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Questions About Accreditation and Certification

- For general inquiries regarding accreditation and certification services, to schedule an accreditation or certification survey, or ask about the application process, please email Joint Commission International Accreditation at jciaccreditation@jcrinc.com.
- To comment about quality or safety at a certified 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 jciconsulting@jcrinc.com.
Introduction

The Joint Commission International Survey Process Guide for Clinical Care Program Certification, Third Edition is designed to help organizations learn about and be better prepared for the Joint Commission International (JCI) survey process. This guide provides organizations with important information about JCI, the clinical care program certification standards manual, eligibility for certification, how to request certification, survey preparation, the on-site survey, and the certification decision.

Clinical care program leaders should not hesitate to contact any of the JCI offices by telephone or e-mail using the contact directory (on page v) 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 proceeded by the words for example in bold text.
Joint Commission International Surveys: General Information
Which Clinical Care Programs Are Eligible for a JCI Certification Survey?

Joint Commission International (JCI) clinical care program certification (CCPC) evaluates the programs that provide clinical care directly to participants of the program and meet the eligibility requirements. Examples of programs may include, but are not limited to, acute myocardial infarction, heart failure, primary stroke, asthma, chronic obstructive pulmonary disease, pain management, palliative care, low back pain, chronic depression, and HIV/AIDS.

Any clinical care program that is provided in association with a JCI–accredited organization is eligible to apply for JCI certification if the following requirements are met:

- The program is appropriately designed and implemented for the population served.
- A minimum of 25 patients have met the program’s eligibility requirements and have been managed under the program’s selected clinical practice guidelines prior to CCPC application.
- The program has been in operation for at least four months prior to CCPC application.
- The program can demonstrate at least a four-month track record of consistent compliance with all of the JCI standards at the time of the CCPC survey.
- Clinical practice guidelines used are evidence based and are sponsored and supported by the auspices of medical specialty associations, relevant professional societies, public or private organizations, government agencies, or other authoritative sources.
- The performance measures selected for the program meet the following requirements:
  - Performance measures selected are appropriate and consistent with the program’s intent and/or clinical practice guidelines.
  - The program has collected four months of data for the selected performance measures at the time of submitting the application.
  - The program has monitored at least four performance measures at the time of submitting the application.

Certification as a Specialty Center for Specialty Hospitals That Are JCI–Accredited

A specialty hospital that is JCI–accredited and meets specific eligibility requirements may apply for certification as a Certified Specialty Center for the specific specialty provided. For example, a JCI–accredited hospital that treats only cancer patients may apply for certification as a Certified Cancer Center. Similarly, a JCI–accredited hospital that only performs joint replacement may apply for certification as a Certified Joint Replacement Center.

Any specialty hospital that is JCI accredited is eligible to apply for JCI certification as a specialty center if the following requirements are met:

- The specialty hospital is accredited under the JCI standards for hospitals.
- The hospital specializes in care for a specific patient population, such as cancer, neurology, or mental health.
- At the time the hospital submits its application, the hospital must have served a sufficient number of patients for the surveyors to adequately survey implementation of each program.
- Every patient must be managed under an approved clinical practice guideline prior to Specialty Center Certification application.
- To qualify as approved, the clinical practice guidelines used must be evidence based and sponsored and supported by the auspices of medical specialty associations, relevant professional societies, public or private organizations, government agencies, or other authoritative sources.
- The specialty hospital can demonstrate at least a four-month track record of consistent compliance with all of the JCI standards for CCPC at the time of the survey.
• A minimum of at least four performance measures must be selected for each of the clinical practice guidelines and must meet the following requirements:
  o Performance measures selected are appropriate and consistent with the clinical practice guideline.
  o The specialty hospital has collected four months of data for each of the selected performance measures.
  o The specialty hospital has monitored at least four performance measures for each clinical practice guideline.
Clinical Care Program Certification Eligibility Self-Evaluation Checklist

Programs interested in a Joint Commission International (JCI) certification survey under JCI’s Standards for Clinical Care Program Certification (CCPC) must meet the following seven eligibility requirements.

**Note:** Please provide an explanation for any requirement that is answered “No.”

1. The host organization for the clinical care program is accredited by JCI.
   - Yes
   - No

2. The program is appropriately designed and implemented for the population served. (Please refer to CCPC standards chapter, “Program Leadership and Management” for the detailed requirements for this criterion.)
   - Yes
   - No

3. A minimum of 25 patients have met the program’s eligibility requirements and have been managed under the program’s selected clinical practice guidelines prior to CCPC application.
   (Although this JCI-required minimum number of 25 patients may be difficult to achieve for some specific clinical care programs that may only be capable of capturing a low volume of eligible patients, the program can still apply for certification by demonstrating the following alternative eligibilities for this criterion:)
   a) Population assessment report to provide evidence that the program is relevant and meets the needs of the target population and/or health care service area (see JCI standard PLM.3)
   b) Statistically valid track records of positive program’s performances and outcomes
   c) Program’s enrolled participants are representative of the target populations
   d) Alternative evidence of the program’s staff competency in delivering care and services despite low volumes
   - Yes
   - No

4. The program has been in operation for at least four months prior to CCPC application.
   - Yes
   - No

5. The program can demonstrate at least a four-month track record of consistent compliance with all of JCI standards at the time of the CCPC survey.
   - Yes
   - No

**Special note for eligibility item numbers 3, 4, and 5:** JCI strongly recommends that the program consider its maturity; that is, the length of time the program has been operating and the ability of the program to demonstrate its full capabilities in providing care and services to the target population. Although JCI uses a four-month track record as a guiding time frame, the program should also consider other methods in measuring the maturity of the program. For example, has the program completed at least one round of the quality improvement cycle, such as Plan-Do-Study-Act (PDSA)? This would allow the program an opportunity to evaluate the data collected and respond by improving and/or modifying the program’s services if indicated.

6. Clinical practice guideline(s) used meet the CCPC program’s policy for clinical practice guidelines.
   - Yes
   - No

7. The performance measures meet the CCPC program’s policy for Performance Measurement (see JCI Standard PMI.3).
   - Yes
   - No
Clinical Care Program Certification Eligibility Self-Evaluation Checklist for Specialty Centers

Specialty centers may request a Joint Commission International (JCI) certification survey under JCI Standards for Clinical Care Program Certification (CCPC) if the following eight eligibility requirements are met:

**Note:** Please provide an explanation for any requirement that is answered “No.”

1. The specialty hospital is accredited under the JCI standards for hospitals.
   - Yes  ❑  No  ❑

2. The hospital specializes in care for a specific patient population, such as cancer, neurology, or mental health.
   - Yes  ❑  No  ❑

3. The hospital must have served a minimum number of patients at the time it submits its application to JCI.
   - Yes  ❑  No  ❑

4. Every patient must be managed under an approved clinical practice guideline prior to Specialty Center Certification application.
   - Yes  ❑  No  ❑

5. To qualify as approved, the clinical practice guideline(s) used must be evidence based and sponsored and supported by the auspices of medical specialty associations, relevant professional societies, public or private organizations, government agencies, or other authoritative sources.
   - Yes  ❑  No  ❑

6. The specialty hospital can demonstrate at least a four-month track record of consistent compliance with all of the JCI standards for CCPC at the time of the CCPC survey.
   - Yes  ❑  No  ❑

7. Clinical practice guideline(s) used meet the CCPC program’s policy for clinical practice guidelines.
   - Yes  ❑  No  ❑

8. A minimum of at least four performance measures must be selected for each of the clinical practice guidelines and must meet the following requirements:

   - Performance measures selected are appropriate and consistent with the clinical practice guideline.
     - Yes  ❑  No  ❑

   - The specialty hospital has collected four months of data for each of the selected performance measures.
     - Yes  ❑  No  ❑

   - The specialty hospital has monitored at least four performance measures for each clinical practice guideline
     - Yes  ❑  No  ❑
How to Request a JCI Certification Survey

Certification of clinical care programs is only available to programs that are hosted by a Joint Commission International (JCI)–accredited organization. To begin the certification process for recertification, go to http://www.jointcommissioninternational.org/Programs-Hospitals and click on the link “JCI Direct Connect.” JCI requires organizations to be accredited at minimum six months prior to the CCPC requested survey dates. After you log into JCI Direct Connect and access your Electronic Application (E-App), please go to Tab 2 (Programs) and select “CCPC.” Please complete all required CCPC information and “submit” your CCPC application. Do not delete the information for the previously accredited Hospital or Ambulatory Care Program. JCI requests that the program 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 surveyor to your organization. From the information your program submits, JCI will develop a certification 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 four-month track record of compliance with the standards at the time of the on-site survey (read more in Certification Preparation on page 26).

In its E-App, the program 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 program representative. JCI’s representative will answer any questions about survey preparation and help guide individuals through each step of the certification 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 months before the survey, the certification survey contract agreement will be sent to the program representative. 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 program representative 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 15), JCI collects core information regarding each organization’s profile in its E-App to understand ownership, licensure, scope and volume of patient services, and types of patient care facilities, as well as information about the clinical care program, leaders of the program, and volumes of patients, 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 certification award. Thus, the organization and/or clinical care program notifies JCI before the change or within 15 days of changes in such core information from the organization’s and clinical care program’s profile, including, but not limited to, the following:

- A change in the clinical care program’s leadership
- A change in the clinical care program’s scope of services
- A change in organization 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 organization’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 certification survey.
- Intentional expansion of the organization’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 organization has merged with, consolidated with, or acquired an uncertified site, service, or program for which there are applicable JCI standards.

JCI may conduct an additional survey for all or a portion of the organization and/or clinical care program again or for the first time in the case of new facilities or services. JCI certification does not automatically extend certification 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 program is certified by or seeking certification by JCI. Changes reported may be evaluated off-site or by a focused survey.

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

If the hospital/clinical care program 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 Certification. 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 certification 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**
Joint Commission International (JCI) schedules surveys systematically and efficiently to keep certification fees to a minimum. Therefore, clinical care programs are encouraged to accept scheduled survey dates. Initial surveys (a program's first full certification survey) should be scheduled within six months from the time JCI receives the organization's application for survey.

JCI tries to honor specific requests for times during which a clinical care program prefers not to be surveyed. The clinical care program 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 clinical care program's request to alter an already scheduled survey date or to push back the survey date before it is actually scheduled. A clinical care program should submit a request for a postponement via email to jciaccreditation@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 clinical care program 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 and clinical care program continue to provide patient care services under such circumstances. Prior to postponing a scheduled survey, it is recommended that hospitals and clinical care programs 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 the clinical care program, JCI, the clinical care program, 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 clinical care program or 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 Joint Commission International (JCI) website and The Joint Commission International Standards for Clinical Care Program Certification, Third Edition, and this publication are the tools programs can use to begin preparing for certification. JCI posts its key certification and certification policies and procedures on its public website. Clinical care programs considering certification can review these policies and procedures to better understand the expectations before beginning the certification journey. Even if clinical care program does not pursue certification immediately, the website and certification manual are excellent tools to help evaluate the clinical care program's current practices and structures. The manual contains functional standards that are organized around the way care is provided in a program setting. The standards address patient-focused performance and are organized around functions and processes, including clinical and organizational, that are common to all clinical care programs. The manual is designed to be used in self-assessment activities and forms the basis for a certification survey.

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

**Section I: Accreditation Participation Requirements**

This section, new to the certification manual, consists of specific requirements for participation in the JCI certification process and for maintaining a certification award. For a clinical care program seeking certification for the first time, compliance with many of the Accreditation Participation Requirements (APR) is assessed during the initial survey. For the already-certified program, compliance with the APRs is assessed throughout the certification cycle, through on-site surveys, the Strategic Improvement Plan (SIP), and periodic updates of host organization– and clinical care program–specific data and information.

Host organizations and the clinical care programs are either compliant or not compliant with the APRs. When a host organization and/or the clinical care program does not comply with certain APRs, the host organization or clinical care program may be asked to submit a SIP, or the noncompliance may result in being placed At Risk for Denial of Certification, or may lead to the loss of certification 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 certification survey.

**Section II: Standards**

The next section of the manual contains standards related to all aspects of the certification process.

**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. Health care organizations that host a clinical care program seeking certification are accredited by JCI and have implemented the requirements of the International Patient Safety Goals (IPSG). All of the IPSG are applicable to every clinical care program, with the exception of IPSG.4 and IPSG.4.1, which may only apply to programs that use surgical interventions as part of their clinical practice guidelines.

**Program Leadership and Management (PLM)**

Providing quality care requires an infrastructure capable of supporting the activities of the participant and care provider. Leadership and leaders must commit the resources to support, evaluate, and improve the services.
The standards in this chapter focus on the following:

- Designing and implementing the program
- Evaluating the program
- Creating a relevant program for participants
- Providing adequate access to care
- Conducting the program in an ethical manner
- Supplying reference resources to practitioners
- Having an organized, comprehensive approach to quality and safety management and improvement

**Delivering or Facilitating Clinical Care (DFC)**

Improving, delivering, or facilitating the delivery of quality clinical care is at the heart of disease management. The standards in this chapter focus on the following:

- Using qualified, competent practitioners
- Delivering or facilitating the delivery of care using evidence-based clinical practice guidelines
- Individualizing care to meet the participant’s needs
- Improving practice and services based on the use of performance measures

**Supporting Self-Management (SSM)**

A basic principle of disease management is that the participant must be actively involved in managing the disease. The standards in this chapter focus on the following:

- Assessing participants’ self-management capabilities
- Providing support for participants in self-management activities
- Involving participants in developing the plan of care
- Educating participants in the theory and skills necessary to manage their disease(s)
- Recognizing and supporting self-management efforts

**Clinical Information Management (CIM)**

Delivering or facilitating the delivery of health care is a complex endeavor that is highly dependent on information. Over time, patients may receive a range of care in multiple settings from multiple practitioners. The goal of coordinating information across the continuum is to manage information, define processes, and sequence activities, thereby maximizing care coordination and improving care. For this reason, it is important that a disease- or condition-specific care program views the care it provides as part of the health care delivery system across settings, services, health care practitioners, and care levels that define the continuum of care.

The standards in this chapter focus on the following:

- Proactively gathering and sharing information across the continuum in order to coordinate care across settings and over time
- Providing easy access to participant-related information
- Preserving confidentiality of participant information
- Maintaining data quality and integrity
- Integrating and interpreting data from various sources

**Performance Measurement and Improvement (PMI)**

Programs are required to collect and submit data for four measures. One measure must relate to clinical care, and one measure must include participant perception of care quality. The remaining two measures can address either of these areas or may relate to health status or administrative/financial areas. If a program wants to submit more than four measures, it may do so. In addition, programs are required to submit post–pilot-test measurement data for at least the most recent 12-month period and must include at least four data points to demonstrate that the program has established a data history that supports quality improvement.

The standards in the chapter focus on the following:

- Trending and comparing data to evaluate processes and outcomes
• Using information garnered from measurement data to improve or validate clinical practice
• Using participant-specific care-related data
• Evaluating the participants’ perception of care quality
• Maintaining data quality and integrity

**Summary of Key Certification Policies**

New to the third edition certification standards, JCI’s policies and procedures are summarized and moved from the front of the manual to its current location following the certification 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. JCI full policies are published on JCI’s public website [http://www.jointcommissioninternational.org/accreditation-policies](http://www.jointcommissioninternational.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 21)*
- 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
  - a 5- to 11-month look-back period of compliance for triennial surveys; or
  - 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.
  o 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 an example:

<table>
<thead>
<tr>
<th>Standard DFC.8</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1. The program identifies processes associated with infection risk.</td>
<td>Not Met</td>
</tr>
<tr>
<td>☐ 2. The program implements strategies to reduce infection risk.</td>
<td>Not Met</td>
</tr>
<tr>
<td>☐ 3. The program identifies which risks require policies and/or procedures, staff education, practice changes, and other activities to support risk reduction.</td>
<td>Not Met</td>
</tr>
</tbody>
</table>

**Compliance Rate**
Compliance with the requirements of the ME is documented as the rate (percentage) of compliance demonstrated by the program. 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 program’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 clinical care program does not perform surgery or other invasive procedures, thus IPSG.4 would be not applicable).

**Other Considerations**

**The Look-Back Period for New Standards**
The effective date of new standards is published with the standards. Programs 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 third edition standard effective on 1 January 2015, the look-back period on a 1 April triennial survey is 3 months back to the 1 January 2015 effective date, not the 12 months for existing standards. Similarly, for a 1 April initial survey, the look-back is 3 months rather than 4 months.
If an organization 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 program is in full compliance (“fully met”) with the ME, but the program 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 certification decision rules (see page 24), 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 program 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 program does not meet the requirements for continuous, ongoing professional practice evaluations of the quality and safety of the clinical care provided by each staff member, standard DFC.3, because not all staff have been given an annual performance evaluation and there is no evidence of an annual performance evaluation in their file.

When the surveyor(s) returns for the focused survey, the organization presents evidence that the professional practice evaluations have been completed for all staff and are up to date. In addition, staff have been provided their review and an opportunity to discuss their review with their supervisor.

**Example 2**

Standard PMI.6 requires the program to develop and implement a process for identifying, reporting, managing, and tracking “near-miss” events.

The program did not meet ME 3 because they did not have a process for tracking near-miss events. Because they were not tracking near-miss events, they were also not analyzing these events (ME 4) and were unable to make changes based on the analysis of near-miss events (ME 5). When the surveyor(s) returned for the focused survey, the program had developed and implemented a process that tracked and trended near-miss events and had begun analysis of these events to identify any changes needed. The plan identified how to trend near-miss events, how the information would be analyzed, and the process for implementing changes as a result of the analysis.

Although the actions by the organization do not meet the required “look-back” or “track record,” based on the program's actions and the evidence observed by the surveyor(s), the program 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 program. 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.
Certification Decision Rules (Effective 1 January 2015)

Certification Decisions

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

Certified

This decision results when an organization meets all of the following conditions:

- The program demonstrates acceptable compliance with each standard. Acceptable compliance is a score of at least "5" on each standard.
- The program demonstrates overall acceptable compliance. Acceptable compliance is an overall aggregate score of at least "9" on all standards.
- No measurable element in the IPSG chapter is scored "not met."
- The program demonstrates acceptable compliance at the measurable element level. Acceptable compliance is: No more than one measurable element is scored a "0" for any standard.

Denial of Certification

This decision results when an organization 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 certification as a result of a focused survey for the evaluation of one or more policy-related conditions that may place the program At Risk for Denial of Certification:

- One or more standards is scored less than "5."
- The aggregate score for all standards is less than "9."
- One or more measurable element in the IPSG is scored “not met”.
- More than one measurable element is scored a "0" for any standard.
- 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 program At Risk for Denial of Certification have not been resolved at the time of the focused survey to evaluate the condition.
- The program voluntarily withdraws from the certification process.
- The program does not permit the performance of any survey by Joint Commission International.

Conditions that place an organization At Risk for Denial of Certification are as follows:

- An immediate threat to patient/public health or staff safety exists within the program (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 program that would, under applicable law or regulation, require such a license, registration, or certification and that placed the program’s patients at risk for a serious adverse outcome (see APR.12 in the standards manual).
- JCI is reasonably persuaded that the program submitted falsified documents or misrepresented information in seeking to achieve or retain certification, as required by the Information Accuracy and Truthfulness Policy (see APR.2 in the standards manual).
- The program 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 program is seeking certification (see APR.3 in the standards manual).
- The program has not met the certification policy for “Reporting Requirements Between Surveys” (see APR.3 in the standards manual).
- The program fails to submit an acceptable Strategic Improvement Plan (SIP) within 120 days of the program’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 certification and at the time of recertification, every three years. At the conclusion of the survey, the findings are evaluated against the required conditions for certification. When the survey results meet all the conditions for certification, the program receives a Certified status. The program 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 certification, the program 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 program. 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 program by the JCI Accreditation Office within 15 days following the survey. A 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 Office, when the program meets the conditions for certification. The SIP explains the program’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 Office for review and acceptance within 45 days after receiving the final survey report. A program that fails to submit an acceptable SIP may be placed at risk of certification denial and require a focused survey to verify evidence of compliance.

A Preliminary Survey Findings Report is sent to the program by the Accreditation Office when the documented findings of the certification survey team do not meet one or more of the conditions for certification. The preliminary report is sent to the program within 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 program received the Preliminary Survey Findings Report. During the on-site visit, the surveyor(s) will determine the program’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 certification, the program receives a Certified status. The program will then be requested to develop a SIP for any “not met” survey findings and/or any “partially met” survey findings as determined by JCI Accreditation.

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

After Joint Commission International (JCI) accepts the program’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 program’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 program. If a JCI surveyor(s) with the appropriate language capabilities is not available, it is the program’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 program, 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 program.

On-site program certification surveys are typically conducted by one or two surveyors, depending on the complexity of the program and the number of individual programs to be surveyed. The survey follows actual patient care through the facility and includes interviews with key personnel, observation of the program’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 program.

The survey team leader will contact the program 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.

**CCPC Items To Be Available**

Please have the following materials to the surveyor in advance of the JCI on-site survey. Please note that the requested information detailed below may be e-mailed (in English) in advance or made available for the surveyor at the airport upon arrival for him/her to review in the hotel the day prior to the actual survey. You will receive further guidance from the surveyor in advance.

1) An organizational chart that includes the disease program and how it fits within the larger organization
2) A list of all clinical units/departments/areas which are directly involved in the program (PLM 2)
3) Summary data of reviews of medical records for timeliness, accuracy, and completeness of all necessary information at the program level (CIM 4)
4) In-service/staff training related to the condition (DFC 5)
5) Any contractual arrangements that provide services for the program (PLM 4)
6) The specific performance measures that are going to be used and a brief summary of any data collected for the past 12 months. If collecting for more than four measures, please provide all (PMI 3)
7) Summary data of patient feedback surveys at the program level (PMI 7)
8) Documents sent to participants about accessing the program’s services, including for emergencies after normal office hours (PLM 3, PLM 6, DFC 7)
9) Any community education about the program—both for patients and for other practitioners; be specific—policies, actual classes to patients and/or clinicians, other outreach programs, analysis of targeted population groups, etc. How was the program designed appropriately to serve the population in question? (PLM 3, PLM 4)
10) Lists and agendas of any classes for patients, including related to life-style changes that may impact on the condition (SSM chapter)
11) Any policies and procedures for identifying and managing unanticipated adverse events and sentinel events (PMI 4, PMI 5, PMI 6)

On the day of the survey, please have the following available:

1) A list of all staff members involved with the program
2) A list of all patients who have been treated in the program in the past 4 months (12 months for triennial surveys)
3) A list of current program patients currently in the hospital, including name, age, diagnosis, and inpatient unit
4) A list of operative and invasive procedures scheduled for program patients
5) Pertinent committee minutes related to the program
6) Required program plans, documents, and policies
7) A map of the organization's campus
8) A copy of all patient record forms
9) For stroke surveys, two closed patient records who were treated with TPA
10) For acute myocardial infarction (AMI) surveys, two closed patient records who had STEMI's, and primary interventions

**Certification Preparation Time Line**

**Programs Requesting an Initial Survey**

<table>
<thead>
<tr>
<th>Time Line</th>
<th>JCI Activity</th>
<th>Program's Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months before preferred month of survey</td>
<td></td>
<td>Review the <em>Joint Commission International Standards for Clinical Care Program Certification, Third Edition,</em> to understand the requirements and expectations related to JCI certification. Register for, complete, and submit the application for survey to JCI Accreditation via E-App, JCI's electronic application tool.</td>
</tr>
<tr>
<td>Upon receipt of the application for survey</td>
<td>JCI Accreditation reviews the application. Once approved, JCI provides the program with broader access to resources on JCI Direct Connect, JCI's client portal, including a complimentary copy of this survey process guide.</td>
<td></td>
</tr>
</tbody>
</table>

**Programs Requesting Recertification**

<table>
<thead>
<tr>
<th>Time Line</th>
<th>JCI Activity</th>
<th>Program's Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td>The program updates its profile on E-App as changes to the organization's facility, services, or other changes make necessary</td>
</tr>
<tr>
<td>6 to 9 months before the due date of the next triennial survey</td>
<td>JCI reminds the program that a triennial survey is forthcoming and that the program's profile on E-App should be updated.</td>
<td>The program submits its application for survey via E-App.</td>
</tr>
<tr>
<td>All Programs Requesting Certification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time Line</strong></td>
<td><strong>JCI Activity</strong></td>
<td><strong>Program’s Activity</strong></td>
</tr>
<tr>
<td>4 to 5 months before survey</td>
<td>A contract agreement is e-mailed to the program.</td>
<td>The program 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.</td>
</tr>
<tr>
<td></td>
<td>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 program. Programs can elect to pay 100% or a smaller percentage of the survey fees due based on its preference.</td>
<td></td>
</tr>
<tr>
<td>8 weeks before survey</td>
<td>JCI verifies the survey date(s) and name(s) of surveyor(s) are e-mailed to the program.</td>
<td>Any changes that have occurred since submission of the application must be reported/submitted to JCI.</td>
</tr>
<tr>
<td>4 to 8 weeks before survey</td>
<td>The JCI survey team leader contacts the program’s contact person to finalize the survey agenda and to request presurvey information.</td>
<td>Appropriate program staff members discuss the proposed survey agenda and determine whether times are feasible for the program, given patient needs and availability of staff. When the program wishes to include an observer during the survey process, programs must request permission from JCI Accreditation prior to the survey for approved survey observers.</td>
</tr>
<tr>
<td>Survey</td>
<td>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 JCI Accreditation has reviewed it.</td>
<td>Leaders and staff should be available during the survey as indicated by the survey agenda.</td>
</tr>
</tbody>
</table>
| Within 15 days after survey         | JCI reviews, approves, and sends the Official Survey Findings Report. A focused survey may be required prior to a certification decision determination. If the certification is granted, the award letter, report, and certification 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 program. JCI sends the chief executive officer of the surveyed program a JCI Certification Satisfaction Survey via e-mail to assist JCI in its performance improvement activities. | After JCI Accreditation sends the Official Survey Findings Report, the program begins either of the two follow-up processes as requested:  
1) Develop the Strategic Improvement Plan (SIP) if certified.  
2) Prepare for the focused survey if the conditions for certification were not met. The program leader of the surveyed program encourages members of the leadership team to provide input for the JCI Certification Satisfaction Survey. |
<table>
<thead>
<tr>
<th>Time Line</th>
<th>JCI Activity</th>
<th>Program's Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 3 days after the certificate is mailed</td>
<td>The program’s name, location, and date of certification is added or updated for public viewing on the JCI website.</td>
<td>The program may request that JCI Accreditation place a link on the JCI website to the certified program’s host organization website.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Each certified program 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 certification activities.</td>
<td>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 certification process. Examples include International Patient Safety Goal monitoring data, SIP compliance data, and self-assessments of standards compliance.</td>
</tr>
<tr>
<td>Approximately 6 months after publication of a new JCI program standards edition</td>
<td>JCI publishes a new edition of the program standards and other requirements approximately every three years. The manual becomes effective for all certified programs and all surveys approximately 6 months after publication.</td>
<td>Staff review the new program standards and other requirements and act on any new and modified standards, scoring guidelines, policies, and procedures. If JCI needs to visit the program, the current, effective standards are used.</td>
</tr>
<tr>
<td>Within 15 days of any significant organizational changes</td>
<td></td>
<td>The program notifies JCI via E-App of any significant change in the program’s profile.</td>
</tr>
<tr>
<td>Within 18 months of receiving Clinical Care Program Certification</td>
<td></td>
<td>The program leader must submit to JCI Accreditation, the intracycle performance review data one week prior to the due date. JCI will review the intracycle review data and notify the program director of any additional information required.</td>
</tr>
<tr>
<td>6 to 9 months before the due date of the next triennial survey</td>
<td>JCI reminds the program that a triennial survey is forthcoming and that the program’s profile on E-App should be updated.</td>
<td></td>
</tr>
</tbody>
</table>
**Certification Process Time Line**

1. **Obtain JCI standards manual and begin preparing for JCI certification**
2. **Receive and complete JCI Survey Contract and travel instructions form**
3. **JCI Certification survey occurs**
4. **Submit intracycle Performance Review Report**
5. **Submit revised application and schedule triennial JCI certification re-survey**

**Timeline:**
- **12 to 24 Months Prior to Survey**
- **6 to 9 Months Prior to Survey**
- **3 Months Prior to Survey**
- **4 to 8 Weeks Prior to Survey**
- **Survey Dates**
- **Within 15 Days After Survey**
- **18 Months Following Certification**
- **6 to 9 Months Prior to Triennial Due Date**

**Steps:**
- **Submit application for survey to JCI and schedule survey dates with JCI**
- **JCI survey team leader contacts the program to determine survey agenda**
- **Receive certification decision and Official Survey Findings Report from JCI**

**Continuous Quality Improvement**
The On-Site Survey

The purpose of a Joint Commission International (JCI) certification survey is to assess the extent of a program's compliance with applicable JCI standards. Programs undergoing their first survey need to demonstrate a track record of 4 months of compliance with the standards. Programs being re-surveyed need to demonstrate 12 months of compliance with the standards. Understanding the program 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 program's operations

The on-site survey uses tracer methodology to follow a sample of active patients through their experiences of care in the program 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 program better meet the intent of the standards and, more importantly, improve performance.

The on-site review consists of the following steps:

- Opening Conference (see page 49) and Orientation to the Program (see page 51)
- Overview of Performance Measures
- Surveyor Planning Session (see page 47)
- Document Review (see page 57)
- Patient care and service area visits guided by patient tracer and system tracer activities (see page 63), including Open/Closed Patient Medical Record Review (see page 73)
- Environmental reviews
- Open/Closed Patient Medical Record Review (see page 73)
- Direct patient interviews (see page 67)
- Staff Education and Qualifications Session (see page 69)
- Exit Conference (see page 87)

Sample agendas for on-site surveys are below.
## Sample CCPC Survey Agenda (2 days, 1 surveyor)

### Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Physician or Nurse Surveyor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800–0815</td>
<td>Opening Conference, Introductions, Agenda Review <em>(see page 49)</em></td>
</tr>
<tr>
<td>0815–0900</td>
<td>Presentation of Overview of Clinical Care Services and Performance Measure Data <em>(see page 51)</em></td>
</tr>
<tr>
<td>0900–1000</td>
<td>Surveyor Document Review, as needed <em>(see page 57)</em></td>
</tr>
<tr>
<td>1000–1200</td>
<td>Unit Visits/Tracer Activity</td>
</tr>
<tr>
<td>1200–1300</td>
<td>Surveyor Working Lunch (debriefing and survey planning)</td>
</tr>
<tr>
<td>1300–1600</td>
<td>Unit Visits/Tracer Activity</td>
</tr>
<tr>
<td>1600–1615</td>
<td>Review any issues as needed with Program Director</td>
</tr>
</tbody>
</table>
### Sample CCPC Survey Agenda (2 days, 1 surveyor)

#### Day 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Surveyor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800–0830</td>
<td>Daily Debriefing <em>(see page 61)</em></td>
</tr>
<tr>
<td>0830–0900</td>
<td>Further discussion of selected four performance improvement measures, as needed</td>
</tr>
<tr>
<td>0900–1100</td>
<td>Closed Medical Record Review <em>(see page 73)</em></td>
</tr>
<tr>
<td>1100–1130</td>
<td>Surveyor interviews with program ambulatory outpatients <em>(see page 67)</em></td>
</tr>
<tr>
<td>1130–1230</td>
<td>Surveyor Working Lunch (debriefing and survey planning)</td>
</tr>
<tr>
<td>1230–1400</td>
<td>SQE Review for Physicians, Nurses, and Other Staff <em>(see page 69)</em></td>
</tr>
<tr>
<td>1400–1430</td>
<td>Leadership Session, if needed</td>
</tr>
<tr>
<td>1430–1530</td>
<td>Surveyor Report Preparation <em>(see page 85)</em></td>
</tr>
<tr>
<td>1530–1600</td>
<td>Exit Conference <em>(see page 87)</em></td>
</tr>
</tbody>
</table>
### Sample CCPC Survey Agenda (1 day, 2 surveyors)

#### Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Physician</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800–0815</td>
<td>Opening Conference, Agenda Review <em>(see page 49)</em></td>
<td></td>
</tr>
<tr>
<td>0815–0900</td>
<td>Overview of Clinical Care Services and Performance Measures <em>(see page 53)</em></td>
<td></td>
</tr>
<tr>
<td>0900–1000</td>
<td>Document Review, as needed <em>(see page 57)</em></td>
<td></td>
</tr>
<tr>
<td>1000–1100</td>
<td>Overview of Required Performance Measurement <em>(see page 53)</em></td>
<td></td>
</tr>
<tr>
<td>1100–1230</td>
<td>Unit Visits/Tracer Activity</td>
<td>Unit Visits/Tracer Activity</td>
</tr>
<tr>
<td>1230–1330</td>
<td>Surveyor Working Lunch (team debriefing and survey planning)</td>
<td></td>
</tr>
<tr>
<td>1330–1500</td>
<td>Closed Medical Record Review <em>(see page 73)</em>, Patient Interviews <em>(see page 67)</em> (30 minutes)</td>
<td></td>
</tr>
<tr>
<td>1500–1600</td>
<td>Staff Education and Qualifications Session for Medical and Other Staff <em>(see page 69)</em></td>
<td>Staff Education and Qualifications Session for Nursing <em>(see page 69)</em></td>
</tr>
<tr>
<td>1600–1700</td>
<td>Surveyor Report Preparation <em>(see page 85)</em></td>
<td></td>
</tr>
<tr>
<td>1700</td>
<td>Exit Conference <em>(see page 87)</em></td>
<td></td>
</tr>
</tbody>
</table>
The Certification Decision

The final certification decision is based on the program’s compliance with Joint Commission International (JCI) standards. Programs do not receive a numeric score as part of the final certification decision. When a program successfully meets JCI certification requirements, it will receive an award of Certified. This decision indicates that a program 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 Certified could be removed.

Promoting Certification

After a program receives official notification of the certification decision, it can publicize its international certification achievement by notifying patients, the public, the local media, third-party payers, and resident referral sources. JCI provides a free publicity kit to certified programs that includes the following:

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

Information about a program’s certification status will be posted on the JCI website. The website allows anyone to locate JCI-certified programs within a country and region of the world.

The Continuing Certification Cycle

The certification process does not end when the on-site survey is completed. In the three years between on-site surveys, JCI requests programs 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 complaints. For this reason, it is very important for the program 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 programs 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.
Intracycle Performance Review Requirements

The Joint Commission International Standards for Clinical Care Program Certification are intended to stimulate continuous and systematic improvement in the daily performance and outcomes of patient care. The intended goal of having the Intracycle Performance Review at the midpoint of certification cycle is to provide a mechanism for assessing the program’s performance and continuous compliance with Joint Commission International (JCI) standards.

After the clinical care program has achieved JCI–certified status, each certified program is required to complete this Intracycle Performance Review 18 months after its regular survey to maintain its certification. Although it is not required that the intracycle review report needs to be presented at any specific format, a copy of the JCI Clinical Care Program Certification Intracycle Report Form is available for the program’s reference and use if applicable. The required components for the CCPC Intracycle Performance Review submission are:

1) Any leadership and personnel updates to the program and host organization. A copy of the organizational chart that includes the clinical care program and how it fits within the host organization’s system is highly recommended.
2) Any updates to the program design and scope, plus inclusion/exclusion criteria.
3) Any updates of the program staff’s qualification and education.
4) A copy or the direct Web link to the selected clinical practice guidelines (CPGs) for CCPC survey along with an executive summary that includes any relevant updates to the original CPGs. If any modifications were done to the program’s clinical protocol since the last survey, the actual program’s clinical protocol is required for submission. See the worksheet on page 41.
5) Performance measure updates including the monthly data points in charts or graphs format and aggregated data summary on the four performance measures identified during the certification survey. See the worksheet on page 42 and.
6) Attestation of continuing standards compliance of the CCPC and executive summary report of the result from program’s self-assessment against the standards, including improvements/updates on all findings from the last survey report.

Each certified program is required to submit the intracycle performance report 30 days before the Intracycle Performance Review due date to JCI Accreditation. Upon the receipt of the required Intracycle Performance Review information, JCI accreditation/certification program office staff may in some cases schedule a phone conference call to review the submitted information.

Each Intracycle Performance Review will be evaluated based on the following review criteria:

- The program provides accurate information throughout the certification process.
- The program reports any changes in the information provided in the application for certification and any changes made between reviews.
- The program continues to meet all the eligibility requirements for JCI Clinical Care Program Certification.
- The program’s leadership and practitioners are qualified and competent to provide care and services to the program’s target population.
- The program demonstrates ongoing accurate implementation and delivery of services consistent with the source CPG(s).
- The program demonstrates accurate and effective use of data and its reporting of the performance measurement result.
- The program reports their level of compliance with all previously cited findings at the last survey.

The outcome of the review will be reached as either “Acceptable” or “Not Acceptable” with recommendations for improvement to be completed before the next regular certification survey.
A failure to submit the measure data required for intracycle monitoring within 120 days of the 18-month midpoint of the certification period will result for the program to be placed under At Risk for Denial of Certification.
### Clinical Practice Guidelines

1. Has there been any change (addition and/or deletion) to the selected clinical practice guidelines since the last survey?
   - [ ] Yes
   - [x] No
   
   If yes, please complete the attached Form A for each clinical practice guideline listed.

2. Has there been any change to the evidence and/or recommendation(s) from the selected clinical practice guidelines since the last survey?
   - [ ] Yes
   - [x] No
   
   If yes, please complete the following questions and the attached Form B for Evidence and Recommendation's updates.
   
   a. Did your program change the delivery of service(s) based on the change of evidence and/or recommendations?
      - [ ] Yes
      - [x] No
      
      If yes, please submit an executive summary of the changes and evidence to support the changes.

   b. Did your program change the clinical protocol(s) based on the change of evidence and/or recommendations?
      - [ ] Yes
      - [x] No
      
      If yes, please submit a copy of the revised clinical protocols.
### Performance Measure Results

<table>
<thead>
<tr>
<th>Performance Measure Name/Type</th>
<th>Rationale for the Measure/Corresponding Guidelines</th>
<th>Description of the Numerator (N)/Denominator (D)</th>
<th>Measure Reporting Interval</th>
<th>Sources of Data</th>
<th>Overall Results (Please also submit the monthly graphical data presentation)</th>
<th>Meet Target/Threshold</th>
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<td>If no, any actions taken to evaluate the reasons of not meeting target and any corrective actions for improvement:</td>
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<td>Target/Threshold:</td>
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<td>Target/Threshold:</td>
<td>Yes ☑ No ☐</td>
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</table>
**Analysis and Application of Each Performance Measure Data**

Please complete this form for each performance measure data.

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<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Were any statistical tools and/or techniques used in data analysis process?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
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<tr>
<td>If Yes, please describe the statistical tool(s) and/or techniques used:</td>
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</table>

Please provide a brief summary of the data result and conclusion, including identification of any desirable and/or undesirable trends or patterns observed and any significant variations noted during the data collection period:

Identify any potential opportunities for improvement:

Describe how the data for this measure have been used to evaluate processes and/or change practice:

Please indicate how the effectiveness of these changes were/will be measured:

Were the data used for any benchmarking opportunities?

[ ] Yes [ ] No

Yes, please check the following boxes that applied:

- [ ] Comparisons were made over time within the program.
- [ ] Comparisons were made with similar program.
- [ ] Comparisons were made with any relevant national, regional, and professional or medical association standards.
- [ ] Comparisons were made with known desirable practices.
Survey Agenda: Detailed Descriptions
Surveyor Planning Session

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

Location
The program 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

Program Participants
- Program survey coordinator (as needed by team)
- Translators (as needed by team)

Surveyor(s)
All surveyors

What Will Occur, Documents/Materials Needed

Prior to the Survey
The Team leader will contact the survey coordinator no less than 4 weeks prior to the survey to request electronic copies of the following to be sent prior to the survey:
- Clinical practice guidelines
- Performance measurement data
- A description of the clinical care program design and overview
- A list of departments/units/areas/programs/services within the organization (if applicable)
- An organization chart and map
- Name of key contact person (such as a supervisor or scheduler) who can assist the surveyor(s) in planning tracer selection

During the Survey
This time is set aside for the surveyor(s) to review and discuss pertinent data and plan the survey agenda. The following materials (as applicable to the setting), are required to be available on the first day of the survey. The surveyor(s) will review these materials and they should remain available to the surveyors for the entire duration of the survey:
- A current list of patients enrolled in the program, including their names, diagnoses, ages, admission dates, physicians, and units/services
- A list of the operative and other invasive procedures scheduled as applicable to the clinical care program; for example, surgeries in the operating theatre(s), day surgeries, cardiac catheterizations, and endoscopies/colonoscopies
- A list of the scheduled home visits for enrolled patients for the duration of the survey, including type of service, disciplines, date of admission, and locations. This list should include branch locations (if applicable)
Selection of Individual Tracers

- Surveyors review the information from the survey application and the list of patients currently enrolled in the program to guide their selection of patients to trace.
- Surveyors describe to the program staff the type of patient that they are seeking to trace and request staff’s assistance in identifying individuals.
- In surveys exceeding one day, the surveyor(s) informs the organization during the morning daily briefing 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 program. For example, the surveyor(s) may choose to trace Chronic Kidney Disease as follows:
  - Patients seen in the past four months (initial survey) or 12 months (triennial survey) with Stage I kidney disease
  - Patients seen in the past four months (initial survey) or 12 months (triennial survey) with Stage II kidney disease
  - Patients seen in the past four months (initial survey) or 12 months (triennial survey) with Stage III kidney disease
  - Patients seen in the past four months (initial survey) or 12 months (triennial survey) with Stage IV kidney disease
  - Patients seen in the past four months (initial survey) or 12 months (triennial survey) with Stage V kidney disease

The surveyor(s) may choose to trace Primary Stroke as follows:
  - Patients seen in the past four months (initial survey) or 12 months (triennial survey) with a diagnosis of ischemic stroke
  - Patients seen in the past four months (initial survey) or 12 months (triennial survey) with a diagnosis of hemorrhagic stroke
  - Patients seen in the past four months (initial survey) or 12 months (triennial survey) with diagnosis of transient ischemic attack (TIA)
  - Patients seen in the past four months (initial survey) or 12 months (triennial survey) who received tissue plasminogen activator tPA

- In team surveys, tracer selection should be coordinated to avoid overlap of visits to various areas to the extent possible.
- In programs with multiple sites, individual tracers will include patients at all sites and/or who move between locations represented clinical care program.

Frontline Staff Ownership of the Process

Involving staff in the initial certification 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.
Opening Conference and Agenda Review

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

**Location**
At the discretion of the program

**Program Participants**
- Chief executive officer
- Chairman, governing body, or similar representative
- Director of the clinical care program
- Medical director, when applicable
- Nurse executive
- Quality improvement coordinator
- Clinical care program survey coordinator
- Host organization's survey coordinator
- Others at the discretion of the organization

**Surveyor(s)**
All surveyors

**Standards/Issues Addressed**
Introduction and coordination of the survey

**Documents/Materials Needed**
- Final survey agenda
- Other as needed for the introduction, determined by program leaders

**What Will Occur**
- Introduction of surveyors
- Introduction of host organization and clinical care program leadership
- Review and modify agenda, as needed
- Surveyors will answer questions about the survey agenda
- Surveyors will explain the use of the tracer methodology during the survey process activities.
- Surveyors will advise leaders the only presentation allowed during the survey is scheduled on the survey agenda for the session entitled Program Design and Quality and Safety Monitoring. The surveyor will follow the planned survey agenda when conducting the tracer and other survey activities. Staff should be prepared to answer questions. The surveyor will also obtain pertinent information through various other methods.
- Surveyors will explain the concept of “drilling down” as an interviewing technique/ approach that has the aim of gathering 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 non-compliance. It is an indication that the surveyor(s) are evaluating the establishment of systems to support a process.
- Surveyors will explain the staff involvement in the patient record review process.
- Surveyors will explain the staff involvement in the staff qualifications and education interview.
Surveyors will explain the purpose and the leaders' involvement in the daily briefing sessions held beginning on day two.

The host organization and program staff will be encouraged to ask questions and seek clarification from surveyors throughout the survey process.

Program staff will show the surveyors where they can meet with each other. This should be the same room where documents are gathered for surveyor review.

Program staff will notify the surveyors where lunch will be served or where they can purchase lunch.

Program staff will identify country-specific information that would ensure that the survey team observes significant customs and values of the organization during the survey process, especially if observance of customs impacts the survey agenda. For example, how would the organization prefer that surveyors conduct survey sessions during times that staff members participate in prayer activities? The host organization and program staff should indicate how staff would prefer to be addressed and discuss the use of interpreters, when needed.

Program staff will introduce the surveyors to the staff member who will provide assistance throughout the day. This staff person will help the surveyor move quickly between hospital locations and maintain the planned schedule. This staff person is usually a leader of the program or the program survey coordinator.

How to Prepare

- Set up a meeting or conference room large enough for the surveyors to meet with the key host organization and clinical care program leaders and survey coordinators.
- Notify organization receptionists so they can direct the surveyors to the room when they arrive.
- Have copies of the survey agenda available for all participants in the opening conference.
- Prior to the survey, decide which program leaders or staff member(s) will accompany each surveyor throughout the survey day.
- Arrange for surveyors to be served or purchase lunch.
- Notify host organization and clinical program staff of the survey agenda and expectations.
- Each surveyor will wear a name badge that will identify him or her as a JCI surveyor. If the organization requires additional organization identification, prepare and make it available to surveyors in the opening conference.

Note: The survey team leader will conduct a brief meeting prior to the opening conference with the CEO, clinical care program director, survey coordinator, and translators to discuss the logistics and expectations for the on-site survey and use of translators.
Orientation to the Clinical Care Program

Purpose
The purpose of this session is for the surveyors to learn more about the clinical care program structure and the scope of care and services.

Location
At the discretion of the program

Program Participants (all at the program’s discretion)
- Chief executive officer
- Director of the clinical care program
- Medical director, when applicable
- Nurse executive
- Quality improvement coordinator
- Clinical care program survey coordinator
- Host organization’s survey coordinator
- Others at the discretion of the organization

Surveyor(s)
All surveyors

Standards/Issues Addressed
- Introduction to the clinical care program by program leaders PLM.1 to PLM.8; DFC.4 to DFC.7

Documents/Materials Needed
- Copy of the program’s presentation for each surveyor
- Organizational chart for clinical services
- Quality improvement example

What Will Occur/How to Prepare
- Host organization will provide a brief overview of the organization and relationship to the program
- Program staff will present an overview of the clinical care program, including the following:
  - Program mission, goals and objectives
  - Program structure and organization (for example, team approach, where the program fits within the larger organization, organized around services and clinical practice guideline direction
  - Design of the program including the review of the model followed (such as the Wagner Chronic Care model), targeted population, identification of target population needs
  - Scope of services and continuum of care
  - Demographics of the community and program patient population
- Discuss the program and clarify what was learned from the documentation submitted with the application for certification and preparatory review of clinical practice
- Surveyors will use the remaining time in the session for questions and answers, as needed to clarify information

How to Prepare
- Set up a meeting or conference room large enough for the surveyors to meet with the key host organization and clinical care program leaders and survey coordinators.
• Provide copies of documents that describe the program, such as an organizational chart that includes the clinical care program and how it fits within the larger organization;
• A statement of the program’s mission, goals, objectives, and scope of services. (This might include the program design, why they selected this clinical care program and the relevance to their specific population, demographics of the community and the specific patient population including any relevant cultural and religious factors).
Overview of Required Performance Measurement

Note: This session will immediately follow the initial Orientation to the Clinical Care Program session.

Performance measurement in health care is an indication of what is done and how well it is done; in other words, an indication of an organization’s or program’s performance in relation to a specified process or outcome. The purpose of measures should demonstrate accountability if appropriate methodological, statistical, and implementation rules are achieved.

Purpose
This session is focused on the organization’s use of data in improving safety and quality of care.

Program Participants
Individuals from the program selected for participation should be able to address issues related to the use of data in all major areas within the program. This group should include but is not limited to representation from the following services:

- Clinical staff, including all individuals involved in performance improvement and a sample of individuals involved in the direct provision of care, treatment, and services
- Representation from all categories of staff involved in the program
- Individuals who are knowledgeable about the information systems available for data collection, analysis, and reporting
- A representative from the program’s leadership

In order to facilitate a beneficial exchange between the surveyor(s) and the program, the program 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 will do so.

What Will Occur
During the session, the surveyor(s) and program participants will discuss the following:

- The measures that are being used for improvement
- Improvements that have been made as the result of data collection and analysis
- How performance improvement methods are used throughout the program
- The basics of data gathering and preparation, including the following:
  - Selection of measures
  - Data collection and aggregation
  - Data analysis and interpretation
  - Dissemination/transmission of findings
  - Taking action
  - Monitoring performance/improvement
  - For triennial surveys, findings from previous surveys and intracycle data review

For triennial surveys, the discussion will include intracycle data review.

Selection of good measures should consider the tight, evidence-based links between process performance and patient outcomes. The following guiding principles demonstrate the characteristics of a good accountable measure that will be used by JCI to determine if the performance measures selected for the program are appropriate and consistent with the program’s intent and/or clinical practice guidelines (CPGs):
A measure must be based on a strong foundation of research showing that the process addressed by the measure, when performed correctly, leads to improved clinical outcomes (Note: “Strong foundation” means more than one study).

The measurement strategy must accurately capture whether the evidence-based care has been delivered or the process of interest.

The required four measures should reflect data on all program patients, not sampling, and should be tracked monthly.

When defining performance measures, it is important to consider the population under study and to define that population appropriately. This may include delineating specific groups of patients that should be included or excluded in the variable. It is important to consider those definitions up front to ensure the measure is specifically defined and reflects the information being sought. Several potential pitfalls about performance measurement that each program should be aware of are selection bias, sampling bias, and measurement error.

Although JCI only requires the program agrees to monitor at least four performance measures, the program can choose to collect more than four measures if needed. Each performance measure needs to demonstrate the following information:

- **Performance measure name** is just the short name for the measure, for example, Blood Pressure Management. If the program’s selected CPGs have a set of specifications for the required measures, the program is expected to follow the exact same specifications defined by the CPG, unless indicated otherwise by unique target population’s reasons for modifications.

- **Purpose or rationale for the measure** should provide a concise statement of the specific aspects of health, the patient population, providers, setting(s) of care, and the time period that the measure addresses. The rationale of the measure should briefly explain the important of the measure to justify why it is used. The explanation should demonstrate the links between the process and outcome measures.

- **Source or corresponding guideline(s)** should include the complete bibliographic source or the CPGs’ source for this measure to demonstrate the evidence-based validity of the measure’s specifications defined by the CPGs.

- **Type of measure**. Each program should consider balancing the selection of performance measures from all different possible domains. The National Quality Measures Clearinghouse (NQMC) classifies performance measures to the following possible domains: Access, Outcome, Patient Experience, Population Health, Process, Structure, and Use of Services.

- **Description of numerator**. The numerator is the upper portion of a fraction used to calculate a rate, proportion or ratio. The numerator depicts the portion of the denominator population that satisfies the condition of the performance measure to be an indicator event. Description of numerator should define the intended audience and patient population, along with the clinical specification as applicable for the inclusion criteria. Likewise, the numerator should also define any measure exclusions with supporting medical, patient, or system reasons for exclusion.

- **Description of denominator**. The denominator is the lower part of a fraction used to calculate a rate, proportion or ratio. Description of denominator should depict the primary or overall population of interest that the measure is interested in evaluating. Similarly to the numerator, denominator needs to clearly define any specific and relevant inclusions and exclusions.

- **Data source**. Each measure should consider using multiple data sources if possible and feasible, such as paper and/or electronic medical records, administrative data, and/or claim data such as diagnosis and procedural codes.

- **Start date of data collection**. The actual start date of data collection for the measures. If the performance measure’s inclusion and exclusion criteria are changed during the data collection process, the program should track the revision date and make notes in the data aggregation and analysis phase.

- **Measure reporting interval**. JCI requires monthly data point for each one of the four performance measures for demonstration of track record during the survey and intracycle review in between certification survey.
- Target or threshold should be predetermined or pre-established based on well-documented evidence and/or consensus agreement reached by program’s staff as the level of acceptable performance for staff, a process, or an outcome related to the specific performance measure. Attainment or nonattainment should trigger a review of why the threshold/target was not reached or crossed.

**Medication Management Data Issues**

Data applicable to the program will be determined on-site.

Medication management data collection issues are addressed in this section for shorter surveys in which only one system tracer (Improvement in Quality and Patient Safety) is scheduled. Discussion explores the following issues:

- Monitoring data collected on the performance of the program’s medication management system and processes, including trends or issues that have been identified and changes made as a result of that review
- Medication measures the program is collecting. Medication management data collection should be relevant to the services provided by the program and to the patients served. The program 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:
  - Number of pharmacy interventions
  - Turnaround times from order to administration
  - Adverse drug events/adverse drug reactions
  - Use of high-risk or high-alert medications

**Infection Prevention and Control Data Issues**

Data applicable to the program will be determined on-site.

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

- 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 program 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
### JCI Performance Measure Information Form

<table>
<thead>
<tr>
<th>Performance Measure (short name)</th>
<th>Purpose or Rationale for the Measure</th>
<th>Source/Corresponding Guideline(s)</th>
<th>Type of Measure</th>
<th>Description of the Numerator (N) and Denominator (D)</th>
<th>Data Source</th>
<th>Start of Data Collection</th>
<th>Measure Reporting Interval</th>
<th>Target/Threshold</th>
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Document Review

**Purpose**
The purpose of the document review is to survey standards that require some written evidence of compliance, such as timeframes for procedures, a consent document, patient education or discharge summary and instructions. The surveyors will review policies, procedures, forms, educational materials and audit forms, as well as data related to the International Patient Safety Goals, clinical pathways and protocols, and performance measures.

**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.

**Program Participants**
Participants should include program staff that manage the program and are familiar with the documents and selected host organization staff members that understand the program. The designated staff can translate the documents and respond to questions that the surveyors may have during the session. At the discretion of the team, surveyors 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. Lists of items the surveyor may request 4 weeks in advance (see page 47) and on the day of arrival (see page 47) are provided earlier in this publication. In addition, the program should complete the Laws and Regulations Worksheet (see page 102) 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 95 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 program 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 programs 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 program’s
policies and procedures or performance. Program 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 other host organizations. Programs do not need to remove or photocopy pertinent sections of these documents. Instead, programs 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. Programs 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 program 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 program, 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 programs
- Required policies
- Program 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 program 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 process or procedure for receiving and managing patient complaints is developed:

- That appropriate staff have been educated about the new process/procedure
• That any special skills or other needed training has taken place
• It can be observed that complaints are actually being managed and resolved according to the new
  process/procedure
• That any documentation required by the process/procedure is available for review

The presence of a policy or procedure alone does not usually determine the score of the standard. Rather, it is
also the daily practice (implementation) of what is in the policy or procedure. The survey team will be seeking
evidence that the practice related to the policy or procedure is well implemented, as appropriate, throughout
the program and thus sustainable. In the event that the implementation appears incomplete to the survey team
or that implementation occurred in a manner that is not sustainable, the survey team will make a
recommendation that more time is allowed for better evidence of sustainable implementation, and to
incorporate that recommendation into the survey follow-up requirements.

In general, the length of time a policy has been implemented is referred to as a “track record.” The survey
team will look for a 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 certification decision

Location
At the discretion of the program

Program Participants
- Program survey coordinator (as needed by team)
- Designated leaders (as determined by the program)
- 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 only during a multi-day survey with the exception of the first day. The session is intended to be brief. When multiple surveyors are on site, the briefing is conducted jointly, with the survey team leader serving as the facilitator.

During the daily briefing with the program, 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 program that final findings for any given standard will be possible only when all activities are complete and results are aggregated.
- Allow the program staff to provide information that may have been missed or misunderstood during the previous survey day.
- Address program 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 program needs or the need for more intensive assessment of an issue.

Do not expect the surveyor(s) to perform the following actions:
- 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.

Conclusion
As a result of this session, the surveyor(s) and the program participants will be able to do the following:
- Identify strengths and weaknesses in the hospital’s implementation of the quality plan, including monitoring of performance measures, data use, areas identified for improvement, and actions that could be taken
- Identify specific data-use issues requiring further exploration as part of subsequent survey activities
- Provide appropriate education, as applicable

It is possible that during this session the surveyors will work with your staff to develop new measures and not necessarily continue to use the ones which were submitted on the E-App. By the end of the survey, the surveyors and your staff should agree on the exact wording of four required measures you will use going forward in time after the on-site survey. The data for these must be collected on a monthly basis.

**Note:** In programs with multiple sites, only one medication management session and one infection control session are usually scheduled. If it is not feasible for staff to participate from all programs/sites, the program may need to teleconference individuals from distant locations into the group discussion.
Individual Patient Tracer Activity

Tracer Methodology
The tracer methodology is the foundation of the Joint Commission International (JCI) on-site survey and does the following:

- Incorporates the use of information provided in the certification survey application
- Follows the experience of care for a number of patients through the clinical program’s entire health care process
- Allows the surveyor(s) to identify issues in one or more steps of the patient care process, or in the interfaces between processes

What Will Occur
The individual 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 as the program’s participants.

The tracer methodology is a way to analyze a program’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 do the following:

- Follow the course of care, treatment, or service 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 experience throughout the organization. Patients typically selected are those who have received multiple or complex services and therefore, more contact with various parts of the organization. This 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 may overlap in terms of sites within the organization.

For all programs that involve in-patient care, please be sure there are two closed records available for the surveyor to bring along during the tracer activity.

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

- Patients in the different stages and/or types of the disease(s) and/or conditions; for example, sampling of patients from each stage of Chronic Kidney Disease program, Stage I to end stage; or NSTEMI Acute Myocardial Infarction versus STEMI Myocardial Infarction versus Unstable Angina patients in the Acute Myocardial Infarction program
- Patients at different phases of receiving the program’s clinical services that will cover the entire spectrum of services from program’s enrollment to discharge/referral/death; for example, patients in outpatient department, inpatient units to home care
- Patients from different demographic and nationality backgrounds in which the surveyed program has to render services to the served population that resides in a diverse multicultural catchment area. Common data source for this patient selection is typically arrived from either the host organization’s admission database or the program’s target population assessment information.

The surveyor will follow the patient’s experience, looking at services provided by various individuals and departments within the organization, as well as “hand-overs” between them.
This type of review is designed to uncover systems issues, looking at both the individual components of an organization, and how the components interact to provide safe and 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 organization’s systems; an area of care provided to the patient that may be a priority for that organization; or to any areas in which the patient received care, treatment and services. The order will vary.

The number of patients followed under the tracer methodology will depend on the size and complexity of the program, 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 record with the staff person responsible for the patient’s care, treatment, or service provided to the patient. If the responsible staff person is not available, the surveyor 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 as the tracer proceeds. For example, the surveyor will speak to a case manager and/or social worker if the patient being traced requires medical repatriation home after a knee replacement surgery at the certified joint replacement program.
- Observation of direct patient care
- Observation of medication process
- Observation of infection prevention and control issues
- Observation of care planning process
- Discussion of data use and program’s selected performance measures—quality improvement measures being used, what has been learned, improvements made using data, data dissemination
- Observation of the environment
- Observation of maintenance of 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, attempt to verify issues identified during the tracer. It is not unusual if the surveyors will request for interviewing program’s discharged patients at home via phone to review the discharge and referral process if indicated.
- When visiting the emergency department and any other time urgency indicated procedural areas as defined by the program’s clinical practice guidelines, the surveyor(s) will address emergency management and explore patient flow issues. Patient flow issues may also be explored in ancillary care areas and other patient care areas as relevant to the patient being traced. Key process measures that provide evidence of turn-around time that meets the required threshold defined by the selected clinical practice guidelines will often be assessed during the patient flow assessment. For example, if the program defines the performance measure and clinical protocol for stroke patients to achieve “Door to CT scan initiation” within 15 minutes of arrival, the surveyors will look for evidence of time documentation in both the patient’s medical record and any electronic medical system that the processes were carried through to meet the program’s established response time frame.

The surveyor(s) may pull 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 clinical care program based services tracers or other survey activities.

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.

Frontline Staff Ownership of the Process
Involving staff in the initial certification 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.
Patient Interview Session

Purpose
The objective of this interview session is to learn from patients and family members about their perception of the program.

Location
Small meeting rooms at the discretion of program leaders

Program Participants
- Three to four ambulatory patients who received care from the program – may include current program patients and those who have been discharged from the program
- Translator(s) if required

Surveyor(s)
Nurse or physician surveyor

Documents/Materials Needed
None

What will Occur
During the on-site survey, it will be beneficial for the surveyor(s) to have the opportunity to interview a few patients who have received care from the program, based on the selected practice guideline. The program leaders should arrange to have 3-4 ambulatory patients contacted to come in to meet with the surveyor as a group, to answer questions about their care experience. These patients will be interviewed together as a group, and no specific, personal information will be asked in front of other patients. Family members may also attend to relate their perceptions and experiences with the program.

How To Prepare
Prior to the start of the survey, the program should contact current and discharged patients and ask if they would be willing to participate in a short 30–45 minute interview about their care experience. Patients should be informed that this is voluntary and that no personal, specific information will be shared with other patients or families.
Staff Education and 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 program’s processes to recruit, orient, educate, and evaluate all program staff. For each clinical care program, it is expected that the program’s clinical staff will demonstrate the required and/or recommended training and competence according to the program’s selected source of clinical practice guidelines (CPGs).

Although the CCPC program’s specific DFC session does not review the host organization’s process for evaluating the credentials for all of the program’s health professional staff, all host organizations who render this specific type of services to the program need to meet all relevant JCI Standards for Hospitals prior to the CCPC survey.

**Location**
Small meeting rooms at the discretion of program leaders

**Program Participants**
- Elected or appointed senior leader of the medical, nursing and other health professional staff who conduct the ongoing professional practice evaluations of the clinical care provided by each of the program’s staff members
- Manager of the human resources/personnel department
- Chief nurse
- Other representatives who are involved in the orientation, education and training of program’s staff members

**Surveyor(s)**
All surveyors

**Standards/Issues Addressed**
- DFC.1, DFC.2, DFC.3,and DFC.5

**Documents/Materials Needed**
- Policies and procedures related to human resources/personnel management, staff credentials, and staff orientation and education
- The program’s orientation and ongoing education and training curriculum that are specific to the program’s disease, condition and/or clinical program
- A sample of program personnel files and health care practitioner staff credential 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 program’s compliance with standards fairly and accurately. The tool merely reflects current JCI standards.
How To Prepare
The program should include a list of all current personnel and medical staff in the Document Review (see page 57) 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 program should closely review all personnel and credential files using the staff qualification worksheets that follow.
**Program Staff Qualifications Worksheet**

Medical Specialty/Health Disciplines: ________________________________

Name: _____________________________

Initial Start Date: _____________________

Degree/Credential: ____________________

<table>
<thead>
<tr>
<th>Standard</th>
<th>Measurable Element</th>
<th>Compliance Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFC.1</td>
<td>1. All clinical staff have educational backgrounds, experience, training, and/or certification consistent with the program’s mission, goals, and objectives.</td>
<td></td>
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<tr>
<td></td>
<td>2. Core criteria for hiring clinical staff in the program include, at a minimum, relevant education, training and experience, current competence, and current licensure.</td>
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<tr>
<td></td>
<td>3. Core criteria for evaluating clinical staff in the program include, at a minimum, current licensure and current competence.</td>
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<td></td>
<td>4. Professional education, advanced training, and experience are verified from primary sources.</td>
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</tr>
<tr>
<td></td>
<td>5. Current licensure and certifications are verified from primary sources.</td>
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<tr>
<td>DFC.2</td>
<td>1. Orientation provides information and necessary training appropriate to program responsibilities.</td>
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<td></td>
<td>2. The competence of all clinical staff is assessed when new techniques or responsibilities are introduced and periodically within the time frames defined by the program.</td>
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<tr>
<td></td>
<td>3. Ongoing in-service and other education and training activities are relevant to the program’s needs.</td>
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</tr>
<tr>
<td>Standard</td>
<td>Measurable Element</td>
<td>Compliance</td>
<td>Comments</td>
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<tr>
<td>DFC.3</td>
<td>1. The performance of individual staff members is reviewed when indicated by findings of quality improvement activities.</td>
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<tr>
<td></td>
<td>2. There is an ongoing professional practice evaluation of each staff member documented in the staff member’s file that includes at least one documented evaluation each year.</td>
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<tr>
<td></td>
<td>3. Corrective action is taken when deficiencies or substandard performance are identified.</td>
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<tr>
<td>DFC.5</td>
<td>1. Clinical staff have been educated about clinical practice guidelines and their use.</td>
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<tr>
<td></td>
<td>2. Assessment activities are consistent with clinical practice guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Intervention activities are consistent with clinical practice guidelines.</td>
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</tbody>
</table>
Open/Closed Patient Medical Record Review

This session is held to validate the program’s compliance with the documentation track record (4 months for initial surveys and 12 months for triennial surveys).

Purpose of the Tool
The purpose of using the Medical Record Review Tool (see page 74) is to gather and record continuous evidence of compliance with standards that require documentation in the patient’s record.

Organization of the Tool
The tool 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 tool will be provided by the survey team and used during the review. The tool 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 tool (for example, “Record #1 Congestive Heart Failure”).
- The record is reviewed briefly to
  - establish what type of patient or care was received (for example, surgery, medical, emergency, rehabilitation); and
  - verify compliance with the documentation track record (4 months for initial surveys and 12 months for triennial surveys).

Using the Tool During the Certification 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 program’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. Program staff should acquaint the survey team with the program’s practice and expectation regarding the completion of a patient record following discharge of the patient.
- For the Closed Patient Medical Record Review, program leaders should provide one staff member with a translator (if needed) for each surveyor involved in the Closed Patient Medical Record Review. To assist the surveyor(s), the selected staff person(s) should be knowledgeable about the medical record and the clinical care processes.
- The surveyor(s) will review the selected records with the assistance of the program representative, as needed, to complete the tool. One column of the tool is completed for each record reviewed. If more than five records are reviewed, the surveyor(s) will use another tool.
- For each documentation requirement, the surveyor(s) will check “Y” (yes) on the tool 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 tools 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 tools to support the survey findings.
## Medical Record Review Tool

<table>
<thead>
<tr>
<th>Standard</th>
<th>Documentation Requirement</th>
<th>Medical Record 1</th>
<th>Medical Record 2</th>
<th>Medical Record 3</th>
<th>Medical Record 4</th>
<th>Medical Record 5</th>
<th>TOTAL</th>
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<td></td>
<td></td>
<td>Y</td>
<td>N</td>
<td>NA</td>
<td>Y</td>
<td>N</td>
<td>NA</td>
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</table>

### Consents

**IPSG.4** (ME 3) 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.

**PLM.6** (ME 4) Patients are given multiple opportunities to participate in the program.

**Note:** Consent is not required, however if the organization chooses to have patients consent, surveyors will look for documentation of consent to participate in the program.

**PLM.7** (ME 2) The program respects the patient’s right to decline participation in the program.
### Assessments

<table>
<thead>
<tr>
<th>Standard</th>
<th>Documentation Requirement</th>
<th>Medical Record 1</th>
<th>Medical Record 2</th>
<th>Medical Record 3</th>
<th>Medical Record 4</th>
<th>Medical Record 5</th>
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<td>N</td>
<td>NA</td>
<td>Y</td>
<td>N</td>
<td>NA</td>
</tr>
</tbody>
</table>

**IPSG.2.1** (ME 3) The organization has defined what information (related to critical results of diagnostic tests) is documented in the patient record.

**IPSG.6** (ME 1) The organization implements a process for assessing all inpatients and those outpatients whose condition, diagnosis, situation, or location identifies them as at high risk for falls.

**DFC.5** (ME 2) Assessment activities are consistent with clinical practice guidelines.

**DFC.6** (ME 2) An assessment is completed for all patients within the time frame determined by the program and is used to develop a plan of care.

**DFC.6** (ME 5) The program continually reassesses, revises, and implements the plan of care to meet the patient's ongoing needs.
### Standard Documentation Requirement

<table>
<thead>
<tr>
<th>Standard</th>
<th>Documentation Requirement</th>
<th>Medical Record 1</th>
<th>Medical Record 2</th>
<th>Medical Record 3</th>
<th>Medical Record 4</th>
<th>Medical Record 5</th>
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<td>Y N NA</td>
<td>Y N NA</td>
<td>Y N NA</td>
<td>Y N NA</td>
<td>Y N NA</td>
<td></td>
<td>Y/N</td>
</tr>
</tbody>
</table>

#### Assessments

**SSM.3**

(ME 1) The patient’s readiness, willingness, and ability to provide or to support self-management activities are assessed.

(ME 2) The family’s readiness, willingness, and ability to provide or to support self-management activities are assessed.

(ME 3) The program makes initial and ongoing assessments of the patient’s comprehension of program-specific information.

**SSM.5**

(ME 1) The patient and, when appropriate and culturally acceptable, the family are assessed for health history, lifestyle, and physiologic data that may put them at increased risk.

(ME 5) The effectiveness of efforts to help the patient in making lifestyle changes is assessed.
**Assessments**

(ME 6) The patient’s response to making the recommended lifestyle changes is assessed and documented.
<table>
<thead>
<tr>
<th>Standard</th>
<th>Documentation Requirement</th>
<th>Medical Record 1</th>
<th>Medical Record 2</th>
<th>Medical Record 3</th>
<th>Medical Record 4</th>
<th>Medical Record 5</th>
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<td>Y</td>
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</table>

**Care Delivery**

**IPSG.4.1** (ME 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.

**DFC.6** (ME 3) The program uses specified methods for prioritizing the needs of patients and identifying patient risks that are tailored to the targeted population’s age and developmental needs.

(ME 4) The program implements interventions based on prioritization of needs and identified patient risks.
<table>
<thead>
<tr>
<th>Standard</th>
<th>Documentation Requirement</th>
<th>Medical Record 1</th>
<th>Medical Record 2</th>
<th>Medical Record 3</th>
<th>Medical Record 4</th>
<th>Medical Record 5</th>
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<td>N</td>
<td>NA</td>
<td>Y</td>
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</tbody>
</table>

**Care Delivery**

(Me 5) The program continually reassesses, revises, and implements the plan of care to meet the patient’s ongoing needs.

<p>| DFC.9    | (Me 5) Medications prescribed and/or administered are noted in the patient’s record. |       |       |       |       |       |       |</p>
<table>
<thead>
<tr>
<th>Standard</th>
<th>Documentation Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(ME 1) Care is coordinated for patients with multiple diseases and/or who are managed by multiple clinical care programs.</td>
</tr>
<tr>
<td></td>
<td>(ME 2) When concurrently occurring conditions are identified, relevant information is communicated to the appropriate clinical staff treating or managing the condition(s).</td>
</tr>
<tr>
<td></td>
<td>(ME 3) When a concurrently occurring condition needs medical intervention, the patient is either treated by clinical staff in the program or referred to an appropriate clinical staff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard</th>
<th>Documentation Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(ME 1) Care is coordinated for patients with multiple diseases and/or who are managed by multiple clinical care programs.</td>
</tr>
<tr>
<td></td>
<td>(ME 2) When concurrently occurring conditions are identified, relevant information is communicated to the appropriate clinical staff treating or managing the condition(s).</td>
</tr>
<tr>
<td></td>
<td>(ME 3) When a concurrently occurring condition needs medical intervention, the patient is either treated by clinical staff in the program or referred to an appropriate clinical staff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Medical Record 1</th>
<th>Medical Record 2</th>
<th>Medical Record 3</th>
<th>Medical Record 4</th>
<th>Medical Record 5</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>DX:</td>
<td></td>
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<tr>
<td>Y</td>
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<td>N</td>
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<td>NA</td>
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</tr>
</tbody>
</table>

|             | Y/N               |                   |                   |                   |                   |       |

| DFC.7       |                  |                   |                   |                   |                   |       |

**80**
### Standard Documentation Requirement

<table>
<thead>
<tr>
<th>Standard Documentation Requirement</th>
<th>Medical Record 1</th>
<th>Medical Record 2</th>
<th>Medical Record 3</th>
<th>Medical Record 4</th>
<th>Medical Record 5</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dx:</td>
<td>Dx:</td>
<td>Dx:</td>
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<td>Dx:</td>
<td></td>
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<tr>
<td>Y</td>
<td>N</td>
<td>NA</td>
<td>Y</td>
<td>N</td>
<td>NA</td>
<td>Y</td>
</tr>
</tbody>
</table>

#### Other

**CIM.3**

1. (ME 1) Standardized diagnosis codes are used and the use is monitored.
2. (ME 2) Standardized procedure codes are used and the use is monitored.
3. (ME 4) Standardized symbols are used, and those not to be used are identified and monitored.
4. (ME 5) Standardized abbreviations are used, and those not to be used are identified and monitored.
### Standard Documentation Requirement

<table>
<thead>
<tr>
<th>Standard</th>
<th>Documentation Requirement</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><strong>Medical Record 1</strong></td>
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<tr>
<td></td>
<td>DX:</td>
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<td></td>
<td>Y</td>
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<tr>
<td></td>
<td><strong>Medical Record 2</strong></td>
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<td></td>
<td>DX:</td>
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<td></td>
<td>Y</td>
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<td></td>
<td><strong>Medical Record 3</strong></td>
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<td>DX:</td>
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<td>Y</td>
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<td><strong>Medical Record 4</strong></td>
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<td>DX:</td>
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<td>Y</td>
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<td><strong>Medical Record 5</strong></td>
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<td>DX:</td>
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<td>Y</td>
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<td></td>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

### Other

**CIM.5**

(ME 2) The program gathers and documents information from all relevant clinical staff or health care organizations, and integrates the information into the plan of care.

**CIM.6**

(ME 1) The health or clinical record is assigned an identifier, in addition to the patient's name, that is unique to the patient to link the patient with his or her record.

(ME 2) The health or clinical record contains sufficient information to support the diagnosis.

(ME 3) The health or clinical record contains sufficient information to justify care, treatment, and services.

(ME 4) The health or clinical record contains sufficient information to document the course and results of care, treatment, and services.
<table>
<thead>
<tr>
<th>Standard Documentation Requirement</th>
<th>Medical Record 1</th>
<th>Medical Record 2</th>
<th>Medical Record 3</th>
<th>Medical Record 4</th>
<th>Medical Record 5</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>DX:</td>
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<td>DX:</td>
<td>DX:</td>
<td>DX:</td>
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</tr>
<tr>
<td>Y  N  NA</td>
<td>Y  N  NA</td>
<td>Y  N  NA</td>
<td>Y  N  NA</td>
<td>Y  N  NA</td>
<td>Y  N  NA</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

**Other**

(ME 5) The health or clinical record contains sufficient information to track the patient’s movement and facilitate continuity of care both within and outside the program.

(ME 6) The program defines methods for adding comments, in the form of statements or addenda into the formal records.
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 program’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.

**Program Participants**
None

**Surveyor(s)**
All surveyors

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

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

**Purpose**
The purpose of this conference is to report the findings of the survey to program leadership.

**Location**
Will be at the discretion of program 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.

**Program 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 program’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 program about the survey report and follow-up process, including review of the SIP. The discussion will cover the following:
   - Purpose of the conference
   - Summary of compliance findings related to standards
   - Emphasis that the surveyor(s) does not make the final decision regarding certification
   - 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 a certification decision, the team leader will inform the CEO in advance of the exit conference.

2) Summary/overview of the report to program staff selected at the discretion of the CEO

At the discretion of the CEO, a brief conference will be held with other selected staff in the program to provide an overview of the report and to complete the survey activities.
Survey Planning Tools
Required Quality Monitors

The program chooses which processes and outcomes are most important to monitor based on its mission, patient needs, and services provided. The organization’s leaders identify key measures (indicators) to monitor and improve the program’s processes and outcomes.

PMI.3 The program uses measurement data to evaluate and to improve processes and outcomes

The performance measures selected for the program meet the following requirements:

- Performance measures selected are appropriate and consistent with the program’s intent and/or clinical practice guidelines.
- The program has collected four months of data for the selected performance measures.
- The program has monitored at least four performance measures.

The program selects valid, reliable performance measures based on clinical practice guidelines or other evidence relevant to the management of the disease or condition.

The program collects data related to processes and/or outcomes of care at the level of the individual patient.

Required general measures to be monitored are the following:

- The process for identifying, reporting, managing, and tracking errors and adverse events is defined and implemented (PMI.5).
- The process for identifying, reporting, managing, and tracking “near-miss” events is defined and implemented (PMI.6).
- The program evaluates patient and family perceptions of the quality of care at the program level (PMI.7).
Required Organization Plans

The following standards identify requirements that relate to a written plan. A plan is usually more comprehensive in content than a policy or procedure. A plan can also be more long range, or strategic in content. Frequently a plan also sets priorities for the entire program. For example, the comprehensive approach to performance improvement program (PMI.1) may address the organization’s commitment to performance improvement and how performance improvement efforts will be organized. It will also identify priorities for the short and long-range, and how those priorities will be achieved.

- **International Patient Safety Goals (IPSG.5 ME 2)**
  - The organization implements an effective hand hygiene program

- **International Patient Safety Goals (IPSG.6)**
  - The organization establishes a fall risk reduction program

- **Program Leadership and Management (PLM.9)**
  - Facilities where patients receive care maintain and implement a program that provides a safe and secure physical environment

- **Delivering or Facilitating Care (DFC.8)**
  - The program identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.

- **Delivering or Facilitating Care (DFC.9)**
  - Medication storage, preparation, and administration follow standardized processes to ensure patient safety.

- **Performance Measurement and Improvement (PMI.1)**
  - The program has an organized, comprehensive approach to performance improvement
    - ME 1: The performance improvement activities are well designed and planned.
    - ME 2: The performance improvement program collects data related to the program.
    - ME 3: The performance improvement program analyzes current performance.
    - ME 4: The performance improvement program improves and sustains performance.
    - ME 5: The program plans performance improvement activities for clinical staff across disciplines and/or settings.
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. Programs 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: Programs 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)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Text</th>
<th>In English?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IPSG.1</strong></td>
<td>The program develops and implements a process to improve accuracy of patient identifications.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>IPSG.2</strong></td>
<td>The program develops and implements a process to improve the effectiveness of verbal and/or telephone communication among caregivers.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>IPSG.2.1</strong></td>
<td>The program develops and implements a process for reporting critical results of diagnostic tests.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>IPSG.2.2</strong></td>
<td>The program develops and implements a process for handover communication.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>IPSG.3</strong></td>
<td>The program develops and implements a process to improve the safety of high-alert medications.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>IPSG.3.1</strong></td>
<td>The program develops and implements a process to manage the safe use of concentrated electrolytes.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>IPSG.4</strong></td>
<td>The program develops and implements a process for ensuring correct-site, correct-procedure, and correct-patient surgery.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>IPSG.4.1</strong></td>
<td>The program 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.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>IPSG.5</strong></td>
<td>The program adopts and implements evidence-based hand-hygiene guidelines to reduce the risk of health care-associated infections.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>IPSG.6</strong></td>
<td>The program develops and implements a process to reduce the risk of patient harm resulting from falls.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Program Leadership and Management (PLM)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Text</th>
<th>In English?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PLM.3</strong></td>
<td>1. The program’s mission and scope of services are defined in writing.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>PLM.6</strong></td>
<td>1. Enrollment and/or participation requirements are well defined.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>2. Criteria for participation are relevant to the program and follow recommendations from the clinical practice guidelines used.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Program Leadership and Management (PLM)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLM.7</td>
<td>4. The host organization develops and implements a code of conduct</td>
</tr>
<tr>
<td>PLM.8</td>
<td>3. The program has reference materials (hard copy or electronic) that are easily accessible to clinical staff.</td>
</tr>
<tr>
<td>PLM.9</td>
<td>1. The program identifies and evaluates potential risks in the facility in which the program operates.</td>
</tr>
</tbody>
</table>

### Delivering or Facilitating Clinical Care (DFC)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFC.6</td>
<td>1. The program defines the patient assessment process, including family risks.</td>
</tr>
<tr>
<td></td>
<td>3. The program uses specified methods for prioritizing the needs of patients and identifying patient risks that are tailored to the targeted population’s age and developmental needs.</td>
</tr>
<tr>
<td></td>
<td>6. The program includes a process for patient referrals and/or patient discharges from the program based on the patient’s identified ongoing needs.</td>
</tr>
</tbody>
</table>

### Supporting Self-Management (SSM)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSM.4</td>
<td>1. Program materials comply with generally recommended elements of intervention in the literature or promoted through the clinical practice guidelines.</td>
</tr>
</tbody>
</table>

### Clinical Information Management (CIM)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIM.1</td>
<td>1. The program has a written process that protects the confidentiality, security, and integrity of patient information and data.</td>
</tr>
<tr>
<td>CIM.2</td>
<td>1. The program defines access limitations to clinical records for individuals and/or positions.</td>
</tr>
<tr>
<td></td>
<td>4. The program defines the process followed if confidentiality and/or security are violated.</td>
</tr>
</tbody>
</table>
### Clinical Information Management (CIM)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Text</th>
<th>In English?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CIM.3</strong></td>
<td>1. Standardized diagnosis codes are used and the use is monitored.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>2. Standardized procedure codes are used and the use is monitored.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>3. Standardized definitions are used.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>4. Standardized symbols are used, and those not to be used are identified and monitored.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>5. Standardized abbreviations are used, and those not to be used are identified and monitored.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>CIM.6</strong></td>
<td>6. The program defines methods for adding comments, in the form of statements or addenda into the formal records.</td>
<td></td>
</tr>
</tbody>
</table>

### Performance Measurement and Improvement (PMI)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Text</th>
<th>In English?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PMI.4</strong></td>
<td>1. A process exists for identifying sentinel events, based on an operational definition that includes at least a) through f) in the intent.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>PMI.5</strong></td>
<td>2. The program has a process for identifying errors or adverse events if and when they occur.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>PMI.6</strong></td>
<td>2. The program has a process for identifying near-miss events if and when they occur.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Standards That Reference Laws and Regulations

The Joint Commission International Standards for Clinical Care Program Certification 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 program 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 certification standard, then the expectation of the certification standard is surveyed and scored.

2) If, on the other hand, the law and/or regulation sets a more stringent expectation than the certification 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 certification 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 certification survey process but may not be referenced in the standards.

Hospitals can use the External Auditing Body Recommendation Worksheet (see page 103) 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 57) session.
Laws and Regulations Worksheet

### Section I: Accreditation Participation Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Applicable Law or Regulation? (Yes/No)</th>
<th>If Yes, Name of the Applicable Law or Regulation</th>
<th>How Law or Regulation Applies to Requirement</th>
<th>Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)</th>
<th>Law or Regulation Is Evaluated on Site? (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR.3</td>
<td></td>
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</table>

### Section II: Standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>Applicable Law or Regulation? (Yes/No)</th>
<th>If Yes, Name of the Applicable Law or Regulation</th>
<th>How Law or Regulation Applies to the Requirement</th>
<th>Law or Regulation Is More Stringent than the JCI Standard? (Yes/No) (note conflicts)</th>
<th>Law or Regulation Is Evaluated on Site? (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPSG.2–IPSG.2.2</td>
<td></td>
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<tr>
<td>DFC.1</td>
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<tr>
<td>CIM.1</td>
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<tr>
<td>PMI.4</td>
<td></td>
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</table>
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 57).

<table>
<thead>
<tr>
<th>Name of Auditing Body</th>
<th>Date of audit</th>
<th>Recommendations or Citations? (Yes/No)</th>
<th>If Yes, Department(s) or Service(s) Cited</th>
<th>Time Allotted for Compliance</th>
<th>Date Full Compliance Achieved</th>
<th>Auditor Returned to Validate Compliance? (Yes/No)</th>
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