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Joint Commission International Survey Process Guide for

Hospitals

Including Surveys for Academic Medical Center Hospitals

5th Edition

Joint Commission International

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Questions About Accreditation

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- To submit a question about International Standards visit our web page, http://www.jointcommissioninternational.org/interpretation-question/.
- To comment about quality or safety at an accredited organization visit our web page, http://www.jointcommissioninternational.org/reporting-quality-and-safety-issues/.
- For general inquiries regarding advisory and educational services, please email JCI Consulting at iciconsulting@jcrinc.com.

Introduction

The Joint Commission International Accreditation Hospital Survey Process Guide, Fifth Edition is designed to help hospitals learn about and be better prepared for the Joint Commission International (JCI) survey process. This guide provides hospitals and academic medical center hospitals with important information about JCI, the hospital standards manual, eligibility for accreditation, how to request accreditation, survey preparation, the on-site survey, and the accreditation decision.

Hospitals should not hesitate to contact any of the JCI Accreditation Offices by telephone or e-mail using the contact directory (on page vii) for any other information.

Notes on This Publication

This publication contains the following enhancements for the reader and user:

- Any time a page number is listed in the text (including the Table of Contents on page iii), clicking on that page number will take the user directly to that page in the publication for easy reference.
- Web addresses and email addresses are also hyperlinked. To go to a web page or send an email to a listed address, click on the hyperlinked text.
- Where examples meant to better illustrate a requirement or other concept are included, they are preceded by the words **for example** in bold text.

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:
 - o Provides a complete range of acute care clinical services—diagnostic, curative, and rehabilitative.
 - o In the case of a specialty hospital, provides a defined set of services, such as pediatric, eye, dental, and psychiatry, among others.
 - o 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 JCI fifth edition hospital accreditation standards.
- 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 (see below), admitting and discharging a volume of patients that will permit the complete evaluation of the implementation and sustained compliance with all the JCI fifth edition hospital accreditation standards.
- The hospital meets the conditions described in the "Accreditation Participation Requirements" (APR) section of the JCI fifth edition hospital accreditation standards.

The applicant academic medical center hospital 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 (see below) 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.

At the time of application, the applicant hospital is conducting academic and/or commercial human subjects research under multiple approved protocols involving patients of the hospital. (errata)

Principal Site

Principal site means the hospital 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 hospital (**for example**, an ophthalmologic hospital, dental hospital, or orthopedic hospital).

Note: If in its reasonable discretion JCI determines that the applicant hospital does not meet the published eligibility criteria, 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. **(errata)**

Full Operation

Full operation means the hospital accurately identifies the following in its electronic application (E-App) at the time of application:

- All clinical services currently provided for inpatients and outpatients. (Those clinical services that are
 planned and thus not identified in the E-App and begin operations at a later time will require a
 separate extension survey to evaluate those services.)
- 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 E-App.

- All inpatient and outpatient clinical services, units, and departments identified in the E-App are
 available for a comprehensive evaluation against all relevant JCI standards for hospitals consistent with
 JCI's normal survey process for the size and type of organization, such as
 - o patient tracer activities, including individual patient and systems tracers;
 - o open and closed medical record review;
 - o direct observation of patient care processes;
 - o interviews of patients; and
 - o interviews with medical students/trainees.

Note: Contact JCI Accreditation prior to submitting an E-App to discuss the criteria and validate whether the hospital meets the above criteria for "in full operation" at least four months or more prior to submitting its E-App and at its initial survey. JCI may request documentation of the hospital's utilization statistics prior to accepting the E-App or conducting the on-site survey. In addition, JCI will not begin an on-site survey, may discontinue an on-site survey, or may cancel a scheduled survey when it determines the hospital is not "in full operation." **(errata)**

How to Request a JCI Accreditation Survey

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

To begin the accreditation process as a new applicant, go to

http://www.jointcommissioninternational.org/Programs-Hospitals and click on the link "Register or Apply." (**Please note:** starting early in 2014, this address will change to

http://www.jointcommissioninternational.org/registration when JCI's new website is launched.) Submit the requested information. Once 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 process for **reaccreditation**, go to http://www.jointcommissioninternational.org/Programs-Hospitals and click on the link "JCI Direct Connect."

JCI provides detailed instructions for completing the application within E-App, as well as access to online and personalized help if needed.

JCI requires organizations to submit one application for each hospital to be surveyed at minimum six months prior to the hospital's requested survey dates. JCI requests that the hospital provides no less than a three-month range of dates (**for example**, October through December of 2016) during which the survey can be scheduled. This allows JCI the flexibility to assign the most appropriate team of surveyors to your organization. From the information your hospital submits, JCI will develop an accreditation contract specifying cost, number of surveyors, number of survey days and other details.

The application for survey is valid for six months from the date it is submitted; this means a hospital can submit its application and have time to finish survey preparations before the on-site survey takes place. Hospitals should request survey dates when the hospital is confident it will be able to demonstrate a fourmonth track record of compliance with the standards at the time of the on-site survey (read more in Accreditation Preparation on page 19).

In its E-App, hospitals must indicate three 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, a JCI representative will contact the hospital. JCI's representative will answer the hospital's questions about survey preparation and help guide individuals through each step of the accreditation process.

JCI schedules on-site surveys based on information provided in the application for survey. Based on this information, JCI determines the number of days required for a survey, the composition of the survey team, and the services to be reviewed.

Three to six months before the survey, the accreditation survey contract agreement will be sent to the hospital. Until the signed contract agreement and the down payment of at least 50% of the survey fees are received, the scheduled survey cannot be confirmed. The hospital will also receive notification of the surveyor's(s') name(s) before its survey. The survey team leader will contact the person responsible for the hospital's survey approximately four to eight 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 on page 8), JCI collects core information regarding each hospital's profile in its E-App to understand ownership,

licensure, scope and volume of patient services, and types of patient care facilities, among other factors. When any of these factors change, JCI must make a deliberate determination if the change is within or outside of the scope of planned initial survey or the scope of a current accreditation award. Thus, the hospital notifies JCI before the change or within 15 days of changes in such core information from the hospital's profile, including, but not limited to, 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 may conduct an additional survey for all or a portion of the hospital again or for the first time in the case of new facilities or services. JCI accreditation does not automatically extend accreditation to new services and facilities without an on-site evaluation.

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 a focused survey.

If the hospital does not provide notification to JCI in advance or within 15 days of these changes, the hospital will be placed At Risk for Denial of Accreditation and a focused survey will be conducted.

If the hospital does not provide notification to JCI in advance of the on-site survey, JCI may need to schedule an additional survey for a later date and the hospital will be placed At Risk for Denial of Accreditation. In that situation, JCI may also review any unreported services addressed by its standards. In either case, additional fees will be assessed to the hospital by JCI. JCI will make the final accreditation decision for the hospital only after reviewing all services provided by the hospital for which JCI has standards.

Survey Scheduling, Postponements, and Cancellations

Initial Schedules for Surveys

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 six 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.

Definition of 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 email to iciaccreditation@jcrinc.com. A new survey application may be required when a new date is established if the original application is older than six months.

Acceptable Reasons for Postponement

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 cease accepting patients and to transfer patients to other facilities
- Patients and/or the hospital are being moved to another building during 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.

Cancellation

The survey may be canceled by JCI or the hospital without penalty or damages in the event that acts of God, wars, terrorism, government regulations, disasters, strikes, civil disorders, or other emergencies of a similar nature make it impossible, illegal, or unreasonable to go forward, provided notice of the event requiring cancellation is communicated in writing as soon as practically possible. Further, JCI may follow the advice of relevant ministries concerned with evaluating political and military circumstances with regard to scheduling surveys.

If the hospital cancels the survey 60 days or less prior to the first day of the survey for any reason(s) other than those previously stated, JCI Accreditation Services may require payment of one half of the survey fees to recover costs JCI Accreditation Services has incurred.

The Standards Manual

The JCI website and *The Joint Commission International Accreditation Standards for Hospitals*, Fifth Edition, and this publication are the tools hospitals can use to begin preparing for accreditation. Starting in late 2013, JCI posts its key accreditation and certification policies and procedures on its public website (http://www.jointcommissioninternational.org/). Hospitals 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 accreditation manual are excellent tools to help evaluate the hospital's current practices and structures. The manual contains functional standards that are organized around the way care is provided in a hospital setting. The standards address patient-focused performance and are organized around functions and processes, including clinical and organizational, that are common to all hospitals, as well as standards for academic medical center hospitals pertaining to medical student education and human subjects research. 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, new to the accreditation manual, 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 (APR) 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 hospital-specific data and information.

Hospitals are either compliant or not compliant with the APRs. When a hospital does not comply with certain APRs, the hospital may be asked to submit a SIP, or the noncompliance may result in being placed At Risk for Denial of Accreditation, or may lead to the loss of accreditation as with any refusal to permit performance of a survey. 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 Functions

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 (IPSG) 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)

These standards address which patient needs can be met by the hospital, the efficient flow of services to patients, and the appropriate transfer or discharge of patients to their home or to another care setting.

Patient and Family Rights (PFR)

These standards address issues such as promoting consideration of patients' values, recognizing the hospital's responsibilities under law, and informing patients of their responsibilities in the care process. Standards

regarding patient rights with respect to informed consent, resolution of complaints, and confidentiality are also included.

Assessment of Patients (AOP)

This chapter addresses patient assessment at all points of care within the hospital. Assessment includes collecting information and data on the patient's physical and psychosocial history, analyzing the data and information to identify the patient's health care needs, and developing a plan of care to meet those identified needs. This chapter also includes standards that address laboratory services and diagnostic imaging and radiology services.

Care of Patients (COP)

This chapter discusses activities basic to patient care, including processes for planning and coordinating care, monitoring results, modifying care, and conducting follow-ups. The chapter also includes high-risk care services, nutrition care, pain management, and end-of-life care.

Anesthesia and Surgical Care (ASC)

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)

This chapter addresses systems and processes for selecting, procuring, storing, ordering/prescribing, transcribing, distributing, preparing, dispensing, administering, documenting, and monitoring medication therapies.

Patient and Family Education (PFE)

This chapter contains standards that address the effectiveness of education that is provided to patients and families and the modalities employed to successfully educate these individuals. This chapter also examines patients' readiness to learn by considering their language needs and learning preferences.

Section III: Organization Functions

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)

The standards in this chapter identify the structure, leadership, and activities to support the data collection, analysis and improvement for the identified priorities—hospitalwide and department- and service-specific. This includes the collection and analysis of data on, and response to, hospitalwide 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. The standards do not identify an organizational structure, such as a department, as this is up to each hospital to determine.

Prevention and Control of Infections (PCI)

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. 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 within and between departments
- Improving performance—leaders' critical roles in initiating performance and maintaining a hospital's performance improvement activities

The GLD chapter has been greatly expanded in the fifth edition standards, focusing even more importance on the role of leadership in a hospital'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 emergency preparedness, security, safety, life safety, medical equipment, utility systems, hazardous materials, and waste management.

Staff Qualifications and Education (SQE)

This chapter includes sections on human resources planning; staff orientation, training, and education; staff competence assessments; handling staff requests; and credentialing and privileging of licensed independent practitioners, nurses, and other practitioners.

Management of Information (MOI)

Formerly named Management of Communication and Information (MCI), these standards have been focused to address how well the hospital obtains, manages, and uses information to provide, coordinate, and integrate services. The principles of good information management apply to all methods, whether paper-based or electronic, and JCI standards are equally compatible with either method.

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? on page 3 or contact JCI Accreditation via email (jciaccreditation@jcrinc.com).

Medical Professional Education (MPE)

These standards address how the academic medical center hospital educates, supervises, grants privileges, and otherwise incorporates its medical students and trainees into its care processes and other daily operations.

Human Subjects Research Programs (HRP)

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

New to the fifth edition hospital standards, JCI's policies and procedures are summarized and moved from the front of the manual to its current location following the accreditation standards. This change reflects customer feedback that the policies and procedures, though important, are secondary in importance to the JCI standards, intents, and measurable elements. Starting in late 2013, JCI full policies are published on JCI's public website http://www.jointcommissioninernational.org/accreditation-policies.

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 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.

Determining the Appropriate 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 on page 15)
- 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:

- A 12-month look-back period of compliance for triennial surveys
- A 4-month look-back period of compliance for initial surveys
- No look-back period for a focused 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
- A finding of "not met" for the ME during the last full survey, or focused 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
 - o a 5- to 11-month look-back period of compliance for triennial surveys; or
 - o a 1- to 3-month look-back period of compliance for initial surveys.
 - No look-back period for a focused 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, or focused 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
 - o a less than 5-month look-back period of compliance for triennial surveys; or
 - o a less than 1-month look-back period of compliance for initial surveys.
 - No look-back period for a focused 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.12 as an example:

MOI.12 As part of its monitoring and performance improvement the hospital regularly assesses patient clinical record completeness of patient clinical records.	
☐ 1. A representative sample of active and discharged patient clinical records are 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 records or to manage patient records.	Not Met ↓
☐ 3. The review focuses on timeliness, legibility, and completeness of the clinical record.	Not Met ↓
☐ 4. Record contents required by laws or regulations are 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

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" (%), which indicates the percentage of demonstrated compliance. 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%.

"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

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 fifth edition standard effective on 1 April 2014, the look-back period on a 1 July triennial survey is 3 months back to the 1 April 2014 effective date, not the 12 months for existing standards. Similarly, for a 1 July initial survey, the look-back is 3 months rather than 4 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 4-month (initial) look-back period would be influenced. For example, on a triennial survey, if the possible look-back period for a new standard is 6 months, and the hospital is in full compliance ("fully met") with the ME, but the hospital can demonstrate compliance going back only 4 months, the ME will be scored "partially met," as 67% of the 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.

The Look-Back Period on Focused Surveys

If, following a full survey—initial or triennial—a focused survey is required within 120 days after the full survey, per the accreditation decision rules (see page 16), the look-back period at the time of the focused survey is from the date the focused survey started back to the last day of the full survey. During this look-back period, the surveyors 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 monitoring and 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.3.3, because clinical guidelines and procedures are not established and implemented and do not address a) through e) of the intent. When the surveyor(s) returns for the focused survey, the organization presents evidence that clinical guidelines and procedures have been established and based on evidence from literature, professional associations, and other credible sources, that include processes for a) through e) 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 clinical records show 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 3 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 3 because the evaluation process for patient services provided by medical staff utilized comparative data that consisted of demographic and administrative content only and did not specifically address clinical performance. When the surveyors returned for the focused 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 record of 1 patient and made by 1 physician are limited in impact and may actually be scored as 1 finding. Twelve incomplete medication orders by multiple physicians in several different patient records indicates far greater potential for patient harm and would be scored as multiple findings. Thus, the sample of 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.

Accreditation Decision Rules (Effective 1 April 2014)

Accreditation Decisions

The Joint Commission International Accreditation Committee considers all information from the initial or triennial full survey and any required focused survey in making its decision regarding accreditation. The outcome is that the hospital meets the criteria for accreditation or does not meet the criteria and is denied accreditation. The criteria for these two potential outcomes are as follows:

Accredited

This decision results when a hospital meets all of the following conditions:

- The hospital demonstrates acceptable compliance with each standard. Acceptable compliance is a score of at least "5" on each standard.
- The hospital demonstrates acceptable compliance with the standards in each chapter. Acceptable compliance is an aggregate score of at least "8" for each chapter of standards.
- The hospital demonstrates overall acceptable compliance. Acceptable compliance is An aggregate score of at least "9" on all standards.
- 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 hospitals surveyed under the hospital accreditation standards within the previous 24 months.
- No measurable element in the IPSG is score "not met."

Denial of Accreditation

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

- One or more standards is scored less than "5."
- The aggregate score of one or more chapter of standards is less than "8."
- The aggregate score for all standards is less than "9."
- The total number of measurable elements found to be "not met" or "partially met" is above the mean (three or more standard deviations) for hospitals surveyed under the hospital accreditation standards within the previous 24 months.
- One or more measurable element in the IPSG is scored "not met".
- A required focused 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 place the hospital At Risk for Denial of Accreditation have not been resolved at the time of the focused survey to evaluate the condition.
- The hospital voluntarily withdraws from the accreditation process.
- The hospital does not permit the performance of any survey by Joint Commission International.

Conditions that place a hospital At Risk for Denial of Accreditation are as follows:

- An immediate threat to patient/public health or staff safety exists within the hospital (see APR.12 in the standards manual).
- An individual who does not possess a license, registration, or certification is providing or has provided health care services in the hospital that would, under applicable law or regulation, require such a license, registration, or certification and that placed the hospital's patients at risk for a serious adverse outcome (see APR.12 in the standards manual).

- JCI is reasonably persuaded that the hospital submitted falsified documents or misrepresented information in seeking to achieve or retain accreditation, as required by the Information Accuracy and Truthfulness Policy (see APR.2 in the standards manual).
- A number of noncompliant standards ("not met" or "partially met") at the time of survey are above the mean (three or more standard deviations) for hospitals in the same program surveyed during the previous 24 months (see APR.4 in the standards manual).
- The hospital 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 hospital is seeking accreditation (see APR 3 in the standards manual).
- The hospital has not met the accreditation policy for "Reporting Requirements Between Surveys" (see APR.3 in the standards manual).
- The hospital fails to submit an acceptable Strategic Improvement Plan (SIP) within 120 days of the hospital's survey (see APR.1 in the standards manual).

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 three 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 a Strategic Improvement Plan (SIP) that defines the improvement strategy(ies) and/or approach to bring any noncompliant standards and/or International Patient Safety Goal(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. The visit is named a focused survey, as only the standards and/or International Patient Safety Goals in noncompliance are the "focus" of the survey.

Process

An Official Survey Findings Report is sent to the hospital by the JCI Accreditation Central Office within 10 to 15 days following the survey. An SIP will be requested for any "not met" standard(s)/measurable element(s) and/or International Patient Safety Goal(s) cited in the survey report, or for a "partially met" finding if determined by JCI Accreditation central office, when the hospital meets the conditions for accreditation. The SIP explains the hospital's process in defining the improvement strategy(ies) and/or approach, including specific actions 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 to the JCI Accreditation Central Office for review and acceptance within 45 days after receiving the final survey report. A hospital that fails to submit an acceptable SIP may be placed at risk of accreditation denial and require a focused survey to verify evidence of compliance

A Preliminary Survey Findings Report is sent to the hospital by the Accreditation 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 to 15 days after the survey; the report includes all standard(s)/measurable element(s) and/or International Patient Safety Goals that were found to be not 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 surveyors during the focused survey.

Focused Survey

A focused survey is required within 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 International Patient Safety Goals 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 focused survey meet all the conditions for accreditation, the hospital receives an Accredited status. The hospital will then be requested to develop an SIP for any "not met" survey findings and/or any "partially met' survey findings as determined by the JCI Accreditation Central Office.

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

Accreditation Preparation

After JCI accepts the hospital's electronic application for survey (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 appropriate 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 personnel, observation of the hospital's administrative and clinical activities, assessment of the physical facilities and patient care 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 four to eight 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
- Accurate list of the patients currently receiving care in the hospital, including their diagnosis, age, unit/service, physician, and date of admission
- List of systemwide priority improvements
- List of departments and services individual measures
- Clinical practice guidelines and any associated pathways and protocols
- Proactive risk assessments, such as a failure mode and effects analysis (FMEA), hazard vulnerability analysis (HVA), and infection control risk assessment (ICRA)
- Required organization plans (for example, facility management and safety plan)
- Required policies and procedures, written documents, or bylaws
- Committee minutes (for example, from governance meetings, infection control meetings, and other meetings)
- Copy of Strategic Improvement Plan (SIP) from previous survey (if applicable)
- A list of the operative and other invasive procedures scheduled for the day, including surgeries in the
 operating theatre, day surgeries, cardiac catheterizations, endoscopies/colonoscopies, and in vitro
 fertilizations
- Current map of the hospital campus
- Sample of all medical record forms

The list of required written policies is available in Required Written Policies (Including Those Required in English on page 131).

Accreditation Preparation Time Line

Hospitals Requesting an Initial Survey

Time Line	JCI Activity	Hospital's Activity
6 months before preferred month of survey		Review the Joint Commission International Accreditation Standards for Hospitals, Fifth Edition, to understand the requirements and expectations related to JCI accreditation.
		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	JCI Accreditation reviews the	
application for	application. Once approved, JCI provides the hospital with broader access to	
survey	resources on <i>JCI Direct Connect</i> , JCI's	
	client portal, including a complimentary copy of this hospital survey process guide.	

Hospitals Requesting Reaccreditation

Time Line	JCI Activity	Hospital's Activity
Ongoing		The hospital updates it profile on E-App as changes to the hospital's facility, services, or other changes make necessary
6 to 9 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.	
Complete application at least 4 to 6 months before the accreditation expires		The hospital submits its application for survey via E-App.

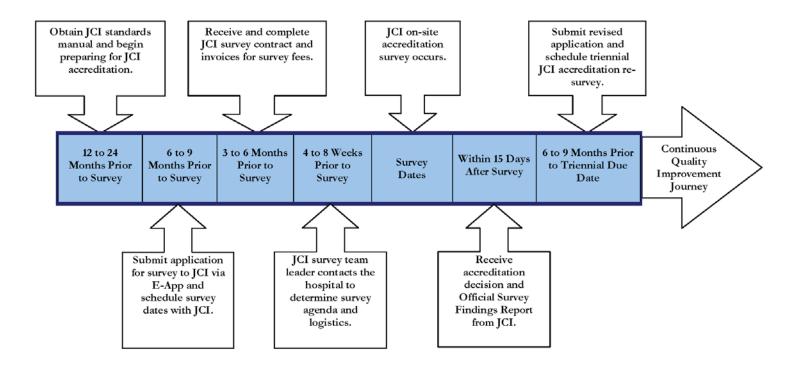
All Hospitals Requesting Accreditation

Time Line	JCI Activity	Hospital's Activity
4 to 5 months before survey	A contract agreement is e-mailed to the hospital. An invoice for down payment of at least 50% of the survey fees is e-mailed by JCI's Finance Department when the signed contract is e-mailed to the hospital. Hospitals can elect to pay 100% or a smaller percentage of the survey fees due based on its preference.	The hospital e-mails or faxes the signed contract to JCI no later than 90 days prior to the preferred survey date, and 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.
8 weeks before survey	JCI verifies the survey date(s) and name(s) of surveyor(s) are e-mailed to the hospital.	Any changes that have occurred since submission of the application must be reported/submitted to JCI.
4 to 8 weeks before survey	The JCI survey team leader contacts the hospital's contact person to finalize the survey agenda and to request presurvey information.	Appropriate hospital staff members discuss the proposed survey agenda and determine whether times are feasible for the hospital, given patient needs and availability of staff. Hospitals also, when necessary, request permission for approved survey observers.
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.
Within 15 days after survey	JCI reviews, approves, and sends the Official Survey Findings Report. A focused 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 chief executive officer of the surveyed hospital a JCI Accreditation Satisfaction Survey via e-mail to assist JCI in its performance improvement activities.	After the JCI Accreditation Central Office sends the Official 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 focused 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.

Time Line	JCI Activity	Hospital's Activity
Within 3 days after the certificate is mailed	The hospital's name, location, and date of accreditation is added or updated for public viewing on the JCI website (http://www.jointcommissioninternation al.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 three years. The manual becomes effective for all accredited hospitals and all surveys approximately 6 months after publication.	Staff review the new hospital standards and other requirements and act on any new and modified standards, scoring guidelines, policies, and procedures. If JCI needs to visit the hospital, the current, effective standards are used.
Within 15 days of any significant organizational changes		The hospital notifies JCI via E-App of any significant change in the hospital's profile.
6 to 9 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.	

To help hospitals prepare for accreditation, JCI offers resources on its website (http://www.jointcommissioninternational.org).

Accreditation Process Time Line



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 4 months of compliance with the standards. Hospitals being re-surveyed need to demonstrate 12 months of compliance with the standards. 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 steps:

- Orientation to the Hospital's Services and the Quality Improvement Plan (see page 45)
- Surveyor Planning Session (see page 47)
- Document Review (see page 50)
- Daily Briefing (see page 54)
- Leadership for Quality and Patient Safety Interview (see page 56)
- Department/Service Quality Measurement Tracer (see page 58)
- Quality Program Interview (see page 60)
- Ethical Framework and Culture of Safety Interview (see page 63)
- Supply Chain Management and Evidence-Based Purchasing Interview (see page 65)
- Individual Patient Tracer Activity (see page 67)
- Organ and Tissue Transplant Services Interview and Tracer (see page 70)
- Facility Tour (see page 72)
- System Tracer: Facility Management and Safety System (see page 76)
- System Tracer: Medication Management (see page 79)
- System Tracer: Infection Control (see page 82)
- Undetermined Survey Activities (see page 85)
- Optional Education Session: Hospital Decision Rules, Scoring Guidelines, and Strategic Improvement Plan (see page 86)
- Staff and Medical Professional Education Qualifications Session (see page 87)
- Closed Patient Medical Record Review (see page 97)
- Leadership Exit Conference (see page 117)
- Additional Sessions for Academic Medical Center Hospitals:
 - o Medical Professional Education Leadership Interview (see page 119)
 - o Medical Student and Trainee Interview (see page 121)
 - o Human Subjects Research Leadership Interview (see page 123)
 - o Human Subjects Research Process Interview (see page 125)

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	nple Hospital Survey Agenda (5 days, 3 surveyors)					
Day 1						
Time	Physician	Nurse	Administrator			
0745– 0800	Team Meeting with Survey Co	ordinator and Translators (discussion of logistica	al support issues and requirements)			
0800- 0830	Opening Conference and Ager	Opening Conference and Agenda Review (see page 42)				
0830- 0915	Orientation to the Hospital's Services and the Quality Improvement Program (see page 45)					
0915– 1200	Document Review (see page 50) (one room with separate working area for each team member)					
1200- 1300	Surveyor Working Lunch (team debriefing and survey planning)					
1300- 1400	Leadership for Quality and Par	ient Safety Interview (see page 56)				
1400- 1600	Tracer Activity	Tracer Activity	Facility Tour (see page 72)			
1600	Meeting with Survey Coordina	tor (as needed, identify needs for the following of	day)			

	mple Hospital Survey Agenda (5 days, 3 surveyors)				
Day 2					
Time	Physician	Nurse		Administrator	
0800 - 0900	Daily Briefing (see page 54)			,	
0900 - 1000	Department/Service Quality Measurement Tracer (see page 58)	Tracer A	ctivity	Facility Management and Safety Document Review (see page 76) and Facility Tour (see	
1000- 1200	Tracer Activity			page 72)	
1200- 1300	Surveyor Working Lunch (team debriefing ar	nd survey p	olanning)		
1300– 1600	Medication Management System Tracer (see page 79) (includes outpatient tracer and review of medication error data and supply chain integrity)	1300– 1400	Quality Program Interview (see page 60)—Failure Modes and Effects Analysis (FMEA), Root Cause Analysis (RCA)	Facility Tour (see page 72)	
		1400- 1600	Tracer Activity		
1600	Meeting with Survey Coordinator (as needed	, identify n	eeds for the following day)	,	

Day 3						
Time	ne Physician Nurse Administrator					
0800 - 0900	Daily Briefing (see page 54)					
0900– 1200	Tracer Activity	Infection Prevention and Control System Tracer (see page 82)	0900- 1100	Facility Management and Safety (FMS) Document Review (see page 72)		
			1100- 1200	Department/Service Quality Measurement Tracer (see page 58)		
1200– 1300	Surveyor Working Lunch (team debriefing a	nd survey planning)				
1300- 1430	Staff and Medical Professional Education Qualifications (physicians) (see page 87)	Department/Service Quality Measurement Tracer (see page 58)	Facility T	our (see page 72)		
1430- 1600	Tracer Activity	Staff and Medical Professional Education Qualifications (nursing) (see page 87)	Tracer/U page 85)	Indetermined Survey Activity (see		
1600	Meeting with Survey Coordinator (as needed	l, identify needs for the following day)				

Day 4						
Time	Physician	Nurse		Administrator		
0800- 0900	Daily Briefing (see page 54)					
0900– 1200	Closed Patient Medical Record Review (see page 97) (combined activity with two surveyors, one room with separate work spaces)		0900 - 1030	Staff Medical Education Qualifications (other health professionals) (see page 87)		
			1030- 1200	Tracer Activity		
1200 – 1300	Surveyor Working Lunch (team debriefing and survey planning)					
1300– 1400	Ethical Framework and Culture of Safety Interview (see page 63)		1300 – 1430	Supply-Chain Management and Evidence-Based Purchasing Interview and Tracer (see page 65)		
1400 - 1600	Tracer/Undetermined Survey Activity (see page 85)	Tracer/Undetermined Survey Activity (see page 85)	1430 – 1600	Tracer/Undetermined Survey Activity (see page 85)		
1600	Meet with Survey Coordinator (as needed, identify needs for the following day)					

Sample Hospital Survey Agenda (5 days, 3 surveyors) Day 5						
Time	Physician Nurse		Administrator			
0800 – 0900	Daily Briefing (see page 54)	ing (see page 54)				
0900 – 1200	(Team Leader) Survey Report Preparation (see page 116) (as needed)	Undetermined Survey Activity (see page 85)	Undetermined Survey Activity (see page 85)			
1200 – 1300	Surveyor Working Lunch. Exit Report Preparation (will require individual Internet access and shared printer access)					
1300 - 1500	Survey Integration					
1500 – 1600	Leadership Exit Conference (see page 117)					

Day 1					
Time	Physician	Nurse	Administrator	Clinician	
0745– 0800	Meet with Survey Coordinator and	Translators			
0800- 0830	Opening Conference and Agenda Review (see page 42)				
0830- 0915	Orientation to the Hospital's Services and the Quality Improvement Program (see page 45)				
0915– 1200	Document Review (see page 50) (one room with separate working area for each team member)				
1200– 1300	Surveyor Working Lunch (team de	briefing and survey planning			
1300– 1430	Medical Professional Education Leadership Interview (see page 119)	Tracer Activity	Facility Tour (see page 72)	Tracer Activity	
1430– 1600	Leadership for Quality and Patient	: Safety Interview (see page 50	5)		
1600		(as needed, identify needs for	1 (1)		

Day 2							
Time	Physician	Nurse		Admini	strator	Clinicia	an
0800 <u>–</u> 0900	Daily Briefing (see page 54)						
)900 – 1000	Medical Student/Trainee Interview (see page 121)	0900-	Tracer Activity	0900-	Facility Tour (see page	0900-	Tracer Activity
1000– 1200	Tracer Activity	1200	1200 Hatel Methy		1200 72)		Tracer Activity
200 – 300	Surveyor Working Lunch (team deb	riefing and	survey planning)				
300– 600	Medication Management System Tracer (see page 38) (includes Medication Data Review, Protocol Medications, and medication	Infection Prevention and Control System Tracer (see page 82) (includes all related data)		Facility Management and Safety (FMS) Document Review (see page 72)		1300- 1500	Human Subjects Research Process Interview (see page 125) (includes evaluation of contracted research)
	supply chain management)					1500- 1600	Human Subjects Research Tracer

Physician Daily Briefing (see page 54) Tracer Activity	Nurse		Admini	strator	Clinicia	ın
Tracer Activity						
			0900 – 1200	FMS Document Review (see page 76)	0900 - 1030	Tracer Activity
Tracer/Undetermined Survey Activity (see page 85)	0900 – 1200	Tracer Activity			1030- 1200	Tracer Activity/ Undetermined Survey Activity (see page 85)
Surveyor Working Lunch (team debriefing and survey planning)						
Medical Record Review (see page 97) (separate room for each team member)		1300- 1600	System Tracer: Facility Management and Safety System Tracer	1300- 1500	Closed Patient Medical Record Review (see page 97) (separate room for each team member)	
Department/Service Quality Measurement Tracer (see page 58)				(see page 76)	1500- 1600	Department/Service Quality Measurement Tracer (see page 58)
	(see page 85) Surveyor Working Lunch (team debriefing Medical Record Review (see page 97) (see member) Department/Service Quality Measurement Tracer (see page 58)	Surveyor Working Lunch (team debriefing and surv Medical Record Review (see page 97) (separate room member) Department/Service Quality Measurement Tracer (see page 58) Tracer Ac Survey Ac	(see page 85) Surveyor Working Lunch (team debriefing and survey planning) Medical Record Review (see page 97) (separate room for each team member) Department/Service Quality Measurement Tracer (see page 58) Tracer Activity/Undetermined Survey Activity (see page 85)	(see page 85) Surveyor Working Lunch (team debriefing and survey planning) Medical Record Review (see page 97) (separate room for each team member) 1300– 1600 Department/Service Quality Tracer Activity/Undetermined	Surveyor Working Lunch (team debriefing and survey planning) Medical Record Review (see page 97) (separate room for each team member) System Tracer: Facility Management and Safety System Tracer (see page 76) Department/Service Quality Measurement Tracer (see page 58) Tracer Activity/Undetermined Survey Activity (see page 85)	Surveyor Working Lunch (team debriefing and survey planning) Medical Record Review (see page 97) (separate room for each team member) System Tracer: Facility Management and Safety System Tracer (see page 76) Department/Service Quality Tracer Activity/Undetermined Survey Activity (see page 85) Tracer Activity (see page 85)

Day 4						
Time	Physician	Nurse	Administrator	Clinician		
0800 - 0900	Daily Briefing (see page 54)					
0900 – 1100	Tracer Activity	Staff and Medical Professional Education Qualifications (nursing) (see page 87)	Staff and Medical Professional Education Qualifications (other professionals) (see page 87)	Tracer Activity		
1100– 1200	Quality Program Interview (see page 60)—Failure Modes and Effects Analysis (FMEA), Root Cause Analysis (RCA), Sentinel Events	Department/Service Quality Measurement Tracer (see page 58)	Department/Service Quality Measurement Tracer (see page 58)	Quality Program Interview (see page 60)—Failure Modes and Effects Analysis (FMEA), Root Cause Analysis (RCA), Sentinel Events		
1200 – 1300	Surveyor Working Lunch (team debriefing and survey planning)					
1300– 1500	Staff and Medical Professional Education Qualifications Session (see page 87)	Tracer Activity/Undetermined Survey Activity (see page 85)	Supply Chain Management and Evidence-Based Purchasing Interview and Tracer (see page 65)	Human Subjects Research Leadership Interview (see page 123)		
1500- 1600	Ethical Framework and Culture of Safety Interview (see page 63)		Tracer/Undetermined Survey Activity (see page 85)	Ethical Framework and Culture of Safety Interview (see page 63		

Day 5						
Time	Physician	Nurse	Administrator	Clinician		
0800 - 0900	Daily Briefing (see page 54)					
0900 – 1200	(Team Leader) Surveyor Report Preparation (as needed) (see page 116)	Tracer/Undetermined Survey Activity (see page 85)	Tracer/Undetermined Survey Activity (see page 85)	Tracer/Undetermined Survey Activity (see page 85)		
1200– 1300	Surveyor Working Lunch. Exit Report Preparation (will require individual Internet access and shared printer access)					
1300- 1500	Survey Integration					
1500 – 1600	Leadership Exit Conference (see page 117)					

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, as appropriate. The surveyor(s) may request assistance from hospital staff for selection of appropriate tracer patients. 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. This staff could include nurses, physicians, residents/trainees, therapists, case managers, aides, pharmacy staff, lab personnel (as appropriate), 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 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 hospital. 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*, Fifth 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 that hospital
- Patients related to system tracers, such as infection prevention or 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 appropriate to the provision of care being reviewed, the tracer will include the following elements:

- Review of the patient 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*, Fifth 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*, Fifth Edition) and review of qualified personnel 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, as appropriate, will attempt to verify issues identified during the tracer.
- Address emergency management and explore patient flow issues in the emergency department. Patient flow issues may also be explored in ancillary care areas and other patient care 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 Records

The surveyor(s) may select and review two to three additional open or closed 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 records. The following criteria can be used to guide the selection of additional 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 Facility Tour (see page 72) and the Leadership for Quality and Patient Safety Interview (see page 56). 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 tracers in that during individual 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

An individual-based system tracer includes unit/department visits to evaluate the implementation of the system process and to review the impact on patient care services and treatments. The tracer also includes an interactive session that involves a surveyor(s) and relevant staff members and that will utilize information from unit/department visits and individual tracers. Points of discussion in the interactive session 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 international standards and IPSG compliance
- Education by the surveyor(s), as appropriate

Medication Management System Tracer

The medication management individual-based system tracer explores a hospital's medication management process while focusing on subprocesses and potential risk points (such as handoff 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 (see page 82) explores a hospital's infection prevention and control processes. The goals of this session are to assess a hospital's compliance with the relevant Prevention and Control of Infections (PCI) and Facility Management and Safety (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 (see page 76) is the process the hospital uses to evaluate the hospital's facility management and safety (FMS) system and performance in managing risk. The surveyor(s) will evaluate the strengths in the hospital's FMS 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.

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 may commence the tracer in the pre-admission area observing the handoff process and review of documentation for patient identification and complete documentation, including consents and surgical-site marking. In the operating theatre, the surveyor will observe the process the hospital 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 Prevention and Control of Infection (PCI) and Facility Management and Safety (FMS) standards, as implemented in the operating theatres, and a review of staffing qualifications and experience of the operating theatre staff. The surveyor may follow the surgical patient to the postanesthesia care unit to observe the care processes, including handoff 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 appropriate disinfection, cleaning, and sterilization of supplies and equipment. The surveyor 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, documentation of test results, and tracking process for sterile supplies. The surveyor 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 Infection (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 will review the patient's documentation for the procedure, including patient identification and appropriate consents and preprocedure assessments. The surveyor 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 Prevention and Control of Infection (PCI) and Facility Management and Safety (FMS) standards. The surveyor will also evaluate the unit's process for the cleaning and high-level disinfection and storage of the endoscopes. The surveyor 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.

The Accreditation Decision

The final accreditation decision is based on the hospital's compliance with JCI standards. Hospitals do not receive a numeric score as part of the final accreditation decision. When a hospital successfully meets JCI accreditation requirements, it will receive an award of Accredited. This decision indicates that a hospital 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, 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 a free publicity kit to accredited hospitals that includes the following:

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

Information about a hospital's accreditation status will be posted on the JCI website (http://www.jointcommissioninternational.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 the JCI Accreditation Program office, 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 compliants. 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 can focus less on "ramping up" for survey every three years and, instead, can (and should) focus on continually improving their systems and operations, thereby eliminating the need for intense survey preparation. 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 will 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 onsite 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 the hospital

Hospital Participants

- Chief executive officer and the hospital leadership team
- Individual responsible for coordinating the hospital's survey agenda, such as a survey coordinator
- Medical school dean
- Director of research
- Others, including medical students and trainees, at the discretion of the hospital

Surveyor(s)

All surveyors

Standards/Issues Addressed

Introduction of the surveyors and key hospital leaders and coordination of the survey

Documents/Materials Needed

Final survey agenda

What Will Occur

- Surveyor(s) and any preceptees will be introduced.
- Hospital leadership will be introduced.
- Agenda will be reviewed and modified.
- Surveyor(s) will answer questions about the survey agenda.
- Surveyor(s) will explain the use of tracer methodology during the survey process activities, and that it
 is important for them to be able to ask questions to the hospital's front line staff who are directly
 taking care of patients. It is acceptable for a small group (4-5 persons) to accompany each surveyor,
 but questions should not be answered by these staff members unless specifically requested. Surveyors
 will also not interrupt patient care in any way.
- Surveyors will try as best as possible to put staff at ease with their questions. In addition, all patientspecific information will remain confidential
- Surveyors will explain the JCI firewall.
- Surveyor(s) will advise leaders that the only presentation allowed during the survey is scheduled on the
 survey agenda for the session entitled "Orientation to the Hospital's Services and the Quality
 Improvement Program (see page 45)." This session should last less than 30 minutes and is intended to
 give the surveyors an introduction to the hospital and to update the data presented on the hospital's
 application. Topics covered include the following:
 - o History of the hospital (1 or 2 slides)

- o Mission and vision of the hospital
- o Organizational structure (chart)
- o Number of buildings, area (square meters)
- o Total number of beds and type of units (ICU, CCU, general wards, and so forth)
- Number of employees, contracted staff, staff physicians, visiting physicians, residents, medical students, and trainees
- o Top-five procedures and diagnosis
- o Average length of stay in inpatients services
- Number of visits of the outpatient clinics
- o Number and type of surgeries performed in the operating theatre
- o Number of visits in the ER
- O Areas where anesthesia and sedation is administered outside the OR
- o Type of contracted services
- o Clinical guidelines, pathways, or protocols implemented.
- O Strategic plan (services or areas the hospital is planning to increase or open during the next three years)
- o The Quality Committee structure and its relationship with other committees (1 or 2 slides)
- 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.
- 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.

Surveyors will explain the staff involvement in the various quality activities, such as the Department/Service Quality Measurement Tracer (see page 58), Quality Program Interview (see page 60), and other quality sessions.

- Surveyor(s) will explain the purpose of and the leaders' involvement in the Daily Briefing (see page 54) 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 a computer 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 and the Quality Improvement Program

Purpose

The hospital orients the surveyor(s) to the services, programs, and strategic activities the hospital provides and its quality improvement process. This information provides the surveyor(s) with baseline information about the hospital and its quality and patient safety program that can help focus subsequent survey activities.

Location

Same location as Opening Conference and Agenda Review (see page 42)

Hospital Participants

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

Surveyor(s)

All surveyors

Standards/Issues Addressed

- Overview of the hospital's services
- Overview of the quality improvement and patient safety program and process
- 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
- Quality improvement example
- 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 hospital will include a brief presentation about the structure and methods of the quality improvement and patient safety program.
- The presentation should show how quality and safety information flows through the hospital/committee structure.
- The presentation should describe the following:
 - o How quality and safety measures were chosen
 - o How the measures were prioritized for data collection
 - o How data are collected, aggregated, and analyzed
 - o How findings from data analysis are communicated and used for planning improvements

- The hospital may choose to present a quality improvement example to demonstrate the hospital's methodology and sustained improvement.
- The surveyor(s) will ask questions, as needed, to clarify information or to request additional information for use later.

Surveyor Planning Session

Purpose

During this session, the surveyor(s) reviews data and information about the hospital and plans the survey agenda. The surveyor(s) also selects initial tracer patients/residents/clients.

Location

The hospital should provide space for this activity, usually the room designated as the "surveyor headquarters." This space should have the following items:

- Conference table
- Power outlets
- Telephone
- High-speed Internet connection/access for each surveyor
- Printer
- Document shredder

Hospital Participants

- Hospital survey coordinator (as needed by team)
- Translators (as needed by team)

Surveyor(s)

All surveyors

What Will Occur, Documents/Materials Needed

This time is set aside for the surveyor(s) to review and discuss pertinent data and plan the survey agenda. The surveyor(s) reviews the following list of references and resources (as applicable to the setting), and these materials should remain available to the surveyor(s) for the entire duration of the survey:

- Performance improvement data, including
 - o a list of system-wide quality improvements;
 - o a list of individual department/service quality measures; and
 - o committee-meeting minutes for 12 months prior to the survey
- Infection prevention and control surveillance data, including committee meeting minutes for 12 months prior to the survey
- Facility management and safety plan annual reviews. The surveyor(s) will review these documents to prepare for the Facility Tour (see page 72) session.
- Facility management and safety multidisciplinary team meeting minutes for the 12 months prior to the survey. The surveyor(s) will review these documents to prepare for the Facility Tour (see page 72) session.
- A list of departments/units/areas/programs/services within the hospital (if applicable)
- An organizational chart and map
- A daily list of inpatients, including their names, diagnoses, ages, admission dates, physicians, and units/services
- A daily list of the operative and other invasive procedures scheduled for the day, including surgeries in the operating theatre(s), day surgeries, cardiac catheterizations, endoscopies/colonoscopies, and in vitro fertilizations
- A list of the scheduled home visits for the duration of the survey, including type of service, disciplines, dates of admission, and locations. The list should include branch locations (if applicable).

- The name of key contact person (such as a supervisor or scheduler) who can assist the surveyor(s) in planning tracer selection
- A list of contact telephone numbers in case the surveyor(s) needs to reach key staff
- 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, such as dentists, psychologists, and others) privileged by the medical staff, with the name, clinical department or specialty and date of appointment or reappointment to the medical staff
- A list of measures from the Joint Commission International Library of Measures (see page 129) selected
- A list of clinical guidelines, pathways, or protocols selected
- A sample of the forms used in the medical record
- Copies of the Strategic Improvement Plans (SIP) submitted to the JCI Central Office
- A list of approved/unapproved abbreviations (one list for each surveyor)
- A list of students/trainees assigned to the hospital and their associated academic program

For academic medical center hospitals:

- A list of all medical student, trainee, and fellowship training programs by specialty, with numbers of individuals in each program
- A list of current medical students, trainees, and fellows by specialty, and year of training
- A list of supervising/attending faculty by specialty and medical staff appointment category
- A grid/matrix of medical record authorization of student, intern, and resident trainee entries for each level of training, with required record review by supervising attending faculty ("responsible" physician) and countersignature with date and time (in English)
- A list of research protocols divided into a) protocols approved and opened to subject participation within 12 months prior to survey and b) all other open protocols at time of survey
- The name of a key contact person (such as a supervisor or scheduler) who can assist the surveyor(s) in planning tracer selection

Selection of Individual Tracers

- Surveyor(s) reviews the information from the survey application and the list of patients currently receiving care in the hospital to guide his or her selection of patients to trace.
- Surveyor(s) identifies a clinical/service group and some general information about the patient population receiving care and services.
- Surveyor(s) describes to the hospital the type of patient that he or she is seeking to trace and requests staff's assistance in identifying an individual.
- In surveys longer than one day, the surveyor(s) informs the hospital during the Daily Briefing (see page 54) about the types of tracers he or she wants to perform that day to facilitate activity planning. This does not mean that the surveyor(s) will identify a specific patient from the list supplied by the hospital. For example, the surveyor(s) may choose to trace the following types of patients:
 - o A hospital orthopedic surgery patient who is receiving physical therapy
 - o A home care patient who is receiving surgical wound care
 - o An ambulatory patient who visited the internal medicine clinic and had laboratory services
 - o A patient with limited mobility, who smokes, who uses oxygen, or who has cognitive impairment
 - o An intensive care patient who is receiving blood gas testing
 - o A patient with developmental disabilities
 - o A patient who is receiving sedation and/or anesthesia
 - o A patient on a research protocol (academic medical center hospitals only)
 - o A patient being cared for by medical students and trainees (for academic medical center hospitals only)

- Surveyor(s) will trace patients in all intensive care units and sedation/anesthesia areas of the hospital, as well as all sites/buildings in which patient care is delivered.
- In team surveys, tracer selection should be coordinated when possible to avoid overlap of visits to various units.
- In hospitals with multiple sites, individual tracers will include patients who move between locations and services addressed by the represented accreditation programs.

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 preparedness plan 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

Hospital Participants

Participants should include hospital staff members who are familiar with the documents that will be reviewed, can translate these, and are able 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 plans, policies, and procedures that are to be written. The following section and the "Survey Planning Tools" section (see page 127) 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 their review or reference during the survey process are listed in the "Survey Planning Tools" section. The list of documents includes the following:

- A list of hospitalwide priority improvement measures
- A list of department/service quality measures
- Required Joint Commission International Library of Measures (see page 129)
- All measurement information is to include data from the past 4 months (initial surveys) and/or 12 months for triennial surveys
- A list of clinical practice guidelines
- 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, Leadership/Management Team Meetings, and Medication Systems
- An accurate list of the patients currently receiving care in the hospital
- A list of the operative and other invasive procedures scheduled for the day, including surgeries in the
 operating theatre(s), day surgeries, cardiac catheterizations, endoscopies/colonoscopies, and in vitro
 fertilizations
- A sample action plan for a root cause analysis for a sentinel event or a near miss
- A sample failure mode and effects analysis (FMEA) action plan
- An example of a measure from the Library of Measures on which a validation was performed
- A current map of the hospital campus

- A sample of all medical record forms
- A list of the five clinical practice guidelines and any associated tools, such as clinical pathways and/or clinical protocols the hospital selected to guide clinical care

In addition, the hospital should complete the Laws and Regulations Worksheet (see page 145) 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 surveyors in English. See Required Written Policies (Including Those Required in English) on page 131 for a complete listing.

What Will Occur

- The documents should be made available to the survey team in the meeting room that has been designated for their 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 can be removed. The surveyor(s) may schedule a second Document Review session during the course of the survey. A second review is generally scheduled for hospitals that have a survey of longer than three days but may be scheduled on surveys of a shorter duration based on need. 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 according to the following three lists provided in this guide:

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

Note: When possible, please indicate the standards that the document addresses. The documents may be grouped in binders or folders, or other means may be used to separate major topical areas.

Gather the documents in one place. Identify the location in the document where the specific information that is required by the standard 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.

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 they expect to see in actual practice during the survey process. **For example**, they would expect to find the following when a new procedure on the disposal of infectious waste is developed:

- That appropriate staff have been educated about the new procedure
- That any special skills 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 MOI chapter in the standards manual will be used to evaluate the hospitals 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, as appropriate, 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.

As there is now one standard that addresses development and implementation of policies for all standards requiring a policy, the survey team will look for the existence and implementation of all policies as a whole. The absence of one policy or the lack of full implementation of one policy will likely not be scored. However, if the surveyor(s) identify multiple missing policies or have evidence that several of the policies have not been fully implemented, this can be an indication of a system-wide problem related to policy management. Scoring of standard MOI.9.1 will be based on the percentage of policies that are missing and/or not fully implemented.

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 4-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. When the track record period has not been met, but the survey team finds that the policy has been implemented in a sustainable manner, the team has the prerogative to score the standard as "fully 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 the hospital

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 intended to be brief; 60 minutes is suggested depending on the number of surveyors on the team. 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 (see page 85) time
- Conclude the briefing and transition to the next activity(s) 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 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 take place 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 and Patient Safety Interview

Purpose

The purpose of this session is to identify how hospital leadership selects the approach to be used to measure, assess, and improve quality and patient safety and the process for identifying hospitalwide strategic priority improvements.

Location

At the discretion of hospital leaders

Hospital Participants

- Chief executive officer
- Chief operating officer, when applicable
- Chair, governing body, or similar representative
- Elected or appointed leader of the medical staff
- Medical director, when applicable
- Nurse executive
- 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)

All surveyors

Standards/Issues Addressed

- GLD.1
- GLD.1.1
- GLD.4
- GLD.4.1
- GLD.5
- GLD.6
- GLD.6.1 and GLD .6.2
- GLD.11
- GLD.11.1
- MPE.1 (academic medical center hospitals only)
- MPE.6 (academic medical center hospitals only)
- HRP.1 (academic medical center hospitals only)

Documents/Materials Needed

- Documents identifying 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 meeting relating to quality reports
- Information about the impact of hospitalwide improvements on efficiency and resource use

What Will Occur

This session is organized to better understand how hospital leadership establishes and supports an organizational commitment to the quality and safety program and ensures that the program has adequate resources to be effective. Hospital leadership also implements a structure and process for the overall monitoring and coordination of the program throughout the hospital. It is important to understand how coordination occurs among all the departments and services in measurement and improvement efforts.

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

The surveyor(s) will assess compliance with certain standards from the "Governance, Leadership, and Direction" (GLD) chapter, particularly those related to development and ongoing support of the quality improvement and patient safety program. Other related chapters may also be addressed. During the leadership for quality improvement and patient safety interview, 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 the Leadership for Quality Improvement and Patient Safety Interview. Although hospital 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 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?

 O. GLD.1.1 ME 4: What are your strategies and programs for health care professional education
 - o GLD.1.1, ME 4: What are your strategies and programs for health care professional 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 lead to improvements in a safety issue. How is information about the quality improvement and patient safety program communicated to staff?
- GLD.5: What are the hospitalwide collective priorities for system improvements? Give us an example of how you assessed the impact of these improvements on efficiency and/or resource use.
- GLD.6: What is your process for identifying, in writing, the services provided by each department? 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 system-wide priorities chosen? Which Library measures were chosen related to the system-wide priorities?
- GLD.11.1: What involvement does leadership have in the leaders' selection of department/service measures? How are results of department/service quality improvements communicated to leadership?

Academic medical center hospitals only

- MPE.1: Which 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?

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 surveyors will evaluate how clinical guidelines are selected and implemented for use in areas providing clinical care.

Location

Selected patient care settings, inpatient and ambulatory units, treatment areas, and other areas, including, but not limited to, admitting, pharmacy, radiology and diagnostic imaging department, clinical laboratory, and others. 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 particular department or service and their participation in the hospitalwide strategic priorities.

Hospital Participants

- Department or service leader of 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 personnel, and support staff.

Surveyor(s)

Nurse, physician, or administrator surveyor(s)

Standards Addressed

- GLD.5
- GLD.11 and 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

The surveyor 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 hospitalwide strategic improvements as well as what department specific measures are being collected. The surveyor 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 the standards, the hospital's leaders should review the QPS chapter and read closely 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:

- GLD.5: How do the department's measures align with hospitalwide priorities chosen by the leaders? What was the impact of department improvements on efficiency and resource use at the department level?
- GLD.11, ME 1: What measures do you collect that are specific to your department/service area?
- GLD.11, ME 3: How did you pick your measures?
- GLD.11, ME 2: Do any measures from the Library relate to your department/service? If yes, have you selected any measures from the Library?
- GLD.11.1: Are there any measures you currently collect that are applicable to physician and/or professional staff evaluations?
- 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.11.2, ME 1: Which clinical 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 was staff trained?
- GLD.11.2, ME 4: How are the guidelines evaluated? Do you have data to show that use of the guidelines improved resource utilization or patient outcomes?

Quality Program Interview

Purpose

The purpose of this session is to identify how the quality program staff support the overall program for quality and patient safety through the use of tools for data collection, data analysis, and response to hospitalwide sentinel events, adverse events, and near-misses.

Location

At the discretion of hospital leadership

Hospital Participants

- Chief executive and/or chief operating office
- Individual 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, nurse, or administrative surveyor

Standards/Issues Addressed

- QPS standards
- The quality staff will be asked about the process for identifying and managing sentinel events, adverse events, and near-miss events (QPS.7 through QPS.9).

Documents/Materials Needed

- Example of data validation
- Root cause analysis from a sentinel event and resulting action plan
- Sample tools, such as data collection tool, FMEA sample, and RCA sample, among others

What Will Occur

The continuous improvement in quality and patient safety requires 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?
- QPS.1: What type of experience and training does the quality support staff receive?
- QPS.2: How does the quality staff support the department/service leaders in their quality improvement efforts?

- QPS.2, ME 4: How do the quality staff help in the coordination of individual department/service measures?
- QPS.4: Who does the actual data collection?
- QPS.5: Please provide an example of how a hospitalwide priority improvement impacted cost and/or efficiency
- QPS.6: How do you determine which data need to validated? How are data validated and who performs the data validation?
- QPS.7: Who is responsible for conducting a root-cause analysis if/when a sentinel event occurs?
- QPS.8 and QPS.9: Who is responsible for the collection and analysis of near-miss and adverse events data?
- QPS.11: How was the proactive risk management process carried out? Which tools were used? Who was involved? What were identified as some examples of potential risks?

Quality Improvement Monitoring Plan

Purpose

The "QPS [Quality Improvement and Patient Safety] Clinical/Managerial Measures Tool" (see page 62) 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
- Methodology for data collection (retrospective or concurrent)
- Type of measure (structure, process, outcome, or process and outcome)
- Reporting time period and frequency of assessment of data
- 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 JCI Library of Measures (see page 129) is reviewed to identify valid and reliable measures to use as part of the requirement in APR.7. One form is used for each measure selected. As required in QPS.2, quality and patient safety program staff support the measurement activities, including helping leadership and department/service leaders understand the principles of quality monitoring and the use of measurement tools needed to collect, aggregate, analyze, and report data effectively. 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.

QPS Clinical/Managerial Measures Tool

What (measure category—for example, strategic priority improvement or individual department/service):	Who (owner—	staff name/title):	When (completion date):				
Performance measure name:	Rationale for n	neasure selection:	Type of measure (indicator; check one):				
Numerator:			☐ Structure				
Denominator:			☐ Process				
Performance measure name:			☐ Outcome				
			☐ Process and outcome				
Numerator:							
Denominator:							
Original source of measure:							
Anticipated reporting time period:		Frequency of assessment of data: (check one)					
		☐ Daily ☐ Weekly ☐ Mont	hly 🗖 Other				
Data collection methodology:		Target sample and sample size ((n):				
Check one: Retrospective Concurrent		Areas of monitoring:					
Measure target and/or threshold:							
Please explain the data aggregation and analysis plan:							
Please indicate how the data results will be disseminated to staff:							
Audit tool name or file name (attach the audit form	tool):						

Ethical Framework and Culture of Safety Interview

Purpose

The purpose of this session is to assess the hospital's development and implementation of an ethical framework and how hospital leadership, through its vision and support, shapes the culture of safety in the hospital.

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
- Human resources leader(s)
- Medical director, when applicable
- Social Service and/or clergy
- Nurse executive
- A representative of the quality department
- Other senior leaders, at the discretion of the hospital

Surveyor(s)

A minimum of two surveyors

Standards/Issues Addressed

- GLD.12 through GLD.12.2 (ethics)
- GLD.13 and GLD.13.1 (culture of safety)

Documents/Materials Needed

- If developed by the hospital, any documentation of 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

What Will Occur

The surveyor(s) will discuss how the hospital identifies and manages ethical issues. The surveyor(s) will ask about how ethical issues are reported and the process to resolve the issues once 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. The surveyor(s) will also ask 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.

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.12: Please describe the ethical framework used in the hospital and discuss how this framework was developed
- GLD.12, ME 4: What national and international norms were reviewed in developing/evaluating the framework?
- GLD.12.1: How do you ensure that patients are billed appropriately? Is any type of a billing audit conducted?
- GLD.12.2, ME 1: What is the process for staff to raise ethical concerns?
- GLD.12.2, ME 2: What type of training related to ethics has been provided to staff?
- GLD.12.2, ME 3: 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.13, ME 2: How was the code of conduct developed? Who provided input into what is included in the code of conduct? How was staff educated about the code of conduct?
- GLD.13, ME 4: How are culture of safety issues identified and managed?
- 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?
- GLD.13.1, ME 4: How have you evaluated the culture of safety within the hospital?

Supply Chain Management and Evidence-Based Purchasing Interview

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 their 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 director, when applicable
- Nurse executive
- Other senior leaders, at the discretion of the hospital

Surveyor(s)

- Administrator
- Physician (for medication supply chain)

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 from contaminated, fake, and diverted products.

In a tracer, the administrator surveyor and the physician surveyor evaluate 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 and use of technical resources?

- GLD.7, ME 3: How are decisions made about staffing resources such as adding staff or downsizing?
 Are staff involved in purchasing decisions? If yes, how? How are staff educated on purchases that they use?
- GLD.7, ME 4: What type of evaluation is done prior to a new purchase, such as the purchase of new medication pumps or cardiac monitors?
- GLD.7, ME 5: 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 critical supplies to prevent diversion or substitution?

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 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 personnel, and support staff.

Surveyor(s)

Nurse, physician, or administrator surveyor(s)

Standards/Issues Addressed

All standards chapters may be addressed during this visit.

Documents/Materials Needed

The clinical 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 hospital. 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 hospital.

The surveyor(s) will follow the patient's experience, looking at services provided by various individuals and departments within the hospital, as well as at "handoffs" between them. This type of review is designed to uncover systems issues, looking at both the individual components of a hospital 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 clinical record are currently located. This is where the surveyor(s) begins to trace the entire care, treatment, or service process from preadmission through postdischarge. The surveyor(s) has approximately two hours to conduct a tracer, although it may be shorter or longer depending on its complexity and other circumstances. Multiple patient records may be reviewed during a single designated tracer activity.

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

- Review of the record with the staff person responsible for the patient's 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. 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 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, as appropriate, will attempt to verify issues identified during the tracer.
- When visiting the emergency department, the surveyor(s) will also address emergency management and explore patient flow issues. Patient flow issues may also 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 may visit the holding area.
- The surveyor(s) may pull and review two to three additional 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 records. The following criteria can be used to guide the selection of additional records depending on the situation:
 - O Similar or same diagnosis or tests
 - o Patient close to discharge
 - o Same diagnosis but different physician/practitioner
 - Same test but different location
 - o Same age or sex
 - Length of stay
 - o Interview with staff
- Review of minutes and procedures as needed

In academic medical center hospitals where patient tracers will include patients receiving care by a team that includes medical students/trainees, the surveyor will want to include the student and/or trainee in their review of the patient's record and the care being provided. Discussion may include reviewing entries made by the student/trainee, the countersignatures required, as well as treatments and interventions that the student/trainee may perform independently and those that require supervision. Surveyors 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 surveyors 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 re-enrolled and sign another consent
- The process when an adverse event occurs

Surveyors will want to review the patient 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). Surveyors will avoid visiting an area at the same time and will minimize multiple visits to the same location.

Tracer Selection Criteria

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

- A patient on dialysis
- A psychiatric patient
- A pediatric and/or neonatal patient
- A maternity patient
- A patient receiving imaging services
- A patient receiving rehabilitation services
- Patients related to system tracers, such as infection prevention and control or medication management
- Patients who cross programs (for example, patients scheduled for a follow-up in ambulatory care or home care)
- Patients received from another hospital, long term care patients transferred from another organization, mental health care clients receiving ambulatory services, and patients receiving home care services
- Patients due for discharge that day or the next day

In academic medical center hospitals, additional patient tracers will include the following:

- Patients receiving care by a team that includes medical students or medical trainees.
- 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 Facility Tour (see page 72) and Leadership for Quality and Patient Safety Interview (see page 56). The surveyor(s) will use time scheduled as "Undetermined Survey Activity" (see page 85) 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 multidisciplinary team. In addition, general information about the number and types of organ and tissue donations performed, data and information about success rates, survival rates, adverse and/or sentinel events, and 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 records when possible
- Assess the interrelationships between and among the multidisciplinary team and the departments, programs, services, or units
- Assess the important functions and inter-relationships 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 (PFR.5.2 and COP.8.5)
- 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 Multidisciplinary Transplant Team
- Leadership Levels II and III CEO/COO, "Chief" of Nursing, Medical, and others as applicable
- Organ donor registries/procurement organization representative (when appropriate)

Surveyor(s)

Physician and/or nurse surveyor(s)

Standards Addressed

- COP.8 through COP.9.3
- PFR.5.2
- QPS.7
- QPS.8, MEs 1 and 7
- OPS.9
- 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 appropriate)

What Will Occur

During the interview session, the surveyor 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 hospitalwide organ and tissue transplant program. The surveyor 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 impacted 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?
- Which 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: Which 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? Which process is used to ensure recipient compatibility?
- COP.8.7, ME 1: Which organ-specific clinical practice guidelines are used?
- COP.9: How do living donors become known? How do you name a living donor advocate?
- 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.8, ME 1 and 7; and QPS.9: What have you learned from analysis of your adverse/nearmiss and/or sentinel events?

Facility Tour

Purpose

The purpose of the Facility Tour is to address issues related to the following:

- The physical facility
- Utility systems
- Fire safety
- Medical technology and other nonmedical equipment
- Patient, visitor, and staff safety and security
- Infection prevention and control
- Emergency preparedness
- Hazardous materials and waste
- Staff education

Location

Selected patient care settings, inpatient and ambulatory units, treatment areas, and other areas, including, but not limited to, admitting, kitchen, pharmacy, central storage, laundry, morgue, and power plant (if applicable). 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 hospital must be prepared to provide JCI surveyors with access to any area(s) upon request.

Hospital Participants

- Chief engineer
- Supervisory engineer(s) (electrical, HVAC, civil)
- Safety officer and/or facility manager
- Fire safety officer
- Directors of all hospital departments (for example, emergency management, pharmacy, dietary, among others) (when the surveyor[s] is present in their areas)
- Infection control practitioner (as appropriate to the area being toured)
- Nursing leadership (as appropriate to the area being toured)

Surveyor(s)

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

Standards/Issues Addressed

- Facility Management and Safety (FMS)
- Prevention and Control of Infections (PCI)
- Staff Qualifications and Education (SQE)
- Assessment of Patients (AOP); laboratory and radiology standards
- Management of Information (MOI)
- Medication Management and Use (MMU); storage of medication
- Access to Care and Continuity of Care (ACC); admission to hospital, transportation
- Patient and Family Rights (PFR); privacy, confidentiality, and security

Documents/Materials Needed

- Documents, such as plans, policies and procedures, and test and maintenance reports (as identified in [a] through [f] of the intent statement for FMS.2), that describe the programs for the following:
 - o Safety and security (FMS.4)

- o Hazardous materials (FMS.5)
- o Disaster preparedness (FMS.6)
- o Fire safety (FMS.7)
- o Medical technology (FMS.8)
- o Utility systems (FMS.9)
- A documented, current, accurate inspection of the hospital's physical facilities (described in the intent statement for FMS.4 through FMS.4.2)
- Documentation related to the clinical laboratory and radiology/diagnostic imaging departments
 - o Laboratory safety (AOP.5.3)
 - o Laboratory equipment (AOP.5.5)
 - o Radiology and diagnostic imaging safety (AOP.6.3)
 - o Radiology and diagnostic imaging equipment (AOP.6.5)

What Will Occur

Prior to the facility tour, the surveyor(s) will have reviewed the documented, current, accurate inspection of the hospital's its physical facilities (described in FMS.4 through FMS.4.2) and the safety program(s) described in FMS.2. They 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:

- Reduce and control hazards and risks
- Prevent accidents and injuries
- Maintain safe conditions
- Maintain secure conditions
- Implement emergency response plans

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 non-patient care areas visited by the surveyor(s) include the following:

- The boiler room
- The emergency power generator
- The loading/receiving dock
- Central storage areas or warehouse
- Central sterile supply department
- Laboratory
- The IT control room
- The laundry, if applicable
- Food service/kitchen
- Medical gas storage areas
- Oxygen storage rooms
- Hazardous materials storerooms
- Areas designated as hazardous, such as locker rooms, clean and soiled linen rooms, and oxygen storage rooms
- The bottoms of laundry and garbage chutes
- The morgue
- Heating and air-conditioning equipment rooms to evaluate storage practices and utility systems maintenance
- The roof
- Helipad

- Outside assembly areas
- Radiology services
- Patient wards
- Automobile parking garages
- Ongoing construction and renovation sites
- Biological waste collection sites outside the main hospital

How to Prepare

Prior to survey, hospital leaders and the facility manager(s) should carefully read the relevant standards.

- The facility manager(s) should tour the facility, conduct an inspection according to the standards, and attempt to address any deficiencies prior to survey.
- FMS.4 requires that the hospital 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 hospital is aware of relevant laws, regulations, and facility inspections and will share as much information as possible with the surveyor(s) (FMS.1) and provide necessary information to the relevant sections of the relevant sections of the Laws and Regulations Worksheet as completely as is possible.
- Representatives of the hospital should be prepared to show the surveyor(s) how their facility
 management plans are implemented. For example, they should demonstrate how hazardous materials
 are stored and disposed of.
- Prior to survey, the hospital should ensure that all medical technology has been inspected, tested, and maintained and that these activities are documented (FMS.8 and FMS.8.1).
- Representatives of the hospital should be prepared to explain or demonstrate how potable water and electrical power are available 24 hours a day (FMS.9.2).
- The hospital should have the following items available for the surveyor(s) to use when conducting the facility tour:
 - o Flashlight
 - Master key
 - o Ladder (to look above ceiling tiles)

Sample Outline of a Facility Inspection Report

- The building(s) included in the report
 - o The patient care activities that take place in each building
 - o Any local codes, laws, or classifications for the buildings based on the activities
 - o The approximate age of each building
- The building-by-building results of the inspection
 - O Any general conditions of the building that relate to local codes, laws, and regulations
 - O Specific findings related to laws, regulations, codes, 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."
- The plan to correct the findings
 - o Timetable
 - o Estimated budget (short range and longer range, if appropriate)
 - o 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 hospital staff or by outside consultants. The

report should be as complete as possible to demonstrate that the hospital is aware of all conditions in its buildings and has plans to improve the safety of its buildings.

System Tracer: Facility Management and Safety System

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 (FMS) 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 will guide how and where the remainder of the FMS 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 during the course of the survey using a variety of techniques. The tracer selections may occur as a result of observations made by all surveyors as they conduct their portions of the survey, and may also encompass topics that are too complex to evaluate during the Facility Tour (see page 72) and/or require a multidisciplinary conversation. For example, the surveyor may have observed water leaks in the basement, water on the kitchen floor and some confusion about what tests to conduct to assure potable water. Additionally other team members may have commented on their concern for how the water treatment program is being conducted for the chronic outpatient dialysis program. From these observations the surveyor 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 may also choose to conduct a 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 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 hospital. This group should include representatives from the following services (in some hospitals, 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 hospital's facility(ies)
- A person(s) responsible for the hospital's emergency management activities
- A person(s) who manages the hospital's building utility systems
- A person(s) responsible for maintaining the hospital's medical/laboratory equipment
- 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 hospital, 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

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 deal with risks in the environment
- The FMS multidisciplinary team meeting minutes (previous 12 months)
- Documents required in this Survey Process Guide

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 hospital'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 hospital's facility management programs. All FMS programs may be discussed; however, specific attention will be paid to how these programs were developed, how risk was evaluated and addressed, and what improvements have been achieved and sustained in the programs from lessons learned.

During this session, the hospital's performance in addressing the emergency management requirements of standards FMS.6 will be reviewed, including its performance in the following areas:

- Identifying and analyzing potential environmental risks in the hospital
- Identifying the hospital's role in relation to the community's, country's, or region'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 hospital'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 hospital's performance in managing FMS risk. 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 hospital manages by doing the following:

- Beginning where the risk is encountered or first occurs. Examples of starting points include
 - o where a particular safety or security incident occurs (FMS.4 and FMS.4.1);
 - o where a particular piece of medical technology is used (FMS.8 and FMS.8.1); and
 - o where a particular hazardous material enters the hospital (FMS.5 and FMS.5.1).
- Having staff describe or demonstrate their roles and responsibilities for minimizing 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, and building features)
- Assessing the emergency management program for mitigation, preparedness, response, and recovery strategies, actions, and responsibilities for each priority emergency (see FMS.6 for more information on the emergency management program)
- Assessing the emergency program for responding to utility system disruptions or failures (see FMS.9, FMS.9.1, FMS.9.2, and FMS.9.2.1). Examples include
 - o having an alternative source of utilities;
 - notifying staff how and when to perform emergency clinical interventions when utility systems fail; and
 - o obtaining repair services.
- Reviewing the implementation of relevant inspection, testing, or maintenance procedures of any
 medical technology, 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 technology or other
 nonmedical equipment used when responding

If the risk moves around in the hospital's facility (**for example**, a hazardous material or waste), the surveyor(s) will follow the risk throughout the lifecycle (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 hospital 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

Purpose

This session explores the hospital's medication management process as well as potential risk points in the system.

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 throughout individual patient tracers and during the various quality activities, such as the Leadership for Quality and Patient Safety Interview (see page 56) and individual Department/Service Measurement Tracers (see page 58).

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 will guide how and where the remainder of the FMS tracer will be conducted. (errata)

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 clinical support departments that are part of the medication management system will participate in the focused-tracer activity.

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

- Clinical staff, such as a nurse, physician, therapist, or dietitian, who have a role in medication management processes 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
- Staff member responsible for medication education of staff and patients
- A clinical staff member who may add a unique perspective about any identifiable or specific patient
- A person who can speak to performance improvement *if* any performance improvement initiatives associated with medication management have been conducted or are being conducted (**Note:** A separate representative from quality improvement is not necessary if other participants can speak to medication management improvements [**for example**, a therapist on a medication quality improvement team]).
- A clinician from the laboratory
- Environmental safety personnel involved in the maintenance of pumps
- Others, including medical resident(s), at the hospital's discretion

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

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)

All surveyors available to participate

Standards/Issues Addressed

- All Medication Management and Use (MMU) standards
- IPSG.3 and IPSG.3.1

What Will Occur, Documents/Materials Needed

The Medication Management System Tracer is composed of three parts.

Part 1

This part consists of a practical medication tracer that extends from the point of order entry to patient administration and monitoring. 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.

Part 2

For the next part, a conference with a small group of leaders involved with the medication system is held. Discussion items may include the following:

- Policy review. A select group of policies chosen from processes just seen on the practical tracer in Part
 1 could be validated during the policy review. A policy review could occur if an issue requires
 clarification or if there were inconsistencies found in processes during a tracer. Examples might
 include pediatric medication processes, destruction of recalled medications, and complete order policy.
- Review of the annual medication system evaluation and actions taken to improve the system based on the evaluation
- 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 hospital 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:
 - o Number of pharmacy interventions
 - o Turnaround times from order to administration
 - o Adverse drug events/adverse drug reactions
 - o Use of high-risk or high-alert medications
- Monitoring data collected on the performance of the hospital'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

The conference agenda is flexible and unique to the system that is being evaluated.

Various methodologies are used to evaluate a hospital's medication management system, including a group discussion session; a medication management focused tracer; a review of data for medication errors, near misses, and other medication monitors; and individual patient tracers. The medication processes that are evaluated are selecting, procuring, storing, ordering/transcribing, administering, and monitoring. As determined by the surveyor(s), the session may start with the focused tracer or with the group discussion.

Part 3

The last part consists of a review of data related to medication errors, near misses, and adverse drug reactions. These data are reviewed during this part or may be included as part of the group discussion rather than as a separate activity.

Focused-Tracer Activity

The focused-tracer activity may take place prior to or after the group discussion. The surveyor(s) explores the path of a selected high-risk, high-alert, or other medication in the hospital using a current medical record and/or a drug selected from the hospital's high-alert medication list. The surveyor(s) will trace the drug for a

patient through all medication processes from adding the drug to the formulary through monitoring the drug's effect on the patient. The surveyor(s) then focuses on medication management processes informed by prior survey activities, such as the medication management group discussion or observations identified during tracers by any member of the survey team..

Group Discussion

The discussion session explores medication management processes in the hospital and handoff points between processes. During the group discussion, the surveyor(s) and hospital staff will do the following:

- Explore each applicable medication management process. Participants in the group share the hospital's approach to medication management based on their experience.
- For each medication management process discuss the following:
 - o Areas of concern or symptoms
 - o Immediate or proximal causes for an area of concern
 - o Potential solutions
- Explore the continuity of medication management processes and their relationship to other supporting processes and systems
- Identify potential areas of concern in the hospital's medication management system and actions that might be taken
- Identify any specific medication management issues requiring further exploration as part of subsequent tracers and other survey activities
- Review the IPSG related to medication management

Specific aspects of medication management that may be addressed during the discussion and focused tracer include the following:

- Medication selection, procurement, and storage, including IPSG.3
- Ordering, order entry, and transcription and IPSG.2
- Preparation and dispensing
- Administration and IPSG.1
- Monitoring of and compliance with IPSG.5 and IPSG.6
- Reporting of errors/system breakdowns/near misses
- Data collection, analysis, and evaluation of systems and actions taken, including any performance improvement initiatives related to medication management
- Medication education for patients and staff
- Information management related to medication management
- Patient involvement as part of a medication management team

The influence of other hospital systems for planning, data use, performance improvement, communication, and staff competence/effectiveness may be explored with respect to the medication management system and processes.

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

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 and Patient Safety Interview (see page 56) and individual Department/Service Measurement Tracers (see page 58).

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 will guide how and where the remainder of the FMS tracer will be conducted. (errata)

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 hospital. This group should include, but not be limited to, representatives from the following departments, as applicable:

- Clinical staff, including physicians, nurses, pharmacists, and laboratory personnel
- Clinicians who are knowledgeable about the selections of medications available for use and pharmacokinetic monitoring
- Clinicians from the laboratory who are knowledgeable about microbiology
- Clinical staff, including all individuals involved in infection prevention and control 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 resident(s), at the hospital's discretion

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

Surveyor(s)

All surveyors available to participate

Standards/Issues Addressed

- Prevention and Control of Infection (PCI)
- IPSG.5
- SQE.8.2
- COP.8.6
- COP.9.2, ME 4

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 includes the following:

- Exploration, critical thinking, and potential problem solving about the infection prevention and control program
- 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

Process

- The tracer may begin with a short group meeting with individuals responsible for the hospital'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
 hospital's infection prevention and control program.
- The surveyor(s) may move to other settings as appropriate and applicable to tracing infection prevention and control processes across the hospital.
- 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.

Discussion

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

- How patients with infections are identified by the hospital
- How patients with infections are considered within the context of the infection prevention and control program
- Current and past surveillance activity that took place in the previous 12 months or more for re-surveys and 4 months or more for initial surveys
- Type of analysis being conducted on the infection prevention and control data, including comparisons
- Reporting of infection prevention and control data, including frequency and audience
- 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/resident/client population, housekeeping procedures)
- Physical facility changes, either completed or in progress, that have an impact on infection prevention and control
- Actions taken as a result of surveillance and the outcomes of those actions
- Effectiveness of implementation of IPSG.5

Hospitals may use infection prevention and control data during this part of the activity if the data are relevant to the discussion.

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 hospital, 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 placed 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 placed in isolation due to an infectious disease. If not easily identifiable, consider patients with
 any of the following diagnoses (this is not an exhaustive list): varicella, pulmonary tuberculosis,
 invasive haemophilus influenzae, meningococcal disease, drug-resistant pneumococcal disease,
 pertussis, Mycoplasma, mumps, rubella, multidrug-resistant Staphylococcus aureus (MRSA), vancomycinresistant Enterrococcus (VRE), Clostridium difficile, respiratory syncytial virus (RSV), enteroviruses, and
 skin infections (impetigo, lice, and scabies).
- Infection prevention and control practices related to emergency management
- 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 hospital 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 hospital. Participants in this system tracer should include individuals who are able to address infection prevention and control in all services offered by the hospital.

Infection Prevention and Control Data Issues

Applicable in smaller surveys in which only one system tracer—Improvement in Quality and Patient Safety—is scheduled. Discussion explores the following topics:

- Risk assessment process and findings
- Surveillance methods for health care—associated and non-health care—associated infections
- Types of monitoring measures and data collected
- Whether infection-related data are collected
- Whether the hospital has developed and implemented a system for measuring improvements
- Using standardized definitions
- Control methods (includes data dissemination to physicians, staff, leaders, and external entities)
- Prevention based on data findings
- The hospital's plans to collect data relevant to the PCI standards

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 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.5 and FMS.5.1.

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
 - o Financial disclosure to patients
 - o Disinfection processes
 - o Blood product infusion processes
 - o Hazardous materials management
 - o Medical transport
 - o Laboratory specimen handling in clinics
 - O Assessing a specific standard or issue using patient 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:
 - o Pharmacy and others; for example, traditional Chinese medicine and chemotherapy
 - Noninvasive diagnostic areas, such as pulmonary laboratory, electrocardiogram, and electroencephalogram
 - o Hyperbaric treatment area
 - o Wound clinics
- Specific patient safety and quality activities:
 - o Failure mode and effects analysis
 - o Root cause analysis review
 - o Sentinel event review
- Focused document/policy review to close gaps in the usual document review exercise
- Other items as appropriate to the needs of the team

Optional Education Session: Hospital Decision Rules, Scoring Guidelines, and Strategic Improvement Plan

Purpose

The purpose of this session is to provide education to hospital leadership to help them understand the decision rules, the surveyor scoring guidelines, and the Strategic Improvement Plan (SIP).

Location

At the discretion of hospital leaders

Hospital Participants

- Chief executive officer
- Chief operating officer
- Chair, governing body, or similar representative
- Medical staff leadership
- Nursing leadership
- Survey coordinator and core quality leadership group
- Others at the discretion of hospital leaders

Standards/Issues Addressed

- Hospital decision rules
- ICI surveyor's scoring guidelines
- SIP tool: corrective action, education plan, compliance

Documents/Materials Needed

None

What Will Occur

The surveyor(s) will cover the following topics:

- Explanation of each of the decision rules for hospitals
- Scoring criteria for "fully met," "partially met," "not met," and "not applicable" logic based on the JCI surveyor's scoring guidelines (see page 12) as described in the Joint Commission International Accreditation Standards for Hospitals, Fifth Edition.
- The survey team leader or designee will provide education on developing a postsurvey SIP to address
 compliance issues identified in the "not met" findings in the survey report and for any "partially met"
 scored findings as determined by the JCI Accreditation Central Office.

Staff and Medical Professional Education Qualifications Session

Note: In past years, this session was called the Staff Qualifications and Education Session."

Purpose

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

Location

Small meeting rooms at the discretion of hospital leaders

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 administrator surveyor(s) will jointly 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 hospital and health care professional staff present in the hospital. Staff who may be interviewed are as follows:

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

Surveyor(s)

- Medical staff: physician surveyor(s)
- Nursing staff: nurse surveyor(s)
- Other hospital staff: administrator and/or nurse surveyor(s)

Standards/Issues Addressed

- Staff Qualifications and Education (SQE)
- GLD.14
- MPE.6 (for academic medical center hospitals)

Documents/Materials Needed

- Policies and procedures related to human resources/personnel management, staff credentials, and staff orientation and education
- A sample of hospital personnel 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 director of human resources with a list that identifies the type and number of personnel and 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 hospital's compliance with standards fairly and accurately. The tool merely reflects current JCI standards.

How To Prepare

The hospital should include a list of all current personnel and medical staff in the Document Review (see page 50) 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 2011; Intensive Care Unit"). These documents should be in English, when possible.

The hospital should closely review all personnel and 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 their 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 their 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.		
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.		

Standard	Measurable Element	Compliance Yes/No	Comments
	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.		
	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.		
SQE.11	1. All medical staff members are included in an ongoing professional practice monitoring and evaluation process as defined by hospital policy and standardized at the department/service level.		
	2. The monitoring and evaluation process identifies areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff member compared to other department/service medical staff members		
	3. The clinical results of data and information available on medical staff members are reviewed with objective and evidence-based information, as available, for external benchmarking.		
	4. 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 credentials file and other relevant files.		

Standard	Measurable Element	Compliance Yes/No	Comments
	5. 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 monitoring and 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 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.8.1	1. Staff members who provide patient care and other staff identified by the hospital to be trained in cardiac life support are identified.		
	3. There is evidence to show if a staff member passed the training.		
SQE.13	1. The hospital has a standardized procedure to gather the credentials of each nursing staff member.		
	2. Licensure, education/training, and, when available, experience, are documented.		
	3. Licensure and education/training are verified from the original source according to the parameters found in the intent of SQE.9.		
	4. There is a record maintained of the credentials of every nursing staff member.		

Other Professional Staff Qualifications Worksheet (errata)

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 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.8.1	1. Staff members who provide patient care and other staff identified by the hospital to be trained in cardiac life support are identified.		
	3. There is evidence to show if a staff member passed the training.		
SQE.13	1. The hospital has a standardized procedure to gather the credentials of each nursing staff member.		
	2. Licensure, education/training, and, when available, experience are documented.		
	3. Licensure and education/training are verified from the original source according to the parameters found in the intent of SQE.9.		
	4. There is a record maintained of the credentials of every nursing staff member.		

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.15	1. The hospital has a standardized procedure to gather the credentials of each health professional staff member.		
	2. Licensure, education/training, and, when available, experience, are documented.		
	3. Licensure and education/training are verified from the original source according to the parameters found in the intent of SQE.9		
	4. There is a record maintained on other health professional staff members that contains copies of any required license, certification, or registration.		
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 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.8.1	1. Staff members who provide patient care and other staff identified by the hospital to be trained in cardiac life support are identified.		
	3. There is evidence to show if a staff member passed the training.		
SQE.13	1. The hospital has a standardized procedure to gather the credentials of each nursing staff member.		
	2. Licensure, education/training, and, when available, experience are documented.		
	3. Licensure, education/training are verified from the original source according to the parameters found in the intent of SQE.9.		
	4. There is a record maintained of the credentials of every nursing staff member.		

Standard	Measurable Element	Compliance Yes/No	Comments
SQE.15	1. The hospital has a standardized procedure to gather the credentials of each professional staff member.		
	2. Licensure, education/training, and, when available, experience are documented.		
	3. Licensure, education/training are verified from the original source according to the parameters found in the intent of SQE.9		
	4. There is a record maintained on other professional staff members.		

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 and other staff identified by the hospital to be trained in cardiac life support are identified.		
	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 a documentation of at least a) through g) of the intent.		
MPE.6	1. All 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 (4 months for initial surveys and 12 months for triennial surveys).

Purpose of the Form

The purpose of using the Closed Patient Medical Record Review Form (see page 99) is to gather and record continuous evidence of compliance with standards that require documentation in the patient's record.

Organization of the Form

The form is organized by topic headings (**for example**, "Consents" and "Assessments") and includes the specific standard number and the standard requirement (**for example**, blood consent and medical assessment). This form will be provided by the survey team and used during the review. The form may be revised periodically to reflect approved changes in the standards.

Review Process

- The surveyor(s) enters the number of the record being reviewed and the type of record requested (recorded by diagnosis) on the top of the form (**for example**, "Record #1 Congestive Heart Failure").
- The record is reviewed briefly to
 - o establish what type of patient or care was received (**for example**, surgery, medical, emergency, rehabilitation); and
 - o verify compliance with the documentation track record (4 months for initial surveys and 12 months for triennial surveys).

Using the Form During the Accreditation Survey

- The survey team leader may request 5 to 10 closed records for review. The records will be requested if the surveyor(s) wants to validate the hospital's documentation track record (4-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 will also indicate the time period for selecting the records, typically the past 4 or 12 months. Hospital staff should acquaint the survey team with the hospital's practice and expectation regarding the completion of a patient record following discharge of the patient.
- For the Closed Patient Medical Record Review, hospital 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. Academic medical center hospitals are encouraged to include residents and fellows in the record review.
- The surveyor(s) will review the selected records with the assistance of the hospital representative, as needed, to complete the form. One column of the form is completed for each record reviewed. If more than five records are reviewed, the surveyor(s) will use another form.
- For each documentation requirement, the surveyor(s) will check "Y" (yes) on the form to indicate that the required element is present, "N" (no) if the element is not present, or "NA" if the element is not applicable to that patient's record.
- The survey team aggregates the completed review forms to score the standards. The findings from the active or open review of patient records are integrated into aggregation and scoring.

The survey team leader retains the forms to support the survey findings.

Integration of Medical Professional Education (MPE) Supervision Medical Record Documentation Information into Records Review

The form below (see page 112) should be completed by the hospital prior to the first day of the survey, to indicate which levels of trainees and students are authorized to make entries and which of those entries must be countersigned by faculty. The hospital may expand the form, or use other symbols, but it must make it clear which entries must also have faculty documentation. Please add any required time frames as applicable. Copies of the completed grid will be available for those participating in the Closed Patient Medical Records Review session to determine whether or not these documentation requirements have been met in the relevant required elements of the medical record review process (MPE.4, MEs 5 and 7).

Patient Medical Record Review Form

Standard	Documentation Requirement	Medical Record 1 DX:				dical cord			dical ord 3	3		lical ord 4	l	Medical Record 5			TOTAL
					DX:			DX:			DX:			DX:			1
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Consents																	
IPSG.4	Document, before the procedure, that the informed consent is appropriate to the procedure; that the correct site, correct procedure, and correct patient are identified; and that all documents and equipment needed are on hand, correct, and functional.																
PFR.5	The hospital defines how a general consent is documented in the patient's record.																
PFR.5.1	Informed consent																
PFR.5.2	Surgical or invasive procedures consent																
	Anesthesia and moderate and deep sedation consent																
	Blood and blood products consent																
	High-risk treatments and procedures consent																

Standard	Documentation Requirement	Record 1			Record 2						Medical Record 4 DX:			Medical Record 5 DX:			TOTAL
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Consents			<u> </u>	-	•	-			-	•			•		-	•	
ASC.5.1	Risks, benefits, and alternatives of anesthesia																
ASC.7.1	Risks, benefits, potential complications, and alternatives of surgery																
GLD.18	The identity of the individual(s) providing the information and obtaining the consent is noted in the patient's record; consent is documented in the patient's record by signature or record of verbal consent.																

Standard	Documentation Requirement	Medical Record 1 DX:			_	dical cord	2	Med	lical ord 3	3	Med Rec	ical ord 4		Medical Record 5			TOTAL
					DX:			DX:			DX:			DX:			
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Assessme	ssessments																
IPSG.2.1	Critical results of diagnostic tests																
AOP.1	The hospital identifies the information to be documented for the assessments.																
AOP.1.2	Patient's medical and nursing needs identified from initial assessments, which are completed within in 24 hours after admission as an inpatient.																
AOP.1.2.1	Initial medical and nursing assessment of emergency patients																
AOP.1.3	Process for accepting initial medical assessments conducted in outpatient setting prior to admission																
	Initial assessment updated if greater than 30 days old																

Standard	Documentation Requirement	Medical Record 1 DX:				dical ord 2	2		dical ord 3	3	Med	lical ord 4	ļ	Medical Record 5			TOTAL
					DX:			DX:			DX:			DX:			
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Assessme	ents	3	<u>=</u>	-	3	-	3		3	3	3	=	-		-	3	
AOP.1.3.1	A preoperative assessment is documented before anesthesia or surgical treatment and includes the patient's medical, physical, psychological and spiritual/cultural needs.																
AOP.1.4	Specialized assessments conducted within the hospital are completed and documented in the patient's record.																
AOP.1.5	Screening for pain on admission																
AOP.1.6	Individualized initial assessments for special populations																
AOP.1.7	Assessment and reassessment for special populations																
AOP.1.8	Early screening for discharge planning																
AOP.2	Reassessments based on condition are documented in the patient's record.																

Standard	Documentation Requirement		dical cord		_	dical cord	2		dical ord 3	3	Med Rec	lical ord 4	ļ		dical ord (5	TOTAL
		DX:			DX			DX:			DX:			DX:			
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Assessme	ents		-		•	•	-	•	-	-	-				•	-	•
COP.2.1	Initial plan of care is documented in the patient's record.																
COP.2.2	Orders are found in a uniform location in patient records																
COP.2.3	Clinical and diagnostic procedures and treatments performed, and the results or outcomes are documented in the patient's record.																
COP.5	Patient's response to nutrition therapy is monitored and documented in the patient record																
ASC.3-	Presedation assessment																
ASC.3.2	Monitoring during sedation																
	Recovery criteria																
ASC.4	Preanesthesia and preinduction assessments																

Standard	Documentation Requirement		dical cord 1	I		dical cord			lical ord 3	3	Med Rec	lical ord 4		Med Rec	lical ord 5	•	TOTAL
		DX:			DX			DX:			DX:			DX:			
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Assessme	ents		-	=	_	-	-				_					=	
PFE.2	Educational needs assessment findings are recorded in the patient's record.																
PFE.2.1	Assessment includes: The patient's and family's beliefs and values																
	Their literacy, educational level, and language																
	Emotional barriers and motivations																
	Physical and cognitive limitations																
	The patient's willingness to receive information																

Standard	Documentation Requirement		dical cord			dical cord			dical cord 3	3		lical ord 4	ı		dical cord		TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Other			=	<u> </u>			=	=	=	=					8	-	=
IPSG.4.1	The full surgical team conducts and documents a time-out procedure in the area in which the surgery/invasive procedure will be performed, just before starting a surgical/invasive procedure.																
ACC.1	Stabilizing treatment provided prior to transport is documented in a record maintained by the transferring hospital.																
ACC.1.2	Any delay in treatment																
ACC.2.3 and ACC.2.3.1	Admission to and discharge or transfer from specialized programs are documented in the patient's record																
ACC.3.1	The process identifies how individuals assume the transferred responsibility and document their participation or coverage.																

Standard	Documentation Requirement		dical cord	1		dical cord	2		dical ord 3	3	Med Rec	lical ord 4			dical ord 5	5	TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Other			=	-		=	=		=	=							
ACC.4.3.2	The clinical records of inpatients contain a copy of the discharge summary.																
ACC.5.2	A patient clinical summary document is transferred with the patient.																
ACC.5.3	The transfer process is documented in the patient's record.																
COP.8.4	The transplant program documents organ compatibility confirmation in the transplant candidate's medical record.																
COP.8.7	The transplant program updates clinical information in the transplant patient's medical record on an ongoing basis.																
COP.9.2	The transplant program documents organ compatibility confirmation in the living donor's medical record.																

Standard	Documentation Requirement	_	dical cord		_	dical cord			dical ord 3	3		lical ord 4	ı		dical cord (5	TOTAL
		DX:	!		DX	:		DX:			DX:			DX:			
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Other			-		3	-3		-	-	-		2	2	3	-	-	
ASC.5	Anesthesia plan																
ASC.5.1	The anesthesiologist or another qualified individual provides and documents the education.																
ASC.6	Each patient's physiological status during anesthesia and surgery is monitored according to professional practice guidelines and documented in the patient's record.																
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.																
ASC.7	Assessment information that supports the planned procedure																

Standard	Documentation Requirement		dical cord			dical cord 2	2		dical cord (3		lical ord 4	l		dical ord 5	5	TOTAL
		DX:			DX:			DX			DX:			DX:			
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Other		2	=		-				•	-	•	2		2			
	Preoperative diagnosis																
	Planned surgical procedure																
ASC.7.1	The patient's surgeon or other qualified individual provides and documents the education.																
ASC.7.2	Written surgical report contains the following: Postoperative diagnosis																
	Name of operative surgeon and assistants																
	Perioperative complications																
	Procedures performed and description of each procedure findings																
	Surgical specimens sent for examination																
	Amount blood loss and amount transfused blood																
	Registry number of all implantable devices																

Standard	Documentation Requirement		dical cord			dical cord			dical cord :			dical ord	4		dical cord		TOTAL
		DX:			DX	•		DX	•		DX:			DX	•		
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Other		_	=	-	_	=	-	_	=	-	=	=		_	=	-	_
	Date, time, and signature of responsible physician																
ASC.7.3	The medical postsurgical plan																
	The nursing postsurgical plan of care																
	Postsurgical plan of care by others as appropriate																
MMU.4	List of current medications taken prior to admission																
MMU.4.3	Medications prescribed or ordered and administered are written in the patient's record.																
MMU.7	Adverse effects																
QPS.6	Data validation is important when the data source has changed, such as when part of the patient record has been turned into an electronic format and thus the source is now both electronic and paper.																

Standard	Documentation Requirement		dical cord			dical cord 2	2		dical ord 3	3	Med Rec	lical ord 4			dical ord 5	5	TOTAL
		DX:			DX:			DX:			DX:			DX:			
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Other	-		_					_	_		_		_		-	_	
MOI.7	Patient records and other data and information are secure and protected at all times.																
MOI.10	The hospital initiates and maintains a clinical record for every patient assessed or treated, and the record's specific content and format is determined by the hospital.																
MOI.10.1	The clinical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, to document the course and results of treatment.																
MOI.10.1.1	The clinical record of every patient receiving emergency care includes the time of arrival, the conclusions at termination of treatment, the patient's condition at discharge, and follow-up care instructions.																

Standard	Documentation Requirement		dical cord			dical cord			dical cord 3	3		dical ord 4	ı		dical cord (5	TOTAL
		DX	•		DX	•		DX:	1		DX:			DX:	1		
		Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Υ	N	NA	Y/N
Other	•	•		-	-			•	•		-	•			•		•
MOI.11	The author, date, and time (when required) of every entry																
	The hospital identifies those authorized to make entries in the patient clinical record																
MOI.11.1	Every patient clinical record entry identifies its author and when the entry was made in the record.																
MOI.12	The hospital regularly assesses patient clinical record content and the completeness of patient clinical records.																
GLD.18	The identity of the individual(s) providing the information and obtaining the consent is noted in the patient's record; consent is documented in the patient's record by signature or record of verbal consent.																

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 patient medical record (**for example**, "1st year medical student," "intern," "4th year resident," "fellow," and so on).

Note: Trainees include interns, residents, and fellows.

Type of Medical Student or Trainee			
	Countersignature Requ	ired by Which Level of P	Physician(s)?
	Most Responsible Physician*	Licensed Resident	Other Licensed Physician (for example, fellow, registrar, etc.)
Inpatient Record	Please mark ($$) the appactivity	ropriate box(es) for eacl	n documentation
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			

Type of Medical Student or Trainee			
	Countersignature Requ	ired by Which Level of F	Physician(s)?
	Most Responsible Physician*	Licensed Resident	Other Licensed Physician (for example, fellow, registrar, etc.)
Inpatient Record	Please mark ($$) the appactivity	propriate box(es) for each	n documentation
Anesthesia Consent Form			
Immediate Postoperative Note			
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			

Type of Medical Student or Trainee			
	Countersignature Requ	ired by Which Level of F	Physician(s)?
	Most Responsible Physician*	Licensed Resident	Other Licensed Physician (for example, fellow, registrar, etc.)
Inpatient Record	Please mark (√) the appactivity	propriate box(es) for eac	h documentation

^{*}Most responsible physician may be a faculty physician, supervising physician, or senior admitting physician.

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 (see page 50).

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 hospital 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 hospital 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 hospital 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 hospital representatives for additional information during this session to confirm or disprove a finding. In addition, the surveyor(s) may request that the hospital 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 leaders. The leaders may decide to have one or two exit conferences. If only one, this may be just with the leaders, or 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 the hospital's leaders

Surveyor(s)

Physician, nurse, and administrator surveyor(s)

Standards/Issues Addressed

Survey findings

Documents/Materials Needed

None

What Will Occur

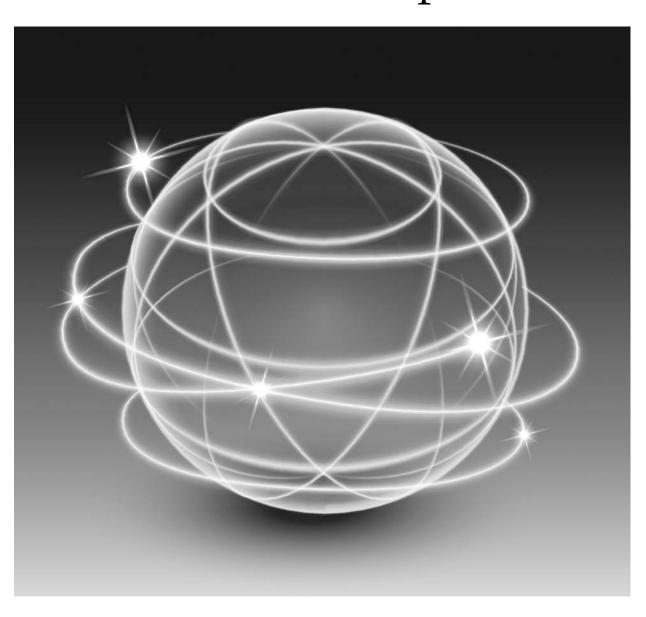
This session includes the following two components:

- 1) Discussion with key leaders of the hospital about the survey report and follow-up process, including review of the SIP. The discussion will cover the following:
 - o Purpose of the conference
 - o Summary of compliance findings related to standards
 - o Emphasis that the surveyor(s) does not make the final decision regarding accreditation
 - o 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 focused survey. If a focused 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 provide education to assist the hospital in developing an SIP based on the "not met" findings from the survey report. The surveyor(s) will explain the survey follow-up process regarding communication of the accreditation decision by the ICI Accreditation Central Office.

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

Additional Sessions Specific to 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 leaders

Hospital Participants

- Medical director of hospital
- Director of medical education
- Directors of residency specialty programs
- Resident representatives from each level of training
- Nursing director
- 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:

- 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 directors, 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, appropriate 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, especially MPE.3 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, the hospital's leaders 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.

- MPE.2, ME 3: What evidence does the hospital have that the facilities and technology support the agreed-on student 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
- QPS standards, particularly QPS.7, QPS.8, and QPS.9

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 "Medical Professional Education" (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 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.

- MPE 4, ME1: 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 what 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.8, and QPS.9: Do you know the process for reporting near misses, adverse events, and sentinel events? Have you reported or been involved in any near misses, adverse events, or sentinel events?

Human Subjects Research Leadership Interview

Purpose

The purpose of the Human Subjects Research Leadership Interview is to assess accountability for all aspects of the research program.

Location

At the discretion of hospital leaders

Hospital Participants

- Medical director of hospital
- Nursing director
- Director of research
- Chair and representative sample of members of the hospital's Institutional Review Board (or designated IRB)
- 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" chapter.
- Human Subjects Research Programs (HRP)

Documents/Materials Needed

- All related documents (as listed in required documents for day 1 of survey)
- Relevant documents for discussion of HRP.1.1, HRP.2, HRP.3, HRP.4, HRP.5, and HRP.6

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 "Human Subjects Research Programs (HPR) chapter. During the management conference, 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 the Human Subjects Research Leadership 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.

- 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?

- HRP.4: What types of research have the leaders defined as exempt from the research review process?
- 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?

Human Subjects Research Process Interview

Purpose

The purpose of the Human Subjects Research Process Interview is to assess

- 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 of this interview 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 leaders

Hospital Participants

- Medical director of hospital
- Director of research
- Chair and representative sample of members of the hospital's (or designated) Institutional Review Board (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

Survevor(s)

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

Standards/Issues Addressed

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

Documents/Materials Needed

- 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 SQE standards.
- Review of at least five human subjects research projects (inpatient or outpatient) currently underway. Review will include subjects entered in protocols as follows:
 - o For triennial surveys, subjects entered in protocols 12 months prior to survey (but not before 1 September 2013, the publication date of these standards)
 - o For initial surveys, subjects entered in protocols 4 months prior to survey (but not before 1 September 2013, the publication date of these standards)
- Information regarding any study patients who had adverse events reported as follows:
 - o For triennial surveys, subjects having adverse events 12 months prior to survey (but not before 1 September 2013, the publication date of these standards)

- o For initial surveys, subjects having adverse events 4 months prior to survey (but not before 1 September 2013, the publication date of these standards)
- 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 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 4 months prior to the on-site survey (but not before 1 January 2013, the publication date of these standards) are the only consents to be evaluated. For triennial surveys, files of subjects entered within the previous 12 months (but not before 1 January 2013, the publication date of these standards) will be evaluated.
- The surveyor(s) will assess compliance with certain standards from the "Human Subjects Research Programs" (HRP) chapter (HRP.6 and HRP.7 through HRP.7.2). During the conference, the surveyor(s) will also identify issues that he or she will pursue in later survey activities.
- 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 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.

How to Prepare

Hospitals should identify the participants in the Human Subjects Research Process Interview. Although the hospital's 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.

- HRP.3.1:
 - o ME 2: Are all contracts with research organizations in compliance with your hospital's policy to determine the activities and responsibilities of the contract research organization?
 - o ME.3: Do all contracts contain the required quality and safety program provided by the contract research organization or the sponsor?
 - o ME.4: How do you know the sponsor is monitoring the contract and is responsible for the quality and integrity of the research data?
- HRP.6: 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) within the past 12 months, 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 (see page 50).

Name of Auditing Body	Date of audit	Recommendations or Citations? (Yes/No)	Time Allotted for Compliance	Achieved	Auditor Returned to Validate Compliance? (Yes/No)

Joint Commission International Library of Measures

Hospital leadership chooses the clinical and managerial structures, processes, and outcomes that are most important to monitor based on its mission, patient needs, and services provided. The hospital's leaders of departments and clinical services identify key measures (indicators) to monitor the hospital's clinical and managerial structures, processes, and outcomes.

Hospitals are required to choose five measures from the Joint Commission International Library of Measures to help them monitor their clinical and managerial structures, processes, and outcomes. The Library of Measures includes the following measure sets:

- Acute myocardial infarction
- Heart failure
- Stroke
- Children's asthma care
- Hospital-based inpatient psychiatric service
- Nursing-sensitive care
- Perinatal care
- Pneumonia
- Surgical Care Improvement Project
- Venous thromboembolism

Required Hospital Programs

The following list identifies required hospital programs. A program is usually more comprehensive in content than a policy or procedure. A program can also be more long range or strategic in content. Frequently, a program also sets priorities for the entire hospital. **For example**, the quality improvement and patient safety program may address the hospital's commitment to quality and safe patient care by identifying short- and long-range priorities and methods to achieve those priorities.

- Laboratory quality and safety program (see AOP chapter)
- Radiation quality and safety program (see AOP chapter)
- Medication management and use program (see MMU chapter)
- Quality improvement and patient safety program (see QPS, PCI, GLD, and FMS chapters)
- Risk management program (see QPS chapter)
- Infection prevention and control program (see PCI chapter)
- Programs for the recruitment, retention, development, and continuing education of all staff (see GLD and SQE chapters)
- Culture of safety program (see GLD chapter)
- Program to provide a safe physical facility (see FMS chapter)
- Program to provide a secure environment for patients, families, staff, and visitors (see FMS chapter)
- Hazardous materials and waste program (see FMS chapter)
- Emergency management program (see FMS chapter)
- Fire and smoke safety program (see FMS chapter)
- Program for inspecting, testing, and maintaining medical technology (see FMS chapter)
- Hospital utility systems program (see FMS chapter)
- Staff health and safety program (see SQE chapter)
- Medical professional education program (see MPE chapter, academic medical center hospitals only)
- Research program (see HRP chapter, academic medical center hospitals only)

• Program for the protection of human subjects (see HRP chapter, academic medical center hospitals only)

Required Written Policies (Including Those Required in English)

The standards in the tables on the following pages identify a requirement for a written document. In some cases, that document is in the form of a policy and procedure. In other cases, the document is less formal but addresses the issue identified in the standard. In many cases, a number of standards requirements or MEs can be combined into one policy and procedure. Hospitals may find it useful to group all related policies and procedures.

The surveyor(s) may not need to review all these documents in detail. However, to facilitate the review, it is best to gather all of the documents into one book or identify each document by the corresponding standard number(s) if they are part of a larger document.

Note: Hospitals should refer to the guidelines for document review for detailed suggestions on the presentation of documents for the surveyor(s).

Some of these documents need to be provided to JCI surveyors in English, and these documents are indicated in the "In English?" column in the tables. 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 of the document and answer questions concerning the document.

International Patient Safety Goals (IPSG)		
Standard	Standard Text	In English?
IPSG.1	The hospital develops and implements a process to improve accuracy of patient identifications.	Yes
IPSG.2	The hospital develops and implements a process to improve the effectiveness of verbal and/or telephone communication among caregivers.	Yes
IPSG.2.1	The hospital develops and implements a process for reporting critical results of diagnostic tests.	Yes
IPSG.2.2	The hospital develops and implements a process for handover communication.	Yes
IPSG.3	The hospital develops and implements a process to improve the safety of high-alert medications.	Yes
IPSG.3.1	The hospital develops and implements a process to manage the safe use of concentrated electrolytes.	Yes
IPSG.4	The hospital develops and implements a process for ensuring correct-site, correct-procedure, and correct-patient surgery.	Yes
IPSG.4.1	The hospital develops and implements a process for the time-out that is performed in the operating theatre immediately prior to the start of surgery to ensure correct-site, correct-procedure, and correct-patient surgery.	Yes
IPSG.5	The hospital adopts and implements evidence-based hand-hygiene guidelines to reduce the risk of health careassociated infections.	Yes
IPSG.6	The hospital develops and implements a process to reduce the risk of patient harm resulting from falls.	Yes

Access to Care and Continuity of Care (ACC)		
Standard	Standard Text	In English?
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.	
ACC.1.2	The hospital considers the clinical needs of patients and informs patients when there are waiting periods or delays for diagnostic and/or treatment services.	
ACC.2	The hospital has a process for admitting inpatients and for registering outpatients	
ACC.2.3	Admission to units providing intensive or specialized services is determined by established criteria.	Yes
ACC.2.3.1	Discharge from units providing intensive or specialized services is determined by established criteria.	Yes

Access to Care and Continuity of Care (ACC) (errata)			
Standard	Standard Text	In English?	
ACC.3	The hospital designs and carries out processes to provide continuity of patient care services in the hospital and coordination among health care practitioners.		
ACC.3.1	During all phases of inpatient care, there is a qualified individual identified as responsible for the patient's care.		
ACC.4	There is a process for the referral or discharge of patients that is based on the patient's health status and the need for continuing care or services.		
ACC.4.3.2	The clinical records of inpatients contain a copy of the discharge summary.		
ACC.4.4	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.		
ACC.5.3	The transfer process is documented in the patient's record.		

Patient and Family Rights (PFR) (errata)		
Standard	Standard Text	In English?
PFR.1	The hospital is responsible for providing processes that support patients' and families' rights during care.	
PFR.2	The hospital supports patients' and families' rights to participate in the care process.	
PFR.2.2	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.	
PFR.3	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.	
PFR.5.1	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
PFR.5.2	Informed consent is obtained before surgery, anesthesia, procedural sedation, use of blood and blood products, and other high-risk treatments and procedures.	
PFR.6.1	The hospital provides oversight for the process of organ and tissue procurement.	

Assessmer	Assessment of Patients (AOP)		
Standard	Standard Text	In English?	
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	
AOP.1.1	Each patient's initial assessment includes an evaluation of physical, psychological, social, and economic factors, including a physical examination and health history.		
AOP.1.2	The patient's medical and nursing needs are identified from the initial assessments, which are completed and documented in the clinical record within the first 24 hours after admission as an inpatient or earlier as indicated by the patient's condition.		
AOP.1.2.1	The initial medical and nursing assessments of emergency patients are based on their needs and conditions.		
AOP.1.6	The hospital conducts individualized initial assessments for special populations cared for by the hospital.		
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.		
AOP.3	Qualified individuals conduct the assessments and reassessments.		
AOP.5.1	A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.		
AOP.5.3	A laboratory safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.	Yes	
AOP.5.3.1	The laboratory uses a coordinated process to reduce the risks of infection as a result of exposure to biohazardous materials and waste.		
AOP.5.4	Laboratory results are available in a timely way as defined by the hospital.		
AOP.5.5	All equipment and medical technology used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.		
AOP.5.6	Essential reagents and other supplies are regularly available and evaluated to ensure accuracy and precision of results.		
AOP.5.7	Procedures for collecting, identifying, handling, safely transporting, and disposing of specimens are established and implemented.		
AOP.5.9	Quality control procedures for laboratory services are in place, followed, and documented.		

Assessment of Patients (AOP)		
Standard	Standard Text	In English?
AOP.5.9.1	There is a process for proficiency testing of laboratory services.	
AOP.6.1	A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services.	
AOP.6.3	A radiation safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.	Yes
AOP.6.4	Radiology and diagnostic imaging study results are available in a timely way as defined by the hospital.	
AOP.6.5	All equipment and medical technology used to conduct radiology and diagnostic imaging studies is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.	
AOP.6.7	Quality control procedures are in place, followed, and documented.	

Care of Patients (COP)		
Standard	Standard Text	In English?
COP.1	Uniform care of all patients is provided and follows applicable laws and regulations.	
COP.2.2	The hospital develops and implements a uniform process for prescribing patient orders.	
COP.3	The care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines, laws, and regulations.	
COP.3.3	Clinical guidelines and procedures are established and implemented for the handling, use, and administration of blood and blood products.	Yes
COP.6	Patients are supported in managing pain effectively.	
COP.8.5	The transplant program obtains informed consent specific to organ transplantation from the transplant candidate.	Yes

Anesthesia and Surgical Care (ASC)			
Standard	Standard Text	In English?	
ASC.3	The administration of procedural sedation is standardized throughout the hospital.	Yes	
ASC.3.1	Practitioners responsible for procedural sedation and individuals responsible for monitoring patients receiving sedation are qualified.		
ASC.3.2	Procedural sedation is administered and monitored according to professional practice guidelines.		
ASC.6	Each patient's physiological status during anesthesia and surgery is monitored according to professional practice guidelines and documented in the patient's record.		
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.		
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.		

Medication Management and Use (MMU)			
Standard	Standard Text	In English?	
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.		
MMU.2	Medications for prescribing or ordering are stocked, and there is a process for medications not stocked or normally available to the hospital or for times when the pharmacy is closed.		
MMU.3	Medications are properly and safely stored.		
MMU.3.1	There is a process for storage of medications and nutrition products that require special consideration.		
MMU.3.2	Emergency medications are available, monitored, and safe when stored out of the pharmacy.		
MMU.3.3	The hospital has a medication recall system.		
MMU.4	Prescribing, ordering, and transcribing are guided by policies and procedures.	Yes	
MMU.4.1	The hospital defines the elements of a complete order or prescription.	Yes	

Medication Management and Use (MMU)		
Standard	Standard Text	In English?
MMU.5.1	Medication prescriptions or orders are reviewed for appropriateness.	
MMU.6.2	Policies and procedures govern medications brought into the hospital for patient self-administration or as samples.	
MMU.7	Medication effects on patients are monitored.	
MMU.7.1	The hospital establishes and implements a process for reporting and acting on medication errors and near misses.	Yes

Quality Improvement and Patient Safety (QPS)		
Standard	Standard Text	In English?
QPS.1	A qualified individual 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.	
QPS.6	The hospital uses an internal process to validate data.	
QPS.7	The hospital uses a defined process for identifying and managing sentinel events.	Yes
QPS.8	Data are always analyzed when undesirable trends and variation are evident from the data.	
QPS.11	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

Prevention and Control of Infections (PCI)			
Standard	Standard Text	In English?	
PCI.5	The hospital designs and implements a comprehensive program to reduce the risks of health care—associated infections in patients and health care workers.	Yes	
PCI.6	The hospital uses a risk-based approach in establishing the focus of the health care–associated infection prevention and reduction program.		
PCI.7	The hospital identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.		

Prevention and Control of Infections (PCI)			
Standard	Standard Text	In English?	
PCI.7.1.1	The hospital identifies and implements a process for managing expired supplies and the reuse of single-use devices when laws and regulations permit.	Yes	
PCI.7.3	The hospital implements practices for safe handling and disposal of sharps and needles.		
PCI.8	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.		
PCI.8.1	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.		
PCI.9	Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly when required.		
PCI.11	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.		

Governance, Leadership, and Direction (GLD)			
Standard	Standard Text	In English?	
GLD.1	Governance structure and authority are described in bylaws, policies and procedures, or similar documents.	Yes	
GLD.1.1	The operational responsibilities and accountabilities of the governing entity are described in a written document(s).		
GLD.1.2	Those responsible for governance approve the hospital's program for quality and patient safety and regularly receive and act on reports of the quality and patient safety program.		
GLD.2	A chief executive(s) is responsible for operating the hospital and complying with applicable laws and regulations.		
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.		
GLD.3.2	Hospital leadership ensures effective communication throughout the hospital.		
GLD.6	Hospital leadership is accountable for the review, selection, and monitoring of clinical or nonclinical contracts.		

Governance, Leadership, and Direction (GLD)						
Standard	Standard Text	In English?				
GLD.6.2	Hospital leadership ensures that independent practitioners not employed by the hospital have the right credentials for the services provided to the hospital's patients.					
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.					
GLD.9	One or more qualified individuals provide direction for each department or service in the hospital.					
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.					
GLD.11.2	Department/service leaders select and implement clinical practice guidelines, and related clinical pathways and/or clinical protocols, to guide clinical care.					
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.					
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.					
GLD.12.2	The hospital's framework for ethical management addresses ethical issues and decision making in clinical care.					
GLD.13	Hospital leadership creates and supports a culture of safety program throughout the hospital.					
GLD.15	Human subjects research, when provided within the hospital, is guided by laws, regulations, and hospital leadership.					
GLD.16	Patients and families are informed about how to gain access to clinical research, clinical investigation, or clinical trials involving human subjects.					
GLD.18	Informed consent is obtained before a patient participates in clinical research, clinical investigation, or clinical trials.					
GLD.19	The hospital has a committee or another way to oversee all research in the hospital involving human subjects.					

Facility Management and Safety (FMS)				
Standard	Standard Text	In English?		
FMS.2	The hospital develops and maintains a written program(s) describing the processes to manage risks to patients, families, visitors, and staff.	Yes		
FMS.4	The hospital plans and implements a program to provide a safe physical facility through inspection and planning to reduce risks.			
FMS.4.1	The hospital plans and implements a program to provide a secure environment for patients, families, staff, and visitors.			
FMS.5	The hospital has a program for the inventory, handling, storage, and use of hazardous materials.			
FMS.5.1	The hospital has a program for the control and disposal of hazardous materials and waste.			
FMS.6	The hospital develops, maintains, and tests an emergency management program to respond to emergencies, epidemics, and natural or other disasters that have the potential of occurring within their community.			
FMS.7	The hospital establishes and implements a program for the prevention, early detection, suppression, abatement, and safe exit from the facility in response to fires and nonfire emergencies.			
FMS.7.1	The hospital regularly tests its fire and smoke safety program, including any devices related to early detection and suppression, and documents the results.			
FMS.7.2	The fire safety program includes limiting smoking by staff and patients to designated non-patient care areas of the facility.			
FMS.8	The hospital establishes and implements a program for inspecting, testing, and maintaining medical technology and documenting the results.			
FMS.8.1	The hospital has a system in place for monitoring and acting on medical technology hazard notices, recalls, reportable incidents, problems, and failures.			

Staff Qualifications and Education (SQE)				
Standard	Standard Text	In English?		
SQE.1.1	Each staff member's responsibilities are defined in a current job description.			
SQE.5	There is documented personnel information for each staff member.			
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.			
SQE.8.2	The hospital provides a staff health and safety program.			
SQE.9	The hospital has a uniform process for gathering the credentials of those medical staff members permitted to provide patient care without supervision.			
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.			
SQE.9.2	There is a uniform, transparent decision process for the initial appointment of medical staff members.			
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		
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		
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.			
SQE.15	The hospital has a uniform process to gather, to verify, and to evaluate other health professional staff members' credentials (license, education, training, and experience).			

Management of Information (MOI) (errata)				
Standard	Standard Text	In English?		
MOI.2	Information privacy, confidentiality, and security—including data integrity—are maintained.			
MOI.3	The hospital determines the retention time of records, data, and information.			
MOI.7	Records and information are protected from loss, destruction, tampering, and unauthorized access or use.			
MOI.9	Written documents, including policies, procedures, and programs, are managed in a consistent and uniform manner.	Yes		
MOI.9.1	The policies, procedure, plans, and other documents that guide consistent and uniform clinical and nonclinical processes and practices are fully implemented.			
MOI.10.1	The clinical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, to document the course and results of treatment, and to promote continuity of care among health care practitioners.			

Medical Pro	Medical Professional Education (MPE)					
Standard	Standard Text	In English?				
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				
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.					

Human Subjects Research Programs (HRP)					
Standard	Standard Text				
HRP.1.1	Hospital leadership complies with all regulatory and professional requirements and provides adequate resources for effective operation of the research program.				
HRP.3	Hospital leadership establishes requirements for sponsors of research to ensure their commitment to the conduct of ethical research.				
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			
HRP.4	Hospital leadership creates or contracts for a process to provide the initial and ongoing review of all human subjects research.				
HRP.5	The hospital identifies and manages conflicts of interest with research conducted at the hospital.				
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	Yes			
	influence.				

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 Pathologists [CAP] or the International Organization for Standardization [ISO]) have conducted inspections. This information will facilitate the survey team's ability to more appropriately and 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 (see page 128) 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 (see page 50) 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)			
APR.3							

Standard	Applicable Law or Regulation? (Yes/No)	If Yes, Name of the Applicable Law or Regulation	How Law or Regulation Applies to the Requirement	(Yes/No) (note	
IPSG.2-				conflicts)	
IPSG.2.2					
ACC.4.5					
ACC.4.5.1					
ACC.6					
PFR.1					
PFR.1.3					
PFR.1.5					
PFR.5.1					

Section II: P	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 the Requirement	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation Is Evaluated on Site? (Yes/No)		
PFR.6							
PFR.6.1							
AOP.1							
AOP.1.6							
AOP.3							
AOP.5							
AOP.5.1							
AOP.5.3							
AOP.5.9.1							
AOP.5.11							
AOP.6							
AOP.6.1							
AOP.6.3							
COP.1							
COP.3							
COP.8.5							
COP.9.2							
ASC.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 the Requirement	Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)	Law or Regulation Is Evaluated on Site? (Yes/No)	
ASC.2						
MMU.1						
MMU.2						
MMU.3						
MMU.4.2						
MMU.5						
MMU.6						

Section III: H	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								
PCI.3								
PCI.7.1.1								
PCI.7.3								
GLD.2								
GLD.8								
GLD.15								
FMS.1								
FMS.4.2								
FMS.8.1								
FMS.9.2 and FMS.9.2.1								
FMS.9.3								
SQE.1								
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.9						
MOI.12						

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 Requirement	More Stringent than	Law or Regulation Is Evaluated on Site? (Yes/No)
MPE.7					
HRP.1					
HRP.3.1					
HRP.4					

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Page 3, Which Hospitals Are Eligible for a JCI Accreditation Survey? (corrected formatting to include text in bulleted list)

The applicant academic medical center hospital must meet each of the criteria above in addition to the following three criteria:

- The applicant hospital is organizationally or administratively integrated with a medical school.
- The applicant hospital is the principal site (see below) 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.
- At the time of application, the applicant hospital is conducting academic and/or commercial human subjects research under multiple approved protocols involving patients of the hospital.



Page 3, Principal Site

(deleted text from this section and placed it on page 4)

Principal Site

Principal site means the hospital 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 hospital (**for example**, an ophthalmologic hospital, dental hospital, or orthopedic hospital).

Note: If in its reasonable discretion JCI determines that the applicant hospital does not meet the published eligibility criteria, 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.



Page 4, Full Operation

(placed deleted text from page 3 in this section)

Note: Contact JCI Accreditation prior to submitting an E-App to discuss the criteria and validate whether the hospital meets the above criteria for "in full operation" at least four months or more prior to submitting its E-App and at its initial survey. JCI may request documentation of the hospital's utilization statistics prior to accepting the E-App or conducting the on-site survey. In addition, JCI will not begin an on-site survey, may discontinue an on-site survey, or may cancel a scheduled survey when it determines the hospital is not "in full operation."

Note: If in its reasonable discretion JCI determines that the applicant hospital does not meet the published eligibility criteria, 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.



Page 133, Survey Planning Tools, Required Written Policies (Including Those Required in English) (policies added)

Access to Care and Continuity of Care (ACC)				
Standard	Standard Text	In English?		
ACC.3	The hospital designs and carries out processes to provide continuity of patient care services in the hospital and coordination among health care practitioners.			
ACC.3.1	During all phases of inpatient care, there is a qualified individual identified as responsible for the patient's care.			
ACC.4	There is a process for the referral or discharge of patients that is based on the patient's health status and the need for continuing care or services.			
ACC.4.3.2	The clinical records of inpatients contain a copy of the discharge summary.			
ACC.4.4	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.			
ACC.5.3	The transfer process is documented in the patient's record.			
ACC.6	The process for referring, transferring, or discharging patients, both inpatients and outpatients, includes planning to meet patients' transportation needs.			

Patient and Family Rights (PFR)			
Standard	Standard Text	In English?	
PFR.1	The hospital is responsible for providing processes that support patients' and families' rights during care.		
PFR.1.3	The patient's rights to privacy and confidentiality of care and information are respected.		



Page 142, Survey Planning Tools, Required Written Policies (Including Those Required in English) (policies added and deleted)

Management of Information (MOI)				
Standard	Standard Text	In English?		
MOI.2	Information privacy, confidentiality, and security—including data integrity—are maintained.			
MOI.3	The hospital determines the retention time of records, data, and information.			
MOI.7	Records and information are protected from loss, destruction, tampering, and unauthorized access or use.			
MOI.9	Written documents, including policies, procedures, and programs, are managed in a consistent and uniform manner.	Yes		
MOI.9.1	The policies, procedure, plans, and other documents that guide consistent and uniform clinical and nonclinical processes and practices are fully implemented.			
MOI.10.1	The clinical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, to document the course and results of treatment, and to promote continuity of care among health care practitioners.			
MOI.10	The hospital initiates and maintains a standardized clinical record for every patient assessed or treated and determines the record's content, format, and location of entries.			
MOI.11	The hospital identifies those authorized to make entries in the patient clinical record.			



Page 79, Medication Management Tracer (substituting words)

Location

The location of the <u>FMS medication management</u> tracer session is at the discretion of the hospital. Following the discussion portion of the tracer, topics selected for further exploration by the surveyor will guide how and where the remainder of the <u>FMS medication management</u> tracer will be conducted.



Page 82, System Tracer: Infection Prevention and Control (substituting words)

Location

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



Pages 93-95, Other Professional Staff Qualifications Worksheet (delete nonapplicable standards from table)

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 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.8.1	1. Staff members who provide patient care and other staff identified by the hospital to be trained in cardiac life support are identified.		
	3. There is evidence to show if a staff member passed the training.		
SQE.13	1. The hospital has a standardized procedure to gather the credentials of each nursing staff member.		



Standard	Measurable Element	Compliance Yes/No	Comments
	2. Licensure, education/training, and, when available, experience are documented.		
	3. Licensure and education/training are verified from the original source according to the parameters found in the intent of SQE.9.		
	4. There is a record maintained of the credentials of every nursing staff member.		
SQE.15	1. The hospital has a standardized procedure to gather the credentials of each health professional staff member.		
	2. Licensure, education/training, and, when available, experience, are documented.		
	3. Licensure and education/training are verified from the original source according to the parameters found in the intent of SQE.9		
	4. There is a record maintained on other health professional staff members that contains copies of any required license, certification, or registration.		
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 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.		



Standard	Measurable Element	Compliance Yes/No	Comments
SQE.8.1	1. Staff members who provide patient care and other staff identified by the hospital to be trained in cardiac life support are identified.		
	3. There is evidence to show if a staff member passed the training.		
SQE.13	1. The hospital has a standardized procedure to gather the credentials of each nursing staff member.		
	2. Licensure, education/training, and, when available, experience are documented.		
	3. Licensure, education/training are verified from the original source according to the parameters found in the intent of SQE.9.		
	4. There is a record maintained of the credentials of every nursing staff member.		
SQE.15	1. The hospital has a standardized procedure to gather the credentials of each professional staff member.		
	2. Licensure, education/training, and, when available, experience are documented.		
	3. Licensure, education/training are verified from the original source according to the parameters found in the intent of SQE.9		
	4. There is a record maintained on other professional staff members.		