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2026 Hospital Compliance Assessment Workbook

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How to Use This Book

Purpose of This Book

The *2026 Hospital Compliance Assessment Workbook* is a comprehensive self-assessment workbook designed to help your hospital maintain continuous compliance and embed processes that promote safety, quality, and compliance into your hospital's operations. For hospitals seeking Joint Commission accreditation, this book can be used to assess compliance and identify areas of improvement prior to survey. You can use this book to look closely at your hospital's compliance with each EP and use the checklists provided to create plans to address any identified compliance issues.

The *2026 Hospital Compliance Assessment Workbook* presents all the Joint Commission hospital accreditation standards and EPs in an easy-to-use workbook format that includes tools to help you do the following:

- Engage staff members and leaders in accreditation activities with questions and easy-to-apply tools
- Identify deficiencies and implement plans to mitigate them
- Prepare for your accreditation survey

What's New in This Edition

This 2026 edition includes all standards updates to E-dition or its counterpart, the *Comprehensive Accreditation Manual for Hospitals* (*CAMH*), from the past year, including all Accreditation 360 enhancements that take effect January 1, 2026.

In 2025 Joint Commission launched Accreditation 360: The New Standard to make accreditation smarter, lighter, and more aligned with how health care is delivered today. Enhancements include the following:

- Removing more than 700 requirements from the hospital accreditation program to reduce burden on accredited organizations
- Identifying EPs that have a direct relationship to Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) in the *CAMH*
- Combining the "Environment of Care" (EC) and "Life Safety" (LS) chapters into one comprehensive "Physical Environment" (PE) chapter
- Adding a "National Performance Goals" (NPG) chapter to the *CAMH* that includes 14 requirements that rise above CMS regulations and cover salient, measurable topics with clearly defined goals

Understanding the Compliance Assessment Checklist

The self-assessment checklists in Chapter 2 help you score your hospital's compliance with Joint Commission standards and EPs. This section is divided into 16 standards chapters on E-dition or in the *CAMH*—from "Accreditation Participation Requirements" (APR) to "Transplant Safety" (TS)—with each chapter consisting of the following elements:

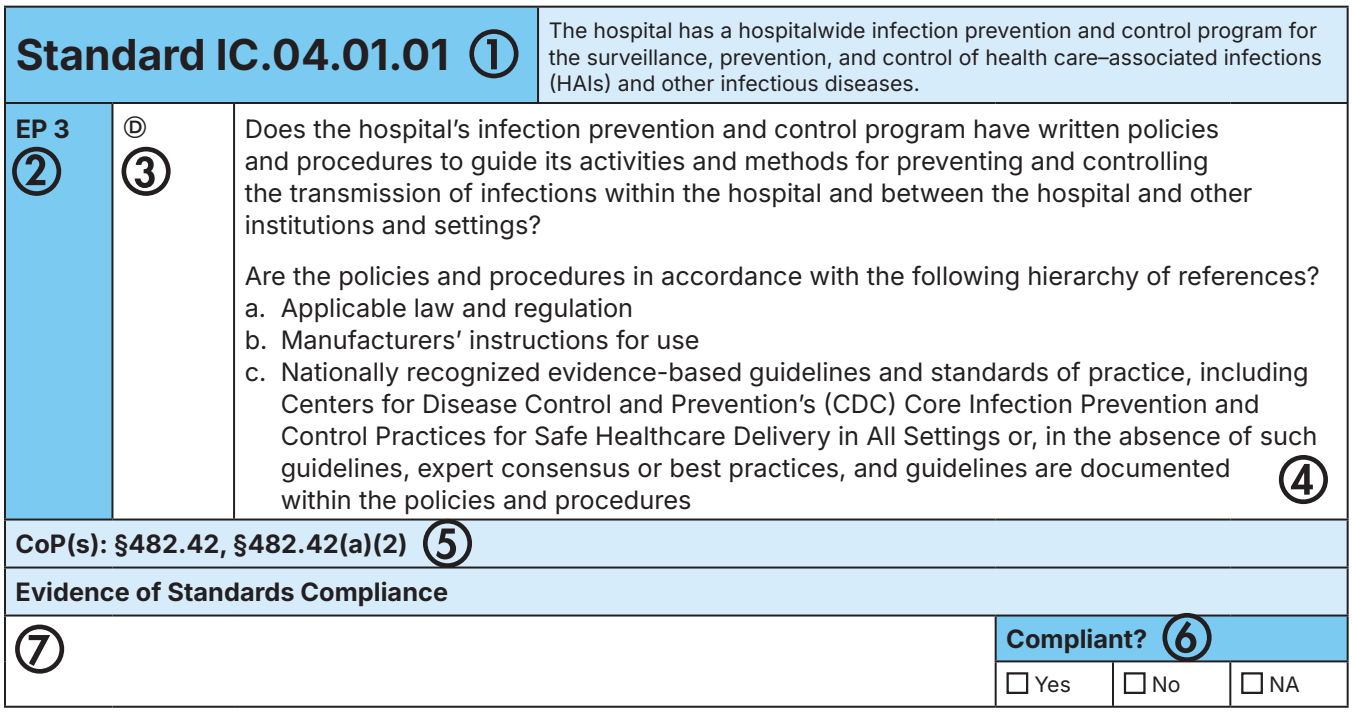
- **Chapter overview.** Each chapter includes a summary of the topics covered by the standards.

- **Standards compliance assessment.** Each EP on E-dition or in the *CAMH* is phrased as a question to help you determine your hospital's compliance with each requirement. The workbook format allows you to document whether your hospital is compliant and capture your evidence of compliance or note why your hospital is noncompliant. For example, Emergency Management (EM) Standard EM.12.02.11, EP 1, reads "The hospital has a plan for managing essential or critical utilities during an emergency or disaster incident," whereas the workbook asks the question "Does the hospital's plan for managing utilities describe in writing the utility system that it considers as essential or critical to provide care, treatment, and services?"

In addition, the Ⓓ icon is denoted, as applicable, to identify EPs that require documentation. A documentation icon is used to identify data collection and documentation requirements that are beyond information required to be in the medical record. Examples are for EPs that require a policy, a written plan, bylaws, a license, evidence of testing, data, performance improvement reports, medication labels, safety data sheets, or meeting minutes. All icons and corresponding notes and cross-references have been removed from applicable standards and EPs to make this workbook easier to navigate. Reference E-dition or your *CAMH* to review additional notes and cross-references.

Elements of the Compliance Assessment

This figure below identifies the compliance assessment checklist elements that you will see in Chapter 2. The numbers in the figure correspond to the numbered list that follows the figure.



Standard IC.04.01.01 ①	The hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.	
EP 3 ②	Ⓓ ③	Does the hospital's infection prevention and control program have written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings? Are the policies and procedures in accordance with the following hierarchy of references? a. Applicable law and regulation b. Manufacturers' instructions for use c. Nationally recognized evidence-based guidelines and standards of practice, including Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices, and guidelines are documented within the policies and procedures ④
CoP(s): §482.42, §482.42(a)(2) ⑤		
Evidence of Standards Compliance		
⑦	**Compliant?** ⑥	☐ Yes ☐ No ☐ NA

1. **Standard number and text.** This is the standard content from E-dition or its counterpart, the *Comprehensive Accreditation Manual for Hospitals* (*CAMH*). Any notes and cross-references that may correspond to the standard number may be reviewed on E-dition or in the *CAMH*.
2. **EP number.** Each EP is included in this book and corresponds to the same number on E-dition or in the *CAMH*.

3. **Documentation icon.** This icon box will include a documentation icon as appropriate. If an EP requires documentation, the Ⓓ icon will be listed. This icon will match the icon on E-dition and in the *CAMH*. If an EP does not have a documentation requirement, the box will be empty. All notes and cross-references have been removed from applicable standards and EPs to make this workbook easier to navigate. Reference E-dition or your *CAMH* to review additional notes and cross-references.
4. **Compliance assessment question.** This content is the EP turned into a question for you to assess compliance.
5. **Corresponding CoPs.** This identifies the CMS regulations that are associated with certain EPs on E-dition or in the *CAMH*. Note that not all EPs are based on CMS regulations.
6. **Compliance assessment.** Once you've determined your compliance with an EP, this section allows you to mark whether your organization is compliant ("Yes") or not compliant ("No"). If an EP is not applicable to your hospital, mark the "NA" box.
7. **Evidence of Standards Compliance.** Use this section to record what information and documentation supports your hospital's compliance with this EP. This section can also be used to record what is noncompliant with this EP, which can later be used when developing the Plan of Action.

Accreditation Participation Requirements (APR)

Overview

This chapter consists of specific requirements for participation in the accreditation process and for maintaining an accreditation award.

For a hospital seeking accreditation for the first time, compliance with most of the Accreditation Participation Requirements, or APRs, is assessed during the initial survey, including the Early Survey Policy Option. Please note that APR.09.01.01 and APR.09.02.01 are not assessed during the initial survey. For the accredited hospital, compliance with the APRs is assessed throughout the accreditation cycle through on-site surveys, the Focused Standards Assessment (FSA), Evidence of Standards Compliance (ESC), and periodic updates of hospital-specific data and information. Organizations are either compliant or not compliant with the APRs. When a hospital does not comply with an APR, the hospital will be assigned a Requirement for Improvement (RFI) in the same context that noncompliance with a standard or element of performance generates an RFI. However, refusal to permit performance of a survey (APR.02.01.01) will lead to a denial of accreditation. Falsification of information (APR.01.02.01) will lead to a preliminary denial of accreditation decision. All RFIs can impact the accreditation decision and follow-up requirements, as determined by established accreditation decision rules. Failure to resolve an RFI can ultimately lead to loss of accreditation.

Standard APR.01.01.01		The hospital submits information to Joint Commission as required.
EP 1		Does the hospital meet all requirements for timely submissions of data and information to Joint Commission?
CoP(s):		
Evidence of Standards Compliance		
		Compliant? ☐ Yes ☐ No ☐ NA

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?
CoP(s):		
Evidence of Standards Compliance		
		Compliant? ☐ Yes ☐ No ☐ NA

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	Ⓓ	Did the hospital notify Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, services offered, or required licensure?
CoP(s):		
Evidence of Standards Compliance		
		Compliant? ☐ Yes ☐ No ☐ NA

EP 2	Ⓓ	**For hospitals that use Joint Commission accreditation for deemed status purposes:** Does the hospital notify Joint Commission immediately upon receiving notice from the Centers for Medicare & Medicaid Services (CMS) that its deemed status has been removed due to Medicare condition-level noncompliance identified during a recent CMS complaint or validation survey?
CoP(s):		
Evidence of Standards Compliance		
		Compliant? ☐ Yes ☐ No ☐ NA