Joint Commission International

Joint Commission International

Survey Process Guide for Hospitals

Including Academic Medical Center Hospitals

7th Edition | Effective 1 January 2021

Joint Commission International Mission

A division of Joint Commission Resources, Inc.

The mission of Joint Commission International (JCI) is to improve the safety and quality of care in the international community through the provision of education, publications, consultation, and evaluation services.

Published by Joint Commission Resources
Oak Brook, Illinois 60523 USA
https://www.jcrinc.com

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ISBN: 978-1-59940-994-8

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Questions About Accreditation

- For general inquiries regarding accreditation services, to schedule an accreditation survey, or to ask about the application process, please e-mail Joint Commission International Accreditation at jciaccreditation@jcrinc.com.
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- To comment about quality or safety at an accredited organization visit our webpage, https://www.jointcommissioninternational.org/contact-us/report-a-quality-and-safety-issue/.
- For general inquiries regarding advisory services, please e-mail JCI Consulting at jciconsulting@jcrinc.com.

Joint Commission International Surveys: General Information

Which Hospitals Are Eligible for a JCI Accreditation Survey?

Any hospital may apply for Joint Commission International (JCI) accreditation if it meets all the following criteria:

- The hospital is located outside of the United States and its territories.
- The hospital is currently operating as a health care provider in the country, is licensed to provide care and treatment as a hospital (if required), and, at minimum, does the following:
  - Provides a complete range of acute care clinical services—diagnostic, curative, and rehabilitative.
  - In the case of a specialty hospital, provides a defined set of services, such as pediatric, eye, dental, and psychiatry, among others.
  - For all types of hospitals, provides services that are available 365 days per year; ensures that all direct patient care services are operational 24 hours per day, 7 days per week; and provides ancillary and support services as needed for emergent, urgent, and/or emergency needs of patients 24 hours per day, 7 days per week (such as diagnostic testing, laboratory, and operating theatre, as appropriate to the type of acute care hospital).
- The hospital provides services addressed by the current JCI accreditation standards for hospitals.
- The hospital assumes, or is willing to assume, responsibility for improving the quality of its care and services.
- The hospital is open and in *full operation*, admitting and discharging a volume of patients that will permit the complete evaluation of the implementation and sustained compliance with all current JCI accreditation standards for hospitals.
- The hospital meets the conditions described in the current Accreditation Participation Requirements (APRs).

Academic medical center hospital applicants must meet each of the criteria above in addition to the following three criteria:

1) The applicant hospital is organizationally or administratively integrated with a medical school.
2) The applicant hospital is the *principal site* for the education of both medical students (undergraduates) and postgraduate medical specialty trainees (**for example**, residents or interns) from the medical school noted in criterion 1.
3) At the time of application, the applicant hospital is conducting *medical research* with approval and oversight by an Institutional Review Board (IRB) or research ethics committee.

Note: If in its reasonable discretion JCI determines that the applicant does not meet the eligibility criteria for the Hospital/Academic Medical Center Hospital accreditation program, JCI will not accept the application or will not process the application for accreditation from the hospital and will notify the hospital of its decision.

Definitions

Full operation

Criteria indicating the organization's readiness for comprehensive on-site evaluation against all relevant JCI standards, based on identification of the following in the organization's electronic application for survey (E-App):

- A list of all clinical services currently provided for inpatients and outpatients
- Utilization statistics for clinical services showing consistent inpatient and outpatient activity levels and types of services provided for at least four months or more prior to submission of the organization's electronic application
- All inpatient and outpatient clinical services, units, and departments

Principal site

The location at which an organization provides the majority of medical specialty programs for postgraduate medical trainees (for example, residents or interns) and not just one specialty, as in a single-specialty organization (for example, an ophthalmologic hospital, dental hospital, or orthopedic hospital).

Medical research

Basic, clinical, and health services research that includes many types of research studies, such as clinical trials, therapeutic interventions, development of new medical technologies, and outcomes research, among others.

How to Request a JCI Accreditation Survey

Hospitals that wish to be accredited by JCI can obtain an application for survey by accessing JCI's electronic application for accreditation (E-App) on the JCI website.

To begin the accreditation process as a **new applicant**, go to https://www.jointcommissioninternational.org/accreditation/request-more-information-on-accreditation/ and submit the requested information. When the initial registration form is received and approved, a login and password to *JCI Direct Connect*, JCI's client portal and the home of E-App, will be sent to your organization.

To begin the accreditation process for **reaccreditation**, go to the JCI website at https://www.jointcommissioninternational.org/ and click on the link "JCI Direct Connect" at the top of the page. Use the designated login and password issued to your organization.

Each organization is assigned a dedicated Account Executive. He or she will serve as your primary contact for any information, questions, or concerns you have with regard to JCI accreditation processes and practices. If you are unsure who the Account Executive assigned to your organization is, please e-mail the JCI Accreditation mailbox at jciaccreditation@jcrinc.com. Your e-mail will be forwarded to the assigned Account Executive for follow-up.

JCI requires organizations to submit one application for each hospital to be surveyed at minimum 6 months prior to the hospital's requested survey dates. JCI requests that the hospital provides no less than a 3-month range of dates (**for example**, January through March 2021) during which the survey can be scheduled. This allows JCI the flexibility to assign the most appropriate team of surveyors to your organization.

A hospital requesting an initial survey should request survey dates when the hospital is confident it will be able to demonstrate a 6-month track record of compliance with the standards at the time of the on-site survey (read more in "Accreditation Preparation").

In its E-App, the hospital must indicate 3 months when it would like the survey to take place. JCI will make every effort to accommodate these time requests. The earlier the request is submitted, the more likely the specific requests can be accommodated.

After the application for survey is received, JCI will review the information in detail and will provide you with an accreditation contract. The contract will specify the number of surveyors assigned to your survey, the duration of the survey, and the associated fees.

Upon receipt of the signed contract and a down payment of at least 50% of the survey fees, the survey will be scheduled and confirmed. The hospital will also receive notification of the name(s) of the surveyor(s) approximately 8 to 12 weeks in advance of the survey. The survey team leader will contact the person responsible for the hospital's survey approximately 4 to 8 weeks before the survey to finalize the agenda and to coordinate the availability of certain staff for key survey activities, as well as to provide information regarding the surveyor's(s') travel arrangements and logistics.

Handling Changes During the Application Process

As noted in the Accreditation Participation Requirements (specifically, APR.3; read more about APRs in "Section I: Accreditation Participation Requirements"), JCI collects core information regarding each hospital's profile in its E-App to understand ownership, licensure, and scope and volume of patient services, among other factors. When any of these factors change, JCI must evaluate the change to determine if the change is within or outside of the scope of a planned initial survey or the scope of a current accreditation award. Thus, the hospital notifies JCI within 30 days of the effective date of the change for the following:

- A change in hospital ownership and/or name
- The revocation or restriction of operational licenses or permits, any limitation or closure of patient care services, any sanctions of professional or other staff, or other actions under laws and regulations brought by relevant health authorities

- Alteration or changes in use of patient care buildings, construction of new or expansion of patient care buildings, or the occupation of buildings in new locations in the community, to expand the types and volume of patient care services 25% or more than was stated in the hospital's profile or was not reported as a patient care location in the E-App, or was not included in the scope of the previous accreditation survey
- Intentional expansion of the hospital's capacity to provide services in the absence of new, renovated, or expanded facilities by 25% or greater, as measured by patient volume, scope of services, or other relevant measures
- The addition or deletion of one or more types of health care services, such as addition of a dialysis unit or discontinuation of trauma care
- The hospital has merged with, consolidated with, or acquired an unaccredited site, service, or program for which there are applicable JCI standards.

JCI accreditation does not automatically extend accreditation to new services and facilities. Based on the change, JCI may request additional information or documents; **for example**, policies, floor plans, fire safety plan, credentials of new staff for a new service, and so on. When JCI is unable to fully evaluate the changes with the additional information or documents provided, an extension survey may be necessary for all or a portion of the hospital again or for the first time in the case of new facilities or services.

Evaluation of this APR begins during the electronic application process and continues as long as the hospital is accredited by or seeking accreditation by JCI. Changes reported may be evaluated off-site or by an extension survey.

If the hospital does not provide notification to JCI in advance or within 30 days of these changes, the hospital will be placed At Risk for Denial of Accreditation and an extension survey may be conducted. JCI requests all organizations to review and update their survey application to indicate any changes that may have occurred since the original application was submitted.

Survey Scheduling, Postponements, and Cancellations

Initial Survey Scheduling

JCI schedules surveys systematically and efficiently to keep accreditation fees to a minimum. Therefore, hospitals are encouraged to accept scheduled survey dates. Initial surveys (a hospital's first full accreditation survey) should be scheduled within 6 months from the time JCI receives the hospital's application for survey.

JCI tries to honor specific requests for times during which a hospital prefers not to be surveyed. The hospital should include these specific dates in the completed application for survey, when possible. There may, however, be circumstances that prevent JCI from accommodating these dates.

Postponement

JCI also allows the postponement of initial surveys or re-surveys. A postponement is a hospital's request to alter an already scheduled survey date or to push back the survey date before it is actually scheduled. A hospital should submit a request for a postponement via e-mail to jciaccreditation@jcrinc.com.

A hospital may postpone scheduled surveys when one or more of the following events occur:

- A natural disaster or another major unforeseen event that totally or substantially disrupts operations
- A major strike that causes a hospital to stop accepting patients, to cancel surgery and/or other elective procedures, and to transfer patients to other facilities
- Patients and/or the hospital are being moved to another building during the dates of the scheduled survey.

JCI reserves the right to conduct an on-site survey if the hospital continues to provide patient care services under such circumstances. Prior to postponing a scheduled survey, it is recommended that hospitals contact JCI Accreditation at jciaccreditation@jcrinc.com.

JCI understands that hospital operations may need to be modified to accommodate construction and temporary disruptions in service. These situations are expected as part of managing hospitals and do not require postponement of a scheduled survey.

If a hospital postpones the survey thirty (30) or fewer days prior to the first date of the survey for reasons other than those previously stated, JCI will require payment of all associated direct costs plus a postponement fee as outlined in the signed contract. If a hospital postpones the survey more than once after the survey dates are confirmed via e-mail by JCI, JCI will require a rescheduling fee. This rescheduling fee will increase for each postponement request. In the event that JCI postpones the survey for any reason or reasons other than those previously stated, JCI does not charge the organization a fee.

Cancellation

The survey may be canceled by JCI or the hospital without penalty or damages in the event that acts of God, wars, terrorism, or other similar emergencies or circumstances make it impossible, illegal, or unreasonable to go forward with a survey. Cancellation due to any of the reasons cited above must be communicated in writing as soon as possible. If the hospital cancels the survey thirty (30) or fewer days prior to the first day of the survey for any reason(s) other than those previously stated, JCI Accreditation will require payment of all associated direct costs plus a cancellation fee as outlined in the signed contract. If a hospital cancels the survey more than once after the survey dates are confirmed via e-mail by JCI, JCI will also require a rescheduling fee. This rescheduling fee will increase for each cancellation request. In the event that JCI cancels the survey for any reason or reasons other than those previously stated, JCI does not charge the organization a fee.

Tools for Accreditation Preparation, Including the Standards Manual

The JCI website, the *Joint Commission International Accreditation Standards for Hospitals Including Standards for Academic Medical Center Hospitals*, 7th Edition, and this publication are the tools hospitals can use to begin preparing for accreditation. JCI posts its key accreditation and certification policies and procedures on its public website. Organizations considering accreditation can review these policies and procedures to better understand the expectations before beginning the accreditation journey.

Even if hospitals do not pursue accreditation immediately, the website and standards manual are excellent tools to help evaluate the organization's current practices and structures. The Pathway to Accreditation (https://www.jointcommissioninternational.org/en/accreditation/pathway-to-accreditation/) outlines a 12-step process for pursuing accreditation. The manual contains functional standards that are organized around the way care is provided in a hospital setting. The standards address patient- and organization-focused performance, practices, and processes common to all hospitals. The manual is designed to be used in self-assessment activities and forms the basis for an accreditation survey.

The standards manual and its features are explained more fully below.

Section I: Accreditation Participation Requirements

This section consists of specific requirements for participation in the JCI accreditation process and for maintaining an accreditation award. For a hospital seeking accreditation for the first time, compliance with many of the Accreditation Participation Requirements (APRs) is assessed during the initial survey. For the already-accredited hospital, compliance with the APRs is assessed throughout the accreditation cycle, through on-site surveys, the Strategic Improvement Plan (SIP), and periodic updates of organization-specific data and information.

Hospitals are either compliant or not compliant with the APRs. When an organization does not comply with certain APRs, the organization may be asked to submit an SIP, or the noncompliance may result in being placed At Risk for Denial of Accreditation. However, refusal to permit performance of on-site survey activities, such as limiting or denying access to authorized JCI staff (APR.4), will lead to the loss or *Denial of Accreditation*. How the requirement is evaluated and the consequences of noncompliance are noted with each APR.

Please note that the APRs are not scored like the standards chapters, and their evaluation does not directly impact the outcome of an on-site initial or triennial accreditation survey.

Section II: Patient-Centered Standards

The next section of the manual contains standards related to the patient and includes the standards in the following paragraphs.

International Patient Safety Goals (IPSG)

The International Patient Safety Goals (IPSGs) promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence- and expert-based consensus solutions to problems related to patient safety. Recognizing that sound system design is intrinsic to the delivery of safe, high-quality health care, the goals generally focus on systemwide solutions, whenever possible.

Access to Care and Continuity of Care (ACC)

This chapter addresses the provision of care as part of a continuum of care. The goal is to correctly match the health care needs of the patient with the services available, coordinate the services provided, and then plan for discharge and follow-up care. The goal is to use resources more efficiently and improve patient care outcomes.

Patient-Centered Care (PCC)

This new chapter combined the "Patient and Family Rights" (PFR) and "Patient and Family Education" (PFE) of the 6th edition and addresses those concepts. Each patient and his or her family have their own unique needs, strengths, values, and beliefs. Health care organizations work to establish trust and open communication with patients and to understand and protect each patient's cultural, psychosocial, and spiritual values. Patient and family education helps patients better understand and participate in their care and make well-informed care decisions. Patient care outcomes can be improved when patients and, as appropriate, their families and/or those who make decisions on their behalf are well informed and involved in care decisions and processes in a way that matches their cultural expectations.

Assessment of Patients (AOP)

This chapter addresses patient assessment and reassessment within the hospital, including screening for pain and considerations for special patient groups and populations. Patient assessment takes place in both inpatient and outpatient departments and clinics. Assessment activities may vary between settings as defined by the hospital leaders. This chapter also includes standards that address laboratory services and diagnostic imaging/radiology services, as applicable to the hospital.

Care of Patients (COP)

Care of patients is provided by many disciplines and support staff. The delivery of care and services must be coordinated and integrated by all individuals caring for the patient. This chapter discusses activities basic to patient care, including processes for planning and coordinating care. The chapter also includes requirements related to high-risk services, resuscitation services, clinical alarm system management, food and nutrition therapy, pain management, laser safety, management of patients at risk of suicide or self-harm, and end-of-life care.

Anesthesia and Surgical Care (ASC)

Surgical anesthesia, procedural sedation, and surgical interventions are common and complex processes in a hospital. They require complete patient assessments, care planning, and comprehensive patient monitoring. This chapter addresses sedation and anesthesia use and surgical care. Topics include procedures for preparing, monitoring, and planning for aftercare for patients who received sedation or anesthesia and/or who had surgery.

Medication Management and Use (MMU)

Medications are an important component of care provided to patients. Medication management in the hospital must include processes that support safe and effective medication use. This chapter addresses systems and processes for selecting, procuring, storing, ordering/prescribing, transcribing, distributing, preparing, dispensing, administering, documenting, and monitoring medication therapies.

Section III: Health Care Organization Management Standards

The chapters in the third section of the manual examine the benefits of the hospital's management system for patients, focusing on core processes that support good management. Examples of core processes include leadership requirements, infection prevention and control, and the qualifications and education of staff.

Quality Improvement and Patient Safety (QPS)

It is essential that organizations have a framework to support ongoing quality improvement and patient safety. The standards in this chapter identify the structure, leadership, and activities necessary for a successful quality improvement and patient safety program. A successful program includes the collection and analysis of data on, and response to, organizationwide sentinel events, adverse events, and near-miss events. The standards also describe the central role of coordinating all the quality improvement and patient safety initiatives in the

hospital and providing guidance and direction for staff training and communication of quality and patient safety information.

Prevention and Control of Infections (PCI)

The goal of an organization's infection prevention and control program is to identify and to reduce or eliminate the risks of acquiring and transmitting infections. These standards address the methods a hospital uses to design and implement a program to identify and reduce the risk of patients and staff acquiring and transmitting infections. In addition, developing hospitalwide initiatives related to evolving health care practices, such as antibiotic stewardship and response to global communicable diseases, is addressed. Other areas covered in this chapter include the process for reporting infections and the types of ongoing surveillance activities that are in place.

Governance, Leadership, and Direction (GLD)

Effective leadership depends on successfully performing the following processes:

- Planning and designing services—defining a clear mission, including a vision of the future and the values that underlie day-to-day activities
- Directing services—developing and maintaining policies, providing an adequate number of staff, and determining their qualifications and competence
- Integrating and coordinating services—identifying and planning the clinical services required and integrating and coordinating those services throughout the organization
- Improving performance—playing a critical role in initiating and maintaining performance improvement activities for the organization

The GLD chapter focuses on the importance of the role of leadership in the organization's safe and effective operation.

Facility Management and Safety (FMS)

These standards measure the hospital's maintenance of a safe, functional, and effective environment for patients, staff members, and other individuals. Areas addressed include safety, security, hazardous materials, emergency management, fire safety, medical equipment, and utility systems. The chapter also addresses staff education regarding their roles in providing a safe and effective patient care facility.

Staff Qualifications and Education (SQE)

Hospitals need a variety of skilled, qualified individuals to fulfill their mission and to meet patient needs. This chapter includes sections on human resources planning; staff orientation, training, and education; staff competence assessments; and credentialing and privileging of licensed independent health care practitioners, nurses, and other health care practitioners. In addition, it is important to ensure staff physical and mental health, productivity, and satisfaction, as well as safe working conditions. The standards in this chapter address the requirements for a staff health and safety program.

Management of Information (MOI)

These standards address how well the hospital obtains, manages, and uses information to provide, coordinate, and integrate services. Although computerization and other technologies improve efficiency, the principles of good information technology management apply to all documentation methodologies. These standards are designed to be equally compatible with noncomputerized systems and current/future technologies.

Section IV: Academic Medical Center Hospital Standards

This section contains standards for hospitals being evaluated for Academic Medical Center Hospital accreditation only. These standards present a framework for including medical education and human subjects research into the quality and patient safety activities of academic medical center hospitals. Hospitals unsure of their eligibility for Hospital or Academic Medical Center Hospital accreditation status should see the

section "Which Hospitals Are Eligible for a JCI Accreditation Survey?" or contact JCI Accreditation at jciaccreditation@jcrinc.com.

Medical Professional Education (MPE)

Integrating education of medical students and trainees into a hospital's operations needs to be consistent with the hospital's mission, strategic plans, resource allocation, and quality programs. The MPE standards emphasize the safety and quality of care provided to patients cared for by trainees and students as part of the hospital's services. These standards address how the academic medical center hospital educates, supervises, grants privileges to, and otherwise incorporates its medical students and trainees into its care processes and other daily operations.

Human Subjects Research Programs (HRP)

Human subjects research is a major commitment for hospitals. Components of the commitment to research involve ethics, communication, responsible leadership, regulatory compliance, and financial and nonfinancial resources. This chapter describes the requirements for hospital leaders, staff, and research sponsors in establishing and maintaining accountable, properly scoped, ethical, legal, and patient-centric human subjects research programs.

Summary of Key Accreditation Policies

The JCI policies and procedures are summarized and located following the accreditation standards in the standards manual. Full versions of the JCI policies and procedures are published on JCI's public website at https://www.jointcommissioninternational.org/standards/accreditation-policies-and-procedures/.

Scoring Guidelines

During an on-site survey, each measurable element (ME) of a standard is scored as either "fully met," "partially met," "not met," or "not applicable." The purpose of the following guidelines is to bring an understanding and consistency to the assignment of these scores, recognizing that many types of evidence will be examined prior to the survey team arriving at a final score for each ME.

Annual Requirements and the Track Record

Annual requirement refers to an activity (such as an evaluation, an inspection, testing of equipment or utilities, and the like) that must be done on a yearly basis. The start and end of the "year" does not necessarily have to follow a calendar year and may actually follow the organization's fiscal year if desired. For survey purposes, the look-back for something that is required to be done annually will be the year previous to the survey dates. **For example**, if a survey is scheduled for 17 January 2021, surveyors will look for completion of an annual requirement anytime within the previous 12 months (back to 17 January 2020). Thus, if a utility inspection was performed on 12 January 2020, the organization would be required to have its next utility inspection completed by 12 January 2021. A 6-month track record does not apply to annual requirements. Organizations are expected to meet all standards identifying an annual requirement.

A track record is used when looking at the expected length of time that something has been in place (such as measurement collection, policy and procedure implementation, processes, and the like). In general, the survey team will look for a 6-month track record for an initial survey and a 12-month track record during a triennial survey that will be effective until 31 December 2020. Beginning 1 January 2021, the survey team may look back from the date of the previous survey for all hospitals undergoing a triennial survey. **For example**, in preparing for an initial survey an organization initiates a new policy on patient and family rights. Because this is a new policy and procedure and the organization has never been surveyed before, surveyors will look for a 6-month track record of implementation. Thus, they will expect to find that over the past 6 months, every patient was provided with information pertaining to his or her rights and responsibilities, and when interviewing staff, they will expect a consistent response regarding how long this policy/procedure was in effect.

On the other hand, if this same organization initiates a new policy or program on annual testing of the disaster program (FMS.11) the organization will be expected to have conducted the first testing of this program prior to the survey date. The organization is **not** given a year from the date of policy/program implementation to conduct the testing. Standard FMS.11, ME 4, requires the organization to test its disaster program at least annually. In order to be in compliance with the standard, it is not sufficient to simply have a policy or process in place; the policy/process must be implemented, and this requires that testing must have already been performed.

If the organization going through an initial survey already has a process in place for testing its disaster program annually, surveyors may look back over the previous 12 months to see that an annual test has occurred. **For example**, if the initial survey is conducted 8–12 February 2021 and the organization conducted its annual testing of the disaster program on 3 March 2020, this would meet standard FMS.11, ME 4.

Determining the Score

"Fully Met" Score

An ME is scored "fully met" if the answer is "yes" or "always" to the specific requirements of the ME. Also considered are the following:

- A single negative observation may not prevent a score of "fully met." (Also see "Consideration of Impact and Criticality.")
- If 90% or more of observations or records (**for example**, 9 out of 10) are met

The track record related to a score of "fully met" is as follows:

- For triennial surveys before 31 December 2020, a 12-month look-back period of compliance
- For triennial surveys on or after 1 January 2021, surveyors may look as far back as the date of the hospital's previous full survey
- For initial surveys, a 6-month look-back period of compliance
- No look-back period for a follow-up survey; sustainability of improvement is used to evaluate compliance

"Partially Met" Score

An ME is scored "partially met" if the answer is "usually" or "sometimes" to the specific requirements of the ME. Also considered are the following:

- If 50% to 89% (**for example**, 5 through 8 out of 10) of records or observations demonstrate compliance
- There was a finding of "not met" for the ME during the last full survey, follow-up survey, or other subsequent survey, and now the finding is 75% to 89% observations of compliance.
- Evidence of compliance cannot be found in all areas/departments in which the requirement is applicable (such as inpatients but not outpatients, surgery but not day surgery, sedating areas except dental).
- When there are multiple requirements in one ME, at least half (50%) are present.
- A policy/process is developed, implemented, and sustainable but does not have the track record required for "fully met."
- A policy/process is developed and implemented but does not seem to be sustainable.

The track record related to a score of "partially met" is as follows:

- The requirements of the ME are "fully met"; however, there is only
  - a 6- to 11-month look-back period of compliance for triennial surveys; or
  - a 3- to 5-month look-back period of compliance for initial surveys.
  - No look-back period for a follow-up survey; sustainability of improvement is used to evaluate compliance.

"Not Met" Score

An ME is scored "not met" if the answer is "rarely" or "never" to the specific requirements of the ME. Also considered are the following:

- If 49% or fewer (**for example**, 4 or less out of 10) records or observations demonstrate compliance
- There was a finding of "not met" for the ME during the last full survey, follow-up survey, or other subsequent survey, and now the finding is 74% or fewer observations of compliance.
- When there are multiple requirements in one ME, 49% or fewer are present.
- A policy/process is developed but is not implemented.

The track record related to a score of "not met" is as follows:

- The requirements of the ME are "fully met"; however, there is only
  - a less than 6-month look-back period of compliance for triennial surveys; or
  - a less than 3-month look-back period of compliance for initial surveys.
  - No look-back period for a follow-up survey; sustainability of improvement is used to evaluate compliance.
- If an ME of a standard was scored "not met" and some or all of the other MEs are dependent on the one scored "not met," then the remaining MEs that are tied to the prior ME are scored as "not met." See the figure below for MOI.10 as an example:

MOI.10	
As part of its monitoring and performance improvement activities, the hospital regularly assesses patient medical record content.	
Measurable Elements of MOI.10	
❑ 1. A representative sample of medical records that includes active and discharged medical records and inpatient and outpatient medical records is reviewed at least quarterly or more frequently as determined by laws and regulations.	**Not Met** ⬇
❑ 2. The review is conducted by physicians, nurses, and others authorized to make entries in patient medical records or to manage patient medical records.	**Not Met** ⬇
❑ 3. The review focuses on the timeliness, accuracy, completeness, and legibility of the medical record.	**Not Met** ⬇
❑ 4. Medical record content required by laws or regulations is included in the review process.	**Not Met** ⬇
❑ 5. The results of the review process are incorporated into the hospital's quality oversight mechanism.	**Not Met** ⬇

"Not Applicable" Score

An ME is scored "not applicable" if the requirements of the ME do not apply based on the hospital's services, patient population, and so forth (**for example**, the hospital does not conduct research).

Other Considerations

Compliance Rate

Compliance with the requirements of the ME is documented as the rate (percentage) of compliance demonstrated by the hospital. The compliance is written in the "positive" (**for example**, 50% compliance with the requirements). The scoring guidelines are written in the positive, which is the percentage of compliance required to achieve a score of "fully met" (90% or greater), "partially met" (50% to 89%), or "not met" (49% or fewer). Whenever possible, the demonstrated compliance is reported as "compliance rate" (%). **For example**, 10 of 15 (67% compliance rate) initial nursing assessments were completed within 24 hours of inpatient admission to the medical/surgical inpatient units (3W, 2E, 4S, and 4N), as required by the hospital's policy. The score for this finding is "partially met," because the compliance rate percentage for the finding is between 50% and 89%.

The Look-Back Period for New Standards

The **effective date** of new standards is published with the standards. Hospitals are expected to be in compliance with the standards on the published effective date. The look-back period for new standards can go back only to the effective date of the standard. Thus, for a new 7th edition standard effective on 1 January 2021, the look-back period on a 1 March 2021 triennial survey is 2 months back to the 1 January 2021 effective date, not the 12 months for existing standards. Similarly, for a 1 February 2021 initial survey, the look-back is 1 month rather than 6 months.

If a hospital does not meet the shorter look-back period for a new standard, the score on the ME will be influenced in the same manner in which a full 12-month (triennial) or 6-month (initial) look-back period would be influenced. **For example**, on a 1 July 2021 triennial survey, the look-back period for a new standard is 6 months—if the hospital is in full compliance ("fully met") with an ME, but the organization can demonstrate compliance going back only 4 months, the ME will be scored "partially met," as 67% of the 6-month required look-back was met. The ME would be scored "not met" if compliance could be demonstrated for only 2 months, or 33% of the possible look-back period.

Changes to the Look-Back Period for Triennial Surveys

For hospitals and academic medical center hospitals undergoing triennial surveys, the following applies:

- For triennial surveys conducted on or after 1 January 2021, JCI surveyors may look as far back as the date of the hospital's previous full survey to assess for continuous compliance.
- When a hospital is required to develop a Strategic Improvement Plan (SIP), the look-back period for the standard/ME requiring an SIP begins when the approved SIP has been fully implemented. (See "Assigning Follow-Up Requirements After a Full Survey" in the next section for more information about SIPs.)

The Look-Back Period on Follow-up Surveys

If, following a full survey—initial or triennial—a follow-up survey is required within 120 days after the full survey, per the "Accreditation Decision Rules," the look-back period at the time of the follow-up survey is from the date the follow-up survey started back to the last day of the full survey. During this look-back period, the surveyor(s) will examine the actions taken by the hospital to address and/or correct the issues identified during the full survey. Rather than looking at the track record for compliance, assessment of compliance will consider

- impact and criticality of the original findings;
- sufficient evidence to support compliance with identified MEs/standards;
- sustainability of the actions taken; and
- plan for ongoing professional practice evaluation of actions.

Example 1

At the time of the full survey, the hospital does not meet the standard for use of blood and blood products, Standard COP.3.4, because clinical guidelines and procedures are not established and implemented and do not address a) through f) of the intent. When the surveyor(s) returns for the follow-up survey, the organization presents evidence that clinical guidelines and procedures have been established and that they include processes for a) through f) of the intent. In addition, staff have been educated on these guidelines, and interviews with staff confirm that they are knowledgeable about the process. Documentation in the medical records shows that processes are being followed.

Based on the hospital's actions and the evidence observed by the surveyor(s), the hospital would be in full compliance.

Example 2

Standard SQE.11, ME 2, requires that clinical results of data and information available on each medical staff member are reviewed with objective and evidence-based information for external benchmarking.

The hospital did not meet ME 2 because the evaluation process for patient services provided by medical staff used comparative data that consisted of demographic and administrative content only and did not specifically address clinical performance. When the surveyor(s) returned for the follow-up survey, the hospital had developed and implemented a form to use that would collect clinical data on an ongoing basis that would be used in the next staff appraisals. The plan identified what type of clinical information would be collected, how the information would be obtained, and potential external sources for benchmarking information—such as internally over time, the literature, and professional societies.

Although the actions by the organization do not meet the required look-back or track record, based on the hospital's actions and the evidence observed by the surveyor(s), the hospital would be in full compliance.

Consideration of Impact and Criticality

Scores may be influenced by other factors, such as the impact or criticality of noncompliance for a standard or an ME. *Impact* refers to the effect or outcome of the finding. *Criticality* refers to the level or measure of importance of the finding. It is important to note that impact and criticality determinations are not rule-based nor are they individual-based; rather, they are determinations made by the entire survey team, usually at the time the findings of each surveyor are integrated for determining the final score of an ME.

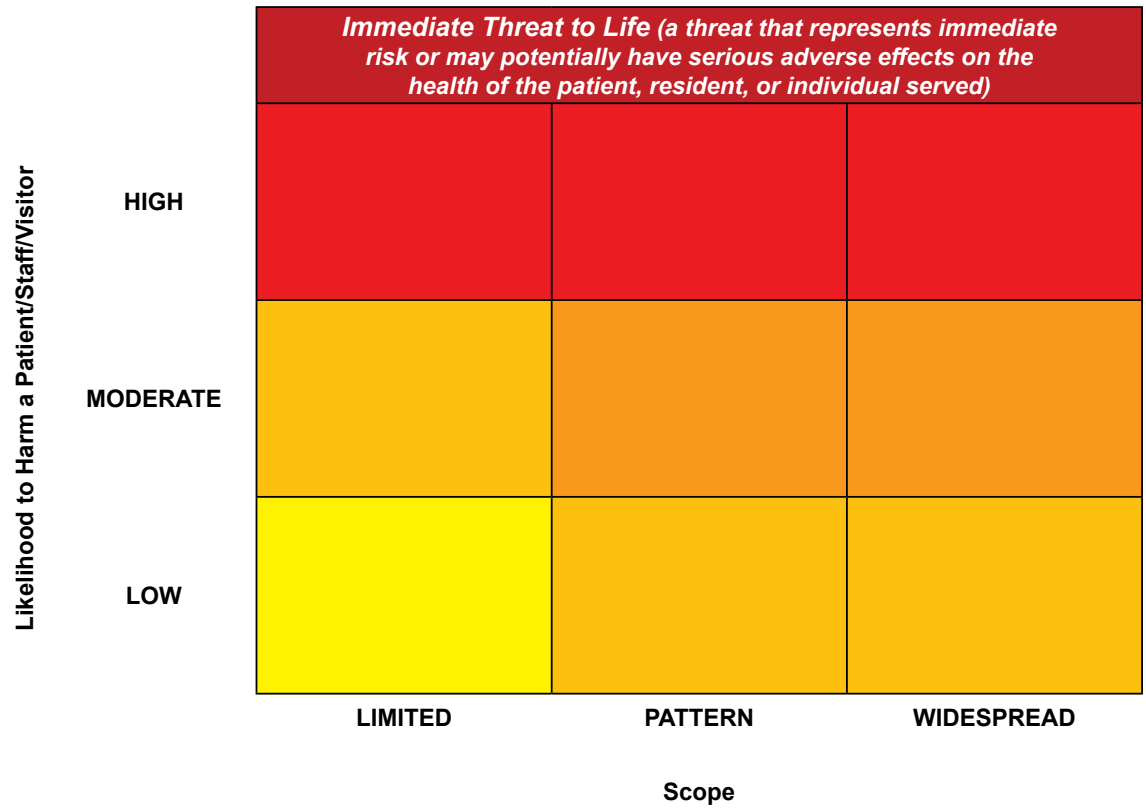
Impact and criticality influence scoring in the following two ways:

1) The *impact* of a particular compliance percentage or the actual number of noncompliant observations is an important consideration. **For example**, 12 incomplete medication orders found in the medical record of 1 patient and made by 1 physician are limited in impact to a single patient and may actually be scored as 1 finding. Twelve incomplete medication orders by multiple physicians in several different patient medical records indicate far greater potential for patient harm and would be scored as multiple findings. Thus, the sample of medical records and/or medication orders for review should be selected in a manner that has the potential to show the greatest impact related to lack of compliance with the medication order system across the hospital. **For example**, the sample of medication orders selected would include multiple clinical units across all services, different patient populations (pediatrics, adults, high risk), and different inpatient and ambulatory settings.
2) The *criticality* of the finding, rather than the actual number of noncompliant observations, is also important. **For example**, 1 blocked emergency exit out of 12 exits observed is a critical finding if the exit is in a patient care area. The finding is less critical if the blocked exit is from a little-used storage area.

SAFER™ Matrix

As part of helping organizations understand the criticality of a finding, the Official Survey Findings Report includes the Survey Analysis for Evaluating Risk® (SAFER) Matrix. The SAFER Matrix provides health care organizations with information needed to prioritize resources and focus corrective action plans in areas that are most in need of compliance activities and interventions. Each finding within your final report is plotted on the SAFER Matrix according to the likelihood the finding could cause harm to patients, staff, and/or visitors and the scope or extent to which the finding was observed. **For example**, is the likelihood to cause harm rare or highly probable, and is the extent to which the finding was observed limited or widespread? As the risk level of a finding increases, the placement of the standard and finding moves from the bottom left corner (lowest risk level) to the upper right corner (highest risk level) of the SAFER Matrix. See the figure below of the SAFER Matrix.

SAFER™ Matrix



SAFER will not impact accreditation decision rules. There are no additional compliance requirements related to SAFER. The matrix is intended to provide one visual representation of survey findings at an aggregate level so that organizations can easily identify findings with higher risk and help organizations prioritize and focus corrective actions.

Accreditation Decision Rules

Accreditation Decisions

The JCI Accreditation Committee considers all information from the initial or triennial full survey and any required follow-up survey in making its decision regarding accreditation. The outcome is that the organization meets the criteria for accreditation and is accredited or does not meet the criteria and is denied accreditation. The criteria for these two potential outcomes (effective 1 January 2021) are as follows:

Accredited

This decision results when an organization meets all the following conditions.

1. The organization demonstrates acceptable compliance with each **standard**. Acceptable compliance is:
   - A score of at least "5" on each standard.
2. The organization demonstrates acceptable compliance with the standards in each **chapter**. Acceptable compliance is:
   - An aggregate score of at least "9" for each chapter of standards.
3. The organization demonstrates **overall** acceptable compliance. Acceptable compliance is:
   - An aggregate score of at least "9.8" on all standards.
4. The **total number of measurable elements** found to be "not met" or "partially met" is not above the mean (three or more standard deviations) for organizations surveyed under the hospital accreditation standards within the previous 24 months.
5. No measurable element in the IPSGs is scored "not met."

Denial of Accreditation

This decision results when an organization meets one or more of the following conditions at the end of any required follow-up survey subsequent to an initial or triennial full survey, or during the period of accreditation as a result of a follow-up survey for the evaluation of one or more policy-related conditions that may place the organization At Risk for Denial of Accreditation.

1. One or more standards is scored less than a "5."
2. The aggregate score of one or more chapter of standards is less than a "9."
3. The aggregate score for all standards is less than "9.8."
4. The total number of measurable elements found to be "not met" or "partially met" is above the mean (three or more standard deviations) for organizations surveyed under the hospital accreditation standards within the previous 24 months.
5. One or more measurable element in the IPSGs is scored "not met."

Any of the following will also result in Denial of Accreditation for the organization:

- A required follow-up survey subsequent to an initial or triennial full survey has not resulted in acceptable compliance with applicable standards.
- One or more of the conditions that placed the organization At Risk for Denial of Accreditation have not been resolved at the time of the follow-up survey to evaluate the condition.
- The organization voluntarily withdraws from the accreditation process.
- The organization does not permit the performance of any survey by Joint Commission International.

At Risk for Denial of Accreditation

Conditions that place an organization At Risk for Denial of Accreditation include the following:

- An immediate threat to patient/public health or staff safety exists within the organization (seen in the top red row of the SAFER Matrix).
- An individual who does not possess a license, registration, or certification is providing or has provided health care services in the organization that would, under applicable laws or regulations, require such

a license, registration, or certification and which placed the organization's patients at risk for a serious adverse outcome.

- Joint Commission International is reasonably persuaded that the organization submitted falsified documents or misrepresented information in seeking to achieve or retain accreditation, as required by the Information Accuracy and Truthfulness Policy.
- The number of not compliant standards ("not met" or "partially met") at the time of survey is above the mean (three or more standard deviations) for organizations in the same program surveyed during the previous 24 months.
- The organization does not possess a license, certificate, and/or permit, as, or when, required by applicable laws and regulations, to provide the health care services for which the organization is seeking accreditation.
- The organization has not met the accreditation policy for "Reporting Requirements Between Surveys."
- The organization fails to submit an acceptable Strategic Improvement Plan (SIP) within 120 days of the organization's survey.

Assigning Follow-Up Requirements After a Full Survey

Full surveys are conducted at the time of initial accreditation and at the time of reaccreditation, every 3 years. At the conclusion of the survey, the findings are evaluated against the required conditions for accreditation. When the survey results meet all the conditions for accreditation, the hospital receives an Accredited status. The hospital will then be requested to develop an SIP that defines the improvement strategy(ies) and/or approach(es) to bring any noncompliant standard(s) and/or IPSG(s) into acceptable compliance. However, when the results of a full survey do not meet one or more of the conditions for accreditation, the hospital will have a period of time to come into acceptable compliance. Acceptable compliance can then be demonstrated by a visit from one or more surveyors to the hospital during the follow-up survey.

Process

The Final Survey Findings Report is sent to the hospital by the JCI Accreditation Central Office within 10 days following the survey and includes the SAFER Matrix. The matrix is used to determine the SIP(s) that will be required. An SIP will be required for any "not met" and "partially met" ME(s) sited in the survey report as follows:

1. Any finding ("not met" or "partially met") that represents a high likelihood to harm—that is, lands in the high-risk boxes (top 3 boxes)—will require an SIP.
2. In addition, any "not met" finding that represents a moderate likelihood to harm showing a pattern or widespread scope—that is, lands in the middle row in the two boxes to the right—will require an SIP.

The SIP explains the hospital's process in defining the improvement strategy(ies) and/or approach(es), including specifications to bring the cited findings into acceptable compliance. The plan also identifies the methodology to prevent reoccurrence, sustain improvements over time, and establish a measure to monitor compliance. The SIP is due at the JCI Accreditation Central Office for review and acceptance within 60 days after receiving the final survey report. A hospital that fails to submit an acceptable SIP may be placed At Risk for Denial of Accreditation and require a follow-up survey to verify evidence of compliance.

A Preliminary Survey Findings Report is sent to the hospital by the JCI Accreditation Central Office when the documented findings of the accreditation survey team do not meet one or more of the conditions for accreditation. The preliminary report is sent to the hospital within 10 days after the survey; the report includes all standards/MEs and/or IPSGs that were found to be not fully compliant at the time of the survey. Each of the noncompliant ("partially met" and/or "not met") findings will be reviewed for compliance by the surveyor(s) during the follow-up survey.

Follow-up Survey

A follow-up survey is an on-site evaluation scheduled 120 days from the date when the hospital received the Preliminary Survey Findings Report. During the on-site visit, the surveyor(s) will determine the hospital's compliance with the standards and IPSGs through various survey activities and methods, such as direct observation, staff or patient interviews, review of documents, review of medical records and/or personnel files, or the inspection of the physical facility.

When the results of the follow-up survey meet all the conditions for accreditation, the hospital receives an Accredited status. The hospital will then be requested to develop an SIP(s) as follows:

1. Any finding ("not met" or "partially met") that lands in the high-risk boxes (top 3 boxes of the SAFER Matrix) will require an SIP.
2. In addition, any "not met" finding that lands in the pattern or widespread moderate-risk boxes will require an SIP.

When the results of the follow-up survey do not meet one or more of the conditions for accreditation, the hospital will receive a Denial of Accreditation decision by the JCI Accreditation Committee.

Accreditation Preparation

After JCI accepts the hospital's E-App both parties make preparations for the on-site survey.

JCI organizes a team of surveyors to match the hospital's needs and unique characteristics. JCI will make every effort to provide a surveyor(s) who is fluent in the language(s) used at the hospital. If a JCI surveyor(s) with the necessary language capabilities is not available, it is the hospital's responsibility to provide interpreter services throughout the survey according to the requirements identified in APR.10. The interpreter(s) must be fluent in English and the language(s) used at the hospital, be experienced in verbal and written translation, be able to follow recognized medical interpreting standards of practice, and abide by the confidentiality policies and regulations set up by the hospital.

On-site hospital accreditation surveys are typically conducted by three or more surveyors, depending on the size and complexity of the hospital. The survey follows actual patient care through the facility and includes interviews with key staff, observation of the hospital's administrative and clinical activities, assessment of the physical facilities and medical equipment, and review of documentation. Sample survey agendas are supplied elsewhere in this publication. The actual agenda is customized by the survey team to fit the needs and services of the hospital.

The survey team leader will contact the hospital approximately 4 to 8 weeks prior to the survey to discuss and coordinate a workable and mutually agreeable agenda. The survey team leader identifies those services/areas that need to be included in the review and suggests staff who should be involved in each survey activity.

Suggested "Ready to Go" List

The survey process can be facilitated if the following items are readily available to the surveyor(s) at the time of the survey:

- High-level organization chart
- List of board of directors or other governing body membership by background and consumer/nonconsumer status
- List of all staff and job titles
- List of all contracted and visiting health care practitioners, including physicians
- Accurate list of the patients currently receiving care in the organization, including each patient's diagnosis, age, unit/service, responsible physician, and date of admission
- List of the operative and other invasive procedures scheduled for the day, including surgeries in the operating theatre, cardiac catheterizations, endoscopies/colonoscopies, and in vitro fertilizations (if applicable)
- Top five diagnoses of patients
- Top five procedures performed
- List of systemwide priority improvements
- List of departments' and services' individual measures
- Clinical practice guidelines and any associated pathways and protocols
- Risk assessments, such as a failure mode and effects analysis (FMEA), hazard vulnerability analysis (HVA), infection control risk assessment (ICRA), and preconstruction risk assessment (PCRA)
- A copy of a comprehensive systematic analysis (**for example**, a root cause analysis) conducted for a sentinel event or significant adverse event if no sentinel event occurred
- Required organization plans (**for example**, facility safety plan)
- Required policies, procedures, and programs (see the "Required Documents" section)
- Documented bylaws
- List of eligible contracts (direct services), if applicable
- Committee minutes (**for example**, from governance meetings, infection prevention and control meetings, other meetings)
- Copy of Strategic Improvement Plan(s) (SIP) from previous survey (if applicable)

- List of hours of operation and schedule for all outpatient clinics or services in the organization
- Current map of the hospital campus
- Sample of all medical record forms

Accreditation Preparation Time Line

To help hospitals prepare for accreditation, JCI offers resources on its website at https://www.jointcommissioninternational.org/.

Hospitals Requesting an Initial Survey

Time Line	JCI Activity	Hospital's Activity
18 to 24 months before preferred month of survey		Review the *Joint Commission International Accreditation Standards for Hospitals*, 7th Edition, to understand the requirements and implement the expectations related to JCI accreditation.
6 to 12 months before preferred month of survey		Register for, complete, and submit the application for survey to the JCI Accreditation Central Office via E-App, JCI's electronic application tool.
Upon receipt of the application for survey	JCI Accreditation reviews the application. When the application is approved, JCI provides the hospital with broader access to resources on *JCI Direct Connect*, JCI's client portal. In addition, JCI will send a contract for review and signature.	

Hospitals Requesting Reaccreditation

Time Line	JCI Activity	Hospital's Activity
Ongoing		The hospital updates its profile on E-App as changes to the hospital's facility, services, or patient volume, among others, take place.
9 to 12 months before the due date of the next triennial survey	JCI reminds the hospital that a triennial survey is forthcoming and that the hospital's profile on E-App should be updated.	
6 to 12 months before the accreditation expires		The hospital submits its updated application for survey via E-App. Upon receipt and approval of the application, JCI sends a contract for survey.

All Hospitals Requesting Accreditation (Initial or Reaccreditation)

Time Line	JCI Activity	Hospital's Activity
Upon receipt of the signed contract	An invoice for down payment of at least 50% of the survey fees is sent to the hospital via e-mail by JCI's Finance Department when the signed contract is submitted to the JCI Accreditation Central Office. The hospital can elect to pay 100% or a smaller percentage of the survey fees due based on its preference. JCI provides the hospital with a complimentary copy of this *Survey Process Guide* after the signed contract is received by JCI.	The hospital notifies its accounts payable staff to expect an invoice from JCI and to remit payment with a wire-transfer form no later than 60 days prior to survey date within 30 days of receipt of the invoice. **Note:** Any changes that have occurred since submission of the application must be reported/submitted to JCI in advance of the survey. In addition, the hospital updates its profile on E-App to reflect these changes.
2 to 4 months before survey	JCI schedules the survey team and sends confirmation of the survey dates and team members to the hospital.	
1 to 2 months before survey	The JCI survey team leader contacts the hospital's accreditation contact person to finalize the survey agenda and request presurvey information.	Hospital staff members discuss the proposed survey agenda and determine whether times are feasible for the hospital, given patient needs and availability of staff. If translators are required, the hospital will submit the licenses and resumes of the selected translators to jciaccreditation@jcrinc.com no later than eight (8) weeks prior to the start of the survey.
Survey	Survey team arrives for the on-site survey. At the conclusion of the survey, the team leaves a copy of the Exit Report, which details partial or noncompliant areas that need to be addressed. This report is not final until the JCI Accreditation Central Office has reviewed it.	Leaders and staff should be available during the survey as indicated by the survey agenda.

Time Line	JCI Activity	Hospital's Activity
Within 10 days after survey	JCI reviews, approves, and sends the Final Survey Findings Report. A follow-up survey may be required prior to an accreditation decision determination. If the accreditation is granted, the award letter, report, and accreditation certificate are mailed after all the survey fees have been paid. The Gold Seal guidelines and publicity kit, as well as all other resources posted to *JCI Direct Connect*, are made available to the hospital. JCI sends the hospital CEO a JCI Accreditation Satisfaction Survey via e-mail to assist JCI in its performance improvement activities.	After the JCI Accreditation Central Office sends the Final Survey Findings Report, the hospital begins either of the two follow-up processes as requested: 1) Develop the Strategic Improvement Plan (SIP) if accredited. 2) Prepare for the follow-up survey if the conditions for accreditation were not met. The CEO of the surveyed hospital encourages members of the leadership team to provide input for the JCI Accreditation Satisfaction Survey.
Within 3 days after the certificate is mailed	The hospital's name, location, and date of accreditation are added or updated for public viewing on the JCI website at http://www.jointcommissioninternational.org/.	The hospital may request that JCI Accreditation place a link on the JCI website to the accredited hospital's website.
Ongoing	Each accredited hospital is given full access to *JCI Direct Connect*, through which JCI communicates necessary and helpful information and resources for achieving continuous compliance with the standards in the time between accreditation activities.	Leaders and staff monitor *JCI Direct Connect* for continuous compliance requirements and resources. Periodic submission of evidence of compliance is required as part of the accreditation process. Examples include International Patient Safety Goal monitoring data, SIP compliance data, and self-assessments of standards compliance.
Approximately 6 months after publication of a new JCI hospital standards edition	JCI publishes a new edition of the hospital standards and other requirements approximately every 3 years. The manual becomes effective for all accredited hospitals and all surveys approximately 6 months after publication.	At the time of publication, staff review the new hospital standards and other requirements to ensure compliance with any new and modified standards, scoring guidelines, policies, and procedures. If JCI needs to visit the hospital, the current, effective standards are used.
Within 30 days of the effective date of any significant organizational change(s)		The hospital notifies JCI via E-App of any significant change in the hospital's profile.

The On-Site Survey

The purpose of a JCI accreditation survey is to assess the extent of a hospital's compliance with applicable JCI standards. Hospitals undergoing their first survey need to demonstrate a track record of 6 months of compliance with the standards. Hospitals being re-surveyed need to demonstrate compliance with the standards as described on pages 11–16. (See "Changes to the Look-Back Period for Triennial Surveys" and "Determining the Score.") Understanding the hospital and assessing compliance is accomplished through a number of methods, including the following:

- Receipt of verbal information concerning implementation of standards or examples of their implementation
- On-site observation by a JCI surveyor(s)
- Review of documents that demonstrate compliance and assistance in orienting the surveyor(s) to the hospital's operations

The on-site survey uses tracer methodology to follow a sample of active patients through their experiences of care in the hospital and to evaluate individual components and systems of care.

An important characteristic of the JCI survey process is on-site education conducted by the surveyor(s). This support occurs throughout the survey as the surveyor(s) offers suggestions and strategies that may help the hospital better meet the intent of the standards and, more importantly, improve performance.

The on-site review consists of the following sessions:

- Opening Conference and Agenda Review
- Orientation to the Hospital's Services
- Document Review
- Daily Briefing
- Leadership for Quality, Patient Safety, Ethics, and Culture of Safety Interview
- Quality Program Interviews: Clinical
- Quality Program Interviews: Operations
- Department/Service Quality Measurement Tracer
- Supply Chain Management and Evidence-Based Purchasing Interview and Tracer
- Individual Patient Tracer Activity
- Organ and Tissue Transplant Services Interview and Tracer
- Patient Interview Session
- FMS Document Review and Facility Tour
- Department/Service-Specific Tracers
- System Tracer: Facility Management and Safety
- System Tracer: Medication Management and Medication Supply Chain
- System Tracer: Infection Prevention and Control
- Undetermined Survey Activities
- Medical, Nursing, and Other Staff Education Qualifications Sessions
- Closed Patient Medical Record Review
- Leadership Exit Conference
- Additional Sessions for Academic Medical Center Hospitals
    - Medical Professional Education Leadership Interview
    - Medical Student and Trainee Interview
    - Human Subjects Research: Leadership and Process Interview

Frontline Staff Ownership of the Process

Involving staff in the initial accreditation process and continuing to involve them in ongoing assessments and process and system reviews enhance ownership, which results in continued safe and high-quality care for patients and their families. During the tracer activities, the surveyor(s) will focus his or her discussions on the clinical and support staff and will request manager and leadership staff only to provide clarification, if needed.

Sample Hospital Survey Agenda

Note: The following agenda serves as an example. The surveyor team may revise the arrangement of each session to better accommodate the organization.

Hospital Survey Agenda (3 surveyors, 5 days)

DAY ONE			
Time	**Physician Surveyor**	**Nurse Surveyor**	**Administrator**
0745 – 0800	Team Meeting with Survey Coordinator and Translators (to discuss logistical support issues and requirements)		
0800 – 0820	Opening Conference and Agenda Review		
0820 – 0900	Orientation to the Hospital's Services		
0900 – 1200	Document Review (one room with separate working areas for each team member)		
1200 – 1300	Surveyor Working Lunch (private surveyor lunch for debriefing and survey planning)		
1300 – 1400	Leadership for Quality, Patient Safety, Ethics, and Culture of Safety Interview		
1400 – 1600	Individual Patient Tracer Activity	Individual Patient Tracer Activity	Facility Management and Safety Document Review and Facility Tour
1600 – 1630	Meeting with Survey Coordinator (as needed, to identify needs for the following day)		
1630 – 1730	Surveyor Meeting (private surveyor meeting for planning agenda activities for the following day; may be held in hotel)		

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Hospital Survey Agenda (3 surveyors, 5 days)

<table>
<tr><th colspan="4">DAY TWO</th></tr>
<tr><th>Time</th><th>Physician Surveyor</th><th>Nurse Surveyor</th><th>Administrator Surveyor</th></tr>
<tr><td>0800 – 0900</td><td colspan="3">Daily Briefing</td></tr>
<tr><td>0900 – 1200</td><td>Individual Patient Tracer Activity</td><td>Individual Patient Tracer Activity</td><td>Facility Management and Safety Document Review and Facility Tour (continued)</td></tr>
<tr><td>1200 – 1300</td><td colspan="3">Surveyor Working Lunch
(private surveyor lunch for debriefing and survey planning)</td></tr>
<tr><td>1300 – 1500</td><td>Medication Management System Tracer, Including Medication Supply Chain</td><td rowspan="2">Individual Patient Tracer Activity</td><td rowspan="2">Facility Management and Safety System Tracer</td></tr>
<tr><td>1500 – 1600</td><td>Undetermined Survey Activity
(time may be used to visit the pharmacy)</td></tr>
<tr><td>1600 – 1630</td><td colspan="3">Meeting with Survey Coordinator
(as needed, identify needs for the following day)</td></tr>
<tr><td>1630 – 1730</td><td colspan="3">Surveyor Meeting
(private surveyor meeting for planning agenda activities for the following day; may be held in hotel)</td></tr>
</table>

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Hospital Survey Agenda (3 surveyors, 5 days)

<table>
<tr><th colspan="4">DAY THREE</th></tr>
<tr><th>Time</th><th>Physician Surveyor</th><th>Nurse Surveyor</th><th>Administrator Surveyor</th></tr>
<tr><td>0800 – 0900</td><td colspan="3">Daily Briefing</td></tr>
<tr><td>0900 – 1100</td><td>Organ and Tissue Transplant Services Interview and Tracer (if applicable)</td><td>Nursing and Other Clinical Staff Education Qualifications Session</td><td>Facility Management and Safety Document Review</td></tr>
<tr><td>1100 – 1200</td><td>Undetermined Survey Activity (Medical Transport as applicable)</td><td>Undetermined Survey Activity</td><td>Undetermined Survey Activity (Laser/ Hemodialysis as applicable)</td></tr>
<tr><td>1200 – 1300</td><td colspan="3">Surveyor Working Lunch
(private surveyor lunch for debriefing and survey planning)</td></tr>
<tr><td>1300 – 1500</td><td>Medical Staff Education Qualifications Session</td><td>Infection Prevention and Control System Tracer</td><td rowspan="2">Individual Patient Tracer Activity</td></tr>
<tr><td>1500 – 1600</td><td>Individual Patient Tracer Activity</td><td>Individual Patient Tracer Activity (Isolation Process at unit level)</td></tr>
<tr><td>1600 – 1630</td><td colspan="3">Meeting with Survey Coordinator
(as needed, identify needs for the following day)</td></tr>
<tr><td>1630 – 1730</td><td colspan="3">Surveyor Meeting
(private surveyor meeting for planning agenda activities for the following day; may be held in hotel)</td></tr>
</table>

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Hospital Survey Agenda (3 surveyors, 5 days)

DAY FOUR			
Time	**Physician Surveyor**	**Nurse Surveyor**	**Administrator Surveyor**
0800 – 0900	Daily Briefing		
0900 – 1100	Closed Patient Medical Record Review (a separate work area or separate room needed for each surveyor)		**0900 – 1030** Quality Program Interview—Operations **1030 – 1200**
1100 – 1200	Individual Patient Tracer Activity	Patient Group Interview	Individual Patient Tracer Activity
1200 – 1300	Surveyor Working Lunch (private surveyor lunch for debriefing and survey planning)		
1300 – 1430	Quality Program Interview—Clinical Measures	Individual Patient Tracer Activity	Supply Chain Management and Evidence-Based Purchasing Interview and Tracer
1430 – 1600	Individual Patient Tracer Activity	Individual Patient Tracer Activity	Individual Patient Tracer Activity
1600 – 1630	Meeting with Survey Coordinator (as needed, identify needs for the following day)		
1630 – 1730	Surveyor Meeting (private surveyor meeting for planning agenda activities for the following day; may be held in hotel)		

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Hospital Survey Agenda (3 surveyors, 5 days)

DAY FIVE			
Time	**Physician Surveyor**	**Nurse Surveyor**	**Administrator Surveyor**
0800 – 0900	Daily Briefing		
0900 – 1100	Individual Patient Tracer Activity / Undetermined Survey Activity	Individual Patient Tracer Activity / Undetermined Survey Activity	Individual Patient Tracer Activity / Undetermined Survey Activity
1100 – 1200	Survey Integration and Report Preparation		
1200 – 1300	Surveyor Working Lunch (private lunch for surveyors to integrate findings)		
1300 – 1430	Survey Integration and Report Preparation (continuation)		
1430 – 1500	Conference with Leadership to Review Exit Report Findings		
1500 – 1530	Conference with Staff to Review Exit Report Findings		

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Sample Academic Medical Center Hospital Survey Agenda

Note: The following agenda serves as an example. The surveyor team may revise the arrangement of each session to better accommodate the organization.

Academic Medical Center Hospital Survey Agenda (5 surveyors, 5 days)

<table>
<tr><th colspan="6">DAY ONE</th></tr>
<tr><th>Time</th><th>Physician Surveyor</th><th>Nurse Surveyor</th><th>Administrator Surveyor</th><th>Physician Surveyor</th><th>Nurse Surveyor</th></tr>
<tr><td>0745 – 0800</td><td colspan="5">Team Meeting with Survey Coordinator and Translators
(to discuss logistical support issues and requirements)</td></tr>
<tr><td>0800 – 0830</td><td colspan="5">Opening Conference and Agenda Review</td></tr>
<tr><td>0830 – 0930</td><td colspan="5">Orientation to the Hospital's Services and Leadership Session</td></tr>
<tr><td>0930 – 1230</td><td colspan="5">Document Review
(one room with separate working areas for each team member)</td></tr>
<tr><td>1230 – 1330</td><td colspan="5">Surveyor Working Lunch
(private surveyor lunch for debriefing and survey planning)</td></tr>
<tr><td>1330 – 1530</td><td>Medical Prof. Education Leadership Interview</td><td rowspan="2">Individual Patient Tracer Activity</td><td rowspan="2">Facility Management and Safety Document Review and Facility Tour</td><td rowspan="2">Individual Patient Tracer Activity</td><td rowspan="2">Individual Patient Tracer Activity</td></tr>
<tr><td>1530 – 1600</td><td>Undetermined Survey Activity</td></tr>
<tr><td>1600 – 1630</td><td colspan="5">Meeting with Survey Coordinator
(as needed, to identify needs for the following day)</td></tr>
<tr><td>1630 – 1730</td><td colspan="5">Surveyor Meeting
(private surveyor meeting for planning agenda activities for the following day; may be held in hotel)</td></tr>
</table>

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Academic Medical Center Hospital Survey Agenda (5 surveyors, 5 days)

<table>
<tr><th colspan="6">DAY TWO</th></tr>
<tr><th>Time</th><th>Physician Surveyor</th><th>Nurse Surveyor</th><th>Administrator Surveyor</th><th>Physician Surveyor</th><th>Nurse Surveyor</th></tr>
<tr><td>0800 – 0900</td><td colspan="5">Daily Briefing</td></tr>
<tr><td>0900 – 1200</td><td>Individual Patient Tracer Activity</td><td>Individual Patient Tracer Activity</td><td>Facility Tour</td><td>0900 – 1100
Quality Program Interview—Clinical Measures
1100 – 1200
Individual Patient Tracer Activity</td><td>Individual Patient Tracer Activity</td></tr>
<tr><td>1200 – 1300</td><td colspan="5">Surveyor Working Lunch
(private surveyor lunch for debriefing and survey planning)</td></tr>
<tr><td>1300 – 1600</td><td>1300 – 1500
Medication Management System Tracer, Including Medication Supply Chain
1500 – 1600
Undetermined Survey Activity</td><td>1300 – 1500
Human Subjects Research: Leadership and Process Interview
1500 – 1600
Human Subjects Tracer</td><td>Facility Tour</td><td>Organ and Tissue Transplant Services Interview and Tracer (if applicable)</td><td>Individual Patient Tracer Activity</td></tr>
<tr><td>1600 – 1630</td><td colspan="5">Meeting with Survey Coordinator
(as needed, identify needs for the following day)</td></tr>
<tr><td>1630 – 1730</td><td colspan="5">Surveyor Meeting
(private surveyor meeting for planning agenda activities for the following day; may be held in hotel)</td></tr>
</table>

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Academic Medical Center Hospital Survey Agenda (5 surveyors, 5 days)

<table>
<tr><th colspan="6">DAY THREE</th></tr>
<tr><th>Time</th><th>Physician Surveyor</th><th>Nurse Surveyor</th><th>Administrator Surveyor</th><th>Physician Surveyor</th><th>Nurse Surveyor</th></tr>
<tr><td>0800 – 0900</td><td colspan="5">Daily Briefing</td></tr>
<tr><td>0900 – 1000</td><td colspan="5">Leadership for Quality, Patient Safety, Ethics, and Culture of Safety Interview</td></tr>
<tr><td rowspan="6">1000 – 1200</td><td>1000 – 1100</td><td rowspan="6">Individual Patient Tracer Activity</td><td>1000 – 1100</td><td rowspan="6">Individual Patient Tracer Activity</td><td>1000 – 1100</td></tr>
<tr><td>Individual Patient Tracer Activity</td><td>Quality Program Interview—Operations</td><td>Nursing and Other Clinical Staff Education Qualifications Session</td></tr>
<tr><td>1100 – 1200</td><td>1100 – 1200</td><td>1100 – 1200</td></tr>
<tr><td>Medical Student and Trainee Interview</td><td>Facility Management and Safety System Tracer</td><td>Patient Group Interview</td></tr>
<tr><td colspan="5">Surveyor Working Lunch
(private surveyor lunch for debriefing and survey planning)</td></tr>
<tr><td rowspan="6">1300 – 1600</td><td rowspan="6">Medical Staff Education Qualifications Session</td><td rowspan="6">Individual Patient Tracer Activity</td><td>1300 – 1500</td><td rowspan="6">Individual Patient Tracer Activity</td><td>1300 – 1500</td></tr>
<tr><td>Facility Management and Safety Document Review</td><td>Infection Prevention and Control System Tracer</td></tr>
<tr><td>1500 – 1600</td><td>1500 – 1600</td></tr>
<tr><td>Undetermined Survey Activity (Laser/ Hemodialysis as applicable)</td><td>Individual Patient Tracer Activity (Isolation Process at unit level)</td></tr>
<tr><td colspan="5">Meeting with Survey Coordinator
(as needed, identify needs for the following day)</td></tr>
<tr><td>1630 – 1730</td><td colspan="5">Surveyor Meeting
(private surveyor meeting for planning agenda activities for the following day; may be held in hotel)</td></tr>
</table>

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Academic Medical Center Hospital Survey Agenda (5 surveyors, 5 days)

DAY FOUR					
Time	**Physician Surveyor**	**Nurse Surveyor**	**Administrator Surveyor**	**Physician Surveyor**	**Nurse Surveyor**
0800 – 0900	Daily Briefing				
0900 – 1100	Closed Patient Medical Record Review (a separate work area or separate room needed for each surveyor)		Supply Chain Management and Evidence-Based Purchasing Interview and Tracer	Closed Patient Medical Record Review (a separate work area or separate room needed for each surveyor)	
1100 – 1200	Undetermined Survey Activity (Medical Transport as applicable)	Undetermined Survey Activity	Undetermined Survey Activity	Undetermined Survey Activity	Undetermined Survey Activity
1200 – 1300	Surveyor Working Lunch (private surveyor lunch for debriefing and survey planning)				
1300 – 1600	Individual Patient Tracer Activity	Individual Patient Tracer Activity	Individual Patient Tracer Activity	Individual Patient Tracer Activity	Individual Patient Tracer Activity
1600 – 1630	Meeting with Survey Coordinator (as needed, identify needs for the following day)				
1630 – 1730	Surveyor Meeting (private surveyor meeting for planning agenda activities for the following day; may be held in hotel)				

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Academic Medical Center Hospital Survey Agenda (5 surveyors, 5 days)

DAY FIVE					
Time	**Physician Surveyor**	**Nurse Surveyor**	**Administrator Surveyor**	**Physician Surveyor**	**Nurse Surveyor**
0800 – 0900	Daily Briefing				
0900 – 1100	Individual Patient Tracer Activity / Undetermined Survey Activity	Individual Patient Tracer Activity / Undetermined Survey Activity	Individual Patient Tracer Activity / Undetermined Survey Activity	Individual Patient Tracer Activity / Undetermined Survey Activity	Individual Patient Tracer Activity / Undetermined Survey Activity
1100 – 1200	Survey Integration and Report Preparation				
1200 – 1300	Surveyor Working Lunch (private lunch for surveyors to integrate findings)				
1300 – 1430	Survey Integration and Report Preparation (continuation)				
1430 – 1500	Conference with Leadership to Review Exit Report Findings				
1500 – 1530	Conference with Staff to Review Exit Report Findings				

Note: Individual Patient Tracer Activity may include Department/Service Quality Measurement Tracers and/or other tracer activity.

Tracer Methodology

Tracer methodology is the foundation of the JCI on-site survey and accomplishes the following:

- Incorporates the use of information provided in the accreditation survey application and previous survey and monitoring reports
- Follows the experience of care for a number of patients through the hospital's entire health care process
- Allows the surveyor(s) to identify issues in one or more steps of the patient care process or the interfaces between processes

The Role of Staff in Tracer Methodology

Staff will be asked to provide the surveyor(s) with a list of patients presently in the hospital, including the patients' names, current locations in the hospital, and diagnoses. The surveyor(s) may request assistance from hospital staff for selection of patients for tracer activities. As the surveyor(s) moves around the hospital, he or she will converse with a wide variety of staff involved in the traced patient's care, treatment, and services. These staff could include nurses, physicians, trainees, therapists, case managers, aides, pharmacy staff, lab staff (as applicable), and support staff. If those staff members are not available, the surveyor(s) will ask to speak to another staff member who would perform the same function(s) as the member who has cared for or is caring for the tracer patient. Although it is preferable to speak with the direct caregiver, it is not mandatory because the questions that will be asked are questions that any caregiver should be able to answer in providing care to the patient being traced.

Individual Patient Tracer Activity

The Individual Patient Tracer Activity is an evaluation method that is conducted during the on-site survey and is designed to "trace" the care experiences that a patient had during his or her stay in the hospital. Tracer methodology is used to analyze a hospital's system of providing care, treatment, and services using actual patients as the framework for assessing international standards compliance. During an individual tracer, the surveyor(s) will perform the following:

- Follow the course of care, treatment, and services provided to the patient by and within the hospital using current medical records whenever possible
- Assess the interrelationships between and among disciplines and departments, programs, services, or units, and the important functions in the care and services being provided
- Evaluate the performance of relevant processes, with particular focus on the integration and coordination of distinct but related processes
- Identify potential concerns in the relevant processes

Using the information from the application, the surveyor(s) will select patients from an active patient list to "trace" their experiences throughout the hospital. Patients typically selected are those who have received multiple or complex services and therefore have experienced more contact with various parts of the organization. This interaction will provide the opportunity to assess continuity-of-care issues (also see the Glossary in the *Joint Commission International Accreditation Standards for Hospitals*, 7th Edition). To the extent possible, the surveyor(s) will make every effort to avoid selecting tracers that occur at the same time and that may overlap in terms of sites within the hospital.

Individual Patient Tracer Selection Criteria

Patient tracer selection may be based on, but not limited to, the following criteria:

- Patients in the top five diagnoses groups for the hospital
- Patients related to system tracers, such as infection prevention and control and medication management

- Patients who cross programs. Examples include the following:
  - Patients scheduled for a follow-up in outpatient care or patients transitioning from hospital to home care
  - Patients entering or leaving the hospital from or to the care continuum, such as long term care and hospice
- Patients receiving care by a medical student or specialty resident
- Patients on a research protocol

The surveyor(s) will follow the patient's experiences, looking at services provided by various individuals and departments within the hospital as well as handovers (handoffs) between them.

This type of review is designed to uncover systems issues, to look at the individual components of a hospital, and to examine how the components interact to provide safe, high-quality patient care.

The surveyor(s) may start a tracer where the patient is currently located. He or she can then move to where the patient first entered the hospital's systems; to an area of care provided to the patient that may be a priority for the hospital; or to any areas in which the patient received care, treatment, and services. The order will vary.

Number of Patients and Other Elements

The number of patients followed under tracer methodology will depend on the size and complexity of the hospital and the length of the on-site survey. As it pertains to the provision of care being reviewed, the tracer will include the following elements:

- Review of the medical record with the staff person responsible for the patient's care, treatment, or service provided. If the responsible staff person is not available, the surveyor(s) may speak with other staff members. Supervisor participation in this part of the tracer should be limited. Additional staff involved in the patient's care will meet with the surveyor(s) as the tracer proceeds. **For example**, the surveyor(s) will speak to a dietitian if the patient being traced has nutritional issues.
- Observation of direct patient care
- Observation of medication processes
- Observation of infection prevention and control issues
- Observation of care planning processes
- Discussion of data use in the hospital. This includes quality improvement measures being used, information that has been learned, improvements made using data, and data dissemination (also see the Glossary in the *Joint Commission International Accreditation Standards for Hospitals*, 7th Edition).
- Observation of the impact of the environment on safety and staff roles in minimizing environmental risk
- Observation of maintenance of medical equipment (also see the Glossary in the *Joint Commission International Accreditation Standards for Hospitals*, 7th Edition) and review of qualified staff responsible for the maintenance of the medical equipment
- Interview with the patient and/or family (if it is appropriate and permission is granted by the patient and/or family). The discussion will focus on the course of care and will attempt to verify issues identified during the tracer.
- Address emergency management and explore patient flow issues. Patient flow issues may be explored in the emergency department or ancillary patient care areas or other areas as relevant to the patient being traced. **For example**, if the patient received a blood transfusion, the surveyor(s) may visit the blood bank.

Other Medical Records

The surveyor(s) may select and review two to three additional open or closed medical records to verify issues that may have been identified. The surveyor(s) may ask staff in the unit, program, or service to assist with the review of the additional medical records. The following criteria can be used to guide the selection of additional medical records depending on the situation:

- Similar or same diagnosis or tests
- Patient close to discharge
- Same diagnosis but different physician/practitioner
- Same test but different location
- Same age or sex
- Length of stay
- Interview with staff
- Review of minutes and procedures as needed

Links to Other Survey Activities

Issues identified from the individual patient tracer activities may lead to further exploration in the system tracers or other survey activities, such as the FMS Document Review and Facility Tour and the Leadership for Quality, Patient Safety, Ethics, and Culture of Safety Interview. Findings from tracer visits provide focus for other tracers and may influence the selection of other tracers. They may also identify issues related to the coordination and communication of information relevant to the safety and quality of care services.

System Tracer Activity

System tracers look at a specific system or process across the hospital. When possible, this activity will focus on the experiences of specific patients or on activities relevant to specific patients. This differs from the individual patient tracers in that, during individual patient tracers, the surveyor(s) follows a patient through his or her course of care, evaluating all aspects of care rather than a system of care. During a system tracer, the surveyor(s) will perform the following:

- Evaluate the performance of relevant processes, with particular focus on the integration and coordination of distinct but related processes
- Evaluate communication among disciplines and departments
- Identify potential concerns in relevant processes

System tracers include the following:

Medication Management System Tracer

The Medication Management System Tracer explores the hospital's medication management process while focusing on subprocesses and potential risk points (such as handover points). This tracer activity helps the surveyor(s) evaluate the continuity of medication management from the procurement of a medication through the monitoring of its effect on patients.

Infection Prevention and Control System Tracer

The Infection Prevention and Control System Tracer explores the hospital's infection prevention and control processes. The goals of this session are to assess the organization's compliance with the relevant PCI and FMS standards, to identify infection prevention and control issues that require further exploration, and to determine actions that may be necessary to address any identified risks and to improve patient safety.

Facility Management and Safety System Tracer

The focus of this system tracer is the process the hospital uses to evaluate the hospital's facility management and safety system and performance in managing risk. The surveyor(s) will evaluate the strengths in the hospital's facility management and safety processes, review the action(s) taken to address any identified areas of concern, and determine the hospital's actual degree of compliance with relevant standards.

Unit/Department Tracer Activity

In addition to system tracers, unit/department tracers may be conducted to evaluate the implementation of the system process and to review the impact on patient care services and treatments. Unit/department tracers may also include an interactive session involving a surveyor(s) and relevant staff members that will use information

from unit/department visits and individual tracers. Points of discussion in the interactive sessions include the following:

- The flow of a process across the hospital, including identification and management of risk points, integration of key activities, and communication among staff/units involved in the process
- Strengths in the process, weaknesses in the process, and possible actions to take in areas needing improvement
- Issues requiring further exploration in other survey activities
- A baseline assessment of JCI standards and IPSG compliance
- Education by the surveyor(s), if needed

Examples of unit/department tracers include (as applicable to the organization) the following:

Operating Theatre Tracer

The focus of this tracer is the process the hospital has implemented to ensure the safety and quality of care that the surgical patient receives throughout the perioperative period. The surveyor(s) may commence the tracer in the preadmission area observing the handover process and review of documentation for patient identification and complete documentation, including consents and surgical-site marking. In the operating theatre or surgery setting, the surveyor(s) will observe the process the organization has implemented to ensure correct-site, correct-procedure, and correct-patient surgery (time-out). Other areas of focus include medication management by both nursing and anesthesiology; the hospital's compliance with the relevant International Patient Safety Goals (IPSG), as well as standards in the "Anesthesia and Surgical Care" (ASC), "Prevention and Control of Infections" (PCI), and "Facility Management and Safety" (FMS) chapters; and a review of staffing qualifications and experience of the staff. The surveyor(s) may follow the surgical patient to the postanesthesia care unit to observe the care processes, including handover communications, monitoring, and medication management.

Central Sterile Supply Department (CSSD) Tracer

The focus of the Central Sterile Supply Department (CSSD) Tracer is the processes the department has implemented to ensure the proper disinfection, cleaning, and sterilization of supplies and equipment. The surveyor(s) will review the transportation and cleaning processes for instruments and equipment, both from the operating theatres and satellite clinics; review the checking and packing process for supplies and instruments; and review the biological tests as applicable, documentation of test results, and tracking process for sterile supplies. The surveyor(s) will also review the safety measures in place for hospitals that use non-steam sterilizers, such as ethylene oxide. Other areas of focus include compliance with the relevant Prevention and Control of Infections (PCI) and Facility Management and Safety (FMS) standards as implemented in the CSSD.

Endoscopy Tracer

The focus of this tracer is the process the hospital has implemented to ensure the safety and quality of care that the endoscopic patient receives throughout the procedure. The surveyor(s) will review the patient's documentation for the procedure, including patient identification and required consents and pre-procedure assessments. The surveyor(s) may also observe the time-out process. Other areas of focus include medication management, monitoring of the patient under sedation, and the unit's compliance with the relevant Anesthesia and Surgical Care (ASC), Prevention and Control of Infections (PCI), and Facility Management and Safety (FMS) standards. The surveyor(s) will also evaluate the unit's process for the cleaning and high-level disinfection and storage of the endoscopes. The surveyor(s) may also trace the patient to the recovery area and review the documentation of the recovery period and the patient and family education. Staff qualifications for sedation administration may also be reviewed.

Department/Service Quality Measurement Tracers

The focus of the Department/Service Quality Measurement Tracers is to identify how individual department/service leaders use quality measurement to improve patient care and services provided in their area. In addition, this tracer activity helps the surveyor(s) evaluate how clinical guidelines are selected and implemented for use in areas providing clinical care. These tracers are conducted as part of other tracer activities, such as system tracers or individual patient tracers, while visiting various wards, departments, and services.

The Accreditation Decision

The final accreditation decision is based on the hospital's compliance with JCI standards. Organizations do not receive a numeric score as part of the final accreditation decision. When an organization successfully meets JCI accreditation requirements, it will receive an award of Accredited. This decision indicates that the organization is in compliance with all applicable standards at the time of the on-site survey. The JCI Accreditation Program may request the submission of an SIP(s)—as determined by the SAFER Matrix and described in the "Assigning Follow-Up Requirements After a Full Survey" section—which must be accepted by the JCI Accreditation Program, or the status of Accredited could be removed.

Promoting Accreditation

After a hospital receives official notification of the accreditation decision, it can publicize its international accreditation achievement by notifying patients, the public, the local media, third-party payers, and resident referral sources. JCI provides each hospital receiving accreditation with publicity guidelines for announcing the accreditation award. A free publicity guide is offered to accredited hospitals that includes the following:

- Suggestions for celebrating accreditation
- Guidelines for publicizing JCI accreditation
- Frequently asked questions
- Sample news release
- Fact sheet

A hospital accredited by JCI must be accurate in describing to the public the nature and meaning of its accreditation award and must not misrepresent its accreditation status or the facilities and services to which the accreditation award applies.

Information about a hospital's accreditation status will be posted on the JCI website at https://www.worldhospitalsearch.org. The website allows anyone to locate JCI–accredited hospitals within a country and region of the world.

The Continuing Accreditation Cycle

The accreditation process does not end when the on-site survey is completed. In the three years between on-site surveys, JCI requests hospitals to report any changes to JCI, as well as submission of ongoing evidence of compliance and corrective actions, such as a self-assessment, periodic submission of compliance data, root cause analyses, and/or response to complaints. For this reason, it is very important for the hospital to maintain a current E-App and continual compliance with standards between on-site surveys as well as new standards published in new editions of the manual.

Continuous survey compliance means that hospitals focus on continually improving their systems and operations, thereby eliminating the need for intense survey preparation prior to their triennial survey. Continuous compliance with JCI standards directly contributes to the maintenance of safe, high-quality care and improved organizational performance.

Survey Agenda: Detailed Descriptions

Opening Conference and Agenda Review

Note: The survey team leader may conduct a brief meeting prior to the Opening Conference and Agenda Review with the CEO, survey coordinator, and translators to discuss the logistics and expectations for the on-site survey and use of translators. If there will be any approved observers, hospitals must provide a list of their names, titles, and hospital affiliations to the survey team leader.

Purpose

During the Opening Conference and Agenda Review, the surveyor(s) describes the structure and content of the survey to the hospital.

Location

At the discretion of hospital leadership

Hospital Participants

- Chief executive officer
- Individual responsible for coordinating the hospital's survey agenda, such as a survey coordinator
- Medical staff leadership
- Nursing leadership
- Medical school dean (for academic medical center hospitals)
- Director of research (for hospitals that conduct research and academic medical center hospitals)
- Others, including medical students and trainees, at the discretion of the hospital

Surveyor(s)

All surveyors

Standards/Issues Addressed

Introduction of the surveyor(s) and key hospital leaders and coordination of the survey

Documents/Materials Needed

Final survey agenda

What Will Occur

- Surveyors and any preceptees or Joint Commission International (JCI) observers will be introduced.
- Hospital leadership will be introduced.
- Agenda will be reviewed and modified as needed.
- Surveyors will answer questions about the survey agenda.

The following information may be discussed, depending on what has already been shared by the survey team leader in an e-mail to the organization prior to the survey:

- The surveyor(s) will explain the use of tracer methodology during the survey process activities and will stress the importance of being able to ask questions of the hospital's frontline staff who are directly taking care of patients. It is acceptable for a small group (four to five persons) to accompany the surveyor(s), but questions should not be answered by these staff members unless specifically requested. The surveyor(s) will also not interrupt patient care in any way. The surveyor(s) will try as best as possible to put staff at ease with his or her questions. In addition, all patient-specific information will remain confidential.
- The surveyor(s) will explain the JCI firewall.
- The surveyor(s) will advise leadership that the only presentation allowed during the survey is scheduled on the survey agenda for the session entitled "Orientation to the Hospital's Services." The session is intended to give the surveyor(s) an introduction to the hospital.

- The surveyor(s) will follow the planned survey agenda when conducting the tracer activities. Staff should be prepared to answer questions. The surveyor(s) will also obtain pertinent information through various other methods.
- The surveyor(s) will explain the concept of "drilling down" as an interviewing technique/approach that aims to gather specific information about a process or outcome. Staff members involved in drilling down inquiries should not perceive this approach as personal or necessarily an indication of noncompliance. It is an indication that the surveyor(s) is evaluating the establishment of systems to support a process.
- The surveyor(s) will explain the staff involvement in the various quality activities, such as the Department/Service Quality Measurement Tracers and the Quality Program Interviews.
- The surveyor(s) will explain the purpose of and the leaders' involvement in the Daily Briefing sessions.
- Hospital staff will be encouraged to ask questions and seek clarification from the surveyor(s) throughout the survey process.
- Hospital staff will identify country-specific information to ensure that the survey team observes significant customs and values of the hospital during the survey process, particularly if observance of customs impacts the survey agenda. **For example**, how would the hospital prefer that the surveyor(s) conduct survey sessions during times that staff members participate in prayer activities? In addition, hospital staff should indicate how staff members would prefer to be addressed and should discuss the use of interpreters, when needed.
- Hospital staff will introduce the surveyor(s) to the staff member who will provide assistance throughout the day. This staff person will help the surveyor(s) move quickly between hospital locations and maintain the planned schedule. This staff person is usually a leader of the hospital or the survey coordinator.

How to Prepare

- Set up a meeting or conference room large enough for the surveyor(s) to meet with key hospital leaders and survey coordinators.
- Set up a surveyor headquarters room with Internet access for each surveyor and one printer for them to share.
- Notify hospital receptionists, so they can direct the surveyor(s) to the room when he or she arrives.
- Have copies of the survey agenda available for all participants in the conference.
- Prior to the survey, decide which hospital leader or staff member will accompany each surveyor throughout the survey day.
- Arrange for the surveyor(s) to be served lunch.
- Notify hospital staff of the survey agenda.
- The surveyor(s) will wear a name badge that will identify him or her as a JCI surveyor(s). If the hospital requires additional hospital identification, prepare and make it available to the surveyor(s) in the conference.

Orientation to the Hospital's Services

Purpose

The hospital orients the surveyor(s) to the services, programs, and strategic activities the hospital provides. This gives the surveyor(s) baseline information about the hospital that can help focus subsequent survey activities.

Location

Same location as Opening Conference and Agenda Review

Hospital Participants

- Chief executive officer
- Individual responsible for coordinating the hospital's survey agenda, such as a survey coordinator
- Medical staff leadership
- Nursing leadership
- Medical school dean (for academic medical center hospitals)
- Director of research (for hospitals that conduct research and academic medical center hospitals)
- Staff responsible for the quality improvement and patient safety program, if applicable
- Others, including medical students and trainees, at the discretion of the hospital

Surveyor(s)

All surveyors

Standards/Issues Addressed

- Overview of the hospital's services
- Overview of medical education (for academic medical center hospitals only)
- Overview of research programs (for academic medical center hospitals only)

Documents/Materials Needed

- Copy of the hospital's presentation for each surveyor
- Organizational chart for clinical services
- Organizational chart for medical education and research (for academic medical center hospitals only)

What Will Occur/How to Prepare

- The hospital will give an overview of its structure, services, and strategic activities.
- The session should last less than 30 minutes and is intended to give the surveyor(s) an introduction to the organization and to update the data presented on the organization's application. Topics covered include the following:
  - History of the hospital (one or two slides)
  - Mission and vision of the hospital
  - Organizational structure (chart)
  - Number of buildings, area (square meters)
  - Total number of beds and type of departments/units
  - Number of staff, contracted staff, staff physicians, visiting physicians, residents, students, and trainees
  - Top five procedures and diagnoses
  - Average length of stay
  - Number of annual visits
  - Number and type of surgeries performed on an annual basis
  - Areas where anesthesia and/or procedural sedation are administered within the organization
  - Type of contracted services

  - Clinical guidelines, pathways, or protocols implemented
  - Strategic plan (services or areas the organization is planning to increase or open during the next three years)
  - The Quality Committee structure and its relationship with other committees (one or two slides)
- The surveyor(s) will ask questions, as needed, to clarify information or to request additional information for later use.

Document Review

Purpose
The objective of the Document Review session is to survey standards that require some written evidence of compliance, such as an emergency management program or a patient's rights document. In addition, this session orients the survey team to the structure of the hospital and management.

Location
A meeting room or office that will be used throughout the duration of the survey as a meeting place and work area for the survey team. During the survey, this room should not be used for any non-survey-related meetings, as the surveyor(s) will need to have access throughout the survey. Whenever there's more than one surveyor on the team, the organization should also avoid scheduling survey-related meetings in this room.

Hospital Participants
The survey team may begin this session alone by reviewing the policies, procedures, and written documents required in English. When necessary, the surveyor(s) may need the assistance of interpreters or other hospital staff members who are familiar with the documents that will be reviewed, can translate these, and are able to respond to questions the surveyor(s) may have during the session. At the discretion of the team, the surveyor(s) may designate a limited number of staff members to attend and participate in the Document Review session. The session may be conducted as an interview of staff about the documents. This approach has been very effective when language barriers exist and the survey activities necessitate the use of professional interpreters.

Surveyor(s)
All surveyors

Standards/Issues Addressed
Almost all standards chapters make reference to policies, procedures, documents, and programs that are to be written. The following section and the "Survey Planning Tools" chapter, specifically the "Required Documents" section, will assist staff members in understanding the particular documents that are a part of the accreditation survey.

Documents/Materials Needed
The documents that should be available to the survey team for review or reference during the survey process are listed in the "Survey Planning Tools" chapter. The list of documents includes the following:

- A list of organizationwide priority improvement measures
- A list of department/service quality measures. All measurement information is to include data from the past 6 months (initial surveys) and/or 12 months for triennial surveys.
- A list of clinical practice guidelines and any associated tools, such as clinical pathways and/or clinical protocols and bundles (evidence-based sets of interventions completed together) the hospital has selected to guide clinical care. Also, include the quality measures related to the processes and outcomes.
- Required hospital programs
- Required policies and procedures, written documents, or bylaws
- Minutes of the key committees for the past year, such as Performance Improvement, Infection Prevention and Control, Safety, and Medication Systems, as well as leadership/management team meetings
- An accurate daily list of the patients currently receiving care in the hospital (with age, diagnosis, and unit)

- Daily lists of the operative and other invasive procedures (if applicable), including surgeries in the operating theatre(s) and other settings, day surgeries, cardiac catheterizations, endoscopies/colonoscopies, laser therapy, radiotherapy, and in vitro fertilizations (inpatients and outpatients)
- A sample action plan for a comprehensive systematic analysis (**for example**, a root cause analysis) for a sentinel event or significant adverse event/near miss (or close call)
- A sample failure mode and effects analysis (FMEA) action plan
- A current map of the hospital campus
- A copy of the architectural drawings of all floors (for each building), including the basement and roof. The format of the drawings should be such that the plans can be easily carried around and the surveyor(s) could write on the plans.
- A sample of all medical record forms (or templates)
- A list of all employees (providing direct and indirect patient care), with name, date of hire, job title, and primary location of work in the hospital
- A list of all independent clinical practitioners (physicians and others if you have them, such as dentists, psychologists, and so on) who are privileged by the medical staff, with the name, clinical department or specialty, and date of appointment or reappointment to the medical staff
- A binder with all contracts of the contracted services in the hospital

In addition, the hospital should complete the "Laws and Regulations Worksheet" (see the "Survey Planning Tools" chapter) and have it available for the survey team.

Documents Available in English

Documents showing evidence of compliance with certain standards must be provided to the surveyor(s) in English. The "Required Documents" table provides a complete listing, including documents required in English.

What Will Occur

- The documents should be made available to the survey team in the meeting room that has been designated for the surveyor's(s') use throughout the duration of the survey.
- At the beginning of the session, one staff person should briefly orient the survey team to the organization of the documents.
- During the remainder of the session, a staff member who can respond to any questions the surveyor(s) may have should be readily available (in person or by telephone).
- The materials should remain available to the survey team throughout the survey for reference purposes. However, if documents are required for use by hospital staff, they may be removed. The surveyor(s) may schedule a second Document Review session during the course of the survey. The survey team may also request additional documents throughout the survey to clarify or become knowledgeable about the hospital's policies and procedures or performance. Hospital staff should be as proactive as possible in complying with requests for documents.
- Some of the documents may need to be translated into English, whereas other documents may require an interpreter to be made available.

How to Prepare

It is highly probable that many of the required documents will be part of larger documents. Hospitals do not need to remove or photocopy pertinent sections of these documents. Instead, hospitals can identify these sections using bookmarks or tabs. Guidelines for cross-referencing this information are provided in the next section.

Other documents, such as minutes and reports, may be freestanding or individual documents. Hospitals should decide whether to provide the original document or a photocopy. It is always beneficial to have several examples of these documents, such as committee minutes from the last few meetings.

If the hospital has a large quantity of examples or a large volume of materials on a given topic, it should select the most representative or the most pertinent examples. There will not be time for the surveyor(s) to review large amounts of material on any given topic.

Organization of the Materials

Because the issues identified in the Document Review list may be addressed in different documents depending on the hospital, the following guidelines for organizing the documents to be used by the surveyor(s) are provided.

Group the freestanding or individual documents (see the "Required Documents" section in this guide) according to the following lists:

- Required quality data
- Required hospital programs
- Required policies
- Hospital scope of services documents

Organize the documents by JCI chapters, by standards in each chapter, and by measurable element (ME) in each standard. Each chapter should be placed in one binder or folder. Also, separate the standards. Then, indicate the ME that the document addresses.

Gather the documents in one place. Identify the location in the document where the specific information that is required by the ME may be found. The hospital may use methods such as the following to identify the information:

- A guide
- An index
- Bookmarks
- Tabs

Note: When information is provided using computer monitors rather than paper, the following conditions should be met:

- Each member of the survey team should be provided with a monitor.
- A printer should be available in case a member of the survey team wishes to print a paper copy of a given document.
- Staff may be needed to assist the surveyor(s) in locating the documents in the computer.

Documents in English should be organized separately from those not in English, following the same method described above.

Printed copies of bylaws and longer documents that may require extensive reading or scanning by the surveyor(s) should be available.

Evaluation of the Policies and Procedures by the Survey Team

The documents reviewed by the survey team provide an overview of what the surveyor(s) expects to see in actual practice during the survey process. **For example**, the surveyor(s) would expect to find the following when a new procedure on the disposal of infectious waste is developed:

- That staff have been educated about the new procedure
- That any special skills training or other needed training has taken place
- That waste is actually being disposed of according to the new procedure
- That any documentation required by the procedure is available for review

The "Management and Implementation of Documents" section of the "Management of Information" (MOI) chapter in the standards manual will be used to evaluate the hospital's compliance with developing and implementing policies and procedures. The presence of a policy or procedure alone usually does not determine the score of the standard. Rather, the score is determined by the daily practice (implementation) of the policy

or procedure. The survey team will look for evidence that the practice related to the policy or procedure is well implemented throughout the hospital and thus is sustainable. In the event the implementation appears incomplete to the survey team, or the implementation occurred in a manner that is not sustainable, the survey team will make a recommendation that more time be allowed for better evidence of sustainable implementation and for incorporating the recommendation into the survey follow-up requirements.

In general, the length of time a policy has been implemented is referred to as a "track record." The survey team will look for a 6-month track record for policy-related standards during an initial survey and for a 12-month track record during a triennial survey. For policy-related standards to be scored "fully met," the track record requirement must be met.

The track record for new standards will be from the "effective date" to the date of survey. **For example**, if a new standard/measurable element (ME) is effective on 1 January, and the survey takes place on 1 June of the same year, the required track record for the new standard/ME is 5 months for "fully met."

Daily Briefing

Purpose
To facilitate understanding of the survey process and the findings that contribute to the accreditation decision.

Location
At the discretion of hospital leadership

Hospital Participants
- Hospital survey coordinator (as needed by team)
- Chief executive officer
- Designated leaders (as determined by the hospital)
- Staff members from areas visited by the surveyor(s) the previous day, at the discretion of the leaders

Surveyor(s)
All surveyors

What Will Occur
The Daily Briefing occurs every morning of a multiday survey with the exception of the first day. The session is 30 minutes and intended to be brief. When multiple surveyors are on site, the briefing is conducted jointly, with the survey team leader serving as the facilitator.

During the Daily Briefing with the hospital, the surveyor(s) will perform the following actions:
- Offer a concise summary of the survey process activities completed on the previous day
- Make general comments regarding significant issues resulting from the previous day's activities
- Note any specific positive findings (although because of time limitations, the session is not intended to review most or all issues that were in full compliance with standards).
- Emphasize patterns or trends of significant concern that could lead to noncompliance determinations. The surveyor(s) may report minor, one-time, or single observations that might not impact final scoring.
- Inform the hospital that final findings for any given standard will be possible only when all activities are complete and results are aggregated
- Allow the hospital staff to provide information that may have been missed or misunderstood during the previous survey day
- Address hospital requests for discussion on findings and indicate when such discussions can take place
- Schedule time for more extensive discussion or review of additional evidence of compliance on issues that arise
- Review the agenda for the survey day ahead (including the identification of individual patient tracers) and make any necessary adjustments based on hospital needs or the need for more intensive assessment of an issue during the "Undetermined Survey Activity" time
- Conclude the briefing and transition to the next activity(ies) according to the agenda

Do not expect the surveyor(s) to perform the following actions:
- Repeat observations made at a previous Daily Briefing unless it is in the context of identifying a systemic issue
- Discuss, in detail, each survey activity, specific medical records, suggestions, and conversations held with individuals during tracers
- Delay scheduled activities for the current day to have an in-depth discussion of issues from the previous day

Special Situations

There may be instances when a surveyor(s) will be scheduled to survey an activity that is not taking place at the same location where a Daily Briefing would normally occur; this may happen particularly when surveying with a team. There may also be situations in which a surveyor(s) is brought in for a day or two and departs earlier than the rest of the team. If a surveyor(s) cannot be physically present for the Daily Briefing, the surveyor(s) will do the following:

- Try to make arrangements to join via conference call
- Share details of the previous day's activities and findings with another surveyor for the Daily Briefing presentation, even if a conference call is anticipated

Leadership for Quality, Patient Safety, Ethics, and Culture of Safety Interview

Purpose

The purpose of this session is to identify leadership's approach for measuring, assessing, and improving quality and patient safety, including the process for selecting organizationwide strategic priority improvements and prioritizing the analysis of patient safety events. The session also assesses the development and implementation of an ethical framework and how leadership has shaped a culture of safety in the organization. Standards from the following chapters will be assessed:

- "International Patient Safety Goals" (IPSG)
- "Patient-Centered Care" (PCC)
- "Care of Patients" (COP)
- "Medication Management and Use" (MMU)
- "Quality Improvement and Patient Safety" (QPS)
- "Prevention and Control of Infections" (PCI)
- "Governance, Leadership, and Direction" (GLD)
- "Staff Qualifications and Education" (SQE)

Location

At the discretion of hospital leadership

Hospital Participants

- Leaders responsible for the management of the ethics program
- Chief executive officer
- Chief operating officer, when applicable
- Chief nursing officer
- Chair, governing body, or similar representative
- Elected or appointed leader of the medical staff
- Leader responsible for quality improvement
- Leader responsible for medical education (academic medical center hospitals only)
- Leader responsible for research (academic medical center hospitals only)
- Other senior leaders, at the discretion of the hospital

To foster an interactive process, a larger group than described above is not recommended for this conference.

Surveyor(s)

One or more surveyors, as applicable

Standards/Issues Addressed

- GLD.1
- GLD.1.1
- GLD.4 and GLD.4.1
- GLD.5
- GLD.6
- GLD.6.1
- GLD.6.2
- GLD.11
- GLD.12 through GLD.12.2 (ethics)
- GLD.13 and GLD.13.1 (culture of safety)

- Other examples of standards that impact and reflect the culture of safety include IPSG.4, IPSG.5, PCC.1, PCC.1.3, PCC.3, COP.2, MMU.4.2, QPS.7, PCI.5.1, SQE.8, and others

Academic medical center hospitals include the following standards—from the "Medical Professional Education" (MPE) and "Human Subjects Research Programs" (HRP) chapters—in addition to those listed above:

- MPE.1
- MPE.6
- HRP.1

Documents/Materials Needed

- Documents that identify systemwide priority improvements
- Quality improvement and patient safety program reports provided to governance
- Action plans for improvements resulting from strategic priority measurement
- Minutes from governance meetings relating to quality reports
- Information about the impact of organizationwide improvements on efficiency and resource use
- Information on the framework used for ethical management
- Any resources reviewed/used for development of the ethical framework
- Copy of guidelines developed by the hospital related to performance and conduct
- Documentation of the hospital's assessment of its culture of safety
- Evidence of a code of conduct
- A sample of resources that promote a culture of safety
- Copies of patient surveys used for patient engagement data

What Will Occur

This session is a combined activity to assess leadership's oversight, support, and participation in the quality and patient safety program as well as the creation, support, and management of an ethical framework and culture of safety. Leaders should be prepared to identify how these programs are organized to assist the surveyor(s) in better understanding how hospital leadership establishes and supports an organizational commitment to quality and safety, ethics, and culture of safety; and ensures that there are adequate resources for each of these areas to be effective. Leadership also implements a structure and process for the overall monitoring and coordination of these programs throughout the organization. It is important to understand how the coordination of measurement and improvement efforts occurs throughout the organization.

The surveyor(s) will ask questions related to leadership activities and the decisions that have been made related to development of the quality improvement and patient safety program. As part of the discussion related to ethics and the culture of safety, the surveyor(s) will discuss how the hospital identifies and manages ethical issues, how ethical issues are reported, and the process to resolve the issues when identified. Issues related to how the framework supports the hospital's health care providers, patients, and patients' families when confronted with ethical decisions will be addressed. The surveyor(s) will ask about how leadership uses any data and information about ethical issues to improve the hospital's services. In addition, the surveyor(s) will ask about the hospital's culture of safety, which will include a discussion of the code of conduct and how it was developed. Information about any assessments used to evaluate and monitor the culture of safety within the hospital and how staff can report any issues relevant to a culture of safety will also be addressed. The surveyor(s) will assess compliance with certain standards from the GLD chapter, particularly those related to development and ongoing support of the quality improvement and patient safety program, an ethical framework, and the culture of safety. Other related chapters may also be addressed. During this interview, the surveyor(s) will also identify issues that he or she will pursue in later survey activities.

Everyone present should participate in answering questions. This is designed to be an interactive session.

Note: Some questions below refer to an RCA (root cause analysis), RCA is one form of a comprehensive systematic analysis referred to in Standards QPS.7 and QPS.7.1.

How to Prepare

Hospitals should identify the participants in the Leadership for Quality, Patient Safety, Ethics, and Culture of Safety Interview. Although organization leadership should be familiar with all the standards, leadership should read closely the GLD chapter prior to survey. In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

Sample questions related to the quality improvement and patient safety program include the following:

- GLD.1: Who makes up the governing body of the hospital and how are they evaluated?
- GLD.1.1: What is the process for approving the hospital's strategic plan and operating budget?
  - GLD.1.1, ME 3: What are your strategies and programs for health care provider education and research?
- GLD.4: What is the structure and process developed for the quality improvement and patient safety program and how was this developed?
- GLD.4.1: Please provide an example of a sentinel event that led to improvements in a safety issue. How is information about the quality improvement and patient safety program communicated to staff?
- GLD.5: Organizational leadership is required to select processes and outcome measures in the clinical and hospital operational areas as described in the intent of GLD.5. How are measures selected for each of the clinical and hospital operational areas? **For example**, what are you measuring in regard to the use of antibiotics and what problems were identified that helped you select that specific measure related to antibiotics?
- GLD.6: What is your process for identifying, in writing, the services provided through contractual agreements? How do you know the documents are current?
- GLD.6.1: How do you involve your contracted services in the quality improvement and patient safety program?
- GLD.6.2: How are the services of independent practitioners monitored for quality as part of the quality improvement and patient safety program?
- GLD.11: How were the hospital's systemwide priorities chosen?
- GLD.11: What involvement does leadership have in the leaders' selection of department/service measures? How are results of department/service quality improvements communicated to leadership?
- PCC.3, ME 2: How are patient engagement data aggregated and used to determine areas for quality improvement?
- PCC.3, ME 3: What priority areas for improvement have the leadership team identified from patient engagement data?
- QPS.7, ME 3: How does leadership and the board ensure that the RCA team addresses all contributing factors to a sentinel event rather than attributing the event to a single "human error"?
- QPS.7, ME 4: How does leadership and the board evaluate the solutions presented by an RCA team in terms of their ability to eliminate or control the system failures that led to the sentinel event?
- QPS.7, ME 4: What is the process if leadership does not feel the actions proposed by the RCA team are adequate?
- QPS.7, ME 5: What measures do leadership and the board review to evaluate the effectiveness of the RCA program?

Sample question about the hospital's ethical framework and culture of safety include the following:

- IPSG.5: Do staff feel comfortable asking others, including physicians, to wash their hands? How do you ensure that staff feel safe intervening in these situations?

- GLD.12: Please describe the ethical framework used in the hospital and discuss how this framework was developed. What is the process for addressing ethical issues? Are specific staff involved in particular issues, or is there a committee? Are outside resources utilized?
- GLD.12.1, ME 3: How do you ensure that patients are billed correctly? Is any type of a billing audit conducted?
- GLD.12.2, ME 1: What is the process for staff to raise ethical concerns?
- GLD.13, ME 2: How was the code of conduct developed? Who provided input into what is included in the code of conduct? How were staff educated about the code of conduct?
- GLD.13.1, ME 1: How are culture of safety issues reported? Do you have examples of some issues that have been reported and how they were handled?
- SQE.8.2, ME 6: Health care is a stressful occupation. How do you support your staff who are dealing with issues of compassion fatigue or burnout?
- SQE.8.2, ME 6: How do you remove the stigma associated with these concerns so that your staff feel comfortable addressing them?
- SQE.8.2, ME 6: What are the risk factors for compassion fatigue/burnout that you have identified in your organization?
- SQE.8.2, ME 6: How do you identify issues of burnout/compassion fatigue in your staff?

Academic medical center hospitals will include a review of the following in addition to those listed above:

- MPE.1: What opportunities for improvement were demonstrated in the review of the monitoring data of the ongoing operation of the medical education program?
- MPE.6: How are medical students and trainees involved in the quality improvement and patient safety program?
- HRP.1: How have the leaders communicated within the hospital your commitment to protect human research subjects and support the code of ethical professional behavior?

Quality Program Interviews: Clinical

Purpose

The purpose of the Quality Program Clinical Interview is to identify how leadership and the quality program staff support the overall program for quality and patient safety as it relates to clinical care. The Clinical Quality Interview focuses on the clinical indicators, including clinical practice guidelines (CPG) and pathways, and department-level indicators, with a strong focus on improvements made.

Location

At the discretion of hospital leadership

Hospital Participants

- Chief executive officer and/or chief operating officer
- Individual(s) who guides the implementation of the quality improvement and patient safety program
- Select support staff from the quality improvement and patient safety program

Surveyor(s)

- Physician or nurse surveyor

Standards/Issues Addressed

- International Patient Safety Goals (IPSG)
- Care of Patients (COP.3.1)
- Medication Management and Use (MMU)
- Quality Improvement and Patient Safety (QPS) (QPS.7 and QPS.7.1 are addressed in the Operations interview)
- Governance, Leadership, and Direction (GLD.11.2)

Documents/Materials Needed

- Example of data validation
- Hospitalwide indicators to demonstrate data aggregation, analysis, and improvements
- Examples of protocols and clinical practice guidelines (CPGs) utilized to guide patient care

What Will Occur

The systemic and continuous actions that lead to measurable improvement require a well-implemented program. Governance approves the program; however, it takes daily guidance, management, and coordination to carry out the program. Management, implementation, and coordination of the program can be achieved through a quality management council/committee or some other structure. The surveyor(s) will discuss what structures and processes are used to support the quality improvement and patient safety program.

How to Prepare

Although the quality program staff should be familiar with all the standards, the surveyor(s) will pay particular attention to the standards in the QPS chapter and those standards that address measurement and improvement in the GLD chapter; **for example**, standards GLD.5, GLD.11, and GLD.11.2. In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

Sample questions include the following:

- IPSG: How are data regarding the hospital's performance on the IPSGs aggregated and shared with frontline staff?
- IPSG: How is the organization performing in relation to the IPSGs? **For example**, how do you measure the effectiveness of your patient identification process?

- COP.3.1: What was your process for determining which clinical alarms you would focus on?
- COP.3.1: What staff representation do you have on your alarm management team/steering committee?
- COP.3.1: What specific alarms have you chosen to focus on?
- COP.3.1: What staff are allowed to adjust alarms and what guidance do they have?
- COP.3.1: How are the outcomes of the alarm management interventions monitored?
- QPS.1 and GLD.4: How is the quality program organized to support leadership in implementation of the quality improvement and patient safety program? How do you know the program has adequate resources and technology?
- QPS.1: What type of education and training do the quality support staff receive?
- QPS.2: How does the quality staff support the department/service leaders in their quality improvement efforts?
- QPS.4: Are any data reported outside the organization (regulatory agencies or external databases)?
- QPS.8, ME 3: How is the organization performing in relation to items a) through g) in the intent of QPS.8?
- GLD.11.2: What protocols or clinical practice guidelines are utilized to guide patient care?
- GLD.11.2: What data do you have to demonstrate the efficacy of these clinical practice guidelines on positively improving patient care outcomes?

Quality Program Interviews: Operations

Purpose

The purpose of the Quality Program Operations Interview is to identify how leadership and the quality program staff support the overall program for quality and patient safety as it relates to operational efficacy. The Hospital Operations Interview examines the processes used for comprehensive systematic analysis (such as a root cause analysis), risk assessments, and data validation.

Location

At the discretion of hospital leadership

Hospital Participants

- Chief executive officer and/or chief operating officer
- Individual(s) who guides the implementation of the quality improvement and patient safety program
- Select support staff from the quality improvement and patient safety program

Surveyor(s)

- Physician or nurse surveyor

Standards/Issues Addressed

- International Patient Safety Goals (IPSG)
- Medication Management and Use (MMU)
- Quality Improvement and Patient Safety (QPS)

Documents/Materials Needed

- Example of data validation
- Hospitalwide indicators to demonstrate data aggregation, analysis, and improvements
- Examples of data from a comprehensive systematic analysis (**for example**, a root cause analysis [RCA]) completed on any sentinel event(s) identified within the look-back period for the survey
- Examples of data from RCA completed on any severe adverse, no-harm, or near-miss events within the look-back period for the survey
- Examples of risk assessments completed using an FMEA, HVA, ICRA process

What Will Occur

The systemic and continuous actions that lead to measurable improvements require a well-implemented program. Governance approves the program; however, it takes daily guidance, management, and coordination to carry out the program. Management, implementation, and coordination of the program can be achieved through a quality management council/committee or some other structure. The surveyor(s) will discuss what structures and processes are used to support the quality improvement and patient safety program.

How to Prepare

Although the quality program staff should be familiar with all the standards, the surveyor(s) will pay particular attention to the standards in the QPS chapter and those standards that address measurement and improvement in the GLD chapter; **for example**, standards GLD.5, GLD.11, and GLD.11.1. In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

Sample questions include the following:

- QPS.1 and GLD.4: How is the quality program organized to support leadership in implementation of the quality improvement and patient safety program? How do you know the program has adequate resources and technology?

- QPS.1: What type of education and training do the quality support staff receive?
- QPS.2: How does the quality staff support the department/service leaders in their quality improvement efforts?
- QPS.4: Are any data reported outside the organization (regulatory agencies or external databases)?
- QPS.4.1: Who does the actual data collection? Give examples of data that were aggregated, analyzed, and turned into useful information for the organization.
- QPS.6: How do you determine which data need to be validated? How are data validated and who performs the data validation?
- QPS.7 and QPS.7.1: How do leadership and members of the board actively support the RCA process? How do leadership and members of the board actively support the process for the identification of patient safety events within the hospital?
- QPS.7 and QPS.7.1: What are the sources of information that your hospital uses to identify harm and potential harm events?
- QPS.7 and QPS.7.1: Who provides information on harm and potential safety hazards within your organization? How do you encourage input from diverse perspectives? Physicians? Pharmacist? Other staff? Patients?
- QPS.7 and QPS.7.1: How do you help staff identify the types of patient safety events that they should report, including those events that did not directly cause patient harm?
- QPS.7 and QPS.7.1: What is the process for training staff about the tools to be used in a root cause analysis?
- QPS.7 and QPS.7.1: How does leadership evaluate the solutions presented by an RCA team in terms of their ability to eliminate or control the system failures that led to the sentinel event? What is the process if leadership does not feel the solutions proposed by the RCA team are adequate?
- QPS.7 and QPS.7.1: How does leadership ensure that actions were implemented? Who is accountable for the implementation of solutions assigned? How are measures to ensure that the implementation has been completed selected?
- QPS.10: Can you provide an example of the program's use of validated tools (**for example**, FMEA, HVA, ICRA) to complete a risk assessment?
- QPS.10: What risk points were identified during this process and what actions were taken by the organization based on these results?

Risk Assessment Examples

JCI accreditation standards emphasize that hospital leadership must prioritize those situations and services that may pose the highest risk of harm and must develop processes and interventions that can be used to mitigate the risk. The first step in this process is the proactive identification of potential risk. Risk assessment can be defined as an assessment that examines a process in detail, including sequencing of events; assesses actual and potential risk, failure, or points of vulnerability; and, through a logical process, prioritizes areas for improvement based on the actual or potential impact (that is, criticality) on care, treatment, and services provided. When completing a proactive risk assessment on a specific process, it is important that leadership involve key staff members who are experts in the process. **For example**, when completing a risk assessment on the outpatient diagnostic cardiac catheterization process, it would be important to involve leaders and staff from outpatient registration, diagnostic imaging, and any other service that interfaces with the cardiac catheterization laboratory. A key component to an effective risk assessment is that the entire process is sequenced, focusing on three distinct phases:

- **Preintervention**—what takes place prior to the cardiac catheterization procedure
  - The registration process prior to the patient arriving at the hospital
  - The process for checking the patient into the waiting area
  - Pre-procedure assessment, time-out
- **Intervention**—the entire process of the cardiac catheterization procedure
- **Postintervention**—what takes place after the procedure is complete

- The recovery process, including how the patient is transferred and monitored
- The criteria used for discharge
- The process for documenting and providing follow-up

This example is not meant to be all inclusive but should function as a framework for what is examined during the risk assessment process. When the team is planning to complete a risk assessment, note that specific risk assessment tools are mentioned in the standards, including FMEA, HVA, and ICRA. Each tool is designed to be used for different types of risk assessment. Please see the descriptions below:

Failure Mode and Effects Analysis (FMEA)

FMEA is a qualitative and systematic approach that allows the team to analyze the entirety of a process and identify potential "failure modes"— points at which the process can break down or fail. To conduct an FMEA, the team lists each step in the process, identifies what could go wrong at each step, and designs and implements actions that can reduce the risk of failure. Based on the potential risks determined, the team can prioritize the actions to take and then measure the success of the process changes.

Hazard Vulnerability Analysis (HVA)

HVA is similar to FMEA in that it is a process and tool that allows the team to assess risk; however, HVA assesses events or potential risk on a less detailed level. **For example**, the team could use HVA to assess the overall risk of a large-scale event such as a fire in the hospital. The team assesses the probability of the event occurring, different types of impact that may result if the event occurs, and the level of preparedness that currently exists. Based on these results the team can then prioritize what areas to focus on.

Infection Control Risk Assessment (ICRA)

An ICRA is a multidisciplinary process that includes key stakeholders to assess the facility's patient population and is intended to address issues through the design, construction, renovation, and facility management process. Use of an ICRA is specific to proactively designing processes that can help mitigate the spread of infection from patient to patient, patient to staff, and staff to patient throughout the entire facility.

Department/Service Quality Measurement Tracer

Purpose

The purpose of this tracer is to identify how individual department/service leaders use quality measurement to improve patient care and services being provided by their area. In addition, the surveyor(s) will evaluate how clinical practice guidelines (CPGs) are selected and implemented for use in areas providing clinical care.

Location

This tracer is not a separate tracer activity but will be combined with the Individual Patient Tracer Activity as well as tracers to individual settings—such as inpatient and outpatient units, treatment areas, and other areas, including, but not limited to, admitting, pharmacy, radiology and diagnostic imaging department, and clinical laboratory services. The surveyor(s) will be talking with the department or service leader as well as a variety of staff to understand the measurement priorities for that department or service and their participation in the organizationwide strategic priorities.

Hospital Participants

- Department or service leader of the area being traced
- Quality program person responsible for supporting the department or service area being traced
- A variety of staff involved in the activities of the department or service. Staff could include nurses, physicians, medical students, trainees, therapists, case managers, aides, pharmacy and lab staff, and support staff.

Surveyor(s)

Nurse, physician, or administrator surveyor(s)

Standards Addressed in Addition to Standards Addressed During Individual, System, and Location Tracers

- QPS.1
- QPS.2
- GLD.5
- GLD.11
- GLD.11.1
- GLD.11.2

Documents/Materials Needed

- The measurement plan for the department/service area being traced
- Copies of data collection tools, definitions, and the like
- Any documentation of communication of measurement activities for the area being traced

What Will Occur

During tracer activities, the surveyor(s) will have an interactive discussion with the department or service leader and other staff about their participation in the quality improvement and patient safety program. In particular, the participants should be able to discuss their involvement in the organizationwide strategic improvements as well as what department-specific measures are being collected. The surveyor(s) may ask to review the measurement activities being done, documentation of data analysis, and any improvements that were a result of their specific measurement. Staff will be asked to discuss how the specific department/service improvement project has affected patient care.

How to Prepare

Although department/service leaders should be familiar with all of the standards, the leaders should review the "Quality and Patient Safety" (QPS) chapter and read closely Governance, Leadership, and Direction (GLD) Standards GLD.5 and GLD.11 through GLD.11.2 prior to survey. In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

Sample questions include the following:

- QPS.1 and QPS.2: How does the organizationwide quality and safety program support you in your quality improvement activities?
  - QPS.1, ME 4: How are staff involved in quality decisions and the resulting quality activities?
  - QPS.1, ME 5: How do you communicate quality information to staff?
  - QPS.2, ME 1: How does the quality staff support you in your quality improvement program?
  - QPS.2, ME 2: How do you integrate the department/service-specific measures with other department/service initiatives?
- GLD.5: How do the department/service's measures align with organizationwide priorities chosen by organization leadership?
- GLD.11, ME 1: What measures do you collect that are specific to your department/service area?
- GLD.11, ME 3: How did you choose your measures?
- GLD.11.1: Are there any measures you currently collect that are applicable to physician and/or professional staff evaluations?
- GLD.11.2, ME 1: What clinical practice guidelines are used in your area and how were they selected?
- GLD.11.2, ME 2: What was the process for implementing the guidelines? How was the information communicated? How were staff trained?
- GLD.11.2, ME 4: How are the guidelines used to evaluate the quality and safety of services? Do you have data to show that use of the guidelines improved resource utilization or patient outcomes?

Quality Improvement Monitoring Plan

Purpose

The "Clinical/Hospital Operations Measures Tool" is a sample form on which hospitals can record the method that will be used to evaluate the effectiveness of ongoing compliance with the measures relating to the priority improvements identified by leadership as required in GLD.5. This tool may also be used by the department/service leaders when selecting measures specific to their department or service as required in GLD.11. The tool will provide a consistent process for documenting each element of the selected measures. The following information should be identified before collecting and measuring data to ensure that the process is clear and transparent:

- Category of the measure (**for example**, strategic priority improvement or individual department/service)
- Name, source, and definition of the measure for the GLD monitoring requirements
- Rationale for selecting the measure
- Type of measure (structure, process, outcome, or process and outcome)
- Reporting time period and frequency of assessment of data
- Methodology for data collection (retrospective or concurrent)
- Target sample size and threshold/target to demonstrate the expected performance outcome
- Data aggregation and analysis plan (to transform the data collected into useful information to reach conclusions and make necessary decisions in response to the results)
- Communication plan for reporting results to staff
- Name or file name for the audit tool used

Procedure

The hospital leadership and department/service leaders, with the support of the quality program staff, develop the measurement plan for each identified measure. The quality program staff help in the integration of measures throughout the hospital and track the progress of the collection and analysis of data. Data that are collected, aggregated, and analyzed are regularly communicated to staff and consistently reported to leadership. Committee minutes or other documents should demonstrate a multidisciplinary approach and process. Documentation should demonstrate that data results are acted on and improvement plans are implemented and sustained over time or that new strategies are used when the results are not met.

Performance improvement is contingent on reliable measurement and assessment in order to understand current performance and to target areas for improvement. In addition, systematic improvement methods are required to guide measurement, assessment, and improvement. For an organization to be able to improve its processes and outcomes it is important that the appropriate performance measures are chosen. By tracking the appropriate measures the organization can use the data to drive change.

Types of Performance Measures

Clinical Measures—Clinical measures are designed to evaluate the processes or outcomes of care associated with the delivery of clinical services for the patient population in question. They allow for intra- and interorganizational comparisons that can be used to continuously improve patient health outcomes. They may focus on the appropriateness of clinical decision making and implementation of those decisions. These measures must be condition specific or procedure specific, or address important functions of patient care (**for example**, medication use, infection prevention and control, patient assessment, patient safety).

Administrative/Financial Measures—Administrative/financial measures address the organizational structure for coordinating and integrating services, functions, or activities across operational components, including financial management (**for example**, financial stability, staff credentialing).

Perception of Care/Service Measures—Perception of care/service measures are satisfaction measures that focus on the delivery of care or service from the patients' and other customers' perspectives. A measure may address one or more aspects of care or service (**for example**, satisfaction with providers and other staff or satisfaction with the care environment). These measures are specific for the patient population certified.

Performance measures can be calculated as follows:

- Proportion
- Ratio
- Continuous variable

A *proportion* is a rate that is a piece of the whole. In a proportion, the numerator is expressed as a subset of the denominator. The following is an example of a proportion performance measure:

> Proportion of ischemic stroke patients discharged on antithrombotic medications

In a *ratio*, a relationship exists between the numerator and denominator, but the numerator is not a subset of the denominator. The following is an example of a ratio measure:

> Number of medication errors per 100 shifts

A *continuous variable* is an aggregate data measure in which the value of each measurement can fall anywhere along a continuous scale. The following is an example of a continuous variable measurement:

> Average number of days to fill 5 open staff positions
>
> 6 + 14 + 32 + 21 + 12 = 85 days
>
> 85 days / 5 cases = 17 days per case (average)

Clinical/Hospital Operations Measures Tool

<table>
<tr><td colspan="3">Who (Owner—Staff Name/Title):</td></tr>
<tr><td colspan="3">What (Measure Category—For example, strategic priority improvement or individual department/service):</td></tr>
<tr><td colspan="3">When (Completion Date):</td></tr>
<tr><td>Performance measure name:
Numerator:
Denominator:
Original source of measure:</td><td>Rationale for measure selection:</td><td>Type of measure (Indicator; check one):
❒ Structure
❒ Process
❒ Outcome
❒ Process and outcome</td></tr>
<tr><td colspan="2">Anticipated reporting time period:</td><td>Frequency of assessment of data: (check one)
❒ Daily ❒ Weekly ❒ Monthly ❒ Other</td></tr>
<tr><td colspan="2">Method of data collection:
❒ Retrospective ❒ Concurrent</td><td>Target sample and sample size (N):
Areas of monitoring:</td></tr>
<tr><td colspan="3">Measure target and/or threshold:</td></tr>
<tr><td colspan="3">Please explain the data aggregation and analysis plan:</td></tr>
<tr><td colspan="3">How will the data results be disseminated to staff?</td></tr>
<tr><td colspan="3">Audit tool name or file name (attach the audit form tool):</td></tr>
</table>

Supply Chain Management and Evidence-Based Purchasing Interview and Tracer

Purpose

The purpose of this session is to identify how hospital leadership uses evidence to make decisions related to purchasing and the use of technical and human resources. As part of the leaders' decision making, it is important to have a thorough understanding of the supply chain for drugs, technology, and supplies. Discussion will include leadership knowledge and understanding of the integrity of the supply chain.

Location

At the discretion of hospital leadership

Hospital Participants

- Chief executive officer
- Chief operating officer, when applicable
- Leader responsible for purchasing
- Leader from human resources
- Medical leader, when applicable
- Nurse executive
- Other senior leaders, at the discretion of the hospital

Surveyor(s)

One or more surveyors, as applicable

Standards/Issues Addressed

- GLD.7
- GLD.7.1

Documents/Materials Needed

Data and information from an example of a major purchasing decision

What Will Occur

In an interview, the surveyor(s) will discuss how the hospital makes decisions related to the purchase and use of resources, both technical and human. Information about the implications of these decisions on quality and safety will also be addressed. As part of these decisions, an understanding of the safety and quality of the supply chain is important. The surveyor(s) will ask about how leadership uses data and information about the supply chain to protect patients and staff by ensuring the integrity of supplies used by patients who are at most risk, and reporting supplies found to be defective.

In a tracer (**for example**, the Medication Management System Tracer), the surveyor(s) evaluates the supply chain by looking for evidence of supply chain management related to medication procurement and purchasing of supplies.

How to Prepare

In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

Sample questions include the following:

- GLD.7, ME 1: What types of data are used to inform decisions about the purchase of technical resources?
- GLD.7, ME 2: How are decisions made about staffing resources, such as adding staff or downsizing?

- GLD.7, ME 3: What professional organizations or other authoritative sources were used in making resource decisions?
- GLD.7.1, ME 1: What is the process for selecting a supplier?
- GLD.7.1, ME 2: What process do you use to investigate the integrity of your suppliers?
- GLD.7.1, ME 3: How does your knowledge about the supply chain influence your purchasing decisions?
- GLD.7.1, ME 4: How do you track supplies identified as "at most risk" to ensure that these supplies are not counterfeit or "fake"?

Individual Patient Tracer Activity

Purpose

An individual patient tracer follows the experiences of an individual patient to evaluate the hospital's performance against international standards. One approach to conducting a tracer is to sequentially follow the course of care, treatment, and services received by the patient from preadmission through postdischarge. During an individual tracer, the surveyor(s) will do the following:

- Follow the course of care, treatment, and services provided to the patient by and within the hospital using current medical records when possible
- Assess the interrelationships between and among disciplines and departments, programs, services, or units and the important functions in the care, treatment, and services being provided
- Evaluate the performance of relevant processes, with particular focus on the integration and coordination of distinct but related processes
- Identify potential concerns in the relevant processes

Hospital Participants

During a tracer, the surveyor(s) will converse with a wide variety of staff involved in the patient's care, treatment, and services. Staff could include nurses, physicians, medical students, trainees, therapists, case managers, aides, pharmacy and lab staff, and support staff.

As the tracer should not disturb patient care, the number of staff members at the beginning of this activity must be very limited. As the tracer proceeds, the surveyor(s) will request that other staff members participate if needed.

Surveyor(s)

Nurse, physician, or administrator surveyor(s)

Standards/Issues Addressed

All standards chapters may be addressed during this visit.

Documents/Materials Needed

The medical records of patients currently receiving care in the unit/setting

What Will Occur

Using the information from the application, the surveyor(s) will select patients from an active patient list to trace their experience throughout the hospital. Patients typically selected are those who have received multiple or complex services and therefore have had more contact with various parts of the organization. This contact will provide the opportunity to assess continuity-of-care issues. To the extent possible, the surveyor(s) will make every effort to avoid selecting tracers that occur at the same time and that may overlap in terms of sites within the organization.

The surveyor(s) will follow the patient's experience, looking at services provided by various individuals and departments within the organization, as well as at handovers between them. This type of review is designed to uncover systems issues, looking at both the individual components of an organization and how the components interact to provide safe, high-quality patient care.

The number of patients followed under tracer methodology will depend on the size and complexity of the hospital, the number of surveyors, and the length of the on-site survey. The tracer starts in the patient care setting or unit where the patient and the medical record are currently located. This is where the surveyor(s) begins to trace the entire care, treatment, or service process from preadmission through postdischarge.

As related to the provision of care being reviewed, the tracer will include the following elements:

- Review of the medical record with the staff person responsible for the patient's assessment, care, treatment, and services. If the responsible staff person is not available, the surveyor(s) may speak with other staff members. Supervisor participation in this part of the tracer should be limited. Additional staff involved in the patient's care will meet with the surveyor(s) as the tracer proceeds and the surveyor(s) requests. **For example**, the surveyor(s) will speak to a dietitian if the patient being traced has nutritional issues.
- Observation of implementation of the International Patient Safety Goals
- Observation of direct patient care
- Observation of medication processes
- Observation of infection prevention and control issues
- Observation of care planning processes
- Discussion of data use in individual departments/services. This discussion may include quality improvement measures being used, analysis of data identifying improvement opportunities, information that has been learned, improvements made using data, and data dissemination.
- Observation of the impact of the environment on safety
- Staff roles in minimizing environmental risk
- Review of emergency equipment, supplies, and processes
- Interview with the patient and/or family (if it is appropriate and permission is granted by the patient and/or family). The discussion will focus on the course of care and will attempt to verify issues identified during the tracer.
- The surveyor(s) will also address emergency management and explore patient flow issues. Patient flow issues may be explored in ancillary care areas and other patient care units as relevant to the patient being traced. **For example**, if the patient received a blood transfusion, the surveyor(s) may visit the blood bank; or if patients are sent to a holding area to wait for admission, the surveyor(s) may visit the holding area.
- The surveyor(s) may pull and review two to three additional medical records to verify issues that may have been identified. The surveyor(s) may ask staff in the unit, program, or service to assist with the review of the additional medical records. The following criteria can be used to guide the selection of additional medical records depending on the situation:
    - Similar or same diagnosis or tests
    - Patient close to discharge
    - Same diagnosis but different physician/practitioner
    - Same test but different location
    - Same age or sex
    - Length of stay
    - Interview with staff
    - High-risk patients and patient at risk of suicide
- Review of minutes and procedures as needed

The surveyor(s) may also create hypothetical situations related to the patient who is being traced or to other patients in the ward. **For example:** "What if this patient had a critical lab result?" "What if there was a fire in this ward?" "What if a patient needed to be restrained?"

In academic medical center hospitals where patient tracers will include patients receiving care by a team that includes medical students/trainees, the surveyor(s) will want to include the student and/or trainee in his or her review of the patient's medical record and the care being provided. Discussion may include reviewing entries made by the student/trainee, the countersignatures required, and treatments and interventions that the student/trainee may perform independently and those that require supervision. The surveyor(s) may also ask staff how they know what the students/trainees are permitted to do and who they would contact if there were a question about the student/trainee's performance.

In academic medical center hospitals where patient tracers will include patients on a research protocol, the surveyor(s) will want to include those students/trainees who are able to provide information about the protocol. This may include the principal investigator or designee, staff trained in participating on the team implementing the protocol, and other staff caring for patients on research protocols. The discussion may include the following:

- How staff were trained on the protocol
- How patients on research protocols were identified
- What staff understand about the informed consent process
- What happens when a patient asks to leave the study
- The process when a protocol has changed
- If a protocol changes, how patients are reenrolled and sign another consent
- The process when an adverse event occurs

The surveyor(s) will want to review the medical record with staff responsible for the patient's care and treatment, and interview the patient and/or family (if it is appropriate and permission is granted by the patient and/or family).

A surveyor(s) may arrive in a patient care setting or unit and may need to wait for staff to become available. In these cases, the surveyor(s) will use this time productively (**for example**, to tour the unit, program, or service; to address environmental issues; or to observe care/treatment/service processes). Every effort will be made to avoid having more than one surveyor visiting the same area at the same time and will minimize multiple visits to the same location.

Tracer Selection Criteria

Patient tracer selection will be related to the hospital's mission and scope of services—both typical patients and those who might require less common treatments or procedures may be selected. **For example**, depending on the organization's mission and services, patients requiring treatment and care that is provided less frequently may include pediatric, dental, or prenatal patients. In addition, patients may be selected because they are receiving a procedure that is provided less frequently in the organization (**for example**, an invasive procedure such as a thoracentesis). In an academic medical center hospital, additional patient tracers may include patients such as those receiving care by a team that includes medical students or trainees or patients on a research protocol.

Links to Other Survey Activities

Issues identified from the tracer activities may lead to further exploration in the system tracers or other survey activities, such as the FMS Document Review and Facility Tour and the Leadership for Quality, Patient Safety, Ethics, and Culture of Safety Interview. The surveyor(s) will use time scheduled as "Undetermined Survey Activity" on the agenda to conduct additional activities to clarify issues, to gather additional information, and to evaluate standards compliance that is not directly related to a patient tracer.

Findings from tracer visits provide focus for other tracers and may influence the selection of other tracers. They may also identify issues related to the coordination and communication of information relevant to the safety and quality of care services.

Organ and Tissue Transplant Services Interview and Tracer

Purpose

The purpose of the interview is to discuss the organization and operations of the transplant program, paying particular attention to the interrelationships between and among the members of the multidisciplinary team and the departments, programs, services, or units. In addition, general information about the number and types of organ and tissue donations performed; data and information about success rates, survival rates, and adverse and/or sentinel events; and information about regional laws, regulations, and resources for organ and tissue transplant.

The purpose of the tracer is to

- follow the course of care, treatment, and services provided to the organ recipient and the living organ donor by and within the hospital using current medical records when possible;
- assess the interrelationships between and among the multidisciplinary team and the departments, programs, services, or units;
- assess the important functions and interrelationships of the care, treatment, and services being provided;
- evaluate the performance of relevant processes, with particular focus on the integration and coordination of distinct, but related, processes; **for example**, the specific organ transplant information required for the informed consent process (PCC.4.2, COP.8.5, COP.9, and COP.9.1); and
- identify potential concerns in the relevant processes.

Location

Location of the interview will be at the discretion of the organ and transplant program leaders. Location of the tracer activities will be in the individual units/wards/departments in which transplant recipients and donors are admitted.

Hospital Participants

- Leaders responsible for organ and tissue transplant services
- Transplant program leader
- Representative members of the multidisciplinary transplant team
- Leadership Levels II and III—CEO and/or chief operating officer (COO), "chief" of nursing, medical, and others as applicable
- Organ donor registries/procurement organization representative (when organ donation and/or transplantation are performed

Surveyor(s)

Physician and/or nurse surveyor(s)

Standards Addressed

- PCC.4.2
- PCC.6 and PCC.6.1
- COP.8 through COP.9.3
- QPS.7
- QPS.7.1
- QPS.8
- GLD.9
- GLD.10

Documents/Materials Needed

- A list of organs and tissues included in the hospital's transplant program
- Clinical practice guidelines for each of the organs/tissues in the hospital's transplant program
- Organ-specific transplant clinical eligibility, psychological, and social suitability criteria for transplant candidates
- Protocols for organ recovery and organ receipt
- Living donor clinical and psychological selection criteria
- Data collected specific to the organ and tissue transplant program
- Any sentinel or adverse event analysis (if applicable)

What Will Occur

During the interview session, the surveyor(s) will have an interactive discussion with all those identified to be included in this session.

In particular, the participants should be able to discuss their involvement in the organizationwide organ and tissue transplant program. The surveyor(s) may ask to review the clinical practice guidelines, criteria for recipient and donor selection, protocols for organ recovery and organ receipt, and measurement activities being done related to organ and tissue transplantation. Staff will be asked to discuss how the specific department/service improvement project has affected patient care.

How to Prepare

Although department/service leaders should be familiar with all the standards, the organ and tissue transplant program leaders should be particularly familiar with Standards COP.8 through COP.9.3. In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

Sample questions include the following:

General Questions

- What types of organs and tissues are part of your hospital's program?
- What regional laws and regulations apply?
- Are there regional resources for organ and tissue donation/transplantation?
- Do you provide services to patients from other countries? If yes, what are the criteria for accepting patients from other countries?
- If patients from other countries are accepted into the program, how is their care monitored after discharge?

Standard-Specific Questions

- COP.8.3: How are transplant activities coordinated to facilitate continuity of care for transplant recipients and living transplant donors?
- COP.8.4: What selection criteria are used for organ/tissue recipients?
- COP.8.5: How is informed consent obtained for transplant recipients and what information is included?
- COP.8.6: What are the protocols for organ recovery and organ receipt? What process is used to ensure viability of the donor organ? What process is used to ensure recipient compatibility?
- COP.8.7, ME 1: What organ-specific clinical practice guidelines are used?
- COP.9: How do living donors become known?
    - o What are the laws and regulations related to living donors?
    - o How do you identify a living donor advocate?
    - o What type of training does the living donor advocate receive?
- COP.9.1: How is informed consent obtained for living donors and what information is included?
- COP.9.2: What criteria do you use for selection of living donors?
- QPS.7, QPS.7.1, and QPS.8: What have you learned from analysis of your adverse/near-miss and/or sentinel events?

Patient Interview Session

Purpose

The objective of this interview session is to learn from patients and family members about their perception of the care and services provided during their hospitalization.

Types of Patient Interviews

There are two types of patient interviews:

- Individual patient interview conducted with an inpatient during a patient tracer session
- Group interview with three to five patients who have been recently discharged from the hospital

Location

The inpatient interview will take place in the patient's room after the patient has granted permission.

The group interview will require a small meeting room as determined by hospital leadership.

Program Participants

The individual patient interview will be conducted by the surveyor(s), along with the translator if required.

The group interview will be conducted with three to five discharged patients who received care as an inpatient, and the translator if required. This interview is not intended to include hospital staff members and leaders.

Surveyor(s)

Nurse or physician surveyor(s)

Documents/Materials Needed

None

What Will Occur

During the on-site survey, it will be beneficial for the surveyor(s) to have the opportunity to interview patients who are receiving or who have received care and services from the hospital. During the individual inpatient tracer activity, a surveyor may elect to interview a patient on the ward. The interview will be conducted with just the surveyor(s) and, if required, the translator.

For the group interview, hospital leaders should arrange to have three to five recently discharged patients (in the last six months) contacted to come in to meet with the surveyor(s) as a group, to answer questions about their care experience. These patients will be interviewed together as a group, and no specific, personal information will be asked in front of other patients. Family members may also attend to relate their perceptions and experiences with the hospital's care and services.

How to Prepare

Prior to the start of the survey, hospital leaders should contact recently discharged patients and ask if they would be willing to participate in a short (30–60 minute) interview about their care experience. Patients should be informed that this is voluntary and that no personal, specific information will be shared with other patients or families.

FMS Document Review and Facility Tour

Purpose

The purpose of the FMS [Facility Management and Safety] Document Review and Facility Tour is to assess the following components:

- Leadership roles and responsibilities regarding Facility Management and Safety
- Risk assessments and monitoring
- Safety
- Security
- Hazardous materials and waste
- Fire safety
- Medical equipment (including laser and radiology safety)
- Utility systems
- Emergency and disaster management
- Construction and renovation activities
- Staff education
- Infection prevention and control

Location

The FMS Document Review will take place at the discretion of hospital leadership. The Document Review will require staff who are familiar with the programs, plans, policies, procedures, tools used (**for example**, the risk assessments), and documentation of inspections. Reports from leadership and governance will also be assessed.

For the Facility Tour, selected patient care settings, inpatient and outpatient units, treatment areas, and other areas, including, but not limited to, admitting, kitchen, pharmacy, central storage, laundry, mortuary, and power plant (if applicable), will be visited. The tour is designed to cover high-risk areas for safety and security. Any and all areas of the hospital's campus may be surveyed, so the organization must be prepared to provide the surveyor(s) with access to any area(s) upon request.

Hospital Participants

FMS Document Review:

- Chief engineer
- Supervisory engineer(s) (electrical, HVAC [heating, ventilation, and air-conditioning], civil)
- Safety officer
- Facility manager
- Fire safety officer
- Staff responsible for the oversight and supervision of the eight FMS programs
- Staff who oversee and supervise the laser and optical radiation safety program

Facility Tour

- Leaders of all hospital departments (**for example**, emergency management, pharmacy, dietary, clinical engineering, among others) (when the surveyor[s] is present in their areas)
- Infection prevention and control practitioner (as related to the area being toured)
- Nursing leadership (as related to the area being toured)

Note: Please keep in mind that as part of the Facility Tour the surveyor(s) and representatives of the hospital will visit high-risk areas (**for example**, mechanical rooms, roofs) as well as restricted areas (kitchen, mortuary, laundry). For safety reasons the surveyor(s) will ask the organization to reduce the number of participants to a minimum when visiting these areas.

Surveyor(s)

Administrator surveyor(s) (physician and/or nurse surveyor[s] when team does not include an administrator)

Standards/Issues Addressed

- Access to Care and Continuity of Care (ACC); admission to the hospital, transportation
- Patient-Centered Care (PCC); privacy, confidentiality, and security
- Assessment of Patients (AOP); laboratory and radiology standards
- Medication Management and Use (MMU); storage of medication
- Prevention and Control of Infections (PCI); construction and renovation activities
- Facility Management and Safety (FMS); eight program documentation, implementation
- Staff Qualifications and Education (SQE); staff education on FMS–related topics
- Management of Information (MOI); security, privacy and confidentiality of information

Documents/Materials Needed

- Documents, such as plans, policies and procedures, and test and maintenance reports, that describe the programs for the following:
  - Risk assessment and monitoring (FMS.3, FMS.4)
  - Safety (FMS.5)
  - Security (FMS.6)
  - Hazardous materials and waste (FMS.7, FMS.7.1, and FMS.7.2)
  - Fire safety (FMS.8, FMS.8.1, FMS.8.2, FMS.8.4, and FMS.8.5)
  - Medical equipment (FMS.9, FMS.9.1, and FMS.9.2)
  - Utility systems (FMS.10, FMS.10.1, FMS.10.2, FMS.10.3, and FMS.10.3.1)
  - Emergency and disaster management (FMS.11)
  - Construction and renovation (FMS.12)
  - Education (FMS.13)
  - Management of lasers and other optical radiation devices (COP.4)
  - Medical equipment, devices, and supplies (PCI.6)
  - Infectious human tissues and waste (PCI.8 and PCI.8.1)
  - Operation of food services (PCI.9)
  - Engineering controls (PCI.10)
- A documented, current, accurate inspection of the hospital's physical facilities (described in the intent of FMS.5)
- When construction is present, a documented preconstruction risk assessment (FMS.12) and infection control risk assessment (PCI.11) and a plan(s) for mitigating identified risks
- Documentation related to the clinical laboratory, radiology/diagnostic imaging, and other departments
  - Laboratory safety and equipment (AOP.5.3)
  - Radiology and diagnostic imaging safety and equipment (AOP.6.2)
  - Laser safety and optical radiation program (COP.4 and COP.4.1)
- Documentation related to interim measures implemented (as applicable)

What Will Occur

During the FMS Document Review the surveyor(s) will analyze the risk assessments developed by the organization and how these tools are implemented and monitored. The FMS chapter also requires periodic reports to leadership and governance, and these documents will also be assessed.

During the Document Review, the surveyor(s) will have reviewed the documented, current, accurate inspection of the hospital physical facilities. He or she will then visit different areas of the facility to check the implementation of these programs. The surveyor(s) will also review selected portions of the facility inspection report prepared by the hospital.

The surveyor(s) will visit patient care areas as well as non–patient care areas of the facility. In all areas, the surveyor(s) will observe the facility and interview staff to learn how the hospital manages the facility to accomplish the following:

- Risks assessments, risk reduction strategies, and monitoring
- Prevent accidents and injuries
- Maintain safe conditions
- Maintain secure conditions
- Implement emergency response plans
- Management of equipment (medical and nonmedical)
- Management of hazardous materials and waste
- Fire risk assessment
- Interim measures implemented (as applicable)

Note: In some survey agendas, two surveyors will visit separate sections of the facility at the same time. The hospital should be prepared to have staff available to guide and assist each surveyor on the tour of the facility.

The areas and functions visited by the surveyor(s) include the following (as applicable):

- Boiler room
- Emergency power generator
- Loading/receiving dock
- Central storage area(s) or warehouse(s)
- Central Sterile Supply Department (CSSD)
- Laboratory and pathology services
- Information technology (IT) control room
- Laundry
- Food service/kitchen
- Medical gas storage areas
- Oxygen storage areas
- Hazardous materials storage areas
- Areas designated as hazardous, clean and soiled linen rooms, and oxygen storage rooms
- Bottom of laundry and garbage chutes
- Morgue
- Heating, ventilation, and air-conditioning (HVAC) equipment rooms
- Roof
- Helipad
- Outside assembly areas
- Radiology services
- Patient wards
- Automobile parking garages
- Ongoing construction and renovation sites
- Biological waste collection sites

How to Prepare

- Hospital leaders and the facility manager(s) should carefully read the relevant standards.
- Hospital representatives conduct the risks assessments of the required eight programs in the FMS chapter, set goals and improvements, and implement actions to reduce and eliminate risks.
- FMS.5 requires that the organization conduct its own inspection of the facility. This information should be available to the surveyor(s). All buildings in which patients are housed or treated are included in the inspection and the report.
- The organization is aware of relevant laws, regulations, and required facility inspections and will share as much information as possible with the surveyor(s) (FMS.1) and provide necessary information

of the relevant sections of the "Laws and Regulations Worksheet" (see the "Survey Planning Tools" chapter) as completely as is possible.

- Representatives of the organization should be prepared to show the surveyor(s) how risk assessments were developed and how the facility management plans are implemented. **For example**, they should demonstrate how hazardous materials are risk assessed and how they are stored and disposed.
- Prior to survey, the organization should ensure that medical equipment has been inspected, tested, and maintained and that these activities are documented (FMS.9, FMS.9.1, and FMS.9.2).
- FMS.8.3 requires that any deficiencies identified in fire safety equipment and systems are immediately corrected, or interim measures are implemented to reduce fire risk until deficiencies can be fully corrected. Please refer to the FMS chapter appendix in the Hospital and Academic Medical Center Hospital standards manual for a detailed explanation of the term *interim measures*.
- Representatives of the organization should be prepared to explain or demonstrate how power, water, and medical gases are available 24 hours a day, 7 days a week (FMS.10.2).
- Another component of the preparation is to show how water testing is conducted in the hemodialysis unit (FMS.10.3.1) and how the treatment and testing in the dental clinic (FMS.10.3) is done.
- The organization should implement a laser safety and optical radiation program (COP.4 and COP.4.1).
- The hospital should have the following items available for the surveyor(s) to use when conducting the Facility Tour:
  - Flashlight
  - Master key
  - Ladder (to look above ceiling tiles)
  - Tape measure

Sample Outline of a Facility Inspection Report

- The building(s) included in the report
  - The patient care activities that take place in each building
  - Any local codes, laws, or classifications for the building(s) based on the activities
  - The approximate age of the building(s)
- The building-by-building results of the inspection
  - Any general conditions of the building(s) that relate to local codes, laws, and regulations
  - Specific findings related to codes, laws, regulations, and accreditation standards. Examples include "Building 1, 2nd floor west, fire exit door does not close properly"; "Building 1, room 210, broken chair next to bed"; "Building 3, 2nd floor laboratory, hazardous materials stored on the floor near an exit."
  - Any interim measures implemented to correct or reduce fire risk until deficiencies are fully corrected
- The plan to correct the findings
  - Timetable
  - Estimated budget (short range and longer range, as needed based on plan of correction)
  - Progress in carrying out the plan
- The plan for monitoring the facility improvement process and for the continuing monitoring and improvement of the facility to ensure that facility safety concerns are prevented or eliminated through an ongoing planning and inspection process

Note: The facility inspection report can be in any format that makes it an effective management tool for the hospital. The inspection can be conducted by knowledgeable organization staff or by outside consultants. The report should be as complete as possible to demonstrate that the organization is aware of all conditions in its building(s) and has plans to improve the safety of its building(s).

Department/Service-Specific Tracers

During the FMS Document Review and Facility Tour or other survey activity, the surveyor(s) will conduct the following department- and service-specific tracers, if applicable to the hospital services.

Hemodialysis Tracer

Purpose

The purpose of the Hemodialysis Tracer is to understand and assess the organization's hemodialysis services, including the course of dialysis treatment provided to patients and the processes associated with the services, such as equipment maintenance; procedures related to dialyzers; and water treatment, testing, and monitoring.

What Will Occur

The Hemodialysis Tracer will take place in the hemodialysis department and associated water treatment room/facility. Hospital participants will include those who provide hemodialysis services, such as physicians, nurses, and technicians, as well as others who are involved in the care of hemodialysis patients, including dietitians, pharmacists, and social workers, as applicable to the organization. Other participants in the tracer will include the water treatment specialist(s)/technician(s) and/or facilities staff who are responsible for water quality in the hemodialysis services.

During the tracer, the surveyor(s) will select a patient and trace his or her experience with the hemodialysis treatment and services, including any supportive care, such as care received from dietitians, social workers, and others. Medical records and patient instruction materials may be reviewed as part of the tracer. The surveyor(s) will assess the interrelationships between and among physicians, nurses, technicians, and water treatment specialists in providing the care and treatment. Other activities during the tracer include evaluating the performance of processes such as testing, cleaning, and storing dialyzers (if applicable) and evaluating the area where dialyzers are reprocessed and stored.

The surveyor(s) will visit the water treatment room/facility to review the organization's water treatment and testing processes and how the room is maintained. The surveyor(s) will discuss with staff which industry standards the hospital uses for maintaining water quality and review water quality testing records. If there have been issues with water quality, the surveyor(s) will review actions the organization has taken to mitigate the risks.

The surveyor(s) will also review maintenance and testing records for the hemodialysis machines and water treatment equipment, and assess equipment maintenance processes, including daily cleaning, preventive maintenance, and equipment repairs.

How to Prepare

Although staff should be familiar with all standards, prior to the survey, staff should carefully read Standard FMS.10.3.1 on hemodialysis water quality and safety. The surveyor(s) will also focus on other relevant standards.

Other standards may include the following:

- IPSG standards
- PCI.4
- PCI.6
- GLD.4
- GLD.6
- GLD.6.1
- FMS.8.1 and FMS.8.2
- FMS.9.1
- FMS.10.2
- FMS.13

It may be useful to turn the identified standards into questions. Mock discussions using the questions could then be conducted with participants so they feel more comfortable with possible questions the surveyor(s) may ask.

Sample questions include the following:

- FMS.10.3.1: What are the water quality industry standards used by the organization? How frequently is the water tested and from what sources is it tested? What processes are used for disinfection of the water distribution system? Are department/service staff familiar with the standards and processes? How are variations in compliance with the water quality standards managed?
- FMS.10.3.1: Are the hemodialysis machines tested for water quality and how often?
- FMS.10.3.1: If dialyzers are reused in the organization, how many times may they be reused? How are they tested, cleaned, and stored?
- IPSG.1: How are patients identified prior to starting hemodialysis treatment?
- PCC.4.1: How frequently must patients sign consent forms for ongoing hemodialysis treatments?
- PCC.5.1 and COP.5: Have patient education materials been developed that address dietary needs/restrictions for those on hemodialysis?
- GLD.11: What are the clinical performance measures that the department is monitoring to ensure adequacy of hemodialysis treatment?
- FMS.8.1 and FMS.8.2: Have evacuation plans been identified and practiced?
- FMS.9: What are the procedures for daily and preventive maintenance for hemodialysis equipment and water treatment equipment? What happens when a piece of equipment requires repair?

Laboratory Tracer

Purpose

The purpose of the visit to the laboratory is to address the following topics:

- Section-specific policies and technical procedures
- Preventive maintenance and quality control documentation
- Infection prevention and control and safety practices
- Specimen collection and processing practices
- Staff competence and whether the number of staff is adequate
- Review of blood bank practices (if applicable)

What Will Occur

The Laboratory Tracer will take place in the laboratory department and may also include areas outside of the department where laboratory tests are performed, including point-of-care testing (POCT). Hospital participants will include the laboratory director, technicians, and others who provide care, treatment, or services to patients undergoing laboratory procedures.

During this tracer, the surveyor(s) will assess the degree of implementation of all elements of the laboratory safety program. The surveyor(s) will also review the organization's list of critical results and the process for managing critical results, as well as the turnaround time (TAT) for critical results and the TAT monitoring process for urgent/emergent tests. In addition, the surveyor(s) will ask to review quality control measures that are in place.

Organizations are required to provide documentation related to inspection, testing, and maintenance of equipment and evidence of compliance with the infection prevention and control and the quality and patient safety programs.

How to Prepare

In preparation for the tracer, it would be useful to turn the standards into questions. Mock discussions can then be conducted with participants so they feel more comfortable with possible questions.

Sample questions include the following:

- AOP.5: What is the scope of services and how is this documented? Are there tests that are performed in outsourced laboratories? If yes, please provide the contract and the process for how these services are selected.
- AOP.5.1: What are the qualifications of the individual who oversees the laboratory? This may include oversight of the point-of-care testing program. How does the organization ensure adequate staffing of the laboratory?
- AOP.5.2: When point-of-care testing (POCT) is used within the organization, who supervises the POCT program? Is there a documented list of point-of-care tests that take place in the hospital? Are all staff allowed to perform POCT? What is the process for determining the necessary qualifications and competency for performing POCT? What is the process for reporting POCT critical results? Who does the daily quality control of the POCT device(s)?
- AOP.5.3: How is the laboratory part of the overall quality and safety program of the hospital? What reports are provided to the governing entity? What is the policy related to addressing staff's risk of developing a laboratory-acquired infection? How is information associated with staff-related injuries, such as needlestick injuries, exposures from major spills or administration of toxic agents, transmission of tuberculosis, and the like, tracked and analyzed? How is that information used to make improvements?
- AOP.5.4: How are turnaround times (TATs) for laboratory tests tracked? Are TATs tracked for outsourced laboratory tests? What is the process for ordering laboratory tests?
- AOP.5.5: Is the equipment maintenance program documented? Is there a register to document all equipment failures or problems?
- AOP.5.9: Is there a quality management system available in the laboratory? Who surveys the test results daily? How are the reagents tested? Is there a corrective and preventive register available? How are the reagents evaluated (internal quality control)? How and for what length of time are the samples preserved?
- AOP.5.11: What services does the blood bank provide? What are the applicable laws and regulations? What are the qualifications for people who can donate blood?

Laser Safety Tracer

Purpose

The purpose of the Laser Safety Tracer is to assess the hospital's safety program for lasers and optical radiation devices. The tracer will focus on how the organization ensures the safety of staff and patients through education and training, administrative and engineering controls, the availability and use of personal protective equipment, and proper maintenance and use of lasers and optical radiation devices.

What Will Occur

The surveyor(s) will visit all locations where lasers and other forms of optical radiation are used. The surveyor(s) will review relevant policies and procedures; equipment inspection, testing, and maintenance reports; documentation of staff training; integration of the laser safety program with the facility management and infection prevention and control programs; and other processes relevant to the requirements in COP.4 and COP.4.1.

How to Prepare

In preparation for the tracer, it would be useful to turn the standards into questions. Mock discussions can then be conducted with participants so they feel more comfortable with possible questions. In addition to the requirements in COP.4 and COP.4.1, other relevant standards may be addressed during this tracer activity.

Sample questions include the following:

- COP.4 and COP.4.1:
  - What are the safety protocols in place for when lasers are in operation?
  - What laser safety precautions have been implemented to protect staff, patients, and visitors?

- How do you educate staff who work with and around lasers about safety protocols and ensure their compliance with the safety measures/protocols?
- How do you prevent and mitigate fire risk during laser procedures?
- What measures are in place to reduce risks to air quality and inhalation risks during laser procedures?
- What are the processes for cleaning, disinfecting, inspecting, testing, and maintaining the lasers and related equipment?

Radiology and Diagnostic Imaging Tracer

Purpose

The purpose of this session is to understand the organization's approach to the provision of radiology and diagnostic imaging services on site, whether provided by the hospital or through contracted services. The session will include a review of adherence to laws and regulations, radiation and magnetic resonance imaging (MRI) safety, equipment management, methodologies for preventing unnecessary exposure to radiation, and procedures used in nuclear medicine.

What Will Occur

The Radiology and Diagnostic Imaging Tracer will take place in the radiology and/or diagnostic imaging department and may also include areas outside of the department where diagnostic imaging and radiology exams occur, as applicable to the services provided by the hospital.

Organization participants may include radiologists, radiography technicians, nuclear medicine physicians and technicians, biomedical technicians, radiation safety officer, and/or others who provide care, treatment, or services to patients undergoing radiology and diagnostic imaging procedures.

During this tracer, the surveyor(s) will assess the degree of implementation of all elements of the radiation and diagnostic imaging safety program as it relates to the services provided by the organization. Services such as radiology, computerized tomography (CT), fluoroscopy, and nuclear medicine will be reviewed, and the tracer will include areas outside of the main department in which radiation and imaging is used (**for example**, the operating theatre and areas in which portable equipment is used).

When an organization provides MRI services, the surveyor(s) will assess how the MRI department establishes safety zones and safety precautions within those zones, access restrictions in the magnetic field area, and safe equipment use, including how staff manage and use fire extinguishers, stretchers, and wheelchairs in the MRI environment. In addition, the surveyor(s) will want to understand the consent process and the process for use of sedation, if needed.

The surveyor(s) will review the organization's list of critical results and the process for managing critical results, as well as the turnaround time (TAT) for critical results and the TAT monitoring process for urgent/emergent tests. The surveyor(s) may also ask to review quality control measures that are in place and the process for ensuring quality imaging. Organizations will be required to provide documentation related to inspection, testing, and maintenance of equipment and evidence of compliance with the infection prevention and control program and the quality and patient safety program.

How to Prepare

Although staff should be familiar with all standards, prior to the survey, radiology and diagnostic imaging staff should carefully read Standards AOP.6 through AOP.6.6. In addition, the surveyor(s) will pay attention to other standards that may relate to this session. Other standards may include the following:

- IPSG.1
- IPSG.2 through IPSG.2.2
- IPSG.3
- GLD.6 through GLD.6.2

- GLD.7
- FMS.11
- FMS.8 and FMS.8.1
- FMS.9

It may be useful to turn the identified standards into questions. Mock discussions utilizing the questions could then be conducted with participants so they feel more comfortable with possible questions the surveyor(s) may ask.

Sample questions include the following:

- AOP.6.2—Radiation and Diagnostic Imaging Safety:
  - Have maximum dosing protocols been established, are staff educated on their use, and are they aware of factors that affect the dosing, such as positioning?
  - What processes are in place to identify and protect pregnant women from radiation exposure?
  - Are staff correctly wearing their dosimeters and turning them in according to the established protocols?
  - Have equipment and rooms been tested for leakage?
  - Have staff been trained to reduce radiation exposure to themselves and other workers during procedures (time, distance, and shielding)?
  - Have criteria and frequency been established for testing of protective devices? How are they documented? Does this extend to other departments outside of the radiology services?
  - Have staff been oriented to the radiation/diagnostic imaging safety program?
  - Is signage in place, as needed, to protect not only patients and staff but visitors as well?
  - What processes are in place to ensure safety related to procedures associated with magnetic resonance imaging (MRI)?
  - Are there access restrictions to the magnetic field area, and what are those restrictions? How do you ensure that patients, visitors, and restricted staff know and understand the access restrictions?
  - Is there special non-ferromagnetic equipment in the MRI environment, such as a nonferrous fire extinguisher?
- AOP.6.4: Is the equipment maintenance program documented?
- AOP.6.5: Are staff knowledgeable about quality control measures? Are there processes in place to evaluate image quality?
- MMU.3: Has the oversight for medications and contrast media been established? Have criteria been established for use of contrast media? Is there documentation for the receipt of radiopharmaceuticals, and is it in compliance with local laws and regulations?

Transfer and Medical Transport Tracer

Purpose

The purpose of the Transfer and Medical Transport Tracer is to understand the organization's approach to referral and transfer of patients and review the manner in which transfers occur.

Documents/Materials Needed

- Policies required for patient transfer
- Measures selected for the quality monitoring of the ambulance services
- Copy of the ambulance contracted services (if applicable)
- Infection prevention and control program
- Regular ambulance vehicles inspection checklist
- Policies and procedures for complaint process related to transport services

What Will Occur

During patient tracer activities the surveyor(s) will observe the process of transferring patients to other health care facilities. A review of the record with the staff person responsible for the patient's care, treatment, and/or services will occur. The record will be reviewed for compliance with the documentation requirements of the transfer. If the responsible staff person is not available, the surveyor(s) may speak with other staff members present. In addition, the surveyor(s) will request to review the quality data on the ambulance services.

The surveyor(s) will identify select clinical staff personnel files from staff who are assigned and competent in the transfer process to be reviewed during the Medical, Nursing, and Other Staff Education Qualifications Sessions. Supervisor participation in this part of the tracer should be limited.

Additional staff involved in the patient's care will meet with the surveyor(s) as the tracer proceeds.

How to Prepare

Although staff should be familiar with all standards, prior to the survey, staff should carefully read Standards ACC.5.1, MEs 3 and 5, and ACC.7.1. In addition, standards from the QPS, PCI, GLD, and FMS chapters related to infection prevention and control, quality improvement, contracted services, and equipment inspection and maintenance may also be reviewed.

The standards require the transport organization to conduct its own inspection of the vehicles fleet. This information should be available to the surveyor(s). All vehicles in which patients are transported are included in the inspection and the report. The surveyor(s) will also request to review relevant laws and regulations. The organization should complete the necessary information in the relevant sections of the "Laws and Regulations Worksheet" as thoroughly as is possible. It may be useful to develop questions related to the identified standards. Mock discussions using the questions could then be conducted with participants so they feel more comfortable with possible questions the surveyor(s) may ask.

Sample questions may include the following:

- ACC.5: What is the process for following up with patients who have been transported to another facility?
- ACC.6: How are patients with infections identified by the transport organization?
- ACC.6 and PCI.5.1: How are patients with infections considered within the context of the infection prevention and control program during the transfer process?
- ACC.6 and GLD.6: What is the process for identifying, in writing, the services provided through contractual agreements? How do you ensure that the documents are current?
- ACC.6: How is the contracted ambulance service involved in the quality improvement and patient safety program?
- ACC.6: How do you determine the appropriate equipment needed for the ambulance transport?
- ACC.6: What is the process for inspecting the equipment and providing required maintenance checks?
- ACC.6 and MMU.3: Are medications stored in the ambulance? If yes, how do you ensure compliance with proper storage of medications as well as the safety and security of the medications?
- ACC.6: If staff are required to accompany the patient during transport, how is their competency assessed?

Information Management and Technology Tracer

Purpose

The purpose of the information management and technology tracer is to determine whether the organization maintains the confidentiality, security, privacy, and integrity of data and information through processes to manage and control access throughout all areas of the organization.

Documents/Materials Needed

- Policies regarding information security
- Data regarding auditing of access to the organization's information and systems
- Contracts with any third-party entities that have access to any information generated by the organization

What Will Occur

The surveyor(s) will discuss processes and procedures that the organization uses to manage, protect, and track all the information and electronic systems that are built into the organization. The surveyor(s) will then pick a patient on the census list who has been in the hospital for a few days. The surveyor(s) will then discuss with the team specific items regarding the patient's information and information security such as information storage and access, the electronic medical record, management of medical equipment, and data security.

Additional staff involved in the patient's care will meet with the surveyor(s) as the tracer proceeds.

How to Prepare

Hospitals should identify the participants in the Information Management and Technology Tracer. Although organization leadership should be familiar with all the standards, leadership should read closely the MOI chapter prior to survey. In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

Sample questions related to the information management and technology program include the following:

- MOI.1: Identification of where information about a patient may be stored: electronic medical record, registration, pharmacy, lab, x-ray or other diagnostic tests, food services, and procedural areas.
  - Are there any third parties with which information is shared? If so, are there appropriate contracts in place with those entities to protect the patient information consistent with local laws and regulations?
  - How does a patient authorize the collection, use, and disclosure of his or her data?
  - How do staff determine that the data are being entered in the right place, on the right patient?
- MOI.1: Who has access to patient data within the electronic medical record? How is that determined? How is it tested? Is logging done and who reviews the logs?
- MOI.2 and MOI.2.1: What policies are in place to address the security of patient information?
- MOI.2.1: How is data integrity assured?
- MOI.2.1: Do all users have a unique user ID to access systems?
  - Are passwords changed on a regular basis?
  - How is user access to private health information tracked?
- MOI.6: How does the hospital train staff on the policies related to information security? How often? Is it mandatory for all staff ?
- MOI.11: How is new equipment onboarded to test the security of the data? How is it kept up to date—patches?
  - Are the default passwords on new equipment changed?
  - How is the information stored, transferred, and destroyed (wiped) if the equipment is leased?
  - If equipment is leased, does the owner have access to data and is there a contract in place governing protection of data?
  - Who maintains the equipment and do they have a contract to require protection of data?
- MOI.11: Description of Privacy and Security Program
  - When was the last time a risk assessment was performed evaluating the security of patient data?
  - Were risks identified? How were they addressed?
- MOI.11: Breaches of Privacy/Security Incidents
  - Is there a policy to address handling a breach/security incident?

  - Does the policy identify if an incident is a critical incident? Is there a different process to handle the event if it is considered critical?
  - Does the information technology program have disaster recovery and system backup plans?
- MOI.12: Use of Mobile Devices (as applicable)
  - If the hospital provides mobile devices to its health care practitioners or allows practitioners to use their personal devices, how does the hospital ensure that patient data and information are kept secure and confidential?
  - How does the hospital inform patients on accessing information that may be secure and confidential though their mobile device?
  - How does the hospital retrieve mobile devices when staff are no longer employed or associated with the hospital?
  - How secure is the mobile messaging platform being used?

System Tracer: Facility Management and Safety

Purpose

The purpose of this session is to provide guidance to the surveyor(s) in his or her evaluation of the hospital's facility management and safety system and the effectiveness of the hospital's FMS programs in managing risk. The surveyor(s) and the hospital will do the following:

- Identify areas of strength and opportunities for improvement in the hospital's FMS programs
- Assess or determine the hospital's actual degree of compliance with relevant standards

Location

The location of the FMS tracer session is at the discretion of the hospital. Following the discussion portion of the tracer, topics selected for further exploration by the surveyor(s) will guide how and where the remainder of the Facility Management and Safety System Tracer will be conducted.

Selection of the Facility Management and Safety System Tracer Topics

The Facility Management and Safety System Tracer topics will be selected by the administrator surveyor(s) during the course of the survey using a variety of techniques. The tracer selections may occur as a result of observations made by the surveyor(s) as he or she conducts portions of the survey and may also encompass topics that are too complex to evaluate during the FMS Document Review and Facility Tour and/or require a multidisciplinary conversation. **For example**, the surveyor(s) may have observed water leaks in the basement, water on the kitchen floor, and some confusion about what tests to conduct to ensure potable water. In addition, other team members may have commented on their concern about how the water treatment program is being conducted for the dialysis program. From these observations the surveyor(s) selects water management for the tracer. Finally, the tracer selections may be the result of convening a facility management program discussion (see below) to identify topics that demonstrate how information is gathered, considered, and applied to meet organizational safety and security objectives. **For example**, if a power outage occurred and the hospital was transferred from the grid to its generators for its power supply, the surveyor(s) may also choose to conduct an FMS tracer on utility management, reviewing how the hospital's utility management plan worked in this particular situation, reviewing any operations that did not work according to plan, and discussing any changes needed to address these issues going forward.

Hospital Participants

Individuals from the hospital selected for participation should be able to address issues related to FMS in all major departments or areas within the organization. This group should include representatives from the following services (in some organizations, individuals may be responsible for multiple roles):

- A person(s)—designated by leadership—who coordinates safety management activities
- A person(s)—designated by leadership—who coordinates security management activities
- A person(s) responsible for infection prevention and control
- A person(s) who manages the organization's facility(ies)
- A person(s) responsible for the organization's emergency management activities
- A person(s) who manages the organization's building utility systems
- A person(s) who manages the organization's fire safety and interim measures
- A person(s) responsible for maintaining the organization's medical/laboratory equipment
- A person(s) responsible for maintaining the organization's medical/imaging equipment
- A person(s) responsible for maintaining the organization's laser and other optical radiation devices
- A leader(s) of the environment of care team or safety committee
- Hospital leadership

In complex hospitals that have decentralized FMS management activities at remote sites, those persons responsible for managing the activities listed above at those sites should be available (either in person, by conference call, or through other means).

Note: To facilitate a beneficial exchange between the surveyor(s) and the organization, the hospital should identify a relatively small group of active participants for discussions and interviews. Other staff may attend as observers.

Surveyor(s)

Administrator surveyor(s)

Standards/Issues Addressed

All FMS standards and other related chapters

What Will Occur, Documents/Materials Needed

The duration of the session will be about 60 to 90 minutes. The group discussion activity (first part of the session) represents approximately 30% of the session and occurs after the surveyor(s) has had the opportunity to review the following documents for orientation purposes:

- The annual evaluations of the FMS programs that address the risks identified in the environment
- Relevant policies and procedures
- The FMS multidisciplinary team meeting minutes
- Documents required in this *Survey Process Guide*
- Previous JCI survey reports for triennial surveys

It is also important that observations related to FMS made by other members of the survey team (if applicable) and any FMS–related issues and information identified from previous surveys be discussed during this session.

Introduction

The surveyor(s) reviews the objectives of the FMS session with the organization's participants.

Discussion Guidelines

During this time, the surveyor(s) will initiate and lead a discussion that will give insight into the development, implementation, and evaluation of the organization's facility management programs. All FMS programs could be discussed; however, specific attention will be paid to how these programs were developed, how risks were assessed and monitored, and what improvements have been achieved and sustained in the programs from lessons learned.

For example, during this session, the organization's performance in addressing the emergency and disaster management requirements of Standard FMS.11 will be reviewed, including its performance in identifying and analyzing potential environmental risks in the hospital.

In addition, organizations may want to focus on performance in these areas:

- Identifying the organization's role in relation to the community's, region's, or country's emergency management program
- Identifying processes for the timely sharing of information with other health care organizations that provide services within the contiguous geographic area
- Identifying a structure used during emergencies that links with the community's incident response structure
- Making any necessary improvements to the organization's emergency management program based on critiques of emergency management drills

Discussion will focus on the management processes and not the FMS risk categories. The surveyor(s) will not be the primary speaker(s) during this time but rather a listener(s) to the discussion. This is not intended to be an interview.

Observation Guidelines

The surveyor(s) then observes and evaluates the organization's performance in managing FMS risk identified in the assessments. This activity represents approximately 70% of the session and occurs after the group discussion portion of the session.

The particular management process or risk selected for observation and further evaluation is based on the following:

- FMS documents previously reviewed
- Observations by other survey team members
- Knowledge gained during the group discussion portion of this session

The surveyor(s) will observe the implementation of those particular management processes determined to be potentially vulnerable or will trace a particular risk(s) in one or more of the FMS risk categories that the organization manages by doing the following:

- Beginning where the risk is encountered or first occurs. Examples of starting points include
  - where a particular safety or security incident occurs (FMS.5 and FMS.6);
  - where a particular piece of medical equipment is used (FMS.9, FMS.9.1, and FMS.9.2); and
  - where a particular hazardous material enters the hospital (FMS.7, FMS.7.1, and FMS.7.2).
- Having staff describe or demonstrate their roles and responsibilities for assessing the risk, the actions they should take if a problem or incident occurs, and how to report the problem or incident
- Assessing any physical controls for minimizing the risk (**for example**, equipment, alarms, building features)
- Assessing the emergency and disaster management program for mitigation, preparedness, response, and recovery strategies, actions, and responsibilities for each priority emergency (see FMS.11 for more information on the emergency management program)
- Assessing the emergency program for responding to utility system disruptions or failures, and monitoring (see FMS.10, FMS.10.1, FMS.10.2, FMS.10.3, and FMS.10.3.1). Examples include
  - having an alternative source of utilities (power, water, and medical gases);
  - notifying staff how and when to perform emergency clinical interventions when utility systems fail; and
  - obtaining repair services.
- Reviewing the implementation of relevant inspection, testing, or maintenance procedures of any medical equipment, nonmedical equipment, alarms, or building features that are available for controlling the particular risk
- Asking others in the hospital who have a role in responding to the particular problem or incident to describe or demonstrate their role and reviewing the condition of any medical equipment or other nonmedical equipment used when responding

If the risk moves around in the organization's facility (**for example**, a hazardous material or waste), the surveyor(s) will follow the risk throughout the life cycle (from creation to disposal).

Conclusion

The surveyor(s) summarizes any potential areas of concern in the management process or risk category observed. Staff responsible for managing the particular process or risk that was reviewed provide information regarding their roles in addressing any areas of concern observed. The organization should provide information regarding processes that have been developed and provide information regarding existing activities that have been implemented to address any potential areas of concern that were observed.

System Tracer: Medication Management and Medication Supply Chain

Purpose

This session explores the hospital's medication management process as well as potential risk points in the system. It also serves to validate information obtained from individual patient tracers.

Note: When a separate Medication Management System Tracer is not noted on the agenda (**for example**, on shorter surveys), the surveyor(s) will address medication management through individual patient tracers and during the Quality Program Interviews.

Location

The location of the medication management tracer session is at the discretion of the organization.

Hospital Participants

Individuals selected by the hospital to participate in the group session should be, as a group, able to speak to the full spectrum of medication management processes, from medication procurement through monitoring the effects of administered medications. Clinical staff of pharmacy and other departments that are part of the medication management system will participate.

As applicable, participants might include a direct care or service representative from the following areas:

- Clinical staff members, such as a nurse and physician, who have a role in medication management processes and medication education as part of the direct care, treatment, and services they render
- A clinician from the pharmacy or a consultant pharmacist who is knowledgeable about the selection of medications available for use and medication monitoring
- A representative from the infection prevention and control committee who can add to the committee's involvement in antibiotic stewardship
- A representative from the Quality Department who can add to the performance improvement activities
- Staff who participate in supply chain management
- Others, including medical residents in an academic medical center hospital survey, at the hospital's discretion

Note: To facilitate a beneficial exchange between the surveyor(s) and the organization during the group session, the organization should identify a relatively small group of active participants for discussions and interviews.

In organizations with more than one program accredited by JCI and in organizations with multiple sites, only one medication management session is scheduled. If it is not feasible for staff from all programs/sites to participate, the organization may need to teleconference individuals from distant locations into the group discussion.

During the focused-tracer activity, the surveyor(s) will visit areas relevant to medication management processes, talk with available staff in these areas about their roles in medication management, visit unit medication storage locations, review documentation, and possibly interview a patient.

Surveyor(s)

Physician and/or nurse surveyor(s)

Standards/Issues Addressed

- Medication Management and Use (MMU) standards
- IPSG.2 and IPSG.2.2
- IPSG.3, IPSG.3.1, and IPSG.3.2
- GLD.7.1; supply chain management

What Will Occur, Documents/Materials Needed

The Medication Management System Tracer is composed of three parts.

Part 1: Group Discussion

For the first part, a conference with a small group of leaders involved with the medication system is held. The discussion session explores medication management processes in the organization, handover points between processes, and the continuity of medication management processes and their relationship to other supporting processes and systems. Any potential areas of concern in the organization's medication management system and actions that might be taken will be identified, and these may be further explored as part of subsequent tracers and other survey activities. Review of the International Patient Safety Goals (IPSGs) related to medication management will also occur.

Discussion items will generally follow the sequence of sections and standards in the MMU chapter, and may include the following:

- General organization and oversight, including review of the annual medication system evaluation and actions taken to improve the system based on the evaluation (MMU.1)
- Review and discussion of the program for antibiotic stewardship (MMU.1.1)
- Selection and procurement, including explanation of the development of a formulary list (MMU.2)
  - The surveyor(s) will also discuss how the hospital makes decisions about the purchase of medications with an understanding of the safety and quality of the supply chain, including: medications the hospital has identified as at most risk of losing stability, becoming contaminated, or being replaced with counterfeit or imitation products. The surveyor(s) may also ask about the process for checking the supply chain of a specific medication on the hospital's list of medications at most risk. (GLD.7.1)
- Storage, including environmental issues, high-alert medications, and narcotics (MMU.3)
- Emergency medications throughout the organization, including development and oversight responsibilities, uniformity, and adult and pediatric needs (MMU.3.1)
- Medication recall (MMU.3.2)
- Ordering, including order entry, verbal and telephone orders, transcribing (MMU.4 through MMU.4.2), and appropriateness review data (MMU.5.1)
- Preparation, including site visits in pharmacy, policies, and staff competencies for non-pharmacists (MMU.5 and MMU.5.2)
- Administration, including policies and safety processes; **for example**, patient identification, hand hygiene, medication verification (MMU.6 and MMU.6.1)
- Monitoring effects on patients, including patient and family education and involvement, and medical record documentation; **for example**, indicators of improvement after treating infections, documented changes in vital signs and cardiac parameters after cardiovascular drugs, effects on fall risk, and the like (MMU.7)

Part 2: Focused Tracer Activity

This part consists of a practical medication tracer that extends from the point of order entry to patient administration and monitoring, as applicable. It is similar to a patient tracer but traces a medication rather than a patient. The medication chosen for the tracer is generally a high-risk/high-alert medication. The surveyor(s) explores the path of a selected high-risk, high-alert, or other medication in the organization (**for example**, chemotherapy or thrombolytics) using a current medical record and/or a drug selected from the organization's high-alert medication list. The surveyor(s) will trace the drug for a patient through all medication processes from initially adding the drug to the formulary through monitoring the drug's effect on the patient, and safe and correct waste disposal. This will include visits to pharmacy areas, where part 3 may also take place. The surveyor(s) then focuses on medication management processes related to questions raised from prior survey activities, such as the medication management group discussion or observations identified during tracers by any member of the survey team. Information management and security related to medications will also be discussed.

Part 3: Data Review

The last part consists of a review of data related to medication errors, near misses, prescription appropriateness reviews, and adverse drug reactions. (MMU.7.1) These data may be reviewed in the pharmacy or may be included as part of the group discussion above, rather than as a separate activity.

- Medication measures the department/service is collecting. Medication management data collection should be relevant to the services provided by the hospital and to the patients served. The organization should be collecting data related to the risk points it has identified in its medication management system evaluation. Examples of such data based on an assessed risk point might include, but are not limited to, the following:
  - Adverse drug events/adverse drug reactions
  - Use of high-risk or high-alert medications
  - Number of pharmacy interventions (related to appropriateness review and other activities)
  - Turnaround times from order to administration
- Monitoring data collected on the performance of the organization's medication management system and processes, including trends or issues that have been identified and changes made as a result of that review
- Review of data related to new services or changes in the medication system
- Reporting of errors/near misses
- Data collection, analysis, and evaluation of systems and actions taken, including any performance improvement initiatives related to medication management

System Tracer: Infection Prevention and Control

Purpose

During the discussion of the infection prevention and control program, the surveyor(s) and hospital will be able to accomplish the following:

- Identify strengths and potential areas of concern in the infection prevention and control program
- Begin determining actions necessary to address any identified risks in infection prevention and control processes
- Begin assessing or determining the degree of compliance with relevant standards
- Identify infection prevention and control issues requiring further exploration

Note: When a separate Infection Prevention and Control System Tracer is not noted on the agenda (**for example**, on shorter surveys), the surveyor(s) will address infection prevention and control throughout individual patient tracers and during the various quality activities, such as the Leadership for Quality, Patient Safety, Ethics, and Culture of Safety Interview and the Quality Program Interviews.

Location

The location of the infection prevention and control tracer session is at the discretion of the organization. Following the discussion portion of the tracer, topics selected for further exploration by the surveyor(s) will guide how and where the remainder of the infection prevention and control tracer will be conducted.

Hospital Participants

Individuals from the hospital selected for participation should be able to address issues related to the infection prevention and control program in all major departments or areas within the organization. This group should include, but not be limited to, representatives from the following departments, as applicable:

- Clinical staff, including physicians, nurses, pharmacists, and laboratory staff
- Clinicians who are knowledgeable about the selections of medications available for use and pharmacokinetic monitoring related to infection prevention and control issues
- Clinicians from the laboratory who are knowledgeable about microbiology
- Clinical staff, including all individuals involved in the infection prevention and control program and a sample of individuals involved in the direct provision of care, treatment, and services
- Staff responsible for the physical plant
- Hospital leadership
- Others, including medical residents, at the hospital's discretion

Note: To facilitate a beneficial exchange between the surveyor(s) and the organization, the organization should identify a relatively small group of active participants for discussions and interviews. Other staff may attend as observers.

Surveyor(s)

Nurse and/or physician surveyor(s)

Standards/Issues Addressed

- Prevention and Control of Infections (PCI) standards
- IPSG.5
- IPSG.5.1
- ASC.7.4
- FMS.3
- SQE.6
- SQE.8.2
- SQE.8.3

What Will Occur, Documents/Materials Needed

The session will open with introductions and a review of the goals for the Infection Prevention and Control System Tracer, which include the following:

- Exploration, critical thinking, and potential problem solving about the infection prevention and control program. **For example**, how risks were reduced during hospitalization or outpatient care at your hospital in the past and what are the techniques for improvement used to redesign or reengineer the processes?
- Identification of potential areas of concern in the infection prevention and control program and areas for improvement and actions that could be taken to address these
- Discussion of the most significant risks related to infection that you have experienced in the past and how you determined which threats were most significant.

Note: As applicable, the session may include discussion of the policy or standard operating procedure for patient handling after death, including mortuary protocols for managing the patient's body to reduce risks related to infection (including the cleaning processes and disinfectants used to reduce risk of infection). Part of this session will discuss how sharps injuries are tracked and reduced in this area if autopsy is performed, material disposal requirements and safety, and handling of potentially contaminated patient belongings and their safe return to the family or disposal if indicated.

Process

- The tracer may begin with a short group meeting with individuals responsible for the organization's infection prevention and control program or in a patient care area identified by the surveyor(s) for the focused-tracer activity.
- During the group meeting, the surveyor(s) will gain a better understanding of the infection prevention and control system and will identify potential areas that could be explored during the patient care area visit and potential areas of concern that require further discussion with staff knowledgeable about the organization's infection prevention and control program.
- The surveyor(s) may move to other settings relevant to tracing infection prevention and control processes across the organization. The surveyor(s) may review the schedule of infection prevention practitioner visits to the various departments throughout the hospital, including interactions with clinical areas and nonclinical areas where infection risk could occur (such as waste management, the kitchen, the lab, pathology, linen, central sterile processing, and so on). In addition, the surveyor(s) may review the process used to ensure that contract services are sufficiently resourced given the volume, the hospital's identified risks, and problem areas.
- The surveyor(s) will observe staff and engage them in discussion focused on infection prevention and control practices in any setting that is visited during this system tracer activity.
- The surveyor(s) will look for quality improvement processes, such as process mapping, measurement of variation in processes, observation of work and practice, multidisciplinary team participation, Ideal State Visioning, and other more common techniques such as root cause analysis, 5 Whys, and fishbone diagramming.
- Surveyors will observe and discuss with staff members ways that the hospital has implemented safe handling of sharps.

Discussion

The surveyor(s) will draw from his or her tracer activity experience and issues reported by other surveyors (as applicable), organization infection prevention and control surveillance data, and other infection prevention and control–related data to inspire scenarios for discussion with the organization. Participants will be asked to discuss the following aspects of the organization's infection prevention and control program as they relate to the scenarios:

- How patients with infections are identified by the organization
- What first points of entry for patients have been identified and the screening process for patients with possible infections

- Testing of the program to respond to the presentation of global communicable diseases
- How patients with infections are considered within the context of the infection prevention and control program
- Process for handling an influx of infectious patients
- Process used to perform an infection prevention and control risk assessment, including the reasons for conducting the assessment and the results of the analysis
- Prevention and control activities (**for example**, staff training, education of patient/visitor population, housekeeping procedures)
- The relationship between the Central Sterile Supply Department (CSSD) and the infection prevention and control program
- Explain standard operating procedures, which reduce cross contamination. Surveyors will discuss with staff members how food is stored, cleaned, and handled to prevent cross contamination.
- The surveyor(s) will review processes used for the preparation of nutritional products that are administered enterally or orally, including infant formula production and breast milk management.
- Physical facility changes, either completed or in progress, that have an impact on infection prevention and control. **For example**, explain the construction risk reduction assessment process and planning, provide a list of construction projects completed or under way, and explain the administration of the plan for a specific project. The surveyor(s) may visit a current construction site or review past project documentation.
- Actions taken as a result of surveillance and the outcomes of those actions
- Effectiveness of the implementation of IPSG.5 and IPSG.5.1

Hospitals may use infection prevention and control data during this part of the activity if the data are relevant to the discussion. In reviewing data, participants will be asked to discuss the following aspects of the organization's infection prevention and control program:

- How the hospital analyzed the current state process (which generated the problems), how processes were changed through the use of process improvement techniques, how the hospital measured success of implementation, and how improvements were tracked to ensure sustained performance
- Current and past surveillance activity that took place within the organization; how the hospital decides which rates required benchmarking and who do they benchmark against; how the data are shared with caregivers so that improvements can be made; and do the data allow action to be taken at a local unit-based level or are all data in aggregate hospital side?
- How did the organization decide to present and work on the areas that require improvement? What types of changes were made?
- Type of analysis being conducted with the infection prevention and control data, including comparisons
- Reporting of infection prevention and control data, including frequency and audience
- How is the infection prevention risk assessment created, and who participates in its development? What data are used to identify risks? How are community, regional, national, and global risks collected, considered, and included if needed?
- Share the hospital's data regarding injuries. Explain how the methods used for data collection will yield valid and reliable data. Share how the data collected regarding risks were used to make meaningful process improvements. The surveyor(s) will observe and discuss with staff members ways that the hospital has implemented safe handling of sharps.

Discussion can revolve around patients already included in infection prevention and control surveillance and reporting activities or around those not yet confirmed as meeting the definition or criteria for entry into and monitoring through the infection prevention and control surveillance system. In addition to surveyor-identified scenarios, the hospital is encouraged to present examples of cases that will highlight various aspects

of the infection prevention and control program. Some of the scenarios the surveyor(s) will want to discuss, as applicable to the organization, may include, but are not limited to, the following:

- Patients with fever of unknown origin
- Patients with a postoperative infection
- Patients admitted to the hospital postoperatively
- Patients on an antibiotic that is new to the list of available medications (preferably one with corresponding culture and sensitivities, blood levels, and/or other laboratories used for dosing)
- Patients in isolation due to infectious disease, such as varicella, pulmonary tuberculosis, invasive haemophilus influenzae, meningococcal disease, drug-resistant pneumococcal disease, pertussis, *Mycoplasma*, mumps, rubella, multidrug-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterrococci (VRE), *Clostridioides difficile (C diff)*, respiratory syncytial virus (RSV), enteroviruses, and skin infections (impetigo, lice, and scabies)
- Infection prevention and control practices related to emergency management
- Hospital's partnering efforts with the community to find out about emergencies and disasters that could affect the hospital. **For example**, how often do they meet with community members? How is the hospital involved in community planning? What role might the hospital play in a large- or small-scale infection-related disaster or outbreak?
- Patients placed in isolation because they are immunocompromised
- Recent changes in physical facilities that have an impact on infection prevention and control
- Patients with a known case of active tuberculosis

Conclusion

The surveyor(s) and organization will summarize identified strengths and potential areas of concern in the infection prevention and control program. The surveyor(s) will provide education as applicable.

Note: Usually, a single Infection Prevention and Control System Tracer session will be scheduled. This session is intended to review infection prevention and control for all services provided by the organization. Participants in this system tracer should include individuals who are able to address infection prevention and control in all services offered by the organization.

Undetermined Survey Activities

Purpose

Tracer methodology is used as the primary tool to assess standards compliance. However, other tools or a focused approach can be used to gather additional information to evaluate standards compliance that is not directly related to a specific patient tracer. Each of these focused activities is listed on the survey agenda as an "Undetermined Survey Activity."

Undetermined Survey Activities are broadly defined and encompass a variety of activities customized to the particular needs of each hospital. Undetermined Survey Activities are selected by the survey team to allow for a more intensified assessment of a targeted area when information from any survey activity, such as tracers or discussions, identifies a need to focus on a specific concern or to increase the sample size of a review item.

Hospital Participants

Participants will be identified by the surveyor(s) depending on the activity being evaluated.

Standards/Issues Addressed

Standards related to the specific activity that is being addressed. **For example**, if the survey activity is focused on hazardous materials, two of the standards that would be addressed are FMS.7 and FMS.7.1.

What Will Occur

Examples of Undetermined Survey Activities include, but are not limited to, the following:

- Focused tracers (a tracer that further evaluates a specific process):
  - Patient education process
  - Access to medical information
  - Financial disclosure to patients
  - Disinfection processes
  - Blood product infusion processes
  - Hazardous materials management
  - Medical transport
  - Laboratory specimen handling in clinics
  - Assessing a specific standard or issue using medical records and document review to evaluate; **for example**, ACC.2 related to admitting or registering patients
- Specific site or department visits to review applicable standards:
  - Pharmacy and others; **for example**, traditional Chinese medicine and chemotherapy
  - Noninvasive diagnostic areas, such as pulmonary laboratory, electrocardiogram, and electroencephalogram
  - Hyperbaric treatment area
  - Wound clinics
- Specific patient safety and quality activities:
  - Failure mode and effects analysis
  - Root cause analysis review
  - Sentinel event review
- Focused document/policy review to close gaps in the usual Document Review exercise
- Other items relevant to the needs of the team

Medical, Nursing, and Other Staff Education Qualifications Sessions

Purpose

The objective of this interview session is to address the hospital's processes to recruit, orient, educate, and evaluate all organization staff. In addition, the session addresses the organization's process for evaluating the credentials of the medical, nursing, and other health care provider staff and their ability to provide clinical services consistent with their qualifications.

Location

Small meeting rooms at the discretion of hospital leadership

Hospital Participants for Each Interview When Held Separately

Generally, two interviews will be conducted. Each should be conducted separately and in different locations. The physician surveyor(s) will conduct the medical staff interview, and the nurse and/or administrator surveyor(s) will conduct the interview for nursing staff and all other staff. The survey team may elect to conduct up to four separate interviews, depending on the size of the hospital and the types of staff present in the organization. Staff who may be interviewed are as follows:

- Medical Staff, Medical Students, and Trainees:
  - Elected or appointed senior leader of the medical staff and/or the medical leader (if applicable)
  - Representatives of the medical staff involved in credential collection and review
  - Leader of medical education programs
  - Representative of leadership responsible for management of medical education
- Nursing Staff:
  - Manager of the human resources department
  - Chief nurse
  - Other representatives of the nursing staff involved in the orientation, education, and training of nursing staff
- Other Health Professional Staff:
  - Manager of the human resources department
  - Representatives of the group(s) involved in the orientation, education, and training of health professional staff
- Other Hospital Staff:
  - Manager of the human resources department
  - Representatives of the group(s) involved in the orientation, education, and training of hospital staff

Surveyor(s)

- Physician surveyor(s), nurse surveyor(s), and/or administrator surveyor(s), as applicable

Standards/Issues Addressed

- Staff Qualifications and Education (SQE) standards
- GLD.14

Documents/Materials Needed

- Policies and procedures related to human resources/staff management, staff credentials, and staff orientation and education
- A sample of organization staff files and health care practitioner staff credential files
- A sample of medical staff files

What Will Occur

The surveyor(s) will provide instructions on the first day of the survey, generally during the Document Review session, regarding this session and the preparation of the files for review. At that time, the survey team will provide the leader of human resources with a list that identifies the type and number of staff files, including medical staff files, selected for review during this interview session. Sample worksheets are shown on the following pages. The survey team will provide copies of the current survey tool on the first day of the survey. It is important to know that the tools used by the surveyor(s) throughout the survey may change at any time to continually improve the survey team's abilities to score the organization's compliance with standards fairly and accurately. The tool merely reflects current JCI standards.

How to Prepare

The organization should include a list of all current staff and medical staff in the Document Review session on the first day. The list should identify each staff member's specific discipline, hire date, and department or service assigned (**for example**, "Registered Nurse; Hired 20 July 2016; Intensive Care Unit"). These documents should be in English, when possible.

The organization should closely review all staff credential files using the staff qualification worksheets that follow.

Medical Staff Qualifications Worksheet

Medical Specialty: _____ Initial Start Date: _____

Name: _____ Degree/Credential: _____

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.9	1. The hospital has an ongoing, uniform process to manage the credentials of medical staff members.		
	2. Medical staff members permitted by laws, regulations, and the hospital to provide patient care without supervision are identified.		
	3. Education, licensure/registration, and other credentials required by law or regulation are copied by the hospital and maintained for each medical staff member in his or her personnel file or in a separate credential file.		
	4. All credentials required by hospital policy are copied by the hospital and maintained for each medical staff member in his or her personnel file or in a separate credential file.		
SQE.9.1	1. Education, licensure/registration, and other credentials required by law or regulation or issued by recognized education or professional entities as the basis for clinical privileges are verified from the original source that issued the credential.		
	2. Additional credentials required by hospital policy are verified from the source that issued the credential when required by hospital policy.		
	3. When third-party verification is used, the hospital verifies that the third party (**for example**, a government agency) implements the verification process as described in policy or regulations and that the process meets the expectations described in the intent.		

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.9.2	1. Medical staff appointments are made according to hospital policy and are consistent with the hospital's patient population, mission, and services provided to meet patient needs.		
	2. Appointments are not made until at least licensure/registration has been verified from the primary source, and the medical staff member then provides patient care services under supervision until all credentials required by laws and regulations have been verified from the original source, up to a maximum of 90 days.		
	3. The method of supervision, frequency of supervision, and accountable supervisors are documented in the credential file of the individual.		
SQE.10	1. The privilege delineation process used by the hospital meets criteria a) through e) found in the intent.		
	2. The clinical privileges of all medical staff members are made available by printed copy, electronic copy, or other means to those individuals or locations (**for example**, operating room, emergency department) in the hospital in which the medical staff member will provide services.		
	3. Each medical staff member provides only those services that have been specifically granted by the hospital.		

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.11	1. All medical staff members are included in an ongoing professional practice evaluation process as defined by hospital policy and standardized at the department/service level.		
	2. The ongoing professional practice evaluation process identifies areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff member, and the results are reviewed with objective and evidence-based information as available. These results are compared to other department/service medical staff members.		
	3. The data and information from the monitoring are reviewed at least every 12 months by the individual's department or service head, senior medical manager, or medical staff body, and the results, conclusions, and any actions taken are documented in the medical staff member's credential file and other relevant files.		
	4. When the findings affect the appointment or privileges of the medical staff member, there is a process to take action on the findings, and such "for cause" actions are documented in the practitioner's file and are reflected in the list of clinical privileges. Notification is sent to those sites in which the practitioner provides services.		
SQE.12	1. Based on the ongoing professional practice evaluation of the medical staff member, the hospital determines, at least every three years, if medical staff membership and clinical privileges are to continue with or without modification.		
	2. There is evidence in the file of each medical staff member that all credentials that require periodic renewal, payment of a registration fee, or other action by the medical staff member are current.		
	3. Credentials obtained subsequent to initial appointment are evident in the file of the medical staff member and have been verified from the primary source prior to use in modifying or adding to clinical privileges.		
	4. The renewal decision is documented in the medical staff member's credential file and includes the identification of the reviewer and any special conditions identified during the review.		

Nursing Staff Qualifications Worksheet

Name: _____ Initial Start Date: _____

Degree/Credential: _____

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.1.1	1. Each staff member not permitted to practice independently has a job description.		
SQE.3	1. The hospital uses a defined process to match clinical staff knowledge, skills, and competency with patient needs.		
	2. New clinical staff members are evaluated before or at the time they begin their work responsibilities.		
	5. There is at least one documented evaluation of each clinical staff member working under a job description each year or more frequently as defined by the hospital.		
SQE.5	1. Personnel files for each staff member are standardized and current and maintained and kept confidential according to hospital policy.		
	2. Personnel files contain the qualifications and the work history of the staff member.		
	3. Personnel files contain the job description of the staff member when applicable.		
	4. Personnel files contain a record of orientation to the hospital and the staff member's specific role and in-service education attended by the staff member.		
	5. Personnel files contain the results of performance reviews.		
	6. Personnel files contain required health information.		
SQE.8.1	1. Staff members who provide patient care, including physicians, are trained in at least basic life support (BLS).		
	3. There is evidence to show if a staff member passed the training.		
	4. The desired level of training for each individual is repeated based on the requirements and/or time frames established by a recognized training program, or every two years if a recognized training program is not used.		

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.13	1. The hospital has a standardized procedure to gather and document the education, certifications, and experience of each nursing staff member.		
	2. Education, training, and certifications are verified from the original source according to parameters found in the intent of SQE.9 and are documented.		
	3. Licensure is verified from the original source according to the parameters found in the intent of SQE.9 and is documented		
	4. There is a record maintained of the credentials of every nursing staff member.		
SQE.14.1	1. Nursing staff participate in the hospital's quality improvement activities.		
	2. The performance of individual nursing staff members is reviewed when indicated by the findings of quality improvement activities.		
	3. Appropriate information from the review process is documented in the nurse's personnel file or in a separate credential file.		

Other Professional Staff Qualifications Worksheet

Name: _____ Initial Start Date: _____

Degree/Credential: _____

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.1.1	1. Each staff member not permitted to practice independently has a job description.		
SQE.3	1. The hospital uses a defined process to match clinical staff knowledge, skills, and competency with patient needs.		
	2. New clinical staff members are evaluated before or at the time they begin their work responsibilities.		
	5. There is at least one documented evaluation of each clinical staff member working under a job description each year or more frequently as defined by the hospital.		
SQE.5	1. Personnel files for each staff member are standardized and current and maintained and kept confidential according to hospital policy.		
	2. Personnel files contain the qualifications and the work history of the staff member.		
	3. Personnel files contain the job description of the staff member when applicable.		
	4. Personnel files contain a record of orientation to the hospital and the staff member's specific role and in-service education attended by the staff member.		
	5. Personnel files contain the results of performance reviews.		
	6. Personnel files contain required health information.		
SQE.8.1	1. Staff members who provide patient care, including physicians, are trained in at least basic life support (BLS).		
	3. There is evidence to show if a staff member passed the training.		
	4. The desired level of training for each individual is repeated based on the requirements and/or time frames established by a recognized training program, or every two years if a recognized training program is not used.		

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.15	1. The hospital has a standardized process to gather and document the education, certifications, and experience of each health care practitioner.		
	2. Education, training, and certifications are verified from the original source according to the parameters found in the intent of SQE.9 and are documented.		
	3. Licensure is verified from the original source according to the parameters found in the intent of SQE.9 and is documented.		
	4. There is a record maintained on other health care practitioners that contains copies of any required license, certification, or registration.		
SQE.16.1	1. Other health care practitioners participate in the hospital's quality improvement activities.		
	2. The performance of other health care practitioners is reviewed when indicated by the findings of quality improvement activities.		
	3. Appropriate information from the review process is documented in the health care practitioner's file.		

Medical Student and Trainee Qualifications Worksheet

Program Specialty: _____ Initial Start Date: _____

Name: _____

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.8.1	1. Staff members who provide patient care, including physicians, are trained in at least basic life support (BLS).		
	3. There is evidence to show if a staff member passed the training.		
	4. The desired level of training for each individual is repeated based on the requirements and/or time frames established by a recognized training program, or every two years if a recognized training program is not used.		
MPE.5	3. There is a complete and current list of all medical students and trainees in the hospital.		
	4. For each medical student and trainee, there is documentation of at least a) through g) of the intent.		
MPE.6	1. All medical students and trainees are provided an orientation that includes at least a) through f) of the intent.		
	5. Those supervising medical students and trainees consider compliance with these programs in their evaluation of medical student and trainee performance.		

Closed Patient Medical Record Review

This session is held to validate the hospital's compliance with the documentation track record (6 months for initial surveys and 12 months for triennial surveys).

Purpose of the Form

The purpose of the Closed Patient Medical Record Review Form is for the organization to gather and document continuous evidence of compliance with standards that require documentation in the medical record. The form is intended to be used on an ongoing basis as well as in preparation for the survey. The organization should use the form as an audit of its medical records to identify potential discrepancies in documentation and areas for improvement. **For example**, use of the form may reveal specific types of information that are consistently missing from some medical records or, documentation that is often omitted by specific health care practitioners or groups of health care practitioners.

Organization of the Form

The form is organized by topic headings (**for example**, "Assessments" and "Consents") and includes the specific standard number and the standard requirement (**for example**, blood consent and medical assessment). This form may be used by the surveyors(s) during the review. As the standards and this accompanying *Survey Process Guide* are updated, the form will be updated to reflect changes to the standards.

Review Process

- The surveyor(s) may use a blank Closed Patient Medical Record Review Form or another means to record information during the session.
- The surveyor(s) enters the number of the medical record being reviewed and the type of medical record requested (recorded by diagnosis); **for example**, "Record #1 Congestive Heart Failure."
- The medical record is reviewed briefly to
  - establish what type of patient or care was received (**for example**, surgery, medical, emergency, rehabilitation); and
  - verify compliance with the documentation track record (6 months for initial surveys and 12 months for triennial surveys).

During the Accreditation Survey

- The survey team leader may request 5 to 10 closed medical records for review. The medical records will be requested if the surveyor(s) wants to validate the organization's documentation track record (6-month or 12-month) and/or to ensure compliance with documentation or patient care process requirements due to situations or information identified during the tracer activities.
- The survey team leader will indicate the time period for selecting the medical records—typically the past 4 or 12 months. Organization staff should acquaint the survey team leader with the organization's practice and expectation regarding the completion of a patient medical record following discharge of the patient.
- Organization leaders should provide one staff member with a translator (if needed) for each surveyor involved in the Closed Patient Medical Record Review. To assist the surveyor(s), the selected staff person(s) should be knowledgeable about the medical record and the clinical care processes.
- The surveyor(s) will review selected medical records with assistance from an organization representative, as needed.
- For each documentation requirement, the surveyor(s) will review the medical record for whether the required element is present, not present, or not applicable to the patient's medical record.
- The survey team aggregates the completed review results to score the standards. The findings from the active or open review of patient medical records are integrated into aggregation and scoring.
- The survey team leader retains the forms on which results were recorded to support survey findings.

Closed Patient Medical Record Review Form

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Assessments																	
IPSG.6 ME 1	The hospital implements a process for assessing all inpatients for fall risk and uses assessment tools/ methods appropriate for the patients being served.																
IPSG.6 ME 2	The hospital implements a process for the reassessment of inpatients who may become at risk for falls due to a change in condition or are already at risk for falls based on the documented assessment.																
IPSG.6.1 ME 1	The hospital implements a process for screening outpatients whose condition, diagnosis, situation, or location may put them at risk for falls and uses screening tools/methods appropriate for the patients being served.																
ACC.1 ME 3	Staff utilize a recognized triage process that includes early recognition of communicable diseases, to prioritize and treat patients with immediate needs.																
ACC.1 ME 4	Emergent patients are assessed and stabilized within the capacity of the hospital prior to transfer, and treatment is documented in a record maintained by the transferring hospital.																
ACC.2.1 ME 1	The screening assessment helps health care practitioners identify the patient's needs.																
ACC.6 ME 1	The process for referring and/or discharging patients includes an assessment of transportation needs for patients who may require assistance.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Assessments																	
PCC.5.1 ME 1	Each patient's and, when appropriate, family's educational needs are assessed and recorded in the patient's medical record.																
PCC.5.1 ME 2	The patient's and family's barriers to learning are assessed and documented.																
AOP.1.2 ME 1	The initial medical assessment, including health history, physical exam, and other assessments required by the patient's condition, is performed and documented within the first 24 hours of admission as an inpatient or sooner as required by patient condition.																
AOP.1.2 ME 3	The initial nursing assessment is performed and documented within the first 24 hours of admission as an inpatient or sooner as required by patient condition.																
AOP.1.2.1 ME 1	The medical assessment of emergency patients is based on their needs and condition and documented in the patient medical record.																
AOP.1.2.1 ME 2	The nursing assessment of emergency patients is based on their needs and condition and documented in the patient's medical record.																
AOP.1.2.1 ME 3	Before surgery is performed, there is at least a brief note and preoperative diagnosis documented for emergency patients requiring emergency surgery.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Assessments																	
AOP.1.3 ME 2	For assessments less than or equal to 30 days old, any significant changes in the patient's condition since the assessment or "no change" are documented in the patient's medical record at the time of admission as an inpatient or prior to an outpatient procedure.																
AOP.1.3 ME 3	If the medical assessment is greater than 30 days old at the time of admission as an inpatient or prior to an outpatient procedure, the medical history is updated and the physical examination repeated.																
AOP.1.3.1 ME 3	The preoperative medical assessment of surgical patients is documented in the medical record before surgery.																
AOP.1.4 ME 6	Specialized assessments conducted within the hospital are completed and documented in the patient's medical record.																
AOP.1.5 ME 1	All inpatients are screened for pain and the screening is documented.																
AOP.1.5 ME 4	The assessment is recorded in a way that facilities regular reassessment and follow-up according to criteria developed by the hospital and the patient's needs.																
AOP.1.6 ME 4	Individualized medical and nursing assessments are performed and documented. [for special populations]																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Assessments																	
AOP.1.7 ME 1	The hospital begins the discharge planning process early in the assessment process to identify those patients for whom discharge planning is critical.																
AOP.2 ME 5	Reassessments are documented in the patient medical record. [Refer to MEs 1–4.)																
COP.2.2 ME 2	The plan of care is individualized based on the patient's initial assessment data and identified needs and is documented in the patient's medical record.																
COP.2.2 ME 3	The plan of care is updated or revised by the multidisciplinary team based on any changes in the patient's condition identified from the reassessment of the patient by the health care practitioners, and is documented in the patient's medical record.																
COP.2.2 ME 4	The results or conclusions of any patient care team meetings or other collaborative discussions are documented in the patient's medical record.																
COP.2.2 ME 5	The plan of care is provided to each patient and evident in the patient's medical record through documentation by the health care practitioners providing the care.																
COP.3.5 ME 2	The hospital uses evidence-based tools to assess patients for suicidal ideation based on established criteria. Patients who screen positive, are identified as "at risk" for suicide and/or self-harm based on the established criteria.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Assessments																	
COP.8.7 ME 4	Transplant candidates receive a psychological evaluation by a psychiatrist, psychologist, or social worker with experience in transplantation to determine the decision-making capacity of the patient and screen for any preexisting psychiatric illness.																
COP.9.2 ME 5	The results of a psychological evaluation conducted by a psychiatrist, psychologist, or social worker with experience in transplantation are included in the determination of suitability for donation.																
ASC.3.2 ME 1	A presedation assessment is performed and documented that includes at least a) through e) to evaluate risk and appropriateness of procedural sedation for the patient.																
ASC.3.2 ME 2	A qualified individual monitors the patient during the period of sedation and documents the monitoring.																
ASC.3.2 ME 3	Established criteria are used and documented for the recovery and discharge from procedural sedation.																
ASC.4 ME 3	The two assessments are performed by an individual(s) qualified to do so and documented in the patient medical record. [preanesthesia and preinduction assessments]																
ASC.6 ME 3	The results of monitoring are documented in the patient's medical record. [during anesthesia and surgery]																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Assessments																	
ASC.6.1 ME 2	Monitoring findings are documented in the patient's medical record. [during the postanestheisa recovery period]																
ASC.7 ME 1	The responsible physician documents the assessment information used to develop and to support the planned invasive procedure in the patient's medical record before the procedure is performed.																
ASC.7.3 ME 4	When indicated by a change in the patient's needs, the postsurgical plan of care is updated or revised based on the reassessment of the patient by the health care practitioners.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Consents																	
PCC.4 ME 2	The hospital defines how a general consent, when used, is documented in the patient medical record.																
PCC.4.1 ME 5	There is a uniform recording of informed consent.																
PCC.4.1 ME 6	The identity of the individual providing the information to the patient and family is documented in the patient's medical record.																
PCC.4.2 MEs 1–3 and ME 5	Consent is obtained before the following treatments and procedures: 1. Diagnostic or therapeutic surgical or invasive procedures. 2. Anesthesia and procedural sedation. 3. The use of blood and blood products. 5. Additional and/or other high-risk procedures and treatments.																
PCC.4.2 ME 4	The hospital lists those additional procedures and treatments that require separate consent																
PCC.4.4 ME 3	The patient's medical record lists the individual(s) granting consent.																
PCC.6.1 ME 2	The hospital identifies consent requirements and develops a consent process consistent with those requirements.																
COP.8.5 MEs 1–6	The transplant program follows the hospital's policy when obtaining informed consent from transplant candidates. [and includes all information required in MEs 2–6]																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Consents																	
COP.9.1 MEs 1–6	Informed consent for living donation is obtained by trained staff and is in a language the prospective living donor can understand. [and includes all information required in MEs 2–6]																
ASC 3.3 ME 3	A qualified individual provides and documents the education. [on the risks, benefits, and alternatives of procedural sedation]																
ASC.5 ME 2	The patient, family, and/or decision makers are educated on the risks, benefits, and alternatives of anesthesia.																
ASC.7.1 ME 3	The patient's surgeon or other qualified individual provides and documents the education. [risks, benefits, potential complications, and alternatives related to the planned surgical procedure]																
GLD.18 ME 3	Consent is documented and dated on the informed consent document by signature or record of verbal consent. [for patients participating in clinical research, clinical investigations, or clinical trials]																
MOI.12 ME 4	When the hospital implements a patient portal or communicates with patients via text messages or e-mails, the hospital first obtains consent from patients to participate in the portal and/or receive text messages or e-mails.																
HRP.7 ME 6	Through the research review function, the hospital establishes and implements how consent for participation will be obtained and documented and under which circumstances consent will be obtained again during the research.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
IPSG.2 ME 1	Complete verbal orders are documented and read back by the receiver and confirmed by the individual giving the order.																
IPSG.2 ME 2	Complete telephone orders are documented and read back by the receiver and confirmed by the individual giving the order.																
IPSG.2 ME 3	Complete test results are documented and read back by the receiver and confirmed by the individual giving the result.																
IPSG.2.1 ME 3	The hospital identifies what information is documented in the medical record.																
IPSG.4 ME 1	The hospital implements a preoperative verification process through the use of a checklist or other mechanism to document, before the surgical/invasive procedure, that the informed consent is appropriate to the procedure; that the correct patient, correct procedure, and correct site are verified; and that all required documents, blood products, medical equipment, and implantable medical devices are on hand, correct, and functional.																
IPSG.4.1 ME 1	The full team actively participates in a time-out process, which includes a) through c) in the intent, in the area in which the surgical/invasive procedure will be performed, immediately before starting the procedure. Completion of the time-out is documented and includes date and time.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
IPSG.6 ME 3	Measures and/or interventions to reduce fall risk are implemented for those identified inpatients, situations, and locations within the hospital assessed to be at risk. Patient interventions are documented.																
IPSG.6.1 ME 2	When fall risk is identified from the screening process, measures and/or interventions are implemented to reduce fall risk for those outpatients identified to be at risk, and the screening and interventions are documented.																
ACC.1.1 ME 3	The information on unusual delay and reasons for the delay are documented in the medical record.																
ACC.2.3 ME 4	The medical records of patients who are admitted to departments/wards providing intensive/ specialized services contain evidence that they meet the criteria for services.																
ACC.2.3 ME 5	The medical records of patients who are transferred or discharged from departments/wards providing intensive or specialized services contain evidence that they no longer meet the criteria for those services.																
ACC.3.1 ME 1	A qualified individual(s) responsible for the coordination of the patient's care is identified in the patient's medical record and is available through all phases of inpatient care.																
ACC.3.1 ME 3	The process identifies how these individuals assume the transferred responsibility and document their participation or coverage.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
ACC.4 ME 6	Discharge planning and instructions are documented in the patient record and provided to the patient in writing.																
ACC.4.2 ME 5	A copy of the completed discharge summary is placed in the patient's medical record in a time frame identified by the hospital.																
ACC.4.2.1 MEs 1–4	The medical records of all emergency patients include the following: 1. Arrival and departure times. 2. Conclusions at the termination of treatment. 3. Patient's condition at discharge. 4. Follow-up care instructions.																
ACC.4.3 ME 3	The hospital uses a process that will ensure the outpatient profile is easy to retrieve and review.																
ACC.5.1 MEs 2–4	The medical records of transferred patients include the following: 2. The name of the receiving health care organization and the name of the individual agreeing to receive the patient. 3. Documentation or other notes as required by the policy of the transferring hospital. 4. The reason(s) for transfer and any special conditions related to transfer.																
PCC.5.1 ME 4	Education provided to patients and families is documented in the patient medical record.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
AOP.5.8 ME 2	The range is included in the medical record at the time test results are reported. [established reference range for each lab test]																
COP.2 ME 5	Orders are found in a uniform location in medical records.																
COP.2.1 ME 1	Procedures and treatments are carried out as ordered and are documented in the patient's medical record.																
COP.2.1 ME 2	The person requesting, and the reason for requesting, the procedure or treatment are documented in the patient's medical record.																
COP.2.1 ME 3	The results of procedures and treatments performed are documented in the patient's medical record.																
COP.5. ME 2	Prior to inpatients being fed, there is an order for food in the patient's medical record that is based on the patient's nutritional status and needs.																
COP.5.1 ME 3	The patient's response to nutrition therapy is monitored and documented in the medical record.																
COP.8.4 ME 1	The transplant program documents organ-specific clinical eligibility criteria for the transplant candidate.																
COP.8.4 ME 2	The transplant program documents the psychological and social suitability criteria for the transplant candidate.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
COP.8.4 ME 4	The transplant program documents organ compatibility confirmation in the transplant candidate's medical record.																
COP.8.6 ME 3	When an organ arrives at the transplant center, the transplanting surgeon and at least one other licensed health care practitioner at the transplant center verify and document that the donor's blood type and other essential data are compatible with the recipient prior to transplantation.																
COP.8.6 ME 4	The transplant surgeon is responsible for confirming that donor evaluation and donor testing for infectious diseases and malignancy have been completed, and are documented in the medical record, before organ recovery and organ transplant occur.																
COP.8.6 ME 5	When an organ arrives at the transplant center, the transplanting surgeon and at least one other licensed health care practitioner at the transplant center verify and document that evaluation and testing of the donor organ shows no evidence of disease and the condition of the organ is suitable for transplant.																
COP.8.7 ME 5	The transplant program updates clinical information in the transplant patient's medical record on an ongoing basis.																
COP.9.2 ME 1	The transplant program documents defined organ-specific living donor selection criteria.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
COP.9.2 ME 6	The transplant program documents organ compatibility confirmation in the living donor's medical record																
COP.9.3 ME 2	Transplant programs performing living donor transplants provide multidisciplinary care by a team coordinated by a physician to each donor throughout the donor evaluation, donation, and discharge phases of donation.																
ASC.5 ME 1	The anesthesia care for each patient is planned and documented in the patient's medical record.																
ASC.5 ME 3	When applicable, the patient, family, and/or decision makers are educated, prior to the procedure being performed, about the options available for postoperative pain management.																
ASC.5 ME 4	The anesthesia agent, dose (when applicable), and anesthetic technique are documented in the patient's anesthesia record.																
ASC.5 ME 5	The anesthesiologist and/or nurse anesthetist and anesthesia assistants are identified in the patient's anesthesia record.																
ASC.6.1 ME 4	Time recovery is started and time recovery phase is complete are recorded in the patient's medical record.																
ASC.7 ME 3	A preoperative diagnosis and the planned procedure are documented in the patient's medical record prior to the procedure.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
ASC.7.2 ME 1	Surgical reports, templates, or operative progress notes include at least a) through g) of the intent.																
ASC.7.3 ME 2	The continuing postsurgical plan(s) is documented in the patient's medical record within 24 hours by the responsible surgeon or verified by a co-signature from the responsible surgeon on the documented plan entered by the surgeon's delegate.																
MMU.4 ME 2	The patient's medical records contain a list of current medications taken prior to admission or registration as an outpatient, and this information is made available to the patient's health care practitioners and the pharmacy as needed.																
MMU.4.2 ME 2	All orders and prescriptions contain the name of the drug, the dose, the frequency and route of administration, the indication for prescribing the medication, and the maximum dose.																
MMU.4.2 ME 3	Additional elements of complete medication orders or prescriptions include at least a) through g) identified in the intent as appropriate to the order.																
MMU.4.2 ME 6	Medications prescribed or ordered are documented in the patient's medical record or inserted into the patient's medical record at discharge or transfer.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
MMU.5.1 ME 4	When the designated licensed professional is not available to perform the full appropriateness review, a trained individual conducts and documents a review of critical elements h) through k) in the intent for the first dose, and a full appropriateness review is conducted within 24 hours.																
MMU.6 ME 3	Medication administration is recorded for each dose.																
MMU.6.1 ME 5	Medications are administered as prescribed on a timely basis and noted in the patient's medical record.																
MMU.6.2 ME 4	The hospital establishes and implements a process to govern the management, use, and documentation of medication brought in by the patient/family.																
MMU.6.2.1 ME 3	The hospital establishes and implements a process to govern the availability, management, use, and documentation of medication samples.																
MMU.7 ME 1	Medication effects on patients are monitored and documented when appropriate.																
MMU.7 ME 2	Medication adverse effects on patients are monitored and documented.																
PCI.6.1 ME 5	The hospital identifies patients on whom reusable medical devices have been used.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
MOI.2 ME 5	The hospital implements processes to ensure that only authorized individuals make entries in the patient medical record and in accordance with their level of access.																
MOI.4 ME 2	The hospital implements the uniform use of approved symbols and identifies those not to be used.																
MOI.4 ME 3	If the hospital allows abbreviations, the hospital implements the uniform use of approved abbreviations, and each abbreviation has only one meaning.																
MOI.4 ME 4	If the hospital allows abbreviations, the hospital develops and/or adopts a do-not-use list of abbreviations.																
MOI.4 ME 5	Abbreviations are not used on informed consent and patient rights documents, discharge instructions, and discharge summaries.																
MOI.8 ME 3	The hospital has a process to monitor compliance with the guidelines on the proper use of copy-and-paste, auto-fill, auto-correct, and templates and provides education and training on the guidelines to all staff who document in the electronic medical record.																
MOI.8.1 ME 1	Patient medical records contain adequate information to identify the patient.																

Standard	Documentation Requirement	Medical Record 1			Medical Record 2			Medical Record 3			Medical Record 4			Medical Record 5			TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y/N
Other																	
MOI.8.1 ME 2	Patient medical records contain adequate information to support the diagnosis and promote continuity of care.																
MOI.8.1 ME 3	Patient medical records contain adequate information to justify and document the course and results of the patient's care, treatment and services.																
MOI.9 ME 1	The author of each entry in the patient medical record can be identified.																
MOI.9 ME 2	The date of each entry in the patient medical record can be identified.																
MOI.9 ME 3	The time of each entry in the patient medical record can be identified.																
MOI.9 ME 4	There is a process that addresses how entries in the patient medical record are corrected or overwritten.																
MOI.9 ME 5	When scribes are used to assist with documentation in the patient medical record, they sign, date, and time their entries, and there is a process for the physician/health care practitioner to review and authenticate the scribe's entries.																

Surveyor Team Meetings

Purpose

For surveys conducted by more than one surveyor, scheduled team meetings provide an opportunity for surveyors to share information and observations, plan for upcoming survey activities, and plan for communication and coordination with the hospital.

Location

Surveyor headquarters room

Hospital Participants

None, unless specifically requested by the surveyor(s); **for example**, the organization survey coordinator

Surveyor(s)

All surveyors

What Will Occur

For surveys lasting more than one day, a short session may be scheduled at the end of each day to allow surveyors an opportunity to debrief and to plan for subsequent survey days and activities. Some survey teams may require longer sessions—as long as 60 minutes. Surveyors will also use lunchtime to discuss and plan for midday activities and observation sharing. During these sessions, surveyors will do the following with each other:

- Identify areas that have been visited during tracer activity
- Coordinate locations, services, and other areas that will be visited during continuing tracer activities
- Share observations on organization performance
- Identify key findings that have surfaced
- Ask other surveyors to follow up on potential issues
- Identify issues/areas that all surveyors should be exploring during individual patient and system tracers

When surveyors are in different locations at the times scheduled for team meetings, they may request assistance from the organization to facilitate communication among the members of the team (such as ensuring availability of a speakerphone or phone with conference call functionality).

Note: When only one surveyor is present, this time is an opportunity to plan upcoming survey activities, including the selection of additional tracers.

Surveyor Report Preparation

Purpose
The surveyor(s) will use this time to compile, analyze, and organize the data collected throughout the survey into a report reflecting the hospital's compliance with standards.

Location
Designated surveyor conference room with a computer for each surveyor that has an Internet connection and a printer provided for the use of the surveyor(s) on each day of the survey.

Hospital Participants
None

Surveyor(s)
All surveyors

What Will Occur
This time is reserved on the agenda for the surveyor(s) to review his or her observations and to determine if there are any findings that reflect issues of standards compliance.

The surveyor(s) may ask organization representatives for additional information during this session to confirm or disprove a finding. In addition, the surveyor(s) may request that the organization photocopy the report, as needed.

Leadership Exit Conference

Purpose

The purpose of this conference is to report the findings of the survey to hospital leadership.

Location

Will be at the discretion of hospital leadership. Leadership may decide to have one or two exit conferences. If only one, this may be just with the leaders, or it could include a much larger group of staff members. If two separate conferences, the first would be with a smaller group of leaders, and then the second could be with a larger group.

Hospital Participants

- Chief executive officer
- Chief operating officer
- Governing body member, or similar representative if available
- Medical staff leadership
- Nursing leadership
- Others, at the discretion of organization leadership

Surveyor(s)

All surveyors

Standards/Issues Addressed

Survey findings

Documents/Materials Needed

None

What Will Occur

This session includes the following two components:

1) Discussion with key leaders of the hospital about the survey report and follow-up process, including review of the Strategic Improvement Plan (SIP). The discussion will cover the following:
    - Purpose of the conference
    - Summary of compliance findings related to standards
    - Emphasis that the surveyor(s) does not make the final decision regarding accreditation
    - Discussion of any compliance findings for which there are questions or differences of perspective
    - The content of the formal report of findings
    - The follow-up to the survey findings; **for example**, an SIP or, if a decision rule has been triggered, a follow-up survey. If a follow-up survey may be needed prior to an accreditation decision, the team leader will inform the CEO in advance of the exit conference.
2) Summary/overview of the report to hospital staff selected at the discretion of the CEO

The surveyor(s) will explain the survey follow-up process regarding communication of the accreditation decision by the JCI Accreditation Central Office.

At the discretion of the CEO, a brief conference will be held with other selected staff in the organization to provide an overview of the report and to complete the survey activities.

Additional Sessions for Academic Medical Center Hospitals: Detailed Descriptions

Medical Professional Education Leadership Interview

Purpose

The purpose of the Medical Professional Education Leadership Interview is to assess the direction and supervision of medical students and trainees related to activities involving patient care and safety.

Location

At the discretion of hospital leadership

Hospital Participants

- Medical leader of hospital
- Leader of medical education
- Leaders of residency specialty programs
- Nursing Leader
- Other senior leaders, at the discretion of the hospital

To foster an interactive process, a large group is not recommended for this conference.

Surveyor(s)

Physician surveyor(s)

Standards/Issues Addressed

Collaborative involvement of the senior leaders of the hospital, university, and medical education programs for medical students and trainees as required in the following standards from the "Medical Professional Education" (MPE) chapter:

- MPE.2
- MPE.3
- MPE.4
- MPE.5
- MPE.6

Documents/Materials Needed

All related documents (as listed in required documents for day 1 of survey)

- List of medical students
- List of trainees
- List of faculty
- List of program leaders as applicable
- Medical professional education policies (MPE.1–MPE.4 and MPE.6)

What Will Occur

The surveyor(s) will ask questions related to the direction of the hospital's medical education activities, with attention to integration with clinical patient care activities, staffing to support education in the context of safe clinical care, and how the supervision of medical students and trainees occurs and how it is monitored.

The surveyor(s) will assess compliance with certain standards from the "Medical Professional Education" (MPE) chapter, particularly MPE.2 through MPE.6. During the session, the surveyor(s) will also identify issues that he or she will pursue in later survey activities.

How to Prepare

Hospitals should identify the participants in this session. Although the hospital's leaders should be familiar with all the standards, they should read closely the MPE chapter prior to survey. In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

The following are a few sample questions:

- MPE.2, ME 3: What evidence does the hospital have that the facilities and technology support the agreed-on medical student/trainee learning?
- MPE.3, ME 3: What process does the hospital have in place to monitor academic titles and renewal requirements to keep such titles current?
- MPE.5, ME 1: What is the operational structure for medical student education and has it been implemented as required?
- MPE.6, ME 2: How are trainees included in the data collection for the hospital's quality monitoring programs?

Medical Student and Trainee Interview

Purpose

The purpose of the Medical Student and Trainee Interview is to determine the level of understanding that the students and trainees have, related to their integration with the hospital's quality improvement and patient safety program; as well as to identify their understanding of how supervision during their hospital activities occurs.

Location

At the discretion of hospital leadership

Hospital Participants

- Medical students
- Medical trainees

Surveyor(s)

Physician surveyor(s)

Standards/Issues Addressed

- MPE.4, MPE.6, and MPE.7
- Quality Improvement and Patient Safety (QPS) standards, particularly QPS.7, QPS.7.1, and QPS.8,

Documents/Materials Needed

None

What Will Occur

The surveyor(s) will ask questions related to the medical student and trainee knowledge of and involvement in the hospital's programs, such as the medication management program and the quality improvement and patient safety program. In addition, the students and trainees will be asked about their participation with the International Patient Safety Goals. The surveyor(s) will explore how supervision of medical students and trainees occurs and how it is monitored.

The surveyor(s) will assess compliance with standards from the MPE chapter and will also identify issues that he or she will pursue in later survey activities.

How to Prepare

Hospitals should identify the participants for the Medical Student and Trainee Interview. A representative sample from each of the specialty programs is desired. Although students and trainees should be familiar with all of the standards in the Academic Medical Center Hospitals section, the MPE chapter will be the main focus of the discussion. In addition, students and trainees should familiarize themselves with the hospital's programs, such as the quality improvement and patient safety program, the infection prevention and control program, and the like. In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

The following are a few sample questions:

- MPE 4, ME 1: What type of supervision is required when you examine a patient and write orders for that patient?
- MPE.4, ME 2: How does that supervision change as you progress through the program?
- MPE.4, ME 3: How do you know who should be supervising you?
- MPE.4, ME 4: How do you know which activities and procedures you are allowed to do independently and which ones require supervision?

- MPE.6, ME 2: How do you participate in the hospital's quality improvement and patient safety program?
- MPE.6, ME 3: Can you tell us what you know about the International Patient Safety Goals? How does IPSG.2.2, "handover communication," apply to you?
- MPE.7: Do you provide any services to the hospital outside of your training program? If yes, how is the type of service you provide determined?
- QPS.7, QPS.7.1, and QPS.8,: Do you know the process for reporting near misses (or close calls), adverse events, and sentinel events? Have you reported or been involved in any near misses, adverse events, or sentinel events?

*MPE Supervision Medical Record Documentation**

Please complete this form as applicable for each year medical student and level of trainee permitted to document in the medical record (**for example**, 1st year medical student, intern, 4th year resident, fellow).

Note: Other titles used for trainee include *intern*, *resident*, *house officer*, and *fellow*, among others.

Type of Medical Student or Trainee →			
	Countersignature Required by Which Level of Physician(s)?		
	Most Responsible Physician†	**Licensed Resident**	**Other Licensed Physician** (**for example**, fellow, registrar, etc.)
Medical Record	**Please mark (✔) the appropriate box(es) for each documentation activity**		
Admission H&P			
Care Plan			
Medication Orders			
Other Orders (**for example**, vital signs, diet, diagnostic studies, and so on)			
Progress Notes			
Transfer Note (within hospital)			
Procedure Note (non-OR)			
Surgery/Invasive Procedure Consent Form			
Preoperative Note and/or Update			
Preanesthesia Assessment			
Anesthesia Consent Form			
Immediate Postoperative Note			

* H&P, history and physical; OR, operating room; ER, emergency room

† Most responsible physician is the physician who has overall responsibility for the care and management of an individual patient at a specific point in time during the patient's hospital stay. This may be a faculty physician, supervising physician, or senior admitting physician.

Type of Medical Student or Trainee →			
	Countersignature Required by Which Level of Physician(s)?		
	Most Responsible Physician*	**Licensed Resident**	**Other Licensed Physician** (**for example**, fellow, registrar, etc.)
Medical Record	**Please mark (✔) the appropriate box(es) for each documentation activity**		
Complete Operative Report			
Postanesthesia Assessment			
Discharge Summary			
Transfer Note (to outside facility)			
Emergency Medical Record			
Physician Evaluation			
ER Orders for Care			
Disposition			
Outpatient/Ambulatory Record			
Physician Evaluation			
Other			

Important: This form(s) must be completed by the hospital before the on-site survey begins and presented to the Team Leader for the Document Review session.

* Most responsible physician is the physician who has overall responsibility for the care and management of an individual patient at a specific point in time during the patient's hospital stay. This may be a faculty physician, supervising physician, or senior admitting physician.

Human Subjects Research: Leadership and Process Interview

Purpose

The purpose of this session is to assess leadership's role and accountability for all aspects of the research program. In addition, the process for how research is conducted and managed in the organization is assessed. This includes

- the integration of the human subjects research program into the quality and patient safety programs of the hospital; and
- how the hospital has implemented policies and procedures necessary to inform and protect patients during the selection process for subjects and during the research.

For organizations that participate in contracted research, the interview will include management of contracted research studies. The purpose is to assess management of all aspects of research conducted by a contract research organization. A *contract research organization* is a person or an organization contracted by the sponsor of the research to perform duties and functions for one or more of a sponsor's research trials.

Location

At the discretion of hospital leadership

Hospital Participants

- Medical leader of hospital
- Nursing leader
- Director of research
- Chair and representative sample of members of the hospital's Institutional Review Board (or designated IRB)
- Representatives from pharmacy, facilities management, human resources, and quality staff
- Other senior leaders, at the discretion of the hospital
- Research program support staff as selected by the hospital

Surveyor(s)

Physician, nurse, and/or administrator surveyor(s)

Standards/Issues Addressed

- Collaborative involvement of the senior leaders of the hospital and the research programs in demonstrating compliance with standards in the "Human Subjects Research Programs" (HRP) chapter.
- HRP standards, particularly HRP.3.1, MEs 1–4; HRP.6; and HRP.7 through HRP.7.2

Documents/Materials Needed

- Relevant documents for discussion of HRP.1.1, HRP.2, HRP.3, HRP.4, HRP.5, and HRP.6
- All reports of adverse events related to research subjects
- Evidence of integration with programs for research-related medication and hazardous materials management, such as policies, inventories of equipment, and inventories of hazardous materials
- Evaluation of staff participating in research is incorporated into Staff Qualifications and Education (SQE) standards.
- Review of at least five human subjects research projects (inpatient or outpatient) currently under way. Review will include subjects entered in protocols as follows:
    - For triennial surveys completed prior to 31 December 2020, subjects entered in protocols 12 months prior to survey

  - For triennial surveys completed on or after 1 January 2021, surveyors may request subjects entered in protocols dating from the time of the previous survey
  - For initial surveys, subjects entered in protocols 6 months prior to survey
- Information regarding any study patients who had adverse events reported as follows:
  - For triennial surveys completed prior to 31 December 2020, subjects having adverse events 12 months prior to survey
  - For triennial surveys completed on or after 1 January 2021, surveyors may request subjects having adverse events dating from the time of the previous survey
  - For initial surveys, subjects having adverse events 6 months prior to survey
- All hospital contracts for the conduct of research by outside entities
- Other relevant documents for discussion of HRP.3.1, including ME.1: the establishment and implementation of a process to determine the activities and responsibilities of a contract research organization

What Will Occur

- The surveyor(s) will ask questions related to research management activities, with attention to the protection of human subjects and safety as it relates to hospital patients.
- The surveyor(s) will assess compliance with certain standards from the HRP chapter. During the management conference, the surveyor(s) will also identify issues that he or she will pursue in later survey activities.
- The surveyor(s) will ask the hospital to explain how the research program is a component of the quality and safety program of the hospital, with attention to the reporting of adverse events to the hospital (in addition to usual and customary research protocol requirements). The remainder of the session will focus on the protection of subjects as demonstrated in study files with documentation of informed consent. Note for initial surveys: As noted above, consents for new subjects added to studies during the 6 months prior to the on-site survey are the only consents to be evaluated. For triennial surveys completed prior to 31 December 2020, files of subjects entered within the previous 12 months, and for triennial surveys completed on or after 1 January 2021, files of subjects entered into protocols from the time of the previous survey may be evaluated.
- The surveyor(s) will assess compliance with Standards HRP.6, HRP.7, and HRP.7.1.
- The surveyor(s) will ask questions related to contract research management activities, with attention to the protection of human subjects and safety as it relates to hospital patients.
- The surveyor(s) will review contracts for research with the participants and assess compliance with standard HRP.3.1.

How to Prepare

Hospitals should identify the participants in the Human Subjects Research Leadership and Process Interview. Although the hospital leaders should be familiar with all the standards, they should read closely the HRP chapter prior to survey. In preparation for this session, it would be useful to turn the standards into questions. Mock discussions could then be conducted with participants so they feel more comfortable with possible questions.

The following are a few sample questions:

- HRP.1: How have the leaders of the hospital and research programs established and promoted a code of ethical professional behavior?
- HRP.2: How have the leaders identified the scope and potential research topics?
- HRP.3: How do you know that sponsors of research within the hospital comply with the hospital's policies and procedures for the monitoring and evaluation of the quality and safety of the research? Do all contracts contain the required quality and safety program provided by the contract research organization or the sponsor?

- HRP.3.1: Are all contracts with research organizations in compliance with your hospital's policy to determine the activities and responsibilities of the contract research organization?
- HRP.4: What types of research have the leaders defined as exempt from the research review process? How do you know the sponsor is monitoring the contract and is responsible for the quality and integrity of the research data?
- HRP.5: What requirements for managing conflicts of interest has the hospital specified?
- HRP.6: Do hospital leaders learn of near misses and adverse events related to the care of study patients? Have any adverse events related to research been reported within the hospital during the previous 12 months? If so, were the events analyzed and acted upon as necessary?
- HRP.6: How does pharmacy manage study drugs?
- HRP.7.1: How are patients and families informed about how to gain access to research trials?

Survey Planning Tools

External Auditing Body Recommendation Worksheet

If an on-site evaluation was conducted by any external auditing body (a government-authorized department, a regulatory agency, or any other evaluator) anytime since the previous hospital survey or within the past 12 months for hospitals undergoing initial survey, please complete and provide this form with an executive summary of the outcome of each on-site evaluation (in English) to the survey team at the Document Review session.

Name of Auditing Body	Date of Audit	Recommendations or Citations? (Yes/No)	If Yes, Department(s) or Service(s) Cited	Time Allotted for Compliance	Date Full Compliance Achieved	Auditor Returned to Validate Compliance? (Yes/No)

Required Documents

The standards in the tables on the following pages identify a requirement for a document. The document may be in the form of a policy, a procedure, a program, or in some cases, a less formal document that addresses the issue identified in the standard.

Some of the documents need to be provided to Joint Commission International (JCI) surveyors in English, and these documents are indicated in the "In English?" column. Other documents do not need to be translated. For non-English documents, the survey team will have one member able to read the documents, or alternatively, the survey team may request that one or more individuals be available to describe the contents and answer questions about the documents.

Note: Hospitals should refer to the Document Review description for detailed suggestions on the presentation of documents for the surveyor(s).

The definitions for each "Type of Document" are as follows:

- **policy** A statement of expectations meant to influence or determine decisions and actions. Policies are the rules and principles that guide and inform the organization's procedures and processes.
- **procedure** How a task is performed, usually including step-by-step instructions
- **program** An organized, official system that guides action toward a specific goal. The program identifies needs, lists strategies to meet those needs, includes staff involved, and sets goals and objectives. The format of the program may include narratives, policies and procedures, plans, protocols, practice guidelines, clinical pathways, care maps, or a combination of these.
- **document** A printed or electronic document furnishing information of a formal or informal nature for a specific purpose (**for example**, a job description, data validation process, and so on)

International Patient Safety Goals (IPSG)			
Standard	**Standard Text**	**In English**	**Type of Document**
IPSG.1	The hospital develops and implements a process to improve accuracy of patient identifications.	**Yes**	**Policy/procedure**
IPSG.2	The hospital develops and implements a process to improve the effectiveness of verbal and/or telephone communication among caregivers.	**Yes**	**Policy/procedure**
IPSG.2.1	The hospital develops and implements a process for reporting critical results of diagnostic tests.	**Yes**	**Policy/procedure**
IPSG.2.2	The hospital develops and implements a process for handover communication.	**Yes**	**Policy/procedure**
IPSG.3	The hospital develops and implements a process to improve the safety of high-alert medications.	**Yes**	**Policy/procedure**
IPSG.3.1	The hospital develops and implements a process to improve the safety of look-alike/sound-alike medications.	**Yes**	**Policy/procedure**
IPSG.3.2	The hospital develops and implements a process to manage the safe use of concentrated electrolytes.	**Yes**	**Policy/procedure**
IPSG.4	The hospital develops and implements a process for the preoperative verification and surgical/invasive procedure site marking.	**Yes**	**Policy/procedure**
IPSG.4.1	The hospital develops and implements a process for the time-out that is performed immediately prior to the start of the surgical/invasive procedure and the sign-out that is conducted after the procedure.	**Yes**	**Policy/procedure**
IPSG.5	The hospital adopts and implements evidence-based hand-hygiene guidelines to reduce the risk of health care–associated infections.	**Yes**	**Policy/procedure**
IPSG.5.1	Hospital leaders identify care processes that need improvement and adopt and implement evidence-based interventions to improve patient outcomes and reduce the risk of hospital-associated infections.	**Yes**	**Policy/procedure**
IPSG.6	The hospital develops and implements a process to reduce the risk of patient harm resulting from falls for the inpatient population.	**Yes**	**Policy/procedure**
IPSG.6.1	The hospital develops and implements a process to reduce the risk of patient harm resulting from falls for the outpatient population.	**Yes**	**Policy/procedure**

Access to Care and Continuity of Care (ACC)			
Standard	**Standard Text**	**In English**	**Type of Document**
ACC.1	Patients who may be admitted to the hospital or who seek outpatient services are screened to identify if their health care needs match the hospital's mission and resources, and those with emergent, urgent, or immediate needs are given priority for assessment and treatment.		**Policy/procedure**
ACC.1.1	The hospital considers the clinical needs of patients and informs patients when there are unusual delays for diagnostic and/or treatment services.		**Policy/procedure**
ACC.2	The hospital has a process for managing the flow of patients throughout the hospital that includes admitting inpatients and registering outpatients.		**Policy/procedure**
ACC.2.3	The hospital establishes criteria for admission to and discharge from departments/wards providing intensive or specialized services	**Yes**	**Policy/procedure**
ACC.3	The hospital designs and carries out processes to provide continuity of patient care services in the hospital, coordination among health care practitioners, and access to information related to the patient's care.		**Policy/procedure**
ACC.3.1	During all phases of inpatient care, there is a qualified individual identified as responsible for the patient's care.		**Policy/procedure**
ACC.4	The hospital develops and implements a discharge planning and referral process that is based on the patient's readiness for discharge.		**Policy/procedure**
ACC.4.3	The records of outpatients requiring complex care or with complex diagnoses contain profiles of the medical care and are made available to health care practitioners providing care to those patients.		**Written document**
ACC.4.4	The hospital has a process for the management and follow-up of patients who notify hospital staff that they intend to leave against medical advice.		**Policy/procedure**
ACC.4.4.1	The hospital has a process for the management of patients who leave the hospital against medical advice without notifying hospital staff.		**Policy/procedure**
ACC.5	The hospital develops a process to transfer patients to other health care organizations based on status, the need to meet their continuing care needs, and the ability of the receiving organization to meet patients' needs.		**Policy/procedure**
ACC.6	The hospital's transportation services comply with relevant laws and regulations and meet requirements for quality and safe transport.		**Policy/procedure**

Patient-Centered Care (PCC)			
Standard	**Standard Text**	**In English**	**Type of Document**
PCC.1.3	The hospital establishes a process to ensure patient privacy and confidentiality of care and information and allows patients the right to have access to their health information within the context of existing law and culture.	**Yes**	**Policy/procedure**
PCC.2	Patients and families are engaged in all aspects of their medical care and treatment through education and participation in care and treatment decisions and care processes.		**Written document**
PCC.2.1	The hospital informs patients and families about their rights and responsibilities to refuse or discontinue treatment, withhold resuscitative services, and forgo or withdraw life-sustaining treatments.		**Written document**
PCC.3	The hospital measures, analyzes, and—when necessary—improves the patient experience in order to enhance the quality of patient care.		**Written document**
PCC.3.1	The hospital informs patients and families about its process to receive and to act on complaints, conflicts, and differences of opinion about patient care and the patient's right to participate in these processes.		**Written document**
PCC.4	General consent for treatment, if obtained when a patient is admitted as an inpatient or is registered for the first time as an outpatient, is clear in its scope and limits.		**Policy/procedure**
PCC.4.1	Patient informed consent is obtained through a process defined by the hospital and carried out by trained staff in a manner and language the patient can understand.	**Yes**	**Policy/procedure**
PCC.4.2	Informed consent is obtained before surgery, anesthesia, procedural sedation, use of blood and blood products, and other high-risk treatments and procedures.		**Policy/procedure**
PCC.6.1	The hospital provides oversight for the process of organ and tissue procurement.		**Program**

Assessment of Patients (AOP)			
Standard	**Standard Text**	**In English**	**Type of Document**
AOP.1	All patients cared for by the hospital have their health care needs identified through an assessment process that has been defined by the hospital.	**Yes**	**Policy/procedure**
AOP.1.2	The patient's medical and nursing needs are identified from the initial assessments, which are completed and documented in the medical record within the first 24 hours after admission as an inpatient or earlier as indicated by the patient's condition.		**Policy/procedure**

Assessment of Patients (AOP)			
Standard	**Standard Text**	**In English**	**Type of Document**
AOP.1.2.1	The initial medical and nursing assessments of emergency patients are based on their needs and conditions.		**Policy/procedure**
AOP.1.6	Individualized medical and nursing initial assessments are performed for special populations cared for by the hospital.		**Policy/procedure**
AOP.1.7	The initial assessment includes determining the need for discharge planning.		**Policy/procedure**
AOP.2	All patients are reassessed at intervals based on their condition and treatment to determine their response to treatment and to plan for continued treatment or discharge.		**Policy/procedure**
AOP.3	Qualified individuals conduct the assessments and reassessments.		**Written document**
AOP.5.1	A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service, and all laboratory staff have the required education, training, qualifications, and experience to administer and perform the tests and interpret the results.		**Program**
AOP.5.2	A qualified individual is responsible for the oversight and supervision of the point-of-care testing program.		**Program**
AOP.5.3	A laboratory safety program is in place, followed, and documented, and compliance with the facility management and infection prevention and control programs is maintained.	**Yes**	**Program**
AOP.5.3.1	The laboratory uses a coordinated process to reduce the risks of infection as a result of exposure to infectious diseases and biohazardous materials and waste.		**Policy/procedure**
AOP.5.4	Laboratory results are available in a timely way as defined by the hospital.		**Policy/procedure**
AOP.5.5	All equipment used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.		**Program**
AOP.5.6	Essential reagents and supplies are available, and all reagents are evaluated to ensure accuracy and precision of results.		**Program**
AOP.5.7	Procedures for collecting, identifying, handling, safely transporting, and disposing of specimens are established and implemented.		**Policy/procedure**
AOP.5.9	Quality control procedures for laboratory services are in place, followed, and documented.		**Policy/procedure**
AOP.5.9.1	There is a process for proficiency testing of laboratory services.		**Policy/procedure**
AOP.5.11	A qualified individual(s) is responsible for blood bank and/or transfusion services and ensures that services adhere to laws and regulations and recognized standards of practice.		**Program**

Assessment of Patients (AOP)			
Standard	**Standard Text**	**In English**	**Type of Document**
AOP.6.1	A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services, and individuals with proper qualifications and experience perform diagnostic imaging studies, interpret the results, and report the results.		**Program**
AOP.6.2	A radiation and/or diagnostic imaging safety program for patients, staff, and visitors is in place, is followed, and is compliant with applicable professional standards, laws, and regulations.	**Yes**	**Program**
AOP.6.3	Radiology and diagnostic imaging study results are available in a timely way as defined by the hospital.		**Policy/procedure**
AOP.6.4	All equipment used to conduct radiology and diagnostic imaging studies is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.		**Program**
AOP.6.5	Quality control procedures are in place, followed, validated, and documented.		**Policy/procedure**

Care of Patients (COP)			
Standard	**Standard Text**	**In English**	**Type of Document**
COP.1	Uniform care of all patients is provided and follows applicable laws and regulations.		**Policy/procedure**
COP.3	The care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines, laws, and regulations.		**Policy/procedure**
COP.3.1	Reduce the risk of harm associated with clinical alarms by developing and implementing risk reduction strategies for managing clinical alarm systems used for patient care.		**Policy/procedure**
COP.3.4	Clinical guidelines and procedures are established and implemented for the handling, use, and administration of blood and blood products.	**Yes**	**Policy/procedure**
COP.3.5	The hospital has a process to identify patients at risk for suicide and self-harm.		**Policy/procedure**
COP.4	The hospital establishes and implements a program for the safe use of lasers and other optical radiation devices used for performing procedures and treatments.		**Policy/procedure**
COP.6	Patients are supported in managing pain effectively.		**Policy/procedure**
COP.8.5	The transplant program obtains informed consent specific to organ transplantation from the transplant candidate.	**Yes**	**Policy/procedure**
COP.8.6	The transplant program has documented protocols, clinical practice guidelines, or procedures for organ recovery and organ receipt to ensure the compatibility, safety, efficacy, and quality of human cells, tissues, and organs for transplantation.		**Policy/procedure**

Care of Patients (COP)			
Standard	**Standard Text**	**In English**	**Type of Document**
COP.9.1	Transplant programs performing living donor transplants obtain informed consent specific to organ donation from the prospective living donor.	**Yes**	**Policy/procedure**
COP.9.2	Transplant programs that perform living donor transplants use clinical and psychological selection criteria to determine the suitability of potential living donors.	**Yes**	**Policy/procedure**

Anesthesia and Surgical Care (ASC)			
Standard	**Standard Text**	**In English**	**Type of Document**
ASC.3	The administration of procedural sedation is standardized throughout the hospital.	**Yes**	**Program**
ASC.3.1	Practitioners responsible for procedural sedation and individuals responsible for monitoring patients receiving procedural sedation are qualified.		**Policy/procedure**
ASC.3.2	Procedural sedation is administered and monitored according to professional practice guidelines.		**Policy/procedure**
ASC.6	Each patient's physiological status during anesthesia and surgery is monitored according to professional practice guidelines and documented in the patient's medical record.		**Policy/procedure**
ASC.6.1	Each patient's postanesthesia status is monitored and documented, and the patient is discharged from the recovery area by a qualified individual or by using established criteria.		**Policy/procedure**
ASC.7.4	Surgical care that includes the implanting of a medical device is planned with special consideration of how standard processes and procedures must be modified.		**Policy/procedure**

Medication Management and Use (MMU)			
Standard	**Standard Text**	**In English**	**Type of Document**
MMU.1	Medication use in the hospital is organized to meet patient needs, complies with applicable laws and regulations, and is under the direction and supervision of a licensed pharmacist or other qualified professional.		**Program**
MMU.1.1	The hospital develops and implements a program for the prudent use of antibiotics based on the principle of antibiotic stewardship.		**Program**
MMU.2	There is a method for overseeing the hospital's medication list, including how listed medications are used; a method for ensuring that medications for prescribing or ordering are stocked; and a process for medications not stocked or not normally available to the hospital or for times when the pharmacy is closed.		**Policy/procedure**

Medication Management and Use (MMU)			
Standard	**Standard Text**	**In English**	**Type of Document**
MMU.3	Medications are properly and safely stored.		**Policy/procedure**
MMU.3.1	Emergency medications are available, uniformly stored, monitored, and secure when stored out of the pharmacy.		**Policy/procedure**
MMU.3.2	The hospital has a medication recall system.		**Policy/procedure**
MMU.4	The hospital identifies and documents a current list of medications taken by the patient at home and reviews the list against all new medications prescribed or dispensed.	**Yes**	**Policy/procedure**
MMU.4.2	The hospital identifies safe prescribing, ordering, and transcribing practices and defines the elements of a complete order or prescription.	**Yes**	**Policy/procedure**
MMU.5.1	Medication prescriptions or orders are reviewed for appropriateness.		**Policy/procedure**
MMU.6.2	Policies and procedures govern medications brought into the hospital by the patient or family and medication prescribed for patient self-administration.		**Policy/procedure**
MMU.6.2.1	Policies and procedures govern medications brought into the hospital as samples.		**Policy/procedure**
MMU.7	Medication effects on patients are monitored.		**Policy/procedure**
MMU.7.1	The hospital establishes and implements a process for reporting and acting on medication errors and near misses (or close calls).	**Yes**	**Policy/procedure**

Quality Improvement and Patient Safety (QPS)			
Standard	**Standard Text**	**In English**	**Type of Document**
QPS.1	A qualified individual(s) guides the implementation of the hospital's program for quality improvement and patient safety and manages the activities needed to carry out an effective program of continuous quality improvement and patient safety within the hospital.		**Program**
QPS.6	The hospital uses an internal process to validate data.		**Written document**
QPS.7	The hospital uses a defined process for identifying and managing sentinel events.	**Yes**	**Policy/procedure**
QPS.7.1	The hospital uses a defined process for identifying and managing adverse, no-harm, and near miss events.		**Policy/procedure**
QPS.8	Data are always analyzed when undesirable trends and variation are evident from the data.		**Written document**
QPS.10	An ongoing program of risk management is used to identify and to proactively reduce unanticipated adverse events and other safety risks to patients and staff.	**Yes**	**Program**

Prevention and Control of Infections (PCI)			
Standard	**Standard Text**	**In English**	**Type of Document**
PCI.4	The hospital designs and implements a comprehensive infection prevention and control program that identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.	**Yes**	**Program**
PCI.5	The hospital uses a risk-based, data-driven approach in establishing the focus of the health care–associated infection prevention and control program.		**Written document**
PCI.6	The hospital reduces the risk of infections associated with medical/surgical equipment, devices, and supplies by ensuring adequate cleaning, disinfection, sterilization, and storage.		**Policy/procedure**
PCI.6.1	The hospital identifies and implements a process for managing the reuse of single-use devices consistent with regional and local laws and regulations and implements a process for managing expired supplies.	**Yes**	**Policy/procedure**
PCI.7	The infection prevention and control program identifies and implements standards from recognized infection prevention and control programs to address cleaning and disinfection of the environment and environmental surfaces.		**Program**
PCI.8	The hospital reduces the risk of infections through proper disposal of waste, proper management of human tissues, and safe handling and disposal of sharps and needles.		**Policy/procedure**
PCI.8.1	The hospital has a process to protect patients and staff from bloodborne pathogens related to exposure to blood and body fluids.		**Policy/procedure**
PCI.12	The hospital provides barrier precautions and isolation procedures that protect patients, visitors, and staff from communicable diseases and protects immunosuppressed patients from acquiring infections to which they are uniquely prone.		**Policy/procedure**
PCI.12.1	The hospital develops and implements a process to manage a sudden influx of patients with airborne infections and when negative-pressure rooms are not available.		**Policy/procedure**
PCI.12.2	The hospital develops, implements, and evaluates an emergency preparedness program to respond to the presentation of global communicable diseases.		**Program**
PCI.13	Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly when required.		**Policy/procedure**
PCI.15	The hospital provides education on infection prevention and control practices to staff, physicians, patients, families, and other caregivers when indicated by their involvement in care.		**Policy/procedure**

Governance, Leadership, and Direction (GLD)			
Standard	**Standard Text**	**In English**	**Type of Document**
GLD.1	The structure and authority of the hospital's governing entity are described in bylaws, policies and procedures, or similar documents.	**Yes**	**Policy/procedure**
GLD.1.1	The operational responsibilities and accountabilities of the governing entity are described in a written document(s).		**Written document**
GLD.1.2	The governing entity approves the hospital's program for quality and patient safety and regularly receives and acts on reports of the quality and patient safety program.		**Program**
GLD.2	A chief executive(s) is responsible for operating the hospital and complying with applicable laws and regulations.		**Written document**
GLD.3.1	Hospital leadership identifies and plans for the type of clinical services required to meet the needs of the patients served by the hospital.		**Written document**
GLD.3.2	Hospital leadership ensures effective communication throughout the hospital.		**Written document**
GLD.6	Hospital leadership is accountable for the review, selection, and monitoring of clinical or nonclinical contracts and inspects compliance with contracted services as needed.		**Written document**
GLD.6.2	Hospital leadership ensures that licensed health care professionals and independent health care practitioners not employed by the hospital have the right credentials and are competent and/or privileged for the services provided to the hospital's patients.		**Policy/procedure**
GLD.8	Medical, nursing, and other leaders of departments and clinical services plan and implement a professional staff structure to support their responsibilities and authority.		**Written document**
GLD.9	One or more qualified individuals provide direction for each department or service in the hospital.		**Program**
GLD.10	Each department/service leader identifies, in writing, the services to be provided by the department, and integrates or coordinates those services with the services of other departments.		**Policy/procedure**
GLD.11.2	Department/service leaders select and implement clinical practice guidelines, and related clinical pathways and/or clinical protocols, to guide clinical care.		**Policy/procedure**
GLD.12	Hospital leadership establishes a framework for ethical management that promotes a culture of ethical practices and decision making to ensure that patient care is provided within business, financial, ethical, and legal norms and protects patients and their rights.		**Written document**
GLD.12.1	The hospital's framework for ethical management addresses operational and business issues, including marketing, admissions, transfer, discharge, and disclosure of ownership and any business and professional conflicts that may not be in patients' best interests.		**Written document**

Governance, Leadership, and Direction (GLD)			
Standard	**Standard Text**	**In English**	**Type of Document**
GLD.12.2	The hospital's framework for ethical management addresses ethical issues and decision making in clinical care.		**Written document**
GLD.13	Hospital leadership creates and supports a culture of safety program throughout the hospital.		**Program**
GLD.15	Human subjects research, when provided within the hospital, is guided by laws, regulations, and hospital leadership.		**Policy/procedure**
GLD.16	Patients and families are informed about how to gain access to clinical research, clinical investigations, or clinical trials involving human subjects.		**Policy/procedure**
GLD.18	Informed consent is obtained before a patient participates in clinical research, clinical investigations, or clinical trials.		**Written document**
GLD.19	The hospital has a committee or another way to oversee all research in the hospital involving human subjects.		**Policy/procedure**

Facility Management and Safety (FMS)			
Standard	**Standard Text**	**In English**	**Type of Document**
FMS.5	The hospital develops and implements a program to provide a safe physical facility through inspection and planning to reduce risks.		**Program**
FMS.6	The hospital develops and implements a program to provide a secure environment for patients, families, staff, and visitors.	**Yes**	**Program**
FMS.7	The hospital develops and implements a program for the management of hazardous materials and waste.		**Program**
FMS.7.1	The hospital's program for the management of hazardous materials and waste includes the inventory, handling, storage, and use of hazardous materials.		**Program**
FMS.7.2	The hospital's program for the management of hazardous materials and waste includes the types, handling, storage, and disposal of hazardous waste.		**Program**
FMS.8	The hospital establishes and implements a program for fire safety that includes an ongoing assessment of risks and compliance with national and local codes, laws, and regulations for fire safety.		**Program**
FMS.8.1	The fire safety program includes the early detection, suppression, and containment of fire and smoke.		**Program**

Facility Management and Safety (FMS)			
Standard	**Standard Text**	**In English**	**Type of Document**
FMS.8.2	The fire safety program includes measures to ensure safe exit from the facility when fire and non-fire emergencies occur.		**Program**
FMS.8.3	All fire safety equipment and systems, including devices related to early detection, alarm notification, and suppression, are inspected, tested, and maintained.		**Written document**
FMS.8.4	The hospital involves staff in regular exercises to evaluate the fire safety program.		**Program**
FMS.8.5	The fire safety program includes limiting smoking by staff and patients to designated non–patient care areas of the facility.		**Program**
FMS.9.1	The medical equipment program includes inspection, testing, preventive maintenance, and documenting the results.		**Program**
FMS.9.2	The hospital has a process for monitoring and acting on medical equipment hazard notices, recalls, reportable incidents, problems, and failures.		**Policy/procedure**
FMS.10.1	The utility systems program includes inspection, testing, and maintenance to ensure that utilities operate effectively and efficiently to meet the needs of patients, staff, and visitors.		**Program**
FMS.10.2	The hospital utility systems program ensures that essential utilities, including power, water, and medical gases, are available at all times and alternative sources for essential utilities are established and tested.		**Program**
FMS.10.3.1	Quality of water used in hemodialysis is tested for chemical, bacterial, and endotoxin contaminants, and processes for hemodialysis services follow professional standards for infection prevention and control.		**Written document**
FMS.11	The hospital develops, maintains, and tests an emergency management program to respond to internal and external emergencies and disasters that have the potential of occurring within the hospital and community.		**Program**
FMS.12	When planning for construction, renovation, and demolition projects, or maintenance activities that affect patient care, the organization conducts a preconstruction risk assessment.		**Policy/procedure**

Staff Qualifications and Education (SQE)			
Standard	**Standard Text**	**In English**	**Type of Document**
SQE.1.1	Each staff member's responsibilities are defined in a current job description.		**Written document**
SQE.5	There is documented personnel information for each staff member.		**Written document**

Staff Qualifications and Education (SQE)			
Standard	**Standard Text**	**In English**	**Type of Document**
SQE.6	A staffing strategy for the hospital, developed by the leaders of hospital departments and services, identifies the number, types, and desired qualifications of staff.		**Written document**
SQE.8.2	The hospital provides a staff health and safety program that addresses staff physical and mental health and safe working conditions.		**Program**
SQE.8.3	The hospital identifies staff who are at risk for exposure to and possible transmission of vaccine-preventable diseases and implements a staff vaccination and immunization program.		**Policy/ procedure**
SQE.9	The hospital has a uniform process for gathering the credentials of those medical staff members permitted to provide patient care without supervision.		**Policy/procedure**
SQE.9.1	Medical staff members' education, licensure/registration, and other credentials required by law or regulation and the hospital are verified and kept current.		**Written document**
SQE.9.2	There is a uniform, transparent decision process for the initial appointment of medical staff members.		**Policy/procedure**
SQE.10	The hospital has a standardized, objective, evidence-based procedure to authorize medical staff members to admit and to treat patients and/or to provide other clinical services consistent with their qualifications.	**Yes**	**Policy/procedure**
SQE.11	The hospital uses an ongoing standardized process to evaluate the quality and safety of the patient care provided by each medical staff member.	**Yes**	**Written document**
SQE.12	At least every three years, the hospital determines, from the ongoing monitoring and evaluation of each medical staff member, if medical staff membership and clinical privileges are to continue with or without modification.		**Written document**
SQE.13	The hospital has a uniform process to gather, to verify, and to evaluate the nursing staff's credentials (license, education, training, and experience).		**Policy/procedure**
SQE.15	The hospital has a uniform process to gather, to verify, and to evaluate other health care practitioners' credentials (license, education, training, and experience).		**Policy/procedure**

Management of Information (MOI)			
Standard	**Standard Text**	**In English**	**Type of Document**
MOI.3	The hospital determines the retention time of patient medical records, data, and other information.		**Policy/procedure**
MOI.7	Documents, including policies, procedures, and programs, are managed in a consistent and uniform manner.	**Yes**	**Written document**

Management of Information (MOI)			
Standard	**Standard Text**	**In English**	**Type of Document**
MOI.7.1	The policies, procedures, plans, and other documents that guide consistent and uniform clinical and nonclinical processes and practices are fully implemented.		**Program**
MOI.8	The hospital initiates and maintains a standardized, accurate medical record for every patient assessed or treated and determines the record's content, format, and location of entries.		**Policy/procedure**
MOI.12	When mobile devices are used for texting, e-mailing, or other communications of patient data and information, the hospital implements processes to ensure quality of patient care and maintains security and confidentiality of patient information.		**Policy/procedure**
MOI.13	The hospital develops, maintains, and tests a program for response to planned and unplanned downtime of data systems.		**Program**

Medical Professional Education (MPE)			
Standard	**Standard Text**	**In English**	**Type of Document**
MPE.4	The hospital understands and provides the required frequency and intensity of medical supervision for each type and level of medical student and trainee.	**Yes**	**Policy/procedure**
MPE.6	Medical students and trainees comply with all hospital policies and procedures, and all care is provided within the quality and patient safety parameters of the hospital.		**Program**

Human Subjects Research Programs (HRP)			
Standard	**Standard Text**	**In English**	**Type of Document**
HRP.3	Hospital leadership establishes requirements for sponsors of research to ensure their commitment to the conduct of ethical research.		**Policy/procedure**
HRP.3.1	When one or more of the research-related duties and functions of the sponsor are provided through an outside commercial or academic contract research organization, the accountabilities of the outside contract research organization are clearly defined.	**Yes**	**Written document**
HRP.4	Hospital leadership creates or contracts for a process to provide the initial and ongoing review of all human subjects research.		**Policy/procedure**
HRP.5	The hospital identifies and manages conflicts of interest with research conducted at the hospital.		**Policy/procedure**
HRP.7.1	The hospital informs patients and families about how to gain access to clinical research, clinical investigations, or clinical trials and includes protections for vulnerable populations to minimize potential coercion or undue influence.	**Yes**	**Written document**

Standards That Reference Laws and Regulations

The Joint Commission International Accreditation Standards for Hospitals were designed to be surveyed in the context of relevant, country-specific local and national laws and regulations. The survey process takes into account laws and regulations under which a hospital operates and provides patient care in one of the following two ways:

1) If a relevant law and/or regulation sets a less stringent expectation than the accreditation standard, then the expectation of the accreditation standard is surveyed and scored.
2) If, on the other hand, the law and/or regulation sets a more stringent expectation than the accreditation standard, then the survey team will expect to find that the hospital is in compliance with the relevant law and/or regulation.

The "Laws and Regulations Worksheet" is designed to familiarize the hospital with those particular standards that reference country-specific laws and/or regulations; to provide a summary of relevant applicable laws and/or regulations; and to provide information regarding the results of any on-site audits or inspections required by local/regional laws or regulatory authorities (**for example**, ministry of health and fire brigade). The worksheet also captures whether or not other invited accrediting bodies (such as the College of American Pathologists [CAP] or the International Organization for Standardization [ISO]) have conducted inspections. This information will facilitate the survey team's ability to more accurately evaluate the related JCI accreditation standards.

Hospitals can use the "Laws and Regulations Worksheet" to identify laws and/or regulations that are in conflict with each other and with a JCI standard. The "Laws and Regulations Worksheet" provides additional space to include other laws and regulations that may be applicable to the accreditation survey process but may not be referenced in the standards.

Hospitals can use the "External Auditing Body Recommendation Worksheet" to provide information regarding the results of on-site evaluations conducted by a government-authorized department, a regulatory agency, or an invited evaluator within the past 12 months prior to the date of the on-site survey. An executive summary (in English) of the outcome of each on-site evaluation should be presented to the survey team for review during the Document Review session.

Laws and Regulations Worksheet

Section I: Accreditation Participation Requirements					
Requirement	Applicable Law or Regulation? (Yes/No)	If Yes, Name of the Applicable Law or Regulation	How Law or Regulation Applies to Requirement	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation Is Evaluated on Site? (Yes/No)
APR.3					

Section II: Patient-Centered Standards					
Standard	Applicable Law or Regulation? (Yes/No)	If Yes, Name of the Applicable Law or Regulation	How Law or Regulation Applies to Requirement	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation Is Evaluated on Site? (Yes/No)
IPSG.2–IPSG.2.2					
ACC.4.2					
ACC.4.4 and ACC.4.4.1					
ACC.6					
PCC.1					
PCC.1.3					
PCC.1.5					
PCC.4.1					
PCC.6 and PCC.6.1					
AOP.1					

Section II: Patient-Centered Standards					
Standard	Applicable Law or Regulation? (Yes/No)	If Yes, Name of the Applicable Law or Regulation	How Law or Regulation Applies to Requirement	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation Is Evaluated on Site? (Yes/No)
AOP.1.6					
AOP.3					
AOP.5					
AOP.5.1					
AOP.5.3					
AOP.5.3.1					
AOP.5.9.1					
AOP.5.11					
AOP.6					
AOP.6.1					
AOP.6.2					
COP.1					
COP.3					
COP.4					
COP.8.5					
COP.9					
COP.9.2					
ASC.1					
ASC.2					
MMU.1					
MMU.1.1					

Section II: Patient-Centered Standards					
Standard	Applicable Law or Regulation? (Yes/No)	If Yes, Name of the Applicable Law or Regulation	How Law or Regulation Applies to Requirement	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation Is Evaluated on Site? (Yes/No)
MMU.2					
MMU.3					
MMU.4.1					
MMU.5					
MMU.6					

Section III: Health Care Organization Management Standards					
Standard	Applicable Law or Regulation? (Yes/No)	If Yes, the Name of the Applicable Law or Regulation	How Law or Regulation Applies to the Requirement	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation Is Evaluated on Site?
QPS.4					
QPS.4.1					
QPS.7					
QPS.10					
PCI.1					
PCI.3					
PCI.6.1					
PCI.7.1					
PCI.8					
PCI.8.1					

Section III: Health Care Organization Management Standards					
Standard	Applicable Law or Regulation? (Yes/No)	If Yes, the Name of the Applicable Law or Regulation	How Law or Regulation Applies to the Requirement	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation Is Evaluated on Site?
PCI.10					
GLD.2					
GLD.8					
GLD.15					
FMS.1					
FMS.2					
FMS.6					
FMS.7–FMS.7.2					
FMS.8					
FMS.8.1 and FMS.8.2					
FMS.8.3					
FMS.9.2					
FMS.10.2					
FMS.10.3 and FMS.10.3.1					
SQE.1					
SQE.1.1					
SQE.5					
SQE.6 and SQE.6.1					

Section III: Health Care Organization Management Standards					
Standard	Applicable Law or Regulation? (Yes/No)	If Yes, the Name of the Applicable Law or Regulation	How Law or Regulation Applies to the Requirement	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation Is Evaluated on Site?
SQE.9–SQE.9.2					
SQE.13					
SQE.14 and SQE.14.1					
SQE.15					
SQE.16 and SQE.16.1					
MOI.2					
MOI.3					
MOI.4					
MOI.7					
MOI.10					

Section IV: Academic Medical Center Hospital Standards					
Standard	Applicable Law or Regulation? (Yes/No)	If Yes, the Name of the Applicable Law or Regulation	How Law or Regulation Applies to the Requirements	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation is Evaluated on Site?
MPE.7					
HRP.4					