the Emergency Management Plan.		
20	Prioritized Potential Emergencies (Hazard Vulnerability Analysis)	
21	Emergency Management Plan	
22	Documentation of review and update of Emergency Management Plan, including communication plans, every two years	
23	Continuity of Operations Plan	
24	Documented process for cooperation and collaboration with local, state, tribal, regional, federal EM officials in organization's service area	
25	Annual training	
26	Patient evacuation procedures	
27	Tracking system for patients sheltered on-site and patients relocated to alternate site	
28	Integrated EM system risk assessments, plan, and annual review	
For Bureau of Primary Health Care (BPHC) surveys:		
29	List of Board of Directors membership, including the user/patient/consumer status, occupational/areas of expertise, geographic location, and special population representation	
30	Board minutes (past 12 months on all surveys); annual Uniform Data System (UDS) report	
31	Most recent BPHC Notice of Grant Award (with any conditions or management assessment items)	
32	Items from most recent BPHC Grant Application: Health Care Plan, Scope of Services; Overall Summary (if available)	
33	Health Center's bylaws, strategic plan, and needs assessment	

Survey Activities

Activity Name	Suggested Activity Duration*	Scheduling Guidelines	Notes
Surveyor Arrival and Preliminary Planning, includes the Safety Briefing	30-60 minutes	1st day, upon arrival	
Opening Conference	15 minutes	1st day, as early as possible	
Orientation to Your Organization	30-60 minutes	1st day, as early as possible	
Individual Tracer	60-120 minutes	Individual Tracer activity occurs throughout the survey; the number of individuals who surveyors trace varies by organization	
Lunch	30 minutes	At a time negotiated with the organization	
Issue Resolution OR Surveyor Planning/Team Meeting	30 minutes	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	15-30 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary	
Competence Assessment and Credentialing & Privileging	30-60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Environment of Care and Emergency Management	45-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
System Tracer – Data Management	30-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization. If this is the only system tracer taking place during survey, the topics of Infection Control and Medication Management will be covered in this discussion.	
Leadership	60 minutes	Towards the middle or end of survey at a time negotiated with the organization	
Surveyor Report Preparation	60-120 minutes	Last day of survey	
CEO Exit Briefing	10-15 minutes	Last day of survey	
Organization Exit Conference	30 minutes	Last day, final activity of survey	
Life Safety Code Building Assessment	45-90 minutes	Occurs on all Ambulatory Surgical Center surveys, both deemed status and non-deemed status; to evaluate compliance with the Ambulatory Health Care Occupancies chapters of the Life Safety Code® (NFPA 101-2012) and Health Care Facilities Code NFPA 99-2012; Also occurs on surveys where four or more individuals are simultaneously rendered incapable of self- preservation	
Facility Orientation and Document Review	60-120 minutes	Occurs on all Ambulatory Surgical Center surveys, both deemed status and non-deemed status.	

Activity Name	Suggested Activity Duration*	Scheduling Guidelines	Notes
Emergency Management	60 minutes	Occurs on all Ambulatory Surgical Center surveys, both deemed status and non-deemed status.	
Program Specific Tracer – Continuity of Care	60-120 minutes	This focused tracer occurs during time designated for Individual Tracer Activity.	
System Tracer – Infection Control	30-60 minutes	Topic is most often covered during the Data Management system tracer and Individual Tracer Activity	
System Tracer – Medication Management	30-60 minutes	Topic is most often covered during the Data Management system tracer and Individual Tracer Activity	
Bureau of Primary Health Care Surveys only -- Governance Discussion	45-60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Bureau of Primary Health Care Surveys only – Clinical Leadership & Staff Discussion	60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	

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

DURING THE SURVEY

Surveyor Arrival and Preliminary Planning Session

Participants
Suggested participants include organization staff and leaders as identified in the Pre-survey Planning process, and individual or individuals that will provide the Safety Briefing to surveyors, if different than the accreditation contact or survey coordinator.

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

Surveyor Arrival Activities

- Notify key 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 Connect* extranet site. A staff member in your organization with a login and password to your *Joint Commission Connect* extranet website will follow through with this by:
    - Accessing Joint Commission's website at www.jointcommission.org
    - Under 'Action Center,' log in to your *Joint Commission Connect* extranet site
    - Enter a login and password
    - If you cannot access your *Joint Commission Connect* extranet site to validate the survey or surveyors, call your Account Executive

  Your organization's *Joint Commission Connect* extranet site contains the following information:
    - Confirmation of unannounced Joint Commission event authorizing the presence of the surveyor(s).
    - Surveyor name(s), picture, and biographical sketch
    - Copy of the survey agenda
- If you have not already downloaded a copy of your survey agenda, do so at this time.
- Begin gathering and present documents as identified in the Survey Document List applicable to your program(s). Surveyors will start reviewing this information immediately.

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

After the surveyor(s) identification has been verified, they will immediately begin planning for tracer activity by reviewing the documents you provide them (refer to the Survey Document List on the preceding pages). The surveyor(s) will 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)

For organizations surveyed under more than one accreditation manual or for more than one service under one accreditation manual, surveyors review information from all accredited programs. It is important to have documents available at this session for each program being surveyed*. See appendices for other accreditation program documentation lists and survey activities.*

For providers of Advanced Diagnostic Imaging (ADI) who serve Medicare beneficiaries and are using Joint Commission for ADI certification

- Organizations will receive no notice of the survey event prior to surveyor arrival.

For organizations electing Primary Care Medical Home (PCMH) certification

- If you have completed the "Primary Care Medical Home Self-Assessment Tool" provide it to the surveyor(s). A copy of the tool can be obtained on Joint Commission's ambulatory care section of the website.

For Ambulatory Surgery Centers (ASC) Deemed Status Surveys

- Two active patients are required at the time of survey, preferably during Day 1.
- Surveyors will observe at least one surgical procedure from the pre-operative phase through to the recovery room and discharge phase during the survey. A schedule of surgical procedures is needed for planning this observation.
- Surveyors will use the list of surgeries from the past six months to select a sample of closed medical records for review. At a minimum, surveyors will:
  - Select 20 records for a facility with a monthly case volume exceeding 50.
  - Select at least 10 records for lower volume ASCs.

  The sample size may be expanded as needed.
- Surveyors will ask to review your policy on pre-surgical assessments. The policy needs to address:
  - The timeframe for completing histories and physicals

- Patient-specific factors, such as age, diagnosis, type and number of same-day procedures, comorbidities, and type of anesthesia
- Intradepartmental and interdepartmental communication

Opening Conference

Participants
Suggested participants include members of the governing body and senior leadership (representing all accredited programs/services). Attendees should be able to address leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your organization's mission and strategic objectives. Leaders of the medical staff should also take part, when applicable.

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

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

- Describe the structure of the survey
- Answer questions your organization has about the survey
- Review your organization's expectations for the survey
- **For PCMH Certification Surveys:** Explain that the survey will include an evaluation of compliance with PCMH-specific requirements.

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

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

Orientation to the Organization

Participants
Suggested participants are the same as those in the Opening Conference. They include members of the governing body and senior leadership (representing all accredited programs/services). Attendees should be able to address leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your organization's mission and strategic objectives.

Duration
The suggested duration of this session is approximately 30-60 minutes, with more time added as needed to complete required evaluation activities.

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

Governance and operations-related topics for discussion include:

- Organization's mission, vision, goals, and strategic initiatives
- Organization structure
- Operational management structure
- Information management, including the format and maintenance of medical records
- Contracted services and performance monitoring of contracted services
- Patient safety initiatives
- National Patient Safety Goals (July 1 ,2019 for Medical Centers only: New and revised requirements at NPSG.03.05.01 related to anticoagulation therapy)
- Community involvement
- Leader's role in emergency management planning
- Organization activities related to risk awareness, detection and response as it relates to cyber emergencies
- Cleaning, disinfection, and sterilization processes
- As applicable to the organization's services: Pain assessment, pain management and safe opioid prescribing
- **For providers of imaging services, including fluoroscopy:** scope, types, locations, and safety
- **For PCMH Certification Surveys**: identify eligible sites

Discussion topics include:

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

- Management and leadership's oversight and other responsibilities

Senior Leadership Role in Improving Performance discussion topics may include:

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

  Note: Surveyor(s) will request examples of performance improvement initiatives including evidence that performance was achieved and sustained.

During this session, the surveyors will:

For PCMH Certification Surveys

- Ask about the **scope** of services provided, (i.e., acute, chronic and urgent care) and the **types** of services available, (i.e., pediatrics, obstetrics/gynecology, behavioral health, dentistry)
- Determine how the organization uses health information technology (HIT) to support continuity of care, and the provision of comprehensive and coordinated care
- The surveyors will also ask leaders to describe processes and infrastructure in place to support the provision of coordinated and comprehensive care, including:
  - 24/7 patient access to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
  - Addressing patient urgent health care needs 24/7
  - Identification of interdisciplinary team members
  - Use of an electronic prescribing process and in what locations/areas; and, if the process is not in use throughout the organization ask about plans to expand use
  - The type of providers that serve in the role of primary care clinician
  - Any sites that have non-physicians serving in the role of primary care clinician
  - Processes in place to support patient selection of a primary care clinician

For ASC Deemed Status Surveys

- Verify that the governing body has full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation
- Explore the operational management structure
- Identify who is responsible for directing nursing services and ask if this individual is a registered nurse
- Request and review governing body meeting minutes or other documents to verify governing body oversight and accountability for the ASC's Quality Assurance

Performance Improvement (QAPI) program. This review can occur during the Surveyor Planning Session or Special Issue Resolution.

- If applicable, select a sample of contractors working with the ASC and request to see documentation of the most recent contractor performance assessment conducted by the ASC. This review can occur during the Surveyor Planning Session or Special Issue Resolution.
- Surveyors will observe at least one surgical procedure during the survey. Be prepared to provide a schedule of surgical procedures.
- Ask about the types of radiologic procedures that are performed in the ASC, and explore whether they are limited to those that are integral to the procedures performed
- Explore whether the ASC has designated someone to be responsible for oversight of radiologic services

For providers of Advanced Diagnostic Imaging (ADI) who serve Medicare beneficiaries and are using Joint Commission for ADI certification

- Identify who serves as the medical director or supervising physician for advanced diagnostic imaging services.

Individual Tracer Activity

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

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

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

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

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

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

- Following the course of care, treatment, or services provided to the patient from entry to the organization through end of episode of care.
- Assessing the interrelationships between disciplines, departments, programs, services, or units Identifying issues that will lead to further exploration in the system tracers or other survey activities such as Environment of Care and Leadership Sessions

Surveyor(s) will try to protect patient confidentiality and privacy and they will seek the assistance of your staff in this effort. Surveyor(s) may use multiple patient records during an individual tracer. The record helps the surveyor follow the care, treatment, or services provided by the organization to the patient.

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

If there are multiple surveyors conducting the survey, they will make every effort to avoid visiting areas at the same time. Surveyors will try to minimize multiple visits to the same location, although they will need to follow the patient to the areas where services were provided.

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

- Care, treatment, or services being provided to patients by clinicians, including physicians
- The medication process (e.g., preparation, dispensing, administration, storage, control of medications)
- Infection control issues (e.g., techniques for hand hygiene, sterilization of equipment, disinfection, food sanitation, and housekeeping)
- The process for planning care, treatment or services
- The environment as it relates to the safety of patients and staff

For ASC Deemed Status Surveys: Surveyors will observe at least one surgical procedure during the survey.

- Surveyors will ask to review your policy on pre-surgical assessments. The policy needs to address:
  - The timeframe for completing histories and physicals
  - Patient-specific factors, such as age, diagnosis, type and number of same-day procedures, comorbidities, and type of anesthesia
  - Intradepartmental and interdepartmental communication
- Surveyors will review surgical procedures to make certain they are performed in a "safe manner" and that your organization follows acceptable surgical standards of practice in all phases of a surgical procedure, beginning with the pre-operative preparation of the patient, through to the post-operative recovery and discharge.
  - Acceptable standards of practice include maintaining compliance with applicable Federal and State laws, regulations and guidelines governing surgical services, as well as, any standards and recommendations promoted by or established by nationally recognized professional organizations (e.g., the American Medical Association, American College of Surgeons, Association of Operating Room Nurses, Association for Professionals in Infection Control and Epidemiology, etc.).

  Note: Ambulatory Surgical Centers that handle, store, or issue tissue are required to comply with Title 21 Code of Federal Regulations (CFR), Parts 1270 and 1271 addressing human cells, tissues, and cellular/tissue-based products (HCT/Ps).

During the individual tracer, the surveyor(s) will interview staff about:

- Intradepartmental and interdepartmental communication for the coordination of care, treatment, or services. (e.g., hand offs)
- The use of data in the care of patients, and for improving organization performance; their awareness and involvement in performance improvement projects
- Patient flow through the organization
- National Patient Safety Goals (July 1 ,2019 for Medical Centers only: New and revised requirements at NPSG.03.05.01 related to anticoagulation therapy)
- Patient education
- Orientation, education, and competency of staff
- The IM systems they use for care, treatment and services (paper, fully electronic or a combination of the two) and about any procedures they must take to protect the confidentiality and integrity of the health information they collect

    - Back up procedures they've been instructed to use if the primary system is unavailable
    - If internet-connected health information, equipment, or devices are used in care, treatment, or service, staff may be asked to describe their access procedures (passwords, authentication, etc.), confidentiality measures, and instructions on down-time procedures
    - How they approach risk awareness, detection and/or response as it relates to potential cyber emergencies
- As applicable to the organization's services: Pain assessment, pain management and safe opioid prescribing initiatives and resources made available by the organization; Prescription Drug Monitoring Database and criteria for accessing
- As applicable to the organization's services, the surveyor may select a patient receiving care, treatment, or services related to the organization's annual antimicrobial stewardship goal and discuss: Antimicrobial stewardship guidelines the organization is using and staff training and education about appropriate prescribing practices.
- Other issues

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

- Organization processes that support or may be a barrier to patient care, treatment, or services
- Communications and coordination with other licensed practitioners (hospitalists, consulting physicians, primary care practitioners)
- As applicable to the organization's services: Pain assessment, pain management and safe opioid prescribing initiatives and resources made available by the organization; Prescription Drug Monitoring Database and criteria for accessing
- As applicable to the organization's services, the surveyor may select a patient receiving care, treatment, or services related to the organization's annual antimicrobial stewardship goal and discuss: Antimicrobial stewardship guidelines the organization is using and provider training and education about appropriate prescribing practices.
- 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

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

- Coordination and timeliness of services provided
- Education, including discharge instructions
- Response time when a call bell is initiated or alarms ring, as warranted by care, treatment, or services
- Perception of care, treatment, or services
- Staff observance of hand-washing and verifying patient's identity
- Understanding of instructions (e.g., diet or movement restrictions, medications, discharge, and provider follow-up), as applicable

- As applicable to the organization's services: How staff involved them in their pain management plan of care, what their pain management plan of care includes (non-pharmacologic, pharmacologic or a combination of approaches)
- Rights of individuals served/patients/residents
- **For ASC Deemed Status Surveys:** Receipt of patient rights information
- Other issues

For PCMH Certification Surveys: The surveyor(s) will select a patient that has had a test ordered or a referral issued. During the individual tracer, the surveyor(s) will interview staff about:

- How staff track and follow-up on test results and referral, validated through a review of clinical records
- Whether recommendations or results from referrals are available to the primary care clinician
- Whether staff can identify the members of the patient's interdisciplinary team
- Whether staff can describe, how the interdisciplinary team works to collaborate on patient care
- Whether staff can describe how patient self-management goals are incorporated into the treatment plan; surveyors may ask to see examples in the clinical record
- How they assess patient health literacy

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

- Information provided to them to help select a primary care clinician
- Information provided to them about how the organization functions and the available services
- Directions they received about obtaining urgent care after the office/clinic is closed and if they have ever needed such care

For ASC Deemed Status Surveys:

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

- How and when the organization provided them with patient rights information --verbally and in writing and prior to the start of their surgical procedure
- Whether they received financial disclosure information in writing
- Whether they were provided with written information concerning organization policies on advance directives prior to the start of their surgical procedure. This includes a description of applicable state health and safety laws and a copy of the official state advance directive forms

The surveyor(s) will also ask about:

- Processes in place to ensure safe handling of hazardous materials and waste
- Radiation exposure monitoring procedures
- The ASC's timeframe for record maintenance

Special Issue Resolution

Participants
As requested by the surveyor or survey team

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

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

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

Surveyor Planning / Team Meeting

Participants
None

Duration
The suggested duration for this session is 30 minutes.

Overview
For surveys lasting more than one day, 30 minutes is scheduled toward the end of each day, except the last, for 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.

Before leaving the organization, the surveyor(s) will return organization documents to the survey coordinator / liaison. If surveyor(s) have not returned documents, your organization is encouraged to ask surveyor(s) for them prior to their departure.

Daily Briefing

Applicability
Applies to Ambulatory Health Care.

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

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

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

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

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

Competence Assessment and Credentialing & Privileging

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

Duration
The suggested duration for this session is 30-60 minutes, with more time added as needed to complete required evaluation activities.

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

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

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

The surveyor(s) 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, physicians, and other licensed practitioners.
- Orientation of staff, physicians, and other licensed practitioners to your organization, and/or job responsibilities.
- Experience, education, and abilities assessment.
- Ongoing education and training.
- Competency assessment, maintenance, and improvement.
- Competency assessment process for contracted staff, as applicable.
- Process for granting of privileges to physicians and other licensed practitioners.
- As applicable to the organization's services: Any educational materials that address the organization's annual antimicrobial stewardship goal and strategies promoting appropriate prescribing practices.
- Other topics and issues discovered during the tracer activity.

During this session, the surveyors will:

For ASC Deemed Status Surveys:

- Review a sample of staff records for non-physician licensed practitioners providing care in the ASC for evidence of:
  - Current licenses in good standing.
  - Qualifications.
  - Periodic performance evaluation in accordance with the ASC's policies.
- Review the staff files of contract staff to verify credentials, privileges, evidence of training, as applicable.
- Review the qualifications of individuals authorized to deliver anesthesia in the ASC, to determine if they are consistent with regulatory requirements.
- Verify that the individuals performing procedures have privileges granted by the governing body.
- Review a sample of credentials files for medical staff (See Sampling Table 1) who have been granted privileges for the following:
  - state licensure, registration, or state certification as applicable.
  - training and pertinent experience.
  - scope of privileges granted.
  - evidence that they are legally and professionally qualified to exercise privileges granted.
  - evidence of reappraisal within the timeframe specified in the ASC's policy.
- Review the personnel file of the individual designated as responsible for oversight of all radiologic services.
- Review personnel files of selected practitioners and staff for their qualifications and competency assessments related to assigned duties.
- Review staff record of the person responsible for directing infection control activities for evidence of training in infection control.

For PCMH Certification Surveys: Review the staff or credentials files of one or more clinicians serving in the role of primary care clinician (PCC) for evidence of broad-based education and experience in the provision of primary care.

For providers of Advanced Diagnostic Imaging (ADI) who serve Medicare beneficiaries and are using Joint Commission for ADI certification: Review the staff/credential file of the medical director or supervising physician of advanced diagnostic imaging services for evidence of training in advanced diagnostic imaging services obtained through:

- residency program
- experience
- continuing medical education courses.

Environment of Care and Emergency Management Session

Joint Commission Participants
Surveyor-clinical

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

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

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

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

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

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

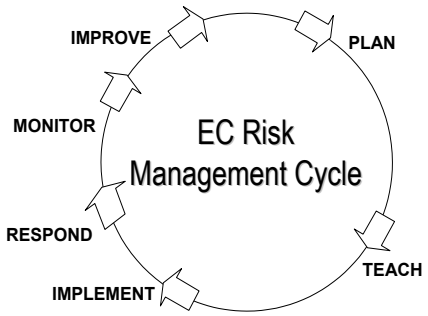
Overview
The duration of this session is **45-90 minutes** depending on the type of organization, services provided and facilities and will consist of two parts: Environment of Care/Emergency Management discussion and Environment of Care tracer.

During the first part of the session, there is a group discussion that takes approximately 70% of this session. The surveyor will initiate a discussion about the organization's environment of care practices that include a focus on high-risk areas, such as life sustaining medical equipment and fire prevention activities relevant to the service or setting where care is provided.

The surveyor will also initiate a discussion about the organization's recent emergency management activities that have occurred in the past 12–36 months. The EM discussion is broken into four distinct discussion topics as described below and the organization should be prepared to discuss the application and use of the emergency operations plan and policies and procedures during an emergency (real or simulated).

In the remaining time (approximately 30%) is spent as the surveyor observes and evaluates your organization's performance in managing a particular risk or management process in the environment of care. The management process or risk selected for observation is based on the environment of care documents previously reviewed, observation by other surveyors, and knowledge gained during the group discussion of this session.

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



Plan

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

Teach

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

Implement

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

Respond

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

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

Monitor

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

Improve

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

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

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

Emergency Management Discussion

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

Part 1: "Actual" emergencies or disaster incidents

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

Be prepared to discuss:

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

Part 2: Emergency exercises

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

Be prepared to discuss:

Describe the one (1) required annual exercise conducted.

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

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

Part 3: Education and training

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

Be prepared to discuss:

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

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

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

Be prepared to discuss:

- As a result of recent events and/or exercises, were any gaps identified in the emergency operations plan or policies or procedures?

- What lessons were learned? What was identified as opportunities for improvement based on recent events and/or exercises? How were they incorporated into revised plans, policies, and procedures?

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

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

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

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

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

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

- **For providers of Advanced Diagnostic Imaging (ADI):** Surveyors will select patients who have received advanced diagnostic imaging services to trace their experience. Tracers will take surveyors to the areas where these services are

performed allowing for evaluation of the services and equipment-related requirements:

- Documented procedures implemented to verify that quality images are being produced.
- Person or persons responsible for conducting annual performance evaluations for imaging equipment. If supporting CT or fluoroscopy, is that individual a medical physicist?
- A sample of annual performance evaluation reports to determine if they provide details about the tests performed, about each unit evaluated and specific recommendations for repair, replacement or recalibration.
- The results of quarterly staff dosimetry monitoring.

Emergency Management Session

Applicability
Applies to Deemed Ambulatory Surgical care and Non-deemed Ambulatory Surgical care with 4 or more patients who are incapable of self-preservation

Joint Commission Participants
Surveyor- Life Safety Code®

Organization Participants
Suggested participants include leaders and other individuals familiar with all aspects of emergency management (EM).

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

- Emergency management program
- Hazard vulnerability analysis
- Emergency operation plan and policies and procedures
- Communications plan
- Continuity of operations plan (applicable to deemed ASCs only)
- Recovery plan
- Education and training program
- Testing program (exercises/drills)
- Program evaluation (after-action/improvement plans)
- Unified and integrated EM program (if applicable)

Objective
To provide consistent and systematic review of the organization'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 organization's degree of compliance with relevant emergency management chapter standards and applicable law and regulation.

Overview
The surveyor initiates discussion about the organization's recent emergency management activities that have occurred in the past 12–36 months. The EM session begins with introductions of leadership and other 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 organization should be prepared to discuss the following topics.

Part 1: "Actual" emergencies or disaster incidents

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

Be prepared to discuss:

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

Part 2: Emergency exercises

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

Be prepared to discuss**:**

Describe the one (1) required annual exercise conducted.

- Did the organization conduct at least one operations-based exercise (either a full-scale, community-based or a functional, or facility-based exercise)?
- ***And,*** in the opposite year did the organization conduct at least one operations-based ***or*** a discussion-based exercise (such as mock disaster drill, a tabletop, seminar, or workshop)?
- Why was the exercise selected?
- Provide documentation of the exercise conducted.

Part 3: Education and training

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

Be prepared to discuss:

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

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

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

Be prepared to discuss:

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

For ambulatory surgical centers that elect to use Joint Commission deemed status organizations and choose to participate in their health care system's unified and integrated emergency management program

In addition to the above, be prepared to discuss:

- The organization's participation in the development of the unified and integrated emergency management program, emergency operations plan, policies and procedures, and the communication plan.
- The organization's specific community-based and facility-based risk assessments
- Involvement in systemwide exercises
- Participation in education and training
- Lessons learned and how the lessons learned/improvement opportunities are incorporated into the unified EM program.

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

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

Facility Orientation and Document Review – Life Safety Surveyor

Applicability
This activity applies to all Ambulatory Surgical Centers.

Joint Commission Participants
Life Safety Code Surveyor

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

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

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 Health Care Facilities Code standards (NFPA 99-2012).
- Review identified building systems, life safety drawings, and select policies to support the building tour activities.
- Review documentation related to 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 Joint Commission).
- Evaluate the effectiveness of processes for identifying and resolving *Life Safety Code® (NFPA 101-2012)* and *Health Care Facilities Code (NFPA 99-2012)* risks.
- Evaluate the effectiveness of processes for activities developed and implemented to protect occupants during periods when a building does not meet the applicable provisions of the *Life Safety Code® (NFPA 101-2012)* or during periods of construction.
- Evaluate the effectiveness of processes for maintaining fire safety equipment and fire safety building features.
- Evaluate the effectiveness of processes for maintaining and testing any emergency power systems.
- Evaluate the effectiveness of processes for maintaining and testing any medical gas and vacuum systems.
- Educate attendees on potential actions to take to address any identified *Life Safety Code® (NFPA 101-2012)* and *Health Care Facilities Code (NFPA 99-2012)* risks.

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

Life Safety Code® Building Assessment

Applicability
This activity applies to all Ambulatory Surgical Centers.

This activity also applies to all Ambulatory Health Care organizations designated as ambulatory health care occupancies (four or more individuals who are simultaneously rendered incapable of self- preservation).

Joint Commission Participants
- A Life Safety Code Surveyor will perform this activity in Ambulatory Surgical Centers seeking CMS recognition of their accreditation.
- A clinical or administrative surveyor will perform this activity on all other applicable Ambulatory Care surveys.

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

Duration
Surveyors will be guided by a variety of factors such as, age and condition of the facility, size of the facility, construction type, number of stories, sprinkler system, and utility systems, when deciding the time needed to complete required evaluation activities.

Overview
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.

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

During this session, the surveyor will:

- Evaluate the effectiveness of processes for maintaining fire safety equipment and fire safety building features according to *Life Safety Code® (NFPA 101-2012)* and *Health Care Facilities Code (NFPA 99-2012).*
- Evaluate the effectiveness of processes for identifying and resolving *Life Safety Code® (NFPA 101-2012)* and *Health Care Facilities Code (NFPA 99-2012)* problems.
- Evaluate the effectiveness of processes for activities developed and implemented to protect occupants during periods when a building does not meet the applicable provisions of the

Life Safety Code® (NFPA 101-2012) and *Health Care Facilities Code (NFPA 99-2012),* or during periods of construction.

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

The surveyor will also:

1. Meet with appropriate organization staff to become oriented to the:
    - Layout of the building (including arrangement of smoke compartments, location of any suites, age of building additions, areas with automatic sprinklers, areas under construction, and any equivalencies granted by the Center for Medicare and Medicaid Services (CMS).
    - Organization processes for Interim Life Safety Measures (ILSMs).

Building Tour

During the building tour, the surveyor will assess all areas and fire protection features based upon applicable code provisions, including, but not limited to the following:

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

- Assess the **main** fire alarm panel (if any)
- Assess the condition of emergency power systems and equipment
- Assess any medical gas and vacuum system components including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets

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

System Tracer – Data Management

Participants
Suggested participants include the individual who manages your organization's information management system and other key staff**.**

Duration
The suggested duration for this activity is 30-90 minutes depending on the number of days the surveyor(s) spend onsite and the size and complexity of your organization, with more time added as needed to complete required evaluation activities.

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

Surveyor(s) will review your organization's data and performance improvement projects during planning activity in order to discuss the following topics:

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

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

- Infection Control
- Medication Management
- National Patient Safety Goal data
- Performance Monitoring of contracted services
- Other federal or state required reports
- Incident/error reporting
- As applicable to the organization's services: Pain assessment, pain management and safe opioid use
- As applicable to the organization's services: Any data the organization is collecting, analyzing, or reporting related to the organization's annual antimicrobial stewardship goal.

For PCMH Certification Surveys:

- Verify that the organization is collecting the following data:
  - Patient experience and satisfaction related to access to care, treatment, or services
  - Patient perception of the comprehensiveness, coordination, and continuity of care, treatment, or services
  - Disease management outcomes

- Patient access to care within timeframes established by the organization
- Ask leaders how they are using data collected to improve their performance

Clinical Leadership and Staff Discussion

Applicability
Applies to the Unified Joint Commission Ambulatory Care and Bureau of Primary Health Care (BPHC) Survey.

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

Duration
The suggested duration of this session is approximately 60 minutes, with more time added as needed to complete required evaluation activities.

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

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

Based on prior survey findings and other available information the surveyor(s) assesses the following issues:
- Pre-entry and entry phases of the continuum of care
  - Linkage with and use of available information sources about the patient's needs
  - Linkages with other care settings within and/or outside your organization
  - Availability of and access to services consistent with your organization's mission, populations, and treatment settings or services to meet the patient's needs, including BPHC required services
  - Arrangements with other organizations and the community to facilitate entry and access to comprehensive health and social services
  - Referrals and transfers to meet the patient's needs and BPHC requirements
  - The use of clinical consultants and contractual arrangements

- Care within your organization
  - Scope of service being provided directly or indirectly; including those required by BPHC
  - Continuous flow of services from assessment through treatment and reassessment
  - Coordination of care among providers

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

Governance Discussion Session

Applicability
Applies to the Unified Joint Commission Ambulatory Care and Bureau of Primary Health Care (BPHC) Survey.

Participants
Required participants include at least the following:

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

Note: Board members may participate by conference call.

Duration
The suggested duration of this session is approximately 45 to 60 minutes, with more time added as needed to complete required evaluation activities.

Overview
During this session, the surveyor(s) will learn about your organization's governance, particularly as it pertains to compliance with BPHCs statutory and regulatory requirements.

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

The surveyor(s) will address the following topics:

- The structure and composition of the governing body
- The functioning, participation, and involvement of the governing body in the oversight and operation of your organization
- The level of communication among the board members
- The governing body's perception and implementation of its role in your organization, especially the governance, mission, and strategy expectations
- The governing body members knowledge of federal law and regulation
- The governing body's understanding of performance improvement approaches and methods and involvement in your organization's approach to performance improvement
- Pertinent Joint Commission Leadership standards relevant to the governing body's role in your organization
- **For PCMH Certification Surveys:** Explore the organization's reasons for pursuing PCMH certification. Determine if this certification fits with the organization's mission and goals.

The surveyor(s) will engage the participants in discussions regarding new processes or services in your organization, and about the collaboration and involvement of appropriate leaders and other individuals.

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

Leadership Session

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.

Duration
The suggested duration of this session is approximately 60 minutes, with more time added as needed to complete required evaluation activities.

Overview
During this session, the surveyor(s) will explore leadership's responsibility for creating and maintaining your organization's systems, infrastructure, and key processes which contribute to the quality and safety of care, treatment, or services.

The surveyor(s) will also discuss:

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

The surveyor(s) will facilitate a discussion with leaders to understand their roles related to performance of your organization-wide processes and functions. This discussion will be a mutual exploration of both successful and perhaps less successful organization performance improvement initiatives, or introduction of a new service or an optimal performing department, unit or area vs. one in need of improvement. The surveyor(s) 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 surveyor(s) 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.

- Improving health outcomes for all and the organization's efforts to reduce differences in the care provided across populations, 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 differences in the care provided to the patient population being served.
  - Differences in the care provided across patient populations identified for initial focus and status of efforts.
  - Key stakeholders that will be receiving reports and monitoring organization progress to improve health outcomes for all.
- As applicable to the organization's services: Pain assessment, management, and safe opioid prescribing
- As applicable to the organization's services: Antimicrobial stewardship efforts, including identification of an individual responsible for antimicrobial stewardship activities and the organization's annual antimicrobial stewardship goal.
- **For PCMH Certification Surveys**: How leaders evaluate the effectiveness of the interdisciplinary teams.

Surveyor Report Preparation

Participants
Surveyor(s)

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

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

CEO Exit Briefing

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

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

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

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

- Review the Summary of Survey Findings Report with the CEO/Administrator.
- Discuss any patterns or trends in performance revealed.
- Determine if the CEO/Administrator wishes to have an Organization Exit Conference or if the CEO/Administrator prefers to deliver the Summary of Survey Findings Report privately to their organization.
- **For PCMH Certification Surveys:** Identify those observations that directly relate to PCMH-specific requirements.
- **For ASC Deemed Status Surveys:** Identify those observations that directly relate to ASC-deemed status specific requirements. The surveyor(s) will also review any findings that relate to the Medicare Conditions of Coverage (CFC),
- **For providers of Advanced Diagnostic Imaging (ADI) who serve Medicare beneficiaries and are using Joint Commission for ADI certification:** Identify those observations that directly relate to ADI-specific requirements.

Organization Exit Conference

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

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

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

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

During this session, surveyor(s) will review the Summary of Survey Findings Report with participants. Discussion will include the SAFER™ matrix, Requirements for Improvement and any patterns or trends in performance. Surveyors will provide information about the revised Clarification process.

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

- **For PCMH Certification Surveys:** The surveyor(s) will identify those observations that directly relate to PCMH-specific requirements.
- **For ASC Deemed Status Surveys:** The surveyor(s) will identify those observations that directly relate to ASC-deemed status specific requirements. The surveyor(s) will also review any findings that relate to the Medicare Conditions of Coverage (CFC),
- **For providers of Advanced Diagnostic Imaging (ADI) who serve Medicare beneficiaries and are using Joint Commission for ADI certification:** The surveyor(s) will identify those observations that directly relate to ADI-specific requirements.

FOLLOWING THE SURVEY

After Your Joint Commission Survey

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

Post-Survey Activities

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

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

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

- Based on the review, staff may recommend a decision of Accreditation with Follow-up Survey or Preliminary Denial of Accreditation. Senior Leadership in the Division of Accreditation and Certification Operations and Division of Healthcare Improvement must review and approve the recommendation before sending it to Joint Commission's Accreditation Committee, which has final authority for assigning the accreditation decision. Your organization will be provided detailed instructions outlining next steps in the accreditation process.

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

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

- Upon the approval of your organization's ESC, your accreditation decision is posted to your *Joint Commission Connect* extranet site and to Quality Check (www.qualitycheck.org). *Note: Your organization's CEO and primary accreditation contact will receive an automated email notification. This decision will be updated to Quality Check the following business day.*

Resources

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

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

APPENDIX

Tips for Conducting Mock Tracers

When conducting mock tracers, consider the following criteria when selecting a patient to trace.

Selection Criteria

- Patients related to system tracers such as infection control and medication management.
- Patients who move between programs/services (for example, patients scheduled for a follow-up in: Ambulatory care, patients receiving behavioral health care, patients referred to a specialty provider within the same organization, patients who received radiology or laboratory services).
- Patients recently admitted.
- Patients due for discharge or recently discharged.

Ambulatory Health Care:
Surgery/Anesthesia Services

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

Medical/Dental Services:

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

Bureau of Primary Health Care:

Care provided to:

- School-based health center patients
- Homeless patients
- Migrant and seasonal farm workers
- Individuals in public housing
- Individuals with HIV/AIDS
- Pain Management (uncontrolled pain)
- High risk areas
- Equipment Maintenance
- Cleaning, disinfection, and sterilization
- Point of Care Testing (CLIA Waived Testing)

Program Specific Tracer – Continuity of Care

Applicability
Applies to Ambulatory Health Care.

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

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

Applicability
- Applies to Medical/Dental organizations only.
- Based on the size of the organization, the surveyor will conducted this session in settings where the expectation is that ongoing continuous care will be provide to patients.
- The surveyor may also conduct this session during surveys that include the Primary Care Medical Home (PCMH) certification option.

Overview
During this session, the surveyor(s) will:
- Evaluate the effectiveness of your organization's processes from prescribing a diagnostic study through the follow-up of the patient
- Identify processes and system level issues contributing to missed follow-up of diagnostic studies
- For PCMH Certification Surveys: Evaluate the effectiveness of your organization's processes for the referral and follow-up of patients to internal and external providers, services, and resources.

Organizations providing medical services, by design, have patients who often receive care from multiple clinicians. A frequently cited concern by care providers is missing an abnormal test result and failing to coordinate necessary follow-up. The surveyor(s) will conduct an in-depth evaluation of the communication, coordination, and continuity of care for a patient receiving laboratory or diagnostic studies, (and if seeking PCMH certification), the referral and follow-up processes being used for internal and external services.

The surveyor(s) will review the clinical record and may interview the patient, family, and other health care staff involved in the patient's care. In addition, the surveyor will also review the organization's tracking methods (e.g., referral logs), and follow-up processes.

System Tracer – Infection Control

Applicability
Applies to Ambulatory Health Care.

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

Duration
The suggested duration of this session is approximately 30-60 minutes, with more time added as needed to complete required evaluation activities. The surveyor(s) may need a quiet area for brief interactive discussion with staff who oversee the infection control process. The remaining session time is spent where care, treatment, or services are provided.

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

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

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

- Actions taken as a result of surveillance and outcomes of those actions

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

- **For ASC Deemed Status Surveys:** Determine if the infection control plan contains the required program components, that is, action plan for managing infections and immediate implementation of preventive and corrective measures.

  Use the Infection Control Surveyor Worksheet while conducting all aspects of this survey activity. The worksheet can be located on your *Joint Commission Connect* extranet site. Doing so will guide you in the evaluation of all the relevant issues around infection control and will help you gather all the information needed to complete the tool for submission.

System Tracer – Medication Management

Applicability
Applies to Ambulatory Health Care.

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

Duration
The suggested duration of this session is approximately 30-60 minutes, with more time added as needed to complete required evaluation activities. The surveyor(s) may need a quiet area for brief interactive discussion with staff who oversee the medication management processes. The remaining session time is spent where care, treatment, or services are provided.

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

The surveyor(s) will target a patient receiving a specific medication. The review begins with the individual's record of care then follows the medication throughout the system.

Other discussion issues include:
- Process for reporting errors, system breakdowns, near misses, or overrides
- Data collection, analysis, systems evaluation, and performance improvement initiatives
- Medications brought into an organization by the patient
- Education of staff and patient
- Information management systems related to medication management
- Patient involvement in medication management
- As applicable to the organization's services: Antimicrobial stewardship guidelines related to the organization's annual antimicrobial stewardship goal.
- **For PCMH Certification Surveys:** The organization's use of electronic prescribing. (Note: Electronic prescribing involves the electronic transmission of a prescription to a pharmacy and does not require the organization to have an electronic medical record in place.)
- Patient prescription refill process (for example, requests accepted 24/7)

SAMPLE SURVEY AGENDAS

SAMPLE SURVEY AGENDA - AMBULATORY CARE

Not for use on any Ambulatory Surgical Center survey

One Surveyor for Two Days

(Note: Start times and session length may be adjusted based on the type of services or settings.)

Day 1

Time	
8:00 – 8:30 a.m.	Surveyor Arrival and Preliminary Planning Session
8:30 – 9:00 a.m.	
9:00 – 9:30 a.m.	Opening Conference and Orientation to Organization
9:30 – 10:00 a.m.	
10:00 – 10:30 a.m.	Individual Tracer Activity
10:30 – 11:00 a.m.	
11:00 – 11:30 a.m.	
11:30 – 12:00 p.m.	
12:00 – 12:30 p.m.	
12:30 – 1:00 p.m.	Surveyor Lunch
1:00 – 1:30 p.m.	Individual Tracer Activity
1:30 – 2:00 p.m.	
2:00 – 2:30 p.m.	
2:30 – 3:00 p.m.	
3:00 – 3:30 p.m.	System Tracer – Data Management
3:30 – 4:00 p.m.	
4:00 – 4:30 p.m.	Special Issue Resolution or Surveyor Planning/Team Meeting

Day 2

Time	
8:00 – 8:30 a.m.	Daily Briefing
8:30 – 9:00 a.m.	Leadership Session
9:00 – 9:30 a.m.	
9:30 – 10:00 a.m.	Individual Tracer Activity
10:00 – 10:30 a.m.	
10:30 – 11:00 a.m.	
11:00 – 11:30 a.m.	
11:30 – 12:00 p.m.	Environment of Care and Emergency Management
12:00 – 12:30 p.m.	
12:30 – 1:00 p.m.	Surveyor Lunch
1:00 – 1:30 p.m.	Competence Assessment and Credentialing/Privileging
1:30 – 2:00 p.m.	
2:00 – 2:30 p.m.	Surveyor Report Preparation
2:30 – 3:00 p.m.	
3:00 – 3:30 p.m.	
3:30 – 4:00 p.m.	CEO Exit Briefing and Organization Exit Conference
4:00 – 4:30 p.m.	

Please Note: Ambulatory sites where four or more individuals are rendered incapable of self-preservation at the same time will include a Life Safety Code® Building Assessment.

SAMPLE SURVEY AGENDA - AMBULATORY CARE

Not for use on any Ambulatory Surgical Center survey

One or More Surveyors for Three Days

(Note: Start times and session length may be adjusted based on the type of services or settings.)

Day 1

Time	
8:00 – 8:30 a.m.	Surveyor Arrival and Preliminary Planning Session
8:30 – 9:00 a.m.	
9:00 – 9:30 a.m.	Opening Conference and Orientation to Organization
9:30 – 10:00 a.m.	
10:00 – 10:30 a.m.	Individual Tracer Activity
10:30 – 11:00 a.m.	
11:00 – 11:30 a.m.	
11:30 – 12:00 p.m.	
12:00 – 12:30 p.m.	
12:30 – 1:00 p.m.	Surveyor Lunch
1:00 – 1:30 p.m.	Individual Tracer Activity
1:30 – 2:00 p.m.	
2:00 – 2:30 p.m.	
2:30 – 3:00 p.m.	
3:00 – 3:30 p.m.	
3:30 – 4:00 p.m.	
4:00 – 4:30 p.m.	Special Issue Resolution or Surveyor Planning/Team Meeting

Day 2

Time	
8:00 – 8:30 a.m.	Daily Briefing
8:30 – 9:00 a.m.	System Tracer – Data Management
9:00 – 9:30 a.m.	
9:30 – 10:00 a.m.	Individual Tracer Activity
10:00 – 10:30 a.m.	
10:30 – 11:00 a.m.	
11:00 – 11:30 a.m.	
11:30 – 12:00 p.m.	
12:00 – 12:30 p.m.	Surveyor Lunch
12:30 – 1:00 p.m.	Individual Tracer Activity
1:00 – 1:30 p.m.	
1:30 – 2:00 p.m.	
2:00 – 2:30 p.m.	
2:30 – 3:00 p.m.	
3:00 – 3:30 p.m.	Environment of Care and Emergency Management
3:30 – 4:00 p.m.	
4:00 – 4:30 p.m.	Special Issue Resolution or Surveyor Planning/Team Meeting

SAMPLE SURVEY AGENDA - AMBULATORY CARE (cont'd)

Not for use on any Ambulatory Surgical Center survey

One or More Surveyors for Three Days

(Note: Start times and session length may be adjusted based on the type of services or settings.)

Day 3

Time	
8:00 – 8:30 a.m.	Daily Briefing
8:30 – 9:00 a.m.	Leadership Session
9:00 – 9:30 a.m.	
9:30 – 10:00 a.m.	Individual Tracer Activity
10:00 – 10:30 a.m.	
10:30 – 11:00 a.m.	
11:00 – 11:30 a.m.	
11:30 – 12:00 p.m.	
12:00 – 12:30 p.m.	
12:30 – 1:00 p.m.	Surveyor Lunch
1:00 – 1:30 p.m.	Competence Assessment and Credentialing/Privileging
1:30 – 2:00 p.m.	
2:00 – 2:30 p.m.	Surveyor Report Preparation
2:30 – 3:00 p.m.	
3:00 – 3:30 p.m.	
3:30 – 4:00 p.m.	CEO Exit Briefing and Organization Exit Conference
4:00 – 4:30 p.m.	

Please Note: Ambulatory sites where four or more individuals are rendered incapable of self-preservation at the same time will include a Life Safety Code® Building Assessment.

SAMPLE SURVEY AGENDA - AMBULATORY CARE

Two Surveyors for Two Days

(Note: Start times and session length may be adjusted based on the type of services or settings.)

Day 1

Time	
8:00 – 8:30 a.m.	Surveyor Arrival and Preliminary Planning Session
8:30 – 9:00 a.m.	
9:00 – 9:30 a.m.	Opening Conference and Orientation to Organization
9:30 – 10:00 a.m.	
10:00 – 10:30 a.m.	Individual Tracer Activity
10:30 – 11:00 a.m.	
11:00 – 11:30 a.m.	
11:30 – 12:00 p.m.	
12:00 – 12:30 p.m.	Surveyor Lunch
12:30 – 1:00 p.m.	Individual Tracer Activity
1:00 – 1:30 p.m.	
1:30 – 2:00 p.m.	
2:00 – 2:30 p.m.	
2:30 – 3:00 p.m.	
3:00 – 3:30 p.m.	System Tracer – Data Management
3:30 – 4:00 p.m.	
4:00 – 4:30 p.m.	Special Issue Resolution or Surveyor Planning/Team Meeting

Day 2

Time		
8:00 – 8:30 a.m.	Daily Briefing	
8:30 – 9:00 a.m.	Leadership Session	
9:00 – 9:30 a.m.		
9:30 – 10:00 a.m.	Individual Tracer Activity	Environment of Care and Emergency Management
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.	Competence Assessment and Credentialing/Privileging	Individual Tracer Activity
12:30 – 1:00 p.m.		
1:00 – 1:30 p.m.	Surveyor Lunch	
1:30 – 2:00 p.m.	Surveyor Report Preparation	
2:00 – 2:30 p.m.		
2:30 – 3:00 p.m.		
3:00 – 3:30 p.m.		
3:30 – 4:00 p.m.	CEO Exit Briefing and Organization Exit Conference	
4:00 – 4:30 p.m.		

Please Note: Ambulatory sites where four or more individuals are rendered incapable of self-preservation at the same time will include a Life Safety Code® Building Assessment.

SAMPLE SURVEY AGENDA - AMBULATORY CARE

Ambulatory Surgical Center Agenda – Deemed/Non-Deemed

Day 1

Time	Clinical Surveyor(s)	Life Safety Code Surveyor
8:00 – 8:30 a.m.	Surveyor Arrival and Preliminary Planning Session	Facility Orientation • Visit main fire alarm panel, generator, fire pump, if applicable • Discuss waivers and equivalencies • Review ILSM policy and procedures • Review written fire response plan • Review Life Safety drawings
8:30 – 9:00 a.m.		
9:00 – 9:15 a.m.	Opening Conference and Orientation to Organization	Opening Conference *Introductions only*
9:15 – 9:30 a.m.		Facility Orientation and Document Review
9:30 – 10:00 a.m.		
10:00 – 10:30 a.m.	Individual Tracer Activity	
10:30 – 11:00 a.m.		Life Safety Code® Building Assessment
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.	Surveyor Lunch	
12:30 – 1:00 p.m.	Individual Tracer Activity	Life Safety Code® Building Assessment continued
1:00 – 1:30 p.m.		
1:30 – 2:00 p.m.		Emergency Management
2:00 – 2:30 p.m.		
2:30 – 3:00 p.m.	System Tracer – Data Management	Document Findings
3:00 – 3:30 p.m.		
3:30 – 4:00 p.m.	Interim Exit Conference	Interim Exit Conference
4:00 – 4:30 p.m.	Special Issue Resolution or Surveyor Planning/Team Meeting	

Day 2

Time	Clinical Surveyor(s)	
8:00 – 8:30 a.m.	Daily Briefing	
8:30 – 9:00 a.m.	Leadership Session	
9:00 – 9:30 a.m.		
9:30 – 10:00 a.m.	Individual Tracer Activity	
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.	Competence Assessment and Credentialing/Privileging	Individual Tracer Activity
12:00 – 12:30 p.m.		
12:30 – 1:00 p.m.		
1:00 – 1:30 p.m.	Surveyor Lunch	
1:30 – 2:00 p.m.	Surveyor Report Preparation	
2:00 – 2:30 p.m.		
2:30 – 3:00 p.m.		
3:00 – 3:30 p.m.		
3:30 – 4:00 p.m.	CEO Exit Briefing and Organization Exit Conference	
4:00 – 4:30 p.m.		

OTHER SURVEY TOOLS & INFORMATION

ASC Life Safety and Environment of Care Document List and Review Tool

The Ambulatory Surgical Center (ASC) Life Safety and Environment of Care Document List and Review Tool presents standards from the Life Safety (LS) and Environment of Care (EC) chapters of the Comprehensive Accreditation Manual for Ambulatory Care (CAMAC). These standards, many of which require detailed documentation to demonstrate compliance, will be the immediate areas of focus for Joint Commission's Life Safety surveyor, if one is part of your on-site survey team. This is the same tool that the surveyors will use in their assessment work.

Organizations are not required to complete or present the tool to surveyors during the on-site visit. It is provided in this guide so that organizations can be prepared for surveyor documentation requests and use it as a tool in continuous compliance and survey readiness efforts.

Effective: 7/1/2024

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

Effective: 7/1/2024

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 organization)/*			
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 7					The organization 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					**Organization Manages Fire Risk – Fire Response Plan**			
EP 9					The written fire response plan describes the specific roles of staff during a 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 Staff periodically instructed on/kept informed of duties under the plan. Copy of plan readily available with telephone operator or security NFPA 101-2012: 20/21.7.1; 7.2	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
COMMENTS:								

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

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					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 Note: Water storage tanks and associated water storage equipment are not required to be tested. NFPA 72-2010: Table 14.4.5	Quarterly				
					Valve supervisory switches NFPA 72-2010: Table 14.4.5	Semiannual				
					Other supervisory initiating devices NFPA 72-2010: Table 14.4.5	Annually				
EP 2					Water flow devices (vane type and pressure type) NFPA 72-2010: Table 14.4.5	Semiannual				
					Mechanical water flow devices (including, but not limited to water motor gongs) NFPA 72-2010: Table 14.4.5	Quarterly				
					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				

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

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**					
					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	5 years				
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					
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 4 years thereafter				
EP 19					Smoke detection shutdown devices for HVAC tested NFPA 90A-2012: 6.4.1	Annually				

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

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 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. NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1	Annually				
EP 27					Elevators with firefighters' emergency operations, Phase I and II 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 (NFPA 99-2012)**			
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		

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

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 (NFPA 99-2012)**			
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		
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		

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

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 (NFPA 99-2012)**			
					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 CONDITION OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
EC.02.05.09					**Medical Gas and Vacuum Systems are Inspected and Tested (NFPA 99-2012)**				
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 patient gases, and inlets and outlets with activities, dates and results documented	Per policy			

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITION OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
EC.02.05.09					**Medical Gas and Vacuum Systems are Inspected and Tested (NFPA 99-2012)**				
					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, please provide five quarters of fire drill data)	Quarterly				

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
	C	NC	NA	IOU						
EC.02.03.03					**Fire Drills**					
					For full text, refer to NFPA 101-2012: 20/21: 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 – greater than one hour apart 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: 20/21: 7.1; 7.1.7; 7.2; 7.3	Quarterly (See fire drill matrix)				
EP 5					Critiques include fire safety equipment and building features, and staff response	YES	NO			
EP 7					The organization conducts annual fire exit drills for operating rooms/surgical suites. (For full text, refer to NFPA 99-2012: 15.13.3.10.3)	Annual				
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 practitioners, 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	Annual				
COMMENTS:										

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.01					**Manages risks associated with utility systems (NFPA 99-2012)**			
EP 7					In 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 relative humidity. *(form of and frequency of assessment per organization policy)* For new health care facilities or altered, renovated, or modernized portions of existing ventilation systems or individual components (constructed or plans approved on or after July 5, 2016), heating, cooling, and ventilation are in accordance with NFPA 99-2012, which includes 2008 ASHRAE 170, or state design requirements if more stringent. Existing systems are in compliance with the ventilation standards that were in effect at the time the facility was constructed or last modified. Note: Areas designed for control of airborne contaminants include spaces such as all classes of operating rooms, special procedure rooms that require a sterile field, caesarean delivery rooms, rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, airborne infection isolation rooms, rooms for patients with pulmonary or laryngeal tuberculosis, bronchoscopy treatment rooms), patients in "protective environment" rooms (for example, rooms for patients receiving bone marrow transplants), laboratories, pharmacies, sterile supply/processing rooms, and other sterile spaces.			

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

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	NC	NA	IOU			
EC.02.04.01					Management of Medical Equipment Risks		
EP 3					Inventory includes activities and associated frequencies for maintaining, inspecting, and testing all medical equipment on the inventory. Activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM) program.		
COMMENTS:							

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.04.03					Medical equipment inspection, testing and maintenance			
EP 2					All high-risk equipment. Note 1: High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment completed in accordance with manufacturers' recommendations must have a 100% completion rate. Note 3: Scheduled maintenance activities for high-risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the organization's AEM program.			
EP 3					Non-high-risk equipment identified on the medical equipment inventory Note: Scheduled maintenance activities for non-high-risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the organization's AEM program.			
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:								

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.05.05					**Utility system Inspection, testing and maintenance (NFPA 99-2012)**			
EP 3					The organization inspects, tests, and maintains the following: Utility systems. The completion dates and test results are documented. NFPA 72-2010: Table 14.4.5; 17.14			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.01.01.01					**The organization plans activities to minimize risks in the environment of care.**			
EP 1-9					The organization 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 Note: 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 organizations that use Joint Commission accreditation for deemed status purposes: The organization 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 Life Safety Code | The Joint Commission and NFPA 99-2012: 1.4.			

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

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

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

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

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy (Policy Review)		Implemented as required (Project Review)	
	C	NC	NA	IOU		Yes	No	Yes	No
LS.01.02.01					**Interim Life Safety Measures (ILSM)**				
EP 1					ILSM policy identifying when and to what extent ILSM implemented				
EP 2					Alarms out of service 4 or more hours in 24 hours or sprinklers out of service more than 10 hours in 24 hours in an occupied building - Fire watch / Fire Dept. notification				
EP 3					Signs for alternate exits posted				
EP 4					Daily inspection of routes of egress (See also 19.7.9.2 RE: daily inspections)				

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy (Policy Review)		Implemented as required (Project Review)	
	C	NC	NA	IOU		Yes	No	Yes	No
LS.01.02.01					Interim Life Safety Measures (ILSM)				
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:									

Ambulatory Surgical Center – Life Safety and Environment of Care Document List and Review Tool

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.02.01					**The organization manages risks related to hazardous materials and waste.**			
EP 1					The organization maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. (See also IC.02.01.01, EP 6; MM.01.01.03, EPs 1 and 2)			
EP 3					The organization 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 organization has the permits, licenses, manifests, and safety data sheets required by law and regulation.			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
EC.02.01.01					**The organization manages safety and security risks.**			
EP 1					The organization 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 organization'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 organization takes action to minimize or eliminate identified safety and security risks in the physical environment.			
COMMENT:								

Imaging Document Review Guide for Ambulatory Health Care Organizations

Rev. 04.07.25

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 10) (EC.02.04.03, EP 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 and EC.02.04.03, EP 3
  - Inventory and inspection for cracks, tears, integrity

2. Radiation Protection and Radiopharmaceutical Management

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

   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

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

- Supervision of Contrast Administration: Policy or protocol defining role of physician or other licensed practitioner in direct supervision of contrast administration, including timely intervention in the event of patient emergency. Either a pharmacist reviews orders for

contrast OR a physician or other licensed practitioner controls the ordering, preparation, and administration of contrast: MM.05.01.01, EP 1

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

4. Reporting and Performance Improvement
   - Data collected on thermal injuries during MRI: PI.01.01.01, EP 34
   - Data collected on incidents and injuries where ferromagnetic objects unintentionally entered MRI scan room: PI.01.01.01, 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 / Radiation Safety Officer: must be designated. LD.04.01.05, EP 25

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

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