2018

HOSPITAL

Compliance Assessment Checklist

The Joint Commission

Joint Commission Resources

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Introduction

The Joint Commission accredits and certifies more than 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects your hospital's commitment to meeting certain performance standards. The Joint Commission accreditation process is data driven and emphasizes continuous improvement and ongoing standards compliance. In this way, the accreditation process can be used as a systems improvement and management tool, essentially becoming a by-product of quality improvement.

Purpose of This Book

The *2018 Hospital Compliance Assessment Checklist* is a self-assessment workbook designed to help you maintain continuous compliance. This easy-to-use workbook can be used both by staff new to the accreditation process and by those experienced with accreditation to assess standards compliance at the level that is most appropriate. The book, with its targeted assessment prompts, expansive compliance checklist, and multiple worksheets, helps in the following ways:

- Engages staff and leadership in accreditation activities with simple questions, checklists, and tools
- Helps you identify deficiencies and plan for addressing them and sustaining improvements
- Improves your understanding of what tracers are and how to plan for and conduct them
- Better prepares you for your next unannounced survey
- Reduces anxiety about the survey process, which will allow for a more relaxed and beneficial on-site survey

Project REFRESH

To reflect recent changes in Joint Commission manuals and surveys, the 2017 edition of this book included a new approach that provides health care organizations with the information necessary to prioritize resources and focus corrective action plans in areas that are in most need of compliance activities and interventions. This 2018 edition continues to follow that approach. The development of this approach was driven by Project REFRESH, a series of interrelated process improvement projects at The Joint Commission. These projects examined various aspects of pre-survey, on-site survey, and post-survey activities in an effort to simplify them, enhance their relevance to accredited organizations, increase transparency within the accreditation process, and utilize innovative approaches and technology to enrich the customer experience. Two of the major improvements resulting from Project REFRESH are substantial streamlining of the standards and elements of performance (EPs) in the *CAMH* and development of the Survey Analysis for Evaluating Risk™ (SAFER™) approach.

Streamlined Standards and EPs

As part of Project REFRESH, The Joint Commission evaluated standards and EPs to modernize and streamline Joint Commission requirements.

The EP Review Project is a multiphased component of Project REFRESH, a series of interrelated process improvement initiatives The Joint Commission has been conducting since 2016. Phases I and II of the EP Review Project resulted in the deletion of 225 hospital EPs over the past few years.

Phase III applied similar deletions to nonhospital programs. The Joint Commission recently began Phase IV of its EP Review Project, which involves streamlining Joint Commission standards for all accreditation programs by consolidating existing requirements. Consolidating requirements has reduced the number of EPs in the following chapters of the *Comprehensive Accreditation Manual for Hospitals* (*CAMH*):

Chapter	Number of EPs Before Consolidation	Number of EPs After Consolidation
Human Resources (HR)	41	31
Infection Prevention and Control (IC)	58	48
Rights and Responsibilities of the Individual (RI)	100	73

Consolidation was considered for requirements that are integral to a concept and can be evaluated together. Figure I-1, page vi, is an example showing how two of these EPs were consolidated into one requirement.

Another type of consolidation involved concepts that, because they are implicit in a requirement, eliminate the need for an additional EP. For example, in Figure I-2, page vi, the fact that a hospital is required to *have* a written policy implies that this policy is also *implemented*; therefore, there is no need for two EPs to demonstrate this singular concept.

These revisions resulting from the first part of Phase IV become effective January 1, 2018. Work on Phase IV continues.

Part 1:
Prompts to Assess Your Standards Compliance

Prompts to Assess Your Standards Compliance

The following worksheets contain questions to prompt staff discussion in your organization regarding compliance with challenging areas in each of the standards chapters of the *2018 Comprehensive Accreditation Manual for Hospitals*. The questions target elements of performance (EPs) considered historically challenging or high risk or those focusing on risk areas related to the Focused Standards Assessment.

Throughout you will also find brief tips offering helpful compliance strategies. Note that these tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Accreditation Participation Requirements (APR) Compliance Prompts

Who is responsible for keeping the electronic application for accreditation (E-App) up to date? Has your account executive been notified of any changes within 30 days of the change occurring?

Who is responsible for maintaining the Statement of Conditions™ when managing survey-related deficiencies (if your hospital uses deemed status)? Have you confirmed that any time-limited waiver is being completed on time and properly managed?

Have any new locations or services been added recently? If so, has your E-App been updated? Has your account executive been notified within 30 days of the time the change(s) occurred?

Has the ownership, control, or capacity of the organization changed recently? If so, has your account executive been notified? And was this completed within 30 days of the time the change(s) occurred?

What process is in place to ensure that all accreditation information is kept current?

TIP: Consider conducting a "paper drill" to ensure that all required documents listed in the *Survey Activity Guide* (at http://www.jointcommission.org/organization_survey_activity_guide/) are easily located, retrievable, and current.

Have responsibilities for completing the Focused Standards Assessment (FSA) tool been determined?

How have the program-specific risk areas been incorporated into your intracycle self-assessment process?

TIP: Be proactive in preparing for your Intracycle Monitoring touchpoint call by using your FSA tool and this workbook as a management tool to track and document organizational findings on an ongoing basis.

Have you determined which option will be selected for submission of an FSA?

TIP: Ensure accurate and timely submission of information by planning ahead.

Are your ORYX® data stable or unstable? Are your data satisfactory?

TIP: If your organization is struggling with ORYX measures, consider visiting the Core Measure Solution Exchange® via your secure *Joint Commission Connect*™ extranet site.

Where are official records or reports from licensing, examining, reviewing, or planning bodies stored?

TIP: Keep official records and reports of licensing, examining, reviewing, or planning bodies easily accessible, as surveyors may ask to review such documents.

How do staff, patients, or the public report concerns to hospital management about quality or safety?

TIP: Confirm that there is a process in place to notify the public about how to contact hospital management and The Joint Commission to report patient safety and quality-of-care concerns.

Do providers of care, treatment, and services know that concerns regarding the safety and/or quality of care provided in the organization may be reported to The Joint Commission without the threat of retaliation from the organization? Is there evidence showing that providers have received education about this?

TIP: Incorporate a method for staff to report concerns regarding safety or quality of care to The Joint Commission without retaliatory action from the hospital.

Environment of Care (EC) Compliance Prompts

Did leadership identify at least one person to manage the environment of care program, pursuant to EC.01.01.01, EP 1?

Are there written management plans for the areas identified in Standard EC.01.01.01? Has the organization evaluated each of these plans in the past 12 months in terms of objectives, scope, performance, and effectiveness?

Is there a risk assessment process for the environment of care? When a risk assessment is completed, is the process documented? Are the implementation and results reported to the environment of care committee?

How is the safety of outside grounds and equipment (that is, the physical environment) monitored? How are safety issues mitigated? Are results reported to the environment of care committee? What resources are allocated for this purpose?

Is the smoking policy up to date and enforced as written?

Is there a documented and current inventory of all required hazardous materials and waste? Has the hospital documented the inspection and monitoring of all required hazardous gases and vapors?

Does the organization have accessible safety data sheets for all hazardous materials? Is there documentation of Department of Transportation training (every three years) for all staff authorized to sign manifests for all hazardous materials (in accordance with the Global Harmonized System [GHS]) and waste shipments?

Are all hazardous material and chemical containers (including secondary containers) labeled per the Occupational Safety and Health Administration's (OSHA's) requirements?

Is all personal protective equipment that is required for handling, storing, transporting, using, and disposing of hazardous materials available and maintained as required?

What is the organizational policy/procedure for handling, storing, transporting, using, and disposing of hazardous medications?

What is the organizational policy/procedure for monitoring radiation workers for radiation exposure?

What is the organization's policy/procedure for routine storage and prompt disposal of trash?

TIP: As part of the process for continually monitoring, internally reporting, and investigating, the organization should establish a process for evaluating hazardous materials and waste spills and exposures that may not have been previously identified. Also evaluate for policy compliance with managing such materials.

Is there a current, written fire response plan that describes the following?

- Specific roles of staff and licensed independent practitioners at and away from a fire's point of origin
- When and how to sound and report fire alarms
- How to contain smoke and fire
- How to use a fire extinguisher
- How to assist and relocate patients
- How to evacuate to areas of refuge
- Who is authorized to turn off the medical gas zone valve during an emergency?

In addition, are staff and licensed independent practitioners periodically instructed on and kept informed of their duties under the plan?

Is a copy of the plan readily available with the telephone operator or security?

When were fire drills conducted over the past year? Were the drills conducted at varying times (with a difference of at least one hour) and under varying conditions? Were critiques completed as planned?

Fire Drill Date	Quarter	Shift (including day and time)	Critique Completed (Y/N)
Health Care Occupancy *(once per shift, per quarter)*			

Part 2:
Compliance Assessment Checklist

Please note: The downloadable, fill-in checklists that appear in Part 2 are available via links on page 54 of this e-book.

Accreditation Participation Requirements (APR)

If you find that your organization is noncompliant with any applicable EPs, plot them on the following SAFER Matrix™. For information on how to determine placement of an EP, *see* page viii in the Introduction.

LIKELIHOOD TO HARM	LIMITED (Unique occurrence that is not representative of routine/regular practice and that has the potential to impact only one or a very limited number of patients/visitors/staff)	PATTERN (Multiple occurrences of the deficiency, or a single occurrence that has the potential to impact more than a limited number of patients/visitors/staff)	WIDESPREAD (Deficiency is pervasive in the facility, or represents systemic failure, or has the potential to impact most or all patients/visitors/staff)
	Immediate Threat to Life		
HIGH (Harm could happen at any time)			
MODERATE (Harm could happen occasionally)			
LOW (Harm could happen but would be rare)			

SCOPE

Standard APR.01.01.01	The hospital submits information to The Joint Commission as required.
EP 1	Does the hospital meet all requirements for timely submissions of data and information to The Joint Commission? **Note 1:** *The Joint Commission will impose the following consequence for failure to comply with this APR: If the hospital consistently fails to meet the requirements for the timely submission of data and information to The Joint Commission, the hospital will be required to undergo an Accreditation with Follow-up Survey. Failure to resolve this issue at the time of the Accreditation with Follow-up Survey may result in an accreditation decision change.* **Note 2:** *The proposed consequences address only compliance with the requirement itself. They do not address the content of the hospital's submissions to The Joint Commission. For example, if information in a hospital's electronic application for accreditation (E-App) leads to inaccuracies in the appropriate length of the survey and a longer survey is required, the hospital will incur the additional costs of the longer survey. In addition, if there is evidence that the hospital has intentionally falsified the information submitted to The Joint Commission, the requirement at APR.01.02.01, EP 1 and its consequences will apply. (*See also *APR.01.02.01, EP 1)*
Compliant?	☐ Yes ☐ No ☐ Not scored ☐ Not applicable
If insufficient compliance:	
Likelihood to harm	☐ Low ☐ Moderate ☐ High ☐ Immediate threat to life
Scope of noncompliance	☐ Limited ☐ Pattern ☐ Widespread ☐ Immediate threat to life

Evidence of Compliance	Plan of Action	Due Date

KEY: Ⓓ indicates that documentation is required; 🅁 indicates an identified risk

Standard APR.01.02.01	The hospital provides accurate information throughout the accreditation process.
EP 1	Does the hospital provide accurate information throughout the accreditation process? (*See also* APR.01.01.01, EP 1) **Note 1:** *Information may be received in any of the following ways:* ■ *Provided verbally* ■ *Obtained through direct observation by, or in an interview or any other type of communication with, a Joint Commission employee* ■ *Derived from documents supplied by the hospital to The Joint Commission* ■ *Submitted electronically by the hospital to The Joint Commission* **Note 2:** *For the purpose of this requirement, falsification is defined as the fabrication, in whole or in part, and through commission or omission, of any information provided by an applicant or accredited organization to The Joint Commission. This includes redrafting, reformatting, or deleting document content. However, the organization may submit supporting material that explains the original information submitted to The Joint Commission. These additional materials must be properly identified, dated, and accompanied by the original documents.*
Compliant?	☐ Yes ☐ No ☐ Not scored ☐ Not applicable
If insufficient compliance:	
Likelihood to harm	☐ Low ☐ Moderate ☐ High ☐ Immediate threat to life
Scope of noncompliance	☐ Limited ☐ Pattern ☐ Widespread ☐ Immediate threat to life

Evidence of Compliance	Plan of Action	Due Date

Standard APR.01.03.01	The hospital reports any changes in the information provided in the application for accreditation and any changes made between surveys.
EP 1 Ⓓ	Does the hospital notify The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered? **Note:** *When the hospital changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to survey the hospital again. If the hospital does not provide written notification to The Joint Commission within 30 days of these changes, the hospital could lose its accreditation.*
Compliant?	☐ Yes ☐ No ☐ Not scored ☐ Not applicable
If insufficient compliance:	
Likelihood to harm	☐ Low ☐ Moderate ☐ High ☐ Immediate threat to life
Scope of noncompliance	☐ Limited ☐ Pattern ☐ Widespread ☐ Immediate threat to life

Evidence of Compliance	Plan of Action	Due Date

KEY: Ⓓ indicates that documentation is required; 🅁 indicates an identified risk