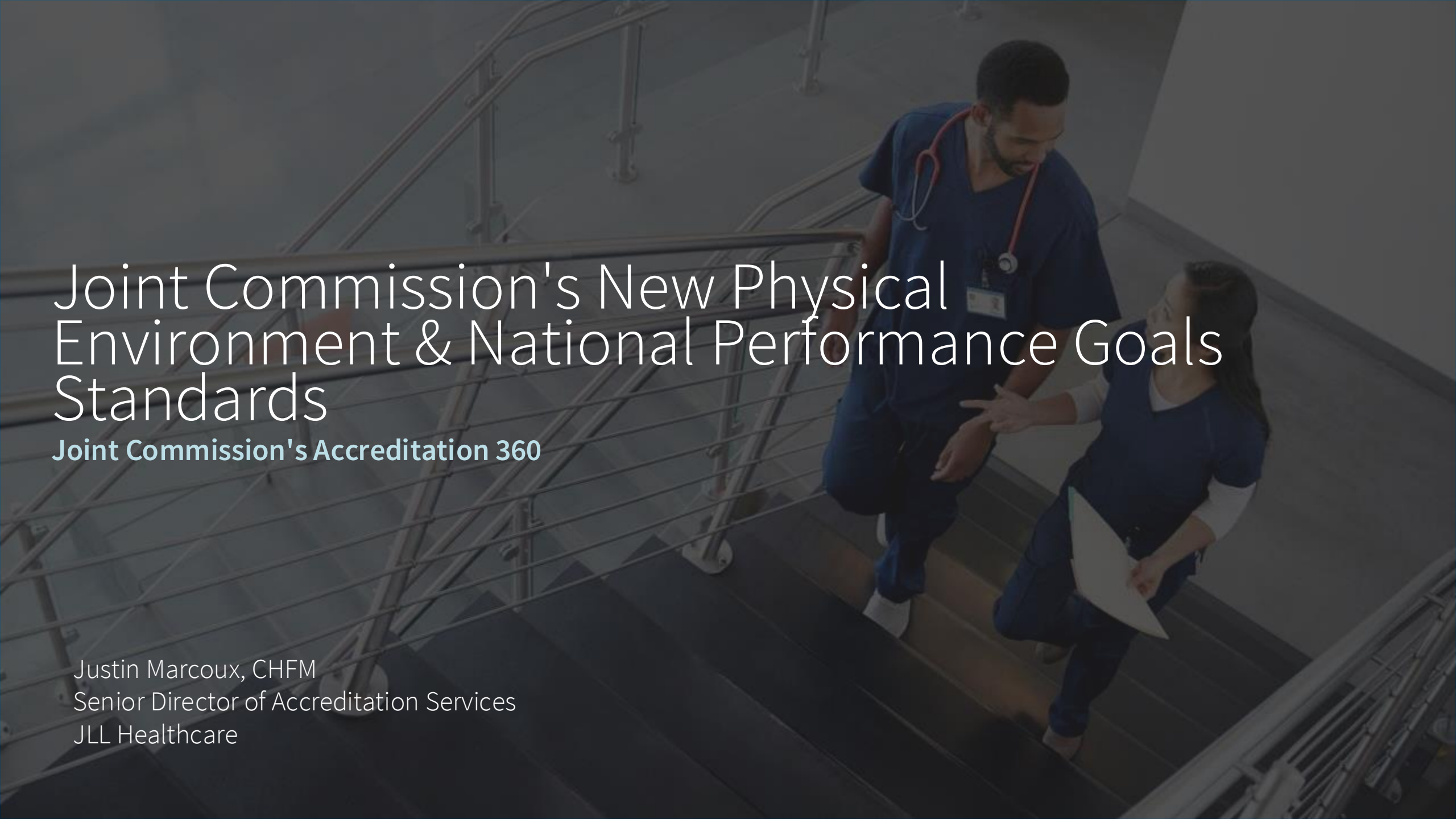

Joint Commission's New Physical Environment & National Performance Goals Standards

Joint Commission's Accreditation 360

Justin Marcoux, CHFM
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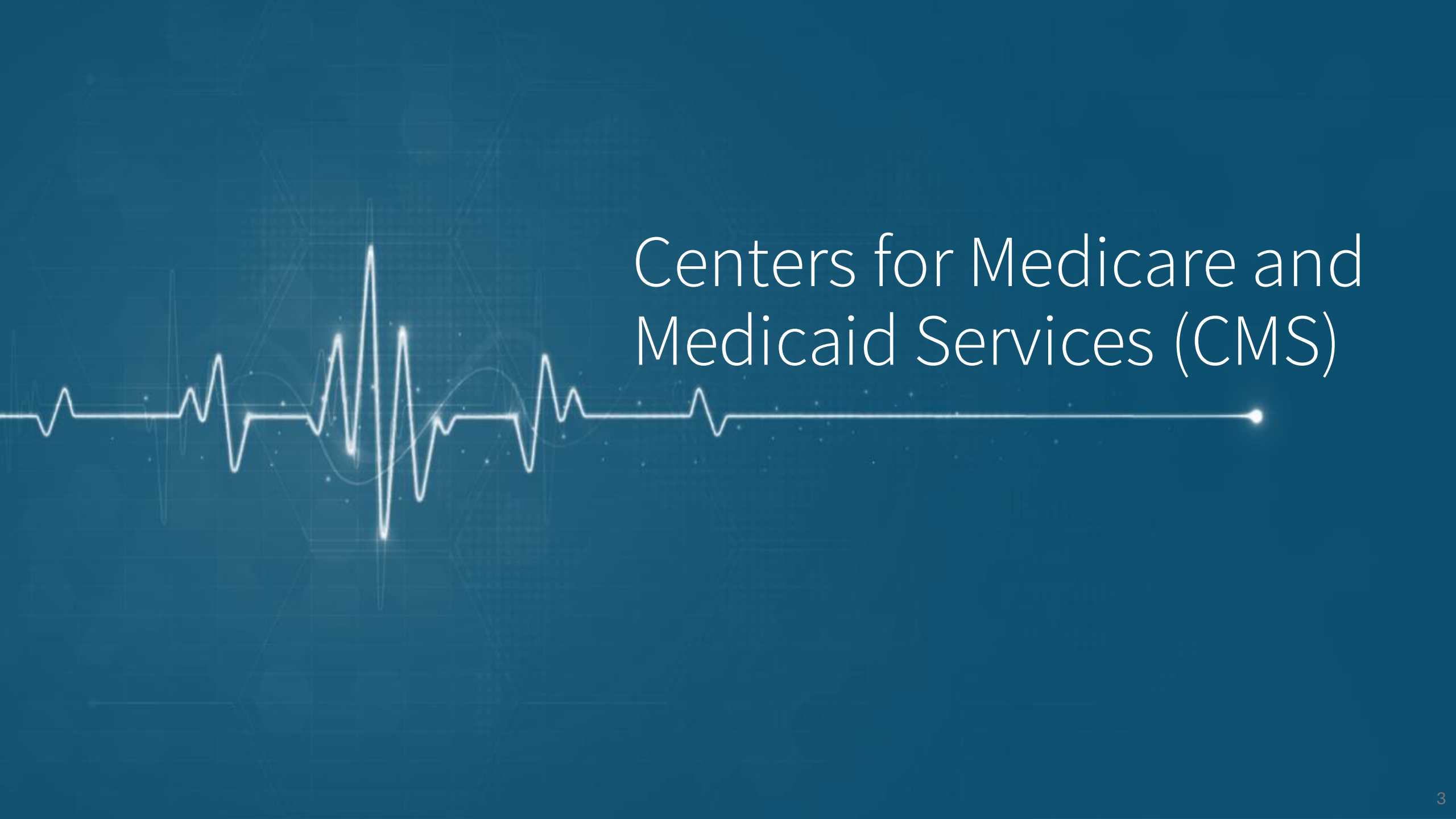
JLL Healthcare

Learning Objectives

- Explain how Centers for Medicare and Medicaid Services (CMS) regulations inform and drive Joint Commission standards
- Describe key updates to the 2026 Joint Commission standards
- Identify available tools and resources to support effective preparedness for Joint Commission surveys
- Explain how the Joint Commission survey process remains consistent despite updates to the standards



Centers for Medicare and Medicaid Services (CMS)

Background on Centers for Medicare and Medicaid Services Conditions of Participation

Simplified, before a hospital can get reimbursement, they must meet the minimum health and safety standards put forth by CMS, which requires a hospital to be evaluated at least every three years.

What are they?

The **Conditions of Participation (CoPs)** are essential qualifications developed by the Centers for Medicare & Medicaid Services (CMS) that healthcare organizations must meet to begin and continue participating in federally funded healthcare programs, including Medicare and Medicaid. These CoPs establish key health and safety guidelines designed to protect beneficiaries by enhancing quality and enforcing patient rights. These CoPs can be found in the State Operations Manual (SOM) for each type of accreditation program (i.e., Hospital, Critical Access Hospital, Ambulatory Surgery Center, etc.)

Understanding the Difference Between Tags, CoPs, and Standards

Centers for Medicare and Medicaid Services

Federal Regulatory Agency

- Conditions of Participations (CoPs)
  - Federal Regulations
  - Broader in scope
- Tags (k-tags, a-tags, c-tags, etc.)
  - More specific identifiers tied to the CoPs
  - Aligned with each accreditation program

Understanding the Difference Between Tags, CoPs, and Standards

State Operations Manual

- Hospitals
  42 CFR Part 482 (A-tags)
- Critical Access Hospitals
  42 CFR Part 485 (C-tags)
- Ambulatory Surgical Centers
  42 CFR Part 416 (Q-tags)

Tags identify the minimum standard requirements

Fire Safety Survey Report – Health Care 2012 Life Safety Code (2786 R)

- Specific to Life Safety Code Compliance
- K-tags
- Consistent across programs but NFPA code references will differ

State Operations Manual
Appendix A - Survey Protocol,
Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 220; Issued:04-19-24)

A-0713
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.41(b)(4) - The hospital must have procedures for the proper routine storage and prompt disposal of trash.

Interpretive Guidelines §482.41(b)(4)

Guidance is pending and will be updated in future release.

A-0714
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.41(b)(5) - The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities.

Survey Procedures §482.41(b)(5)

Guidance is pending and will be updated in future release.

A-0715
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.41(b)(6) - The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.

Interpretive Guidelines §482.41(b)(6)
Guidance is pending and will be updated in future release

A-0716
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.41(b)(7) - A hospital may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

Interpretive Guidelines §482.41(b)(7):

Name of Facility | 2012 LIFE SAFETY CODE

		MET		NA	REMARKS
K162	2012 NEW ... 19.1.6.2, ASTM E108, ANSI/UL 790				
K163	**Interior Nonbearing Wall Construction** ... 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5				
	SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** ... 18.2, 19.2				
K211	**Means of Egress – General** ... 18.2.1, 19.2.1, 7.1.10.1				

Understanding the Difference Between Tags, CoPs, and Standards

K-tag	Code Requirement	CoP	Joint Commission Standard
K200	**Means of Egress Requirements – Other** Any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3

Accreditation Organizations then take these Federal Regulations and develop their standards for purpose of scoring.

- Each standard correlates to both CoP(s) and Tags.
- When Joint Commission scores a finding, they apply a CoP to the finding when applicable.
- The Joint Commission Crosswalk tool assists organizations in understanding how the new standards are crosswalked to the CMS Regulations.
  - Critical Access Hospital Crosswalk*
  - Critical Access Hospital DPU Crosswalk*
  - Hospital Crosswalk*
  - Psychiatric Hospital Crosswalk

Joint Commission New Standards

What is Accreditation 360?

- Comprehensive accreditation approach integrating on-site surveys with continuous performance monitoring and improvement tools
- Provides holistic view of organizational performance, safety, and quality standards throughout the accreditation cycle
- Emphasizes continuous relationship with The Joint Commission beyond traditional periodic survey model
- Enables sustained compliance, quality improvement, and regulatory preparedness year-round

Standards Compliance

Performance Analytics

Educational Support

Quality Improvement Resource

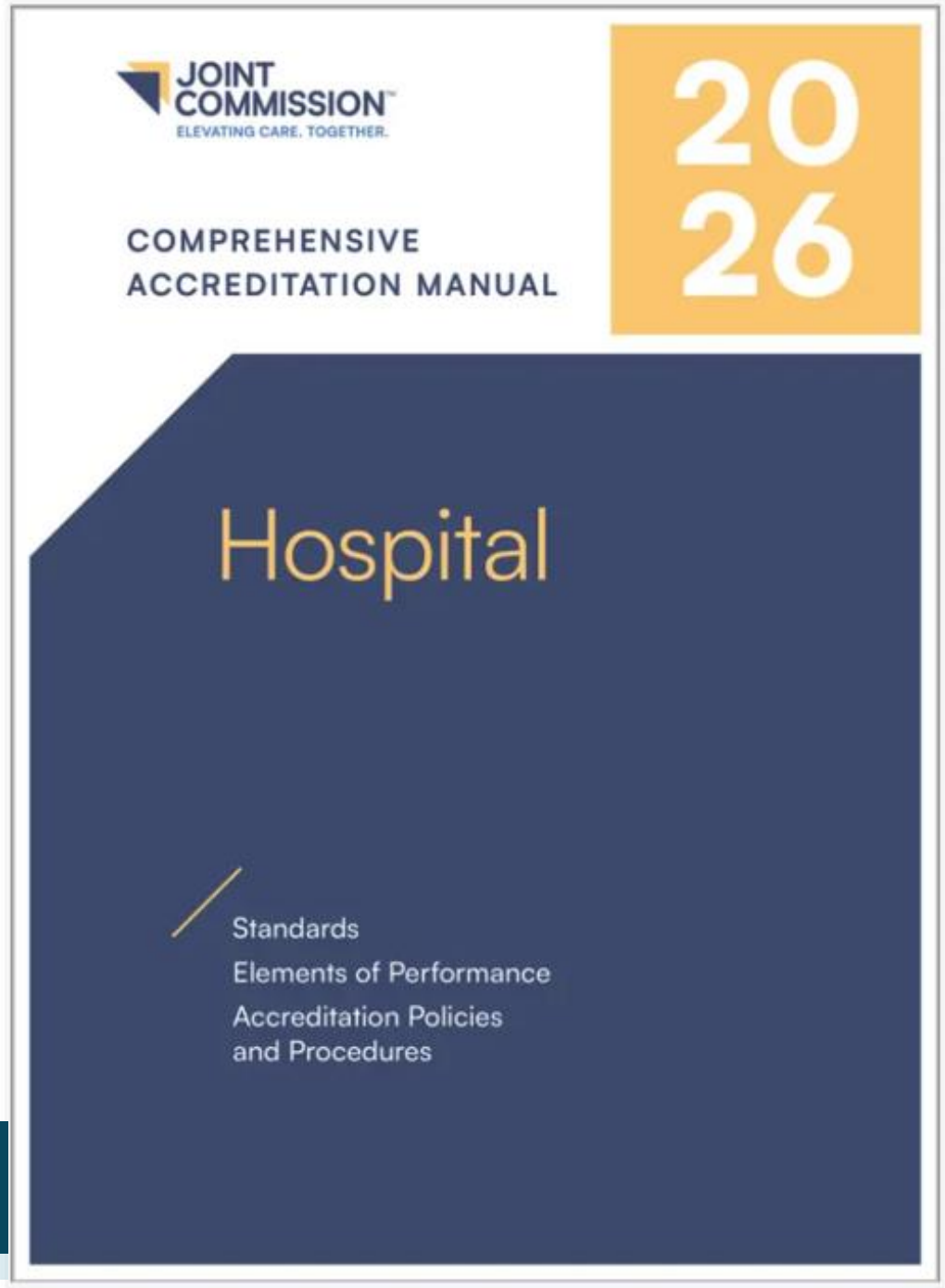
What Changed in 2026?

Accreditation 360 has streamlined and simplified the standards and elements of performance, including the Environment of Care (EC) and Life Safety (LS) chapters.

This does not remove or eliminate any codes, regulations, or inspection, testing, or maintenance requirements, etc. from the survey process –deficiencies will be scored differently, and the standards are less prescriptive.

Accreditation 360 does offer enhancements:

- **New Continuous Engagement Model** is a support system between triennial surveys including touchpoints and leading practices.
- **Public access** to standards online, including rationale of standards and chapter overviews.



Where Did the Standards Go?

- Joint Commission's Accreditation 360 has organized and simplified standards, including those managed by Facilities.
- Various resources were published to help Healthcare Professionals understand where the new standards were moved.
  - Updated Accreditation Manuals for Hospitals and Critical Access Hospitals
  - Crosswalks for the CMS CoPs to the Joint Commission element of performance (EP)
  - Survey Process Guides for Hospitals and Critical Access Hospitals
  - Disposition Report show former to new Joint Commission EPs

Physical Environment

PE standards crosswalked to CMS Conditions of Participation

National Performance Goals

NPG standards are specific to Joint Commission Accreditation and not crosswalked to CMS Conditions of Participation

Physical Environment Standards

PE.01.01.01 Safe and Adequate Physical Environment

Safety and Security, including PCRA

PE.02.01.01 Managing Risks to Hazardous Materials and Waste

PE.03.01.01 Designs and Manages the Physical Environment to the Life Safety Code

LSD (EP 1); NFPA 101 Design and Installation (EP 3); Fire Control Plan (EP 4)

PE.03.02.01 Protects Occupants During Periods when Life Safety Code Not Met and Construction

Interim Life Safety Measures

PE.04.01.01 Building Safety and Facility Management

NFPA 99 Design and Installation (EP 1) and Unmaintained and ITM (EP 2)

PE.04.01.03 Manages Utility Systems

Providing Emergency Power (EPs 1 & 3) and Testing Emergency Power (EP 3)

PE.04.01.05 Water Management Program

PE.05.01.01 Manages Imaging Safety Ris

National Performance Goal Standards

NPG.02.03.01 Work Processes to Focus Individuals on Safety and Quality Issues

Hospital-wide Patient Safety Program

NPG.02.04.01 Workplace Violence Prevention Program

NPG.08.01.01 Reduces Risk for Suicide

Environmental (Ligature and Self-harm) Risk Assessment (EP 1)

NPG.11.01.01 Manages Security Risks

Access Contro1 (EP 1) and Policies and Procedures (EP 2)

NPG.11.03.01 Manages Utility Systems

Policies/SOPs Utility Disruptions (EP 1) and Em Med Dispensing and Refrigeration (EPs 2 – 3)

NPG.12.05.01 Provides Education and Training and Evaluates Staff Competence

Job Training (EP 1) and Competency (EP 2)

Where Did the Documentation Go?

Documentation Required per the Survey Process Guide Physical Environment Document List and Review Tool

(excludes Medical Equipment)

PE.01.01.01 Safe and Adequate Physical Environment

PE.02.01.01 Managing Risks to Hazardous Materials and Waste

EP 1 – Inventory
EP 2 – Permits, Licenses, Manifests, and Safety Data Sheets (SDS)
EP 4 – Written Procedures

PE.03.01.01 Designs and Manages the Physical Environment to the Life Safety Code

EP 1- Life Safety Drawings
EP 2 – SOC/BBI
EP 3 – Fire Drills
EP 4 – Written Fire Control Plan
EP 5- AHJ Inspections

PE.03.02.01 Protects Occupants During Periods when Life Safety Code Not Met and Construction

EP 1 – ILSM Policy
EP 2 – Fire Watch
EP 4 – Daily Inspections
EP 10 – Additional Training Equipment
EP 11 – Fire Drill
EP 12 – Temporary System ITM
EP 13 – Additional Training Deficiencies
EP 14 – Additional Training Impairments

Where Did the Documentation Go?

Documentation Required per the Survey Process Guide Physical Environment Document List and Review Tool

(excludes Medical Equipment)

PE.04.01.01 Building Safety and Facility Management

EP 1 – OR and Hyperbaric Fire Drills and Critical Ventilation ITM
EP 2 – Fire Alarm, Suppression, Exit Signs, Emergency Lighting, MGV, LIMs, and Utilities ITM; Utilities Inventory
EP 3 – Noncritical Ventilation ITM

PE.04.01.03 Manages Utility Systems

EP 3 – Emergency Power ITM
EP 4 - PCRA

PE.04.01.05 Water Management Program

EP 1 – Multidisciplinary Team
EP 2 – Program
EP 3 – Monitoring Activities and Corrective Action
EP 4 – Annual Review

PE.05.01.01 Manages Imaging Safety Risks

Where Did the Documentation Go?

Documentation Required per the Survey Process Guide Physical Environment Document List and Review Tool

(excludes Medical Equipment)

NPG.02.04.01 Workplace Violence Prevention Program

EP 3 – Annual Worksite Analysis for Workplace Violence Prevention Program

NPG.08.01.01 Reduces Risk for Suicide

EP 1 – Ligature and Self-Harm Risk Assessment (Designated and Non-designated)

NPG.11.01.01 Manages Security Risks

EP 1 – Security Procedures
EP 3 – Process for Monitoring, Reporting and Investigating

NPG.11.03.01 Manages Utility Systems

NPG.12.05.01 Provides Education and Training and Evaluates Staff Competence

Joint Commission Tools and Resources

Tool 1 – Disposition Report

The Disposition Report shows the former standard and whether it has been moved, consolidated, or removed. If remaining it shows the new standard and element of performance (EP), as well as the language of the new EP.

- Disposition Report for Hospitals
- Disposition Report for Critical Access Hospitals

Former standard and element of performance
Includes former element of performance language and applicable CoPs

New standard and element of performance
Includes new element of performance language and applicable CoPs

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
EC.02.02.01, EP 1	The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. CoPs: §482.26(b)(1), §482.41(a)	Moved	PE.02.01.01, EP 1	The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation.

Tool 2 – Survey Process Guide

Formerly known as the Survey Activity Guide, this tool has several resources for leadership, clinical, and facilities that assist with understanding the survey process for the various Elements of Performance (EPs)

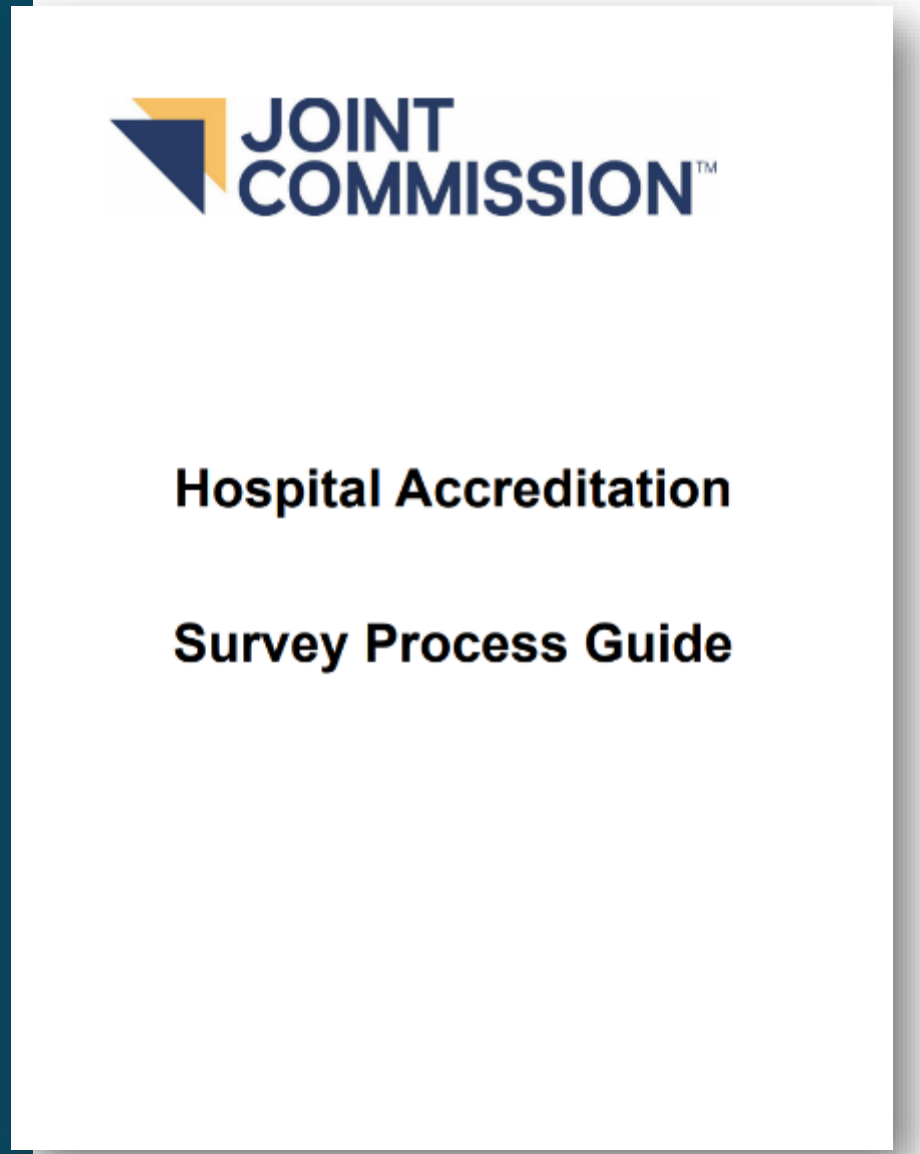
- Hospital Survey Process Guide (SPG)
- Critical Access Hospital Survey Process Guide (SPG)

What Does this Mean for Me?

1. Surveyors should follow the new guide closely – organizations should be familiar with it
2. Additional time at Business Occupancies listed under the CCN or Statement of Conditions.
3. The new standards at times will need to be clarified and will cause some confusion on placement.
4. Overall, the survey process will still be the same.

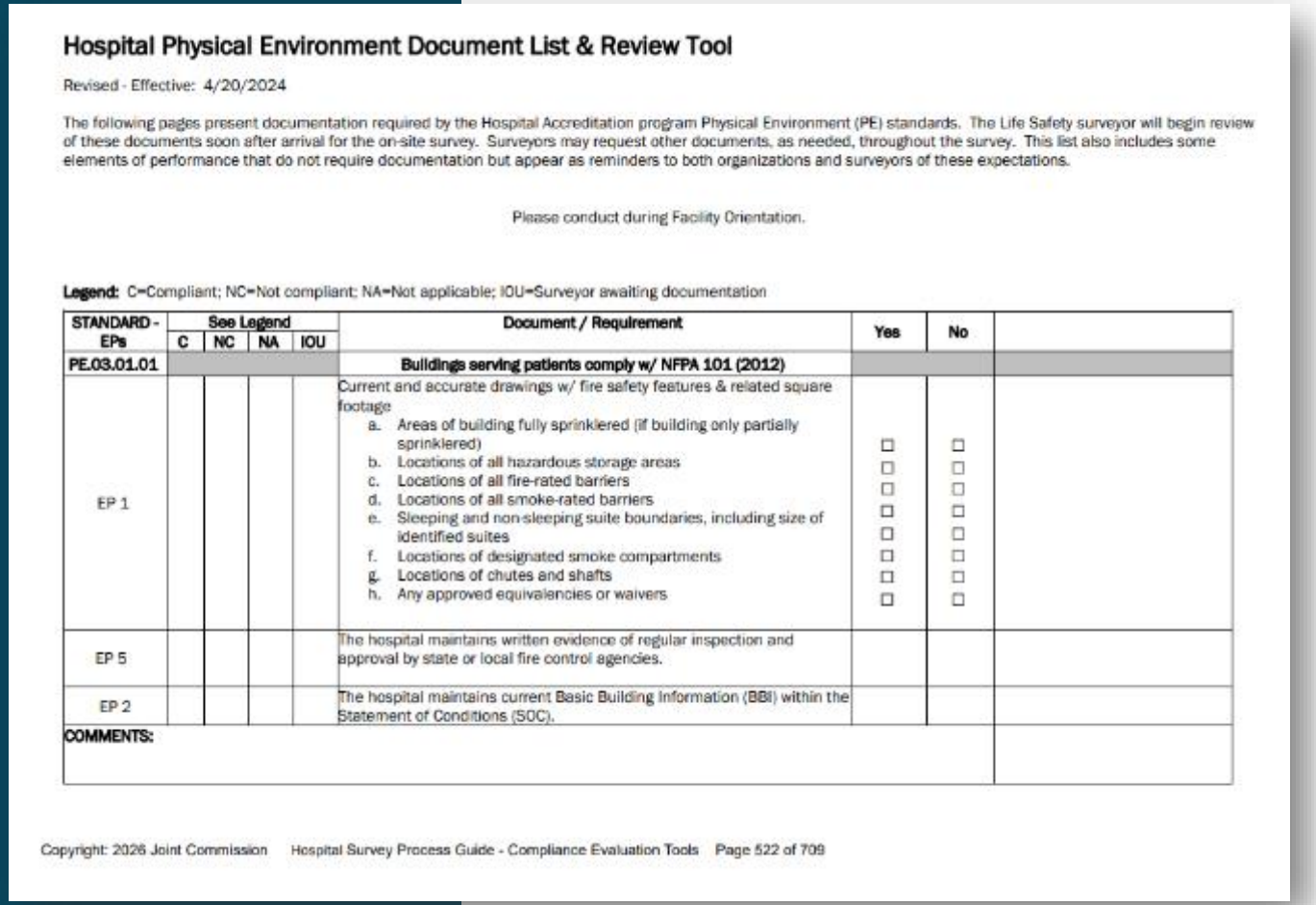
Resources in the Survey Process Guide

- Physical Environment and Document List and Review Tool
- Healthcare Occupancy LSC and HCFC Evaluation Tool
- Ambulatory Health Care Occupancy LSC and HCFC Evaluation Tool
- Hospital Building Tour Guidance
- Business and Ambulatory Building Tour Guidance
- National Performance Goals Evaluation Module
- Fire Drill Matrix
- Kitchen Tracer Survey Guide – Hospital and Critical Access Hospital
- Emergency Management Evaluation Module
- Emergency Management Discussion Tool
- Infection Prevention and Control Program Assessment Tool
- Suicide Prevention, including Ligature and Other Safety Risks Assessment



Physical Environment Document List and Review Tool

- Document requirements are similar to content in the former Survey Activity Guide, but not necessarily in alignment with new standard language.
- Documentation does not need to be in this order, but should be organized in a system familiar with the organization
- Pages 522 - 537



Hospital Physical Environment Document List & Review Tool

Revised - Effective: 4/20/2024

The following pages present documentation required by the Hospital Accreditation program Physical Environment (PE) standards. The Life Safety surveyor will begin review of these documents soon after arrival for the on-site survey. Surveyors may request other documents, as needed, throughout the survey. This list also includes some elements of performance that do not require documentation but appear as reminders to both organizations and surveyors of these expectations.

Please conduct during Facility Orientation.

Legend: C=Compliant; NC=Not compliant; NA=Not applicable; IOU=Surveyor awaiting documentation

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Yes	No	
PE.03.01.01					**Buildings serving patients comply w/ NFPA 101 (2012)**			
EP 1					Current and accurate drawings w/ fire safety features & related square footage a. Areas of building fully sprinklered (if building only partially sprinklered) b. Locations of all hazardous storage areas c. Locations of all fire-rated barriers d. Locations of all smoke-rated barriers e. Sleeping and non-sleeping suite boundaries, including size of identified suites f. Locations of designated smoke compartments g. Locations of chutes and shafts h. Any approved equivalencies or waivers	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
EP 5					The hospital maintains written evidence of regular inspection and approval by state or local fire control agencies.			
EP 2					The hospital maintains current Basic Building Information (BBI) within the Statement of Conditions (SOC).			
COMMENTS:								

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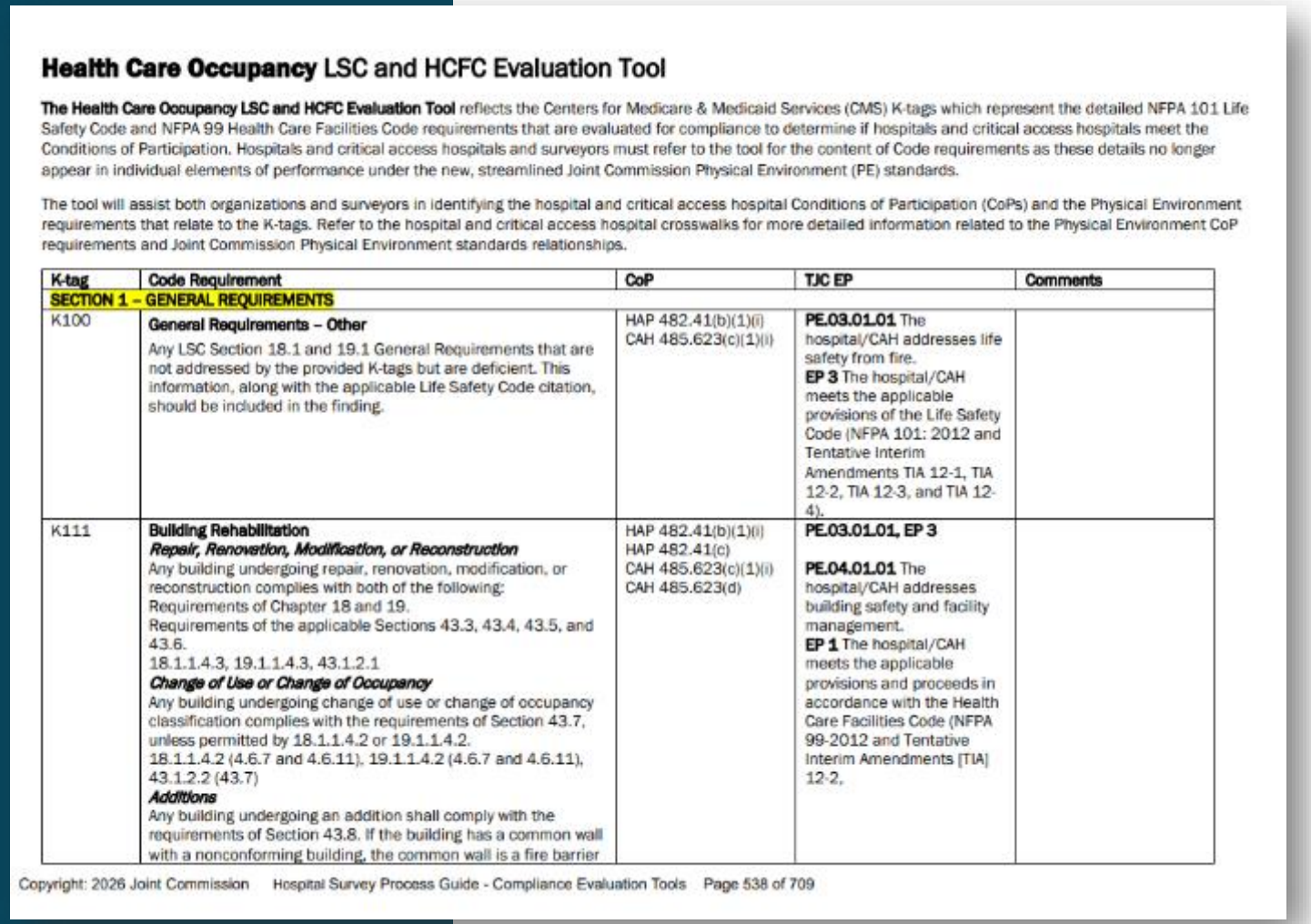
LSC and HCFC Evaluation Tool

- This is the CMS 2786 R Form but is also crosswalked to the CoPs and Joint Commission standard(s) that would be scored if found non-compliant.

- Reviews all k-tag requirements and their code references for:
  - NFPA 101 – 2012
  - NFPA 99 – 2012
  - NFPA 10NFPA 13
  - NFPA 25 -
  - NFPA 70
  - NFPA 72 - 2010
  - NFPA 80
  - NFPA 82
  - NFPA 96
  - NFPA 105
  - NFPA 110
  - NFPA 111
  - ASME A17.1
  - ASME A17.3
  - TIAs

- Healthcare pages 538 – 588

- Ambulatory - pages 481 - 520



Health Care Occupancy LSC and HCFC Evaluation Tool

The Health Care Occupancy LSC and HCFC Evaluation Tool reflects the Centers for Medicare & Medicaid Services (CMS) K-tags which represent the detailed NFPA 101 Life Safety Code and NFPA 99 Health Care Facilities Code requirements that are evaluated for compliance to determine if hospitals and critical access hospitals meet the Conditions of Participation. Hospitals and critical access hospitals and surveyors must refer to the tool for the content of Code requirements as these details no longer appear in individual elements of performance under the new, streamlined Joint Commission Physical Environment (PE) standards.

The tool will assist both organizations and surveyors in identifying the hospital and critical access hospital Conditions of Participation (CoPs) and the Physical Environment requirements that relate to the K-tags. Refer to the hospital and critical access hospital crosswalks for more detailed information related to the Physical Environment CoP requirements and Joint Commission Physical Environment standards relationships.

K-tag	Code Requirement	CoP	TJC EP	Comments
SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** Any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 3** The hospital/CAH meets the applicable provisions of the Life Safety Code (NFPA 101: 2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: Requirements of Chapter 18 and 19. Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) ***Additions*** Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01** The hospital/CAH addresses building safety and facility management. **EP 1** The hospital/CAH meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2,	

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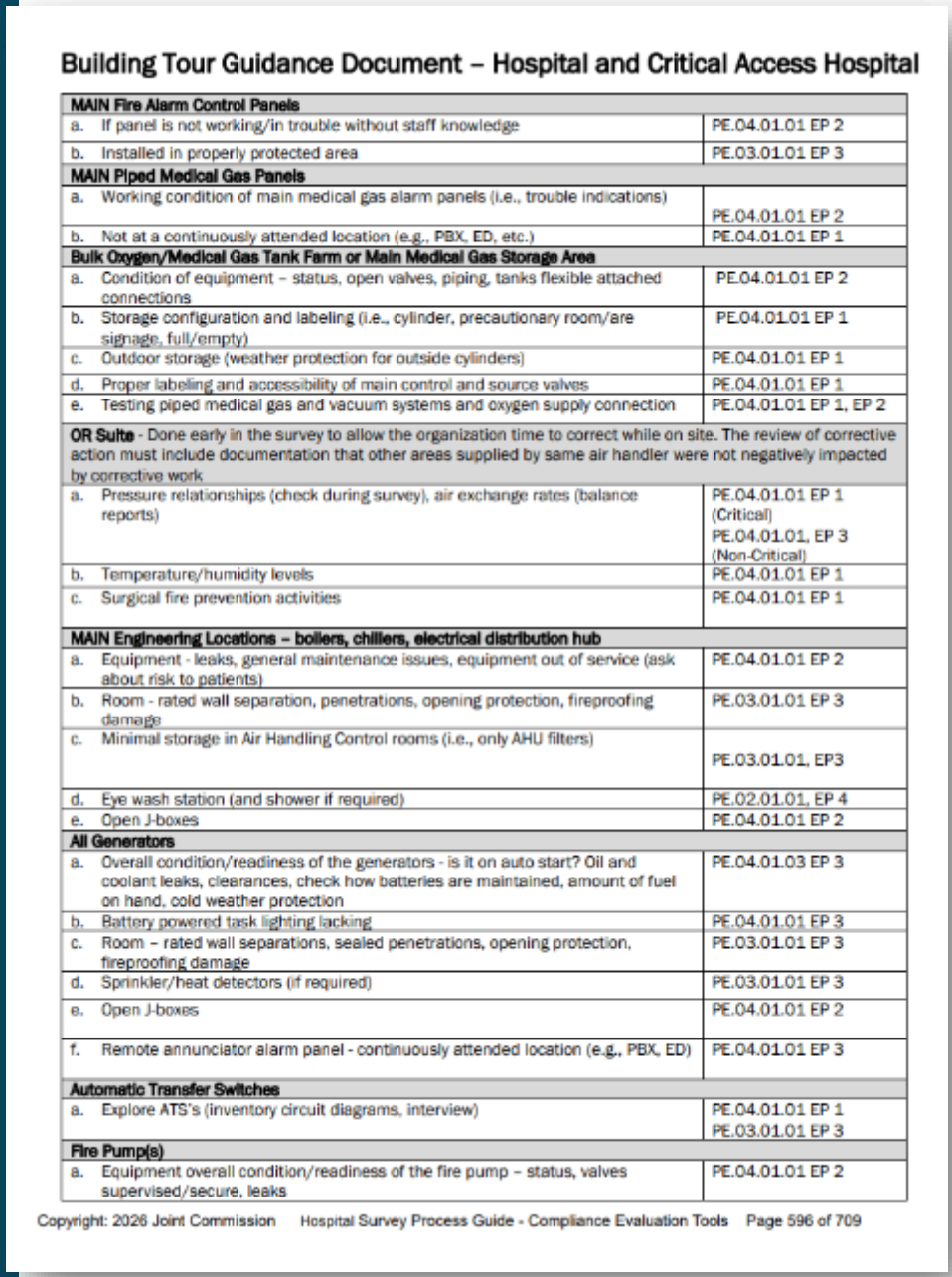
Hospital Building Tour Guidance

- List of key areas and equipment that the LSCS will review as part of their tracer
  - Main Fire Alarm Control Panels
  - Main Piped Medical Gas Panels
  - Bulk Oxygen/Medical Gas Tank Farm or Main Medical Gas Storage Area
  - Main Engineering Locations – Boilers, Chillers, Electrical Distribution Hub
  - Generators
  - Automatic Transfer Switches
  - Fire Pumps
  - Kitchen
  - Main Entries/Lobby
  - Construction Areas
  - Loading Dock and Receiving Dept.
  - Roof
  - Empty Patient Rooms
  - Exit Stairs, Rated Exit Passageways, Exterior Discharge Areas
  - Smoke Barriers
  - Two-hour Fire-rated Barriers
  - Hazardous Areas
  - Corridors
  - Electrical Closets
  - Various Indoor Air Quality Location Areas

- Pages 596 - 598



Building Tour Guidance Document – Hospital and Critical Access Hospital

MAIN Fire Alarm Control Panels	
a. If panel is not working/in trouble without staff knowledge	PE.04.01.01 EP 2
b. Installed in properly protected area	PE.03.01.01 EP 3
MAIN Piped Medical Gas Panels	
a. Working condition of main medical gas alarm panels (i.e., trouble indications)	PE.04.01.01 EP 2
b. Not at a continuously attended location (e.g., PBX, ED, etc.)	PE.04.01.01 EP 1
Bulk Oxygen/Medical Gas Tank Farm or Main Medical Gas Storage Area	
a. Condition of equipment – status, open valves, piping, tanks flexible attached connections	PE.04.01.01 EP 2
b. Storage configuration and labeling (i.e., cylinder, precautionary room/are signage, full/empty)	PE.04.01.01 EP 1
c. Outdoor storage (weather protection for outside cylinders)	PE.04.01.01 EP 1
d. Proper labeling and accessibility of main control and source valves	PE.04.01.01 EP 1
e. Testing piped medical gas and vacuum systems and oxygen supply connection	PE.04.01.01 EP 1, EP 2
OR Suite - Done early in the survey to allow the organization time to correct while on site. The review of corrective action must include documentation that other areas supplied by same air handler were not negatively impacted by corrective work	
a. Pressure relationships (check during survey), air exchange rates (balance reports)	PE.04.01.01 EP 1 (Critical) PE.04.01.01, EP 3 (Non-Critical)
b. Temperature/humidity levels	PE.04.01.01 EP 1
c. Surgical fire prevention activities	PE.04.01.01 EP 1
MAIN Engineering Locations – boilers, chillers, electrical distribution hub	
a. Equipment - leaks, general maintenance issues, equipment out of service (ask about risk to patients)	PE.04.01.01 EP 2
b. Room - rated wall separation, penetrations, opening protection, fireproofing damage	PE.03.01.01 EP 3
c. Minimal storage in Air Handling Control rooms (i.e., only AHU filters)	PE.03.01.01, EP3
d. Eye wash station (and shower if required)	PE.02.01.01, EP 4
e. Open J-boxes	PE.04.01.01 EP 2
All Generators	
a. Overall condition/readiness of the generators - is it on auto start? Oil and coolant leaks, clearances, check how batteries are maintained, amount of fuel on hand, cold weather protection	PE.04.01.03 EP 3
b. Battery powered task lighting lacking	PE.04.01.01 EP 3
c. Room – rated wall separations, sealed penetrations, opening protection, fireproofing damage	PE.03.01.01 EP 3
d. Sprinkler/heat detectors (if required)	PE.03.01.01 EP 3
e. Open J-boxes	PE.04.01.01 EP 2
f. Remote annunciator alarm panel - continuously attended location (e.g., PBX, ED)	PE.04.01.01 EP 3
Automatic Transfer Switches	
a. Explore ATS's (inventory circuit diagrams, interview)	PE.04.01.01 EP 1 PE.03.01.01 EP 3
Fire Pump(s)	
a. Equipment overall condition/readiness of the fire pump – status, valves supervised/secure, leaks	PE.04.01.01 EP 2

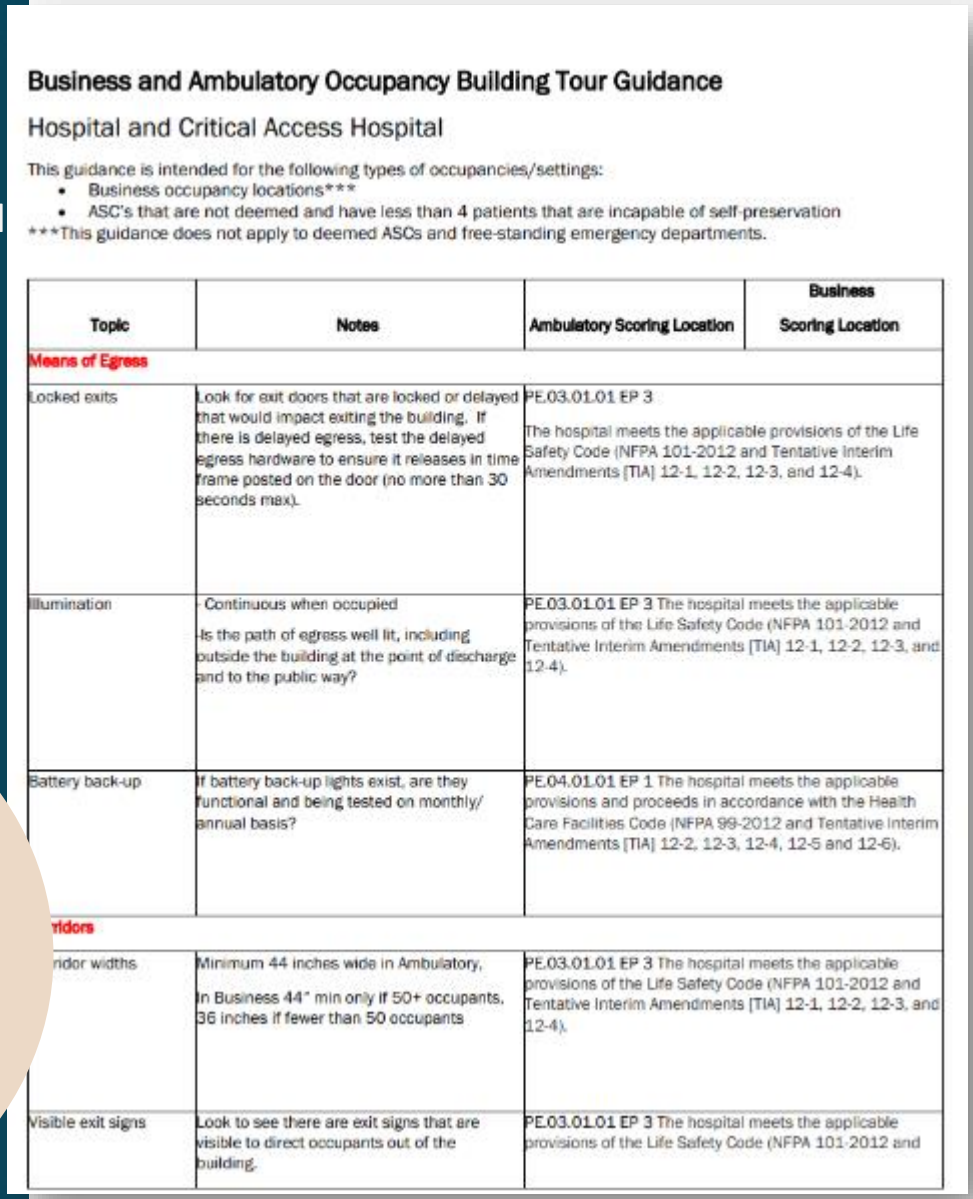
Business/Ambulatory Building Tour Guidance

- List of key areas and equipment that the LSCS will review as part of their tracer
  - Fire Drills
  - Means of Egress: locked exits, illumination, battery back-up
  - Storage Rooms
  - Corridors: width and exit signs
  - Sprinkler Heads/System: clearance, obstructions, and damage
  - Fire Extinguishers: inspection, mounting and visibility, and MRI
  - Junction Boxes
  - Electrical Outlets
  - Electrical Panel
  - Security / Access
  - Safety Data Sheets (SDS)
  - Biohazardous and Pharmaceutical Waste
  - Compounding
  - Alcohol-based Hand Rub (ABHR) Dispensers
  - Emergency Eyewash and Shower Stations
  - Cylinder Storage
  - Medical Equipment

- Pages 604 - 709

REMEMBER

Surveys now include more time for the LSCS to survey Business Occupancies on the BBI. This could result in up to an extra survey day based on the size of the facility.



Business and Ambulatory Occupancy Building Tour Guidance

Hospital and Critical Access Hospital

This guidance is intended for the following types of occupancies/settings:

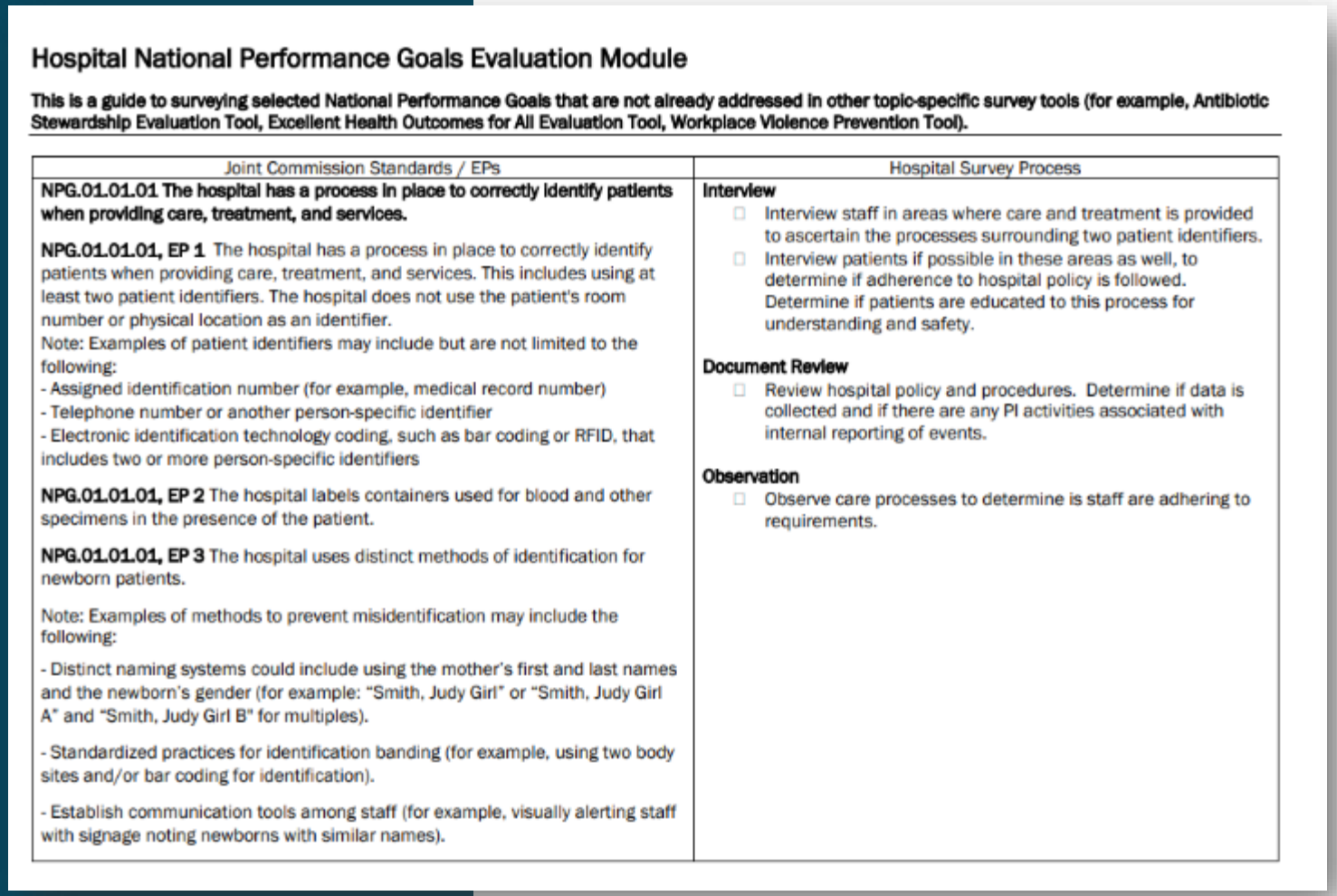
- Business occupancy locations***
- ASC's that are not deemed and have less than 4 patients that are incapable of self-preservation

***This guidance does not apply to deemed ASCs and free-standing emergency departments.

Topic	Notes	Ambulatory Scoring Location	Business Scoring Location
Means of Egress			
Locked exits	Look for exit doors that are locked or delayed that would impact exiting the building. If there is delayed egress, test the delayed egress hardware to ensure it releases in time frame posted on the door (no more than 30 seconds max).	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Illumination	Continuous when occupied -Is the path of egress well lit, including outside the building at the point of discharge and to the public way?	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Battery back-up	If battery back-up lights exist, are they functional and being tested on monthly/ annual basis?	PE.04.01.01 EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).	
ridors			
ridor widths	Minimum 44 inches wide in Ambulatory, In Business 44" min only if 50+ occupants, 36 inches if fewer than 50 occupants	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Visible exit signs	Look to see there are exit signs that are visible to direct occupants out of the building.	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and	

National Performance Goals Evaluation Module

- Guide to surveying selected National Performance Goals that are not addressed in another tool.
  - NPG.01.05.01 Safety of Clinical Alarm Systems
  - NPG.02.03.01 Patient Safety Program
  - NPG.11.01.01 Security Risks
  - NPG.11.03.01 Utility Systems
  - NPG.12.05.01 Education, Training, and Competency
- Pages 658 - 694



Hospital National Performance Goals Evaluation Module

This is a guide to surveying selected National Performance Goals that are not already addressed in other topic-specific survey tools (for example, Antibiotic Stewardship Evaluation Tool, Excellent Health Outcomes for All Evaluation Tool, Workplace Violence Prevention Tool).

Joint Commission Standards / EPs	Hospital Survey Process
NPG.01.01.01 The hospital has a process in place to correctly identify patients when providing care, treatment, and services. **NPG.01.01.01, EP 1** The hospital has a process in place to correctly identify patients when providing care, treatment, and services. This includes using at least two patient identifiers. The hospital does not use the patient's room number or physical location as an identifier. Note: Examples of patient identifiers may include but are not limited to the following: - Assigned identification number (for example, medical record number) - Telephone number or another person-specific identifier - Electronic identification technology coding, such as bar coding or RFID, that includes two or more person-specific identifiers **NPG.01.01.01, EP 2** The hospital labels containers used for blood and other specimens in the presence of the patient. **NPG.01.01.01, EP 3** The hospital uses distinct methods of identification for newborn patients. Note: Examples of methods to prevent misidentification may include the following: - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example: "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples). - Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification). - Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).	**Interview** ☐ Interview staff in areas where care and treatment is provided to ascertain the processes surrounding two patient identifiers. ☐ Interview patients if possible in these areas as well, to determine if adherence to hospital policy is followed. Determine if patients are educated to this process for understanding and safety. **Document Review** ☐ Review hospital policy and procedures. Determine if data is collected and if there are any PI activities associated with internal reporting of events. **Observation** ☐ Observe care processes to determine is staff are adhering to requirements.

Fire Drill Matrix

- Joint Commission will no longer be surveying to 1-hour between drills since this is not a code requirement.

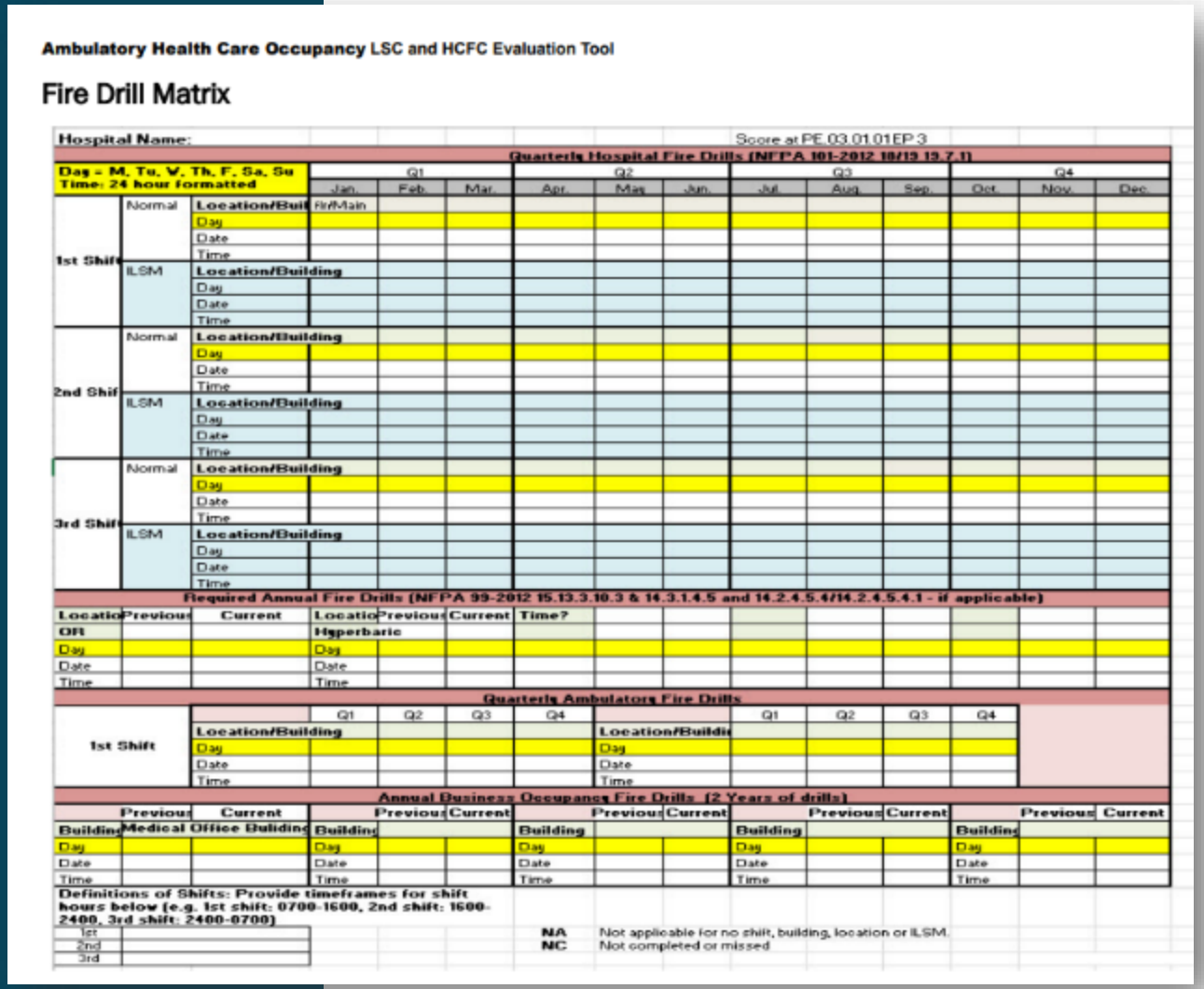
What is the Code Language?

Healthcare Occupancy 18/19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required **under varied conditions**.

Ambulatory Occupancy 20/21.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required **under varied conditions**.

Business Occupancy 38/39 No requirement

- Ambulatory – page 521
- Healthcare - removed



Ambulatory Health Care Occupancy LSC and HCFC Evaluation Tool

Fire Drill Matrix

Hospital Name: Score at PE.03.01.01EP 3

Quarterly Hospital Fire Drills (NFPA 101-2012 18/19.7.1)

Day – M, Tu, W, Th, F, Sa, Su
Time: 24 hour formatted

			Q1			Q2			Q3			Q4		
			Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
1st Shift	Normal	Location/Buil	Fir/Main											
		Day												
		Date												
		Time												
	ILSM	Location/Building												
		Day												
		Date												
		Time												
2nd Shif	Normal	Location/Building												
		Day												
		Date												
		Time												
	ILSM	Location/Building												
		Day												
		Date												
		Time												
3rd Shif	Normal	Location/Building												
		Day												
		Date												
		Time												
	ILSM	Location/Building												
		Day												
		Date												
		Time												

Required Annual Fire Drills (NFPA 99-2012 15.13.3.10.3 & 14.3.1.4.5 and 14.2.4.5.4/14.2.4.5.4.1 - if applicable)

Locatio	Previous	Current	Locatio	Previous	Current	Time?
OR			Hyperbaric			
Day			Day			
Date			Date			
Time			Time			

Quarterly Ambulatory Fire Drills

		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4
1st Shift	Location/Building					Location/Buildi				
	Day					Day				
	Date					Date				
	Time					Time				

Annual Business Occupancy Fire Drills (2 Years of drills)

	Previous	Current		Previous	Current		Previous	Current		Previous	Current		Previous	Current
Building	Medical Office Buliding		Building			Building			Building			Building		
Day			Day			Day			Day			Day		
Date			Date			Date			Date			Date		
Time			Time			Time			Time			Time		

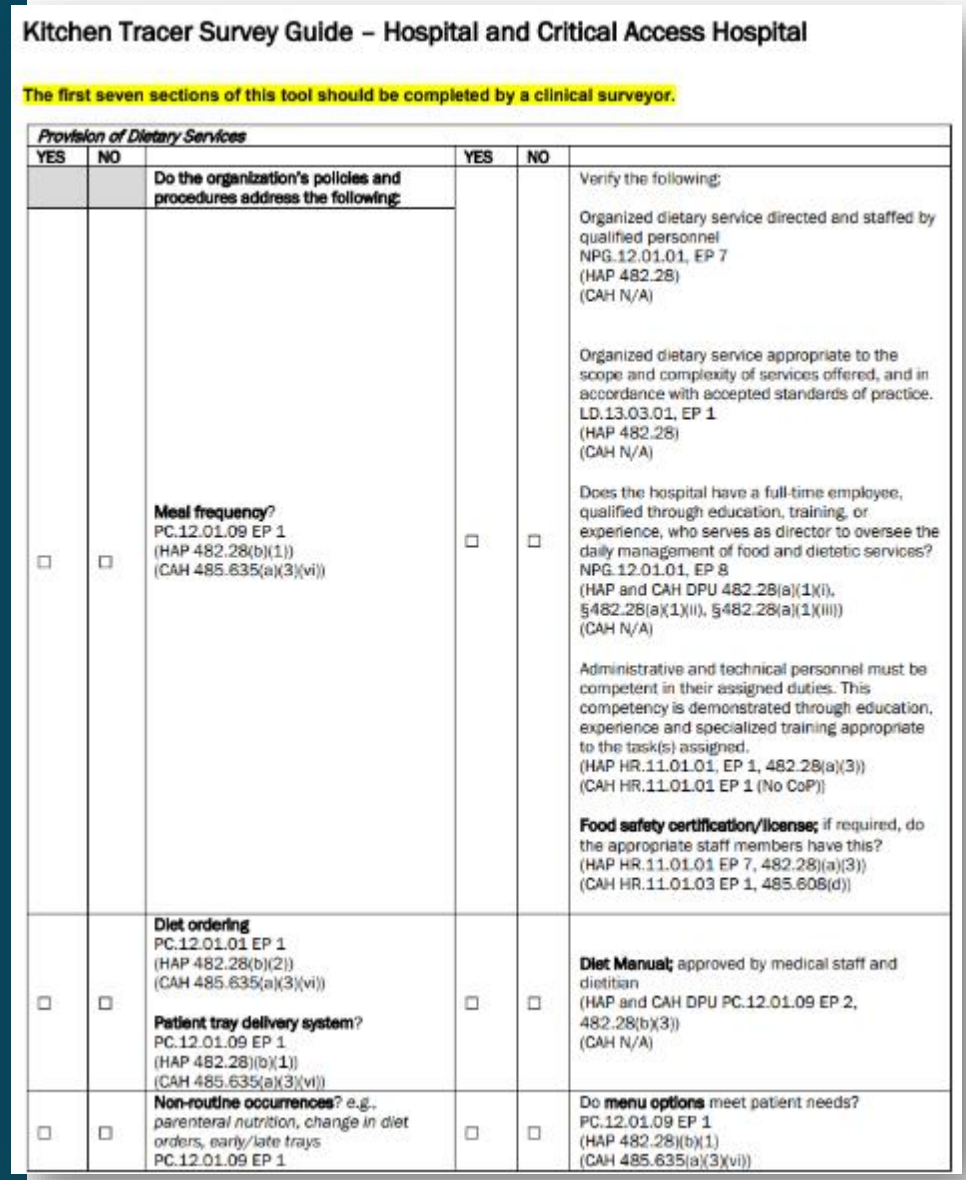
Definitions of Shifts: Provide timeframes for shift hours below (e.g. 1st shift: 0700-1600, 2nd shift: 1600-2400, 3rd shift: 2400-0700)

1st	
2nd	
3rd	

NA Not applicable for no shift, building, location or ILSM.
NC Not completed or missed

Kitchen Tracer Survey Guide

- Survey checklist for both clinical and Life Safety Code Surveyors (LSCS) that focuses on Food Safety, Infection Control, and the Physical Environment
- Applicable to Hospitals and Critical Access Hospitals
- Pages 589 – 595; pages 594 – 595 are completed by the LSCS but there are PE standards under the clinical portion



Kitchen Tracer Survey Guide – Hospital and Critical Access Hospital

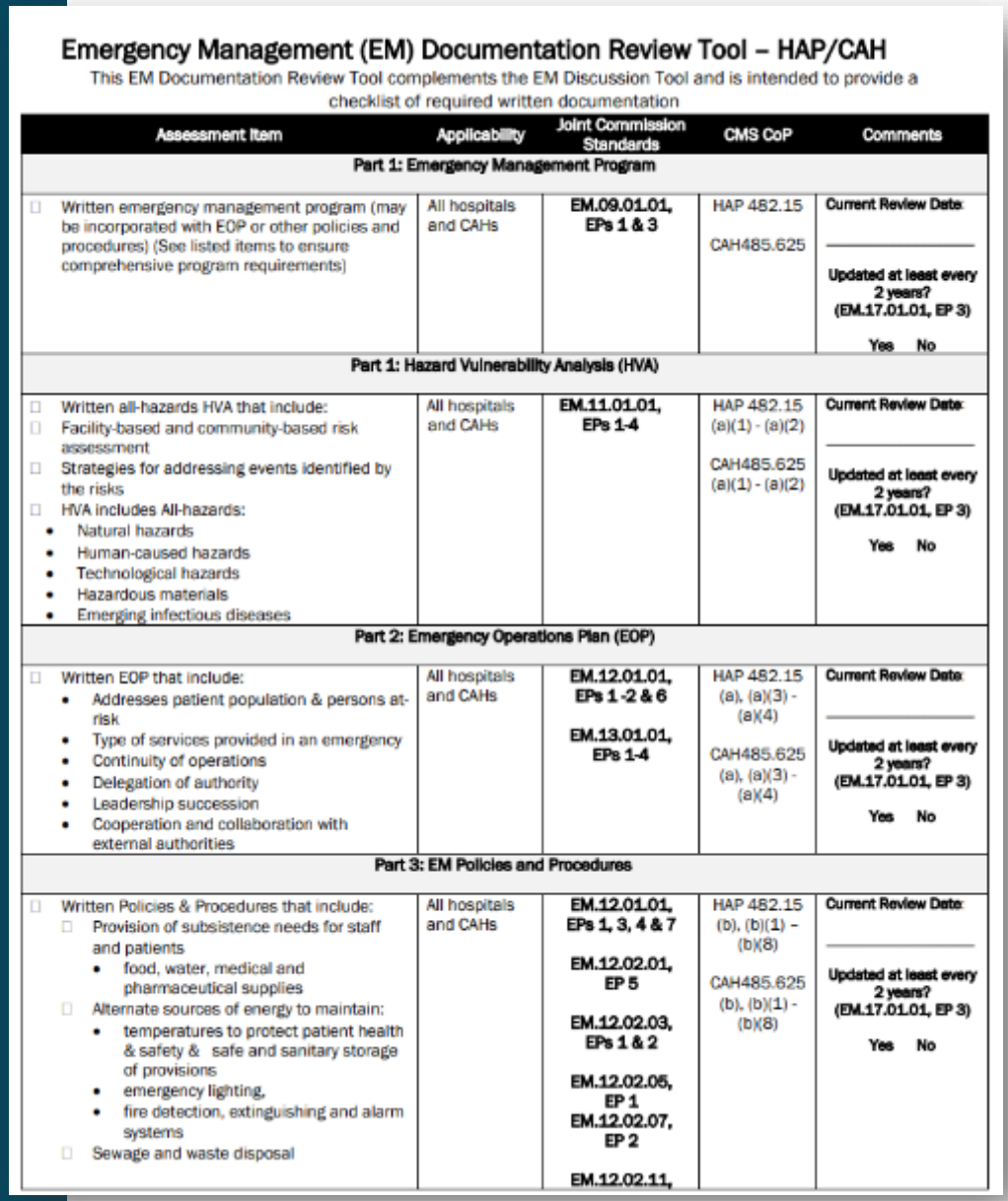
The first seven sections of this tool should be completed by a clinical surveyor.

Provision of Dietary Services

YES	NO	Do the organization's policies and procedures address the following:	YES	NO	Verify the following:
					Organized dietary service directed and staffed by qualified personnel NPG.12.01.01, EP 7 (HAP 482.28) (CAH N/A)
					Organized dietary service appropriate to the scope and complexity of services offered, and in accordance with accepted standards of practice. LD.13.03.01, EP 1 (HAP 482.28) (CAH N/A)
☐	☐	**Meal frequency**? PC.12.01.09 EP 1 (HAP 482.28(b)(1)) (CAH 485.635(a)(3)(vi))	☐	☐	Does the hospital have a full-time employee, qualified through education, training, or experience, who serves as director to oversee the daily management of food and dietetic services? NPG.12.01.01, EP 8 (HAP and CAH DPU 482.28(a)(1)(i), §482.28(a)(1)(ii), §482.28(a)(1)(iii)) (CAH N/A)
					Administrative and technical personnel must be competent in their assigned duties. This competency is demonstrated through education, experience and specialized training appropriate to the task(s) assigned. (HAP HR.11.01.01, EP 1, 482.28(a)(3)) (CAH HR.11.01.01 EP 1 (No CoP))
					Food safety certification/license; if required, do the appropriate staff members have this? (HAP HR.11.01.01 EP 7, 482.28)(a)(3)) (CAH HR.11.01.03 EP 1, 485.608(d))
☐	☐	**Diet ordering** PC.12.01.01 EP 1 (HAP 482.28(b)(2)) (CAH 485.635(a)(3)(vi))	☐	☐	**Diet Manual;** approved by medical staff and dietitian (HAP and CAH DPU PC.12.01.09 EP 2, 482.28(b)(3)) (CAH N/A)
		Patient tray delivery system? PC.12.01.09 EP 1 (HAP 482.28)(b)(1)) (CAH 485.635(a)(3)(vi))			
☐	☐	**Non-routine occurrences**? e.g., *parenteral nutrition, change in diet orders, early/late trays* PC.12.01.09 EP 1	☐	☐	Do **menu options** meet patient needs? PC.12.01.09 EP 1 (HAP 482.28)(b)(1) (CAH 485.635(a)(3)(vi))

EM Documentation Review Tool – HAP/CAH

- Includes Emergency Management (EM) and Physical Environment (PE) standards
- Crosswalks the CMS Conditions of Participation (CoPs)
- Pages 638 - 641



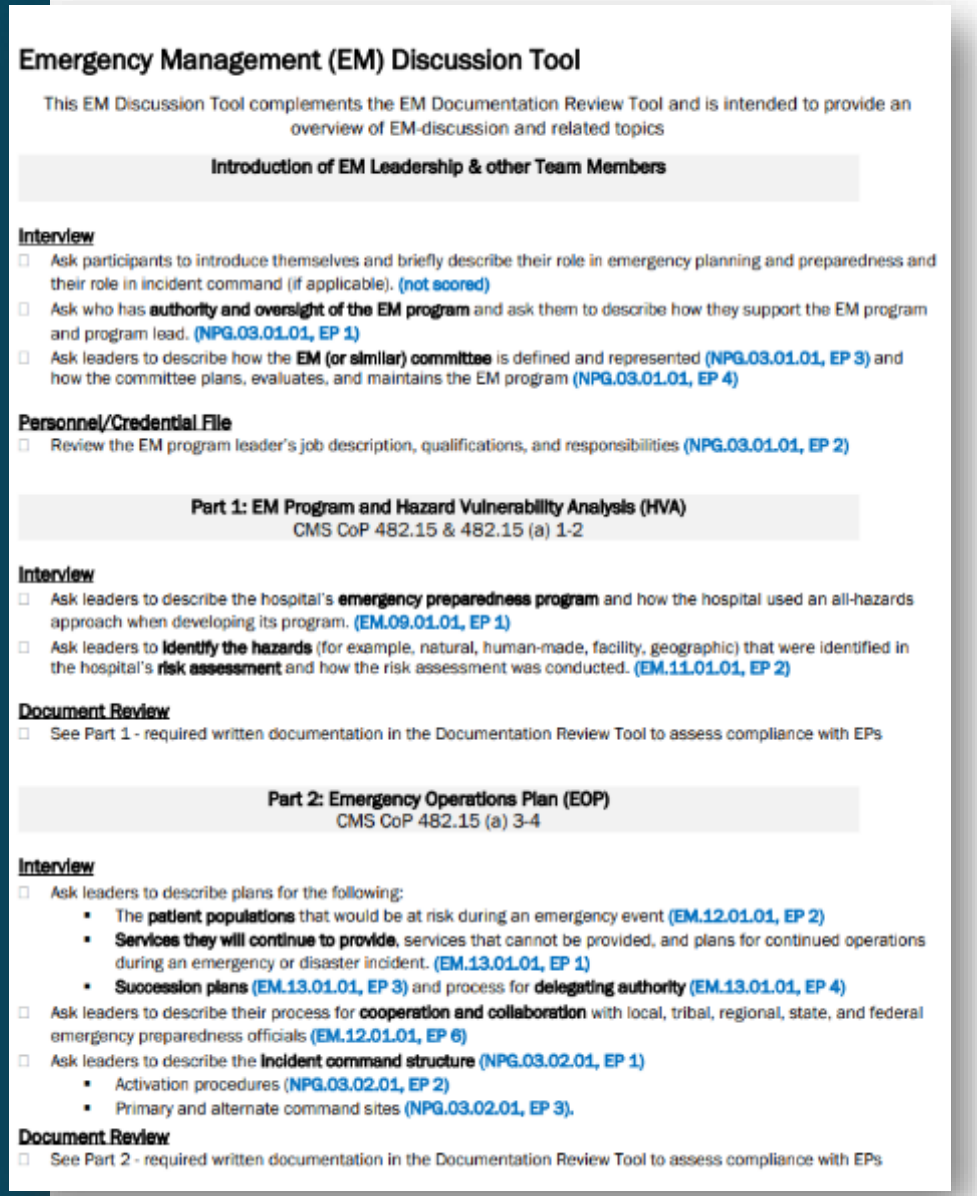
Emergency Management (EM) Documentation Review Tool – HAP/CAH

This EM Documentation Review Tool complements the EM Discussion Tool and is intended to provide a checklist of required written documentation

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
Part 1: Emergency Management Program				
☐ Written emergency management program (may be incorporated with EOP or other policies and procedures) (See listed items to ensure comprehensive program requirements)	All hospitals and CAHs	**EM.09.01.01, EPs 1 & 3**	HAP 482.15 CAH485.625	**Current Review Date:** **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 1: Hazard Vulnerability Analysis (HVA)				
☐ Written all-hazards HVA that include: ☐ Facility-based and community-based risk assessment ☐ Strategies for addressing events identified by the risks ☐ HVA includes All-hazards: • Natural hazards • Human-caused hazards • Technological hazards • Hazardous materials • Emerging infectious diseases	All hospitals and CAHs	**EM.11.01.01, EPs 1-4**	HAP 482.15 (a)(1) - (a)(2) CAH485.625 (a)(1) - (a)(2)	**Current Review Date:** **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 2: Emergency Operations Plan (EOP)				
☐ Written EOP that include: • Addresses patient population & persons at-risk • Type of services provided in an emergency • Continuity of operations • Delegation of authority • Leadership succession • Cooperation and collaboration with external authorities	All hospitals and CAHs	**EM.12.01.01, EPs 1 -2 & 6** **EM.13.01.01, EPs 1-4**	HAP 482.15 (a), (a)(3) - (a)(4) CAH485.625 (a), (a)(3) - (a)(4)	**Current Review Date:** **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 3: EM Policies and Procedures				
☐ Written Policies & Procedures that include: ☐ Provision of subsistence needs for staff and patients • food, water, medical and pharmaceutical supplies ☐ Alternate sources of energy to maintain: • temperatures to protect patient health & safety & safe and sanitary storage of provisions • emergency lighting, • fire detection, extinguishing and alarm systems ☐ Sewage and waste disposal	All hospitals and CAHs	**EM.12.01.01, EPs 1, 3, 4 & 7** **EM.12.02.01, EP 5** **EM.12.02.03, EPs 1 & 2** **EM.12.02.05, EP 1** **EM.12.02.07, EP 2** **EM.12.02.11,**	HAP 482.15 (b), (b)(1) – (b)(8) CAH485.625 (b), (b)(1) - (b)(8)	**Current Review Date:** **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**

EM Discussion Tool

- Utilized in the Emergency Management Breakout Session
- Evaluates documentation, but also team collaboration and knowledge as to the development and implementation of the Emergency Operations Plan
- Pages 634 - 637



Emergency Management (EM) Discussion Tool

This EM Discussion Tool complements the EM Documentation Review Tool and is intended to provide an overview of EM-discussion and related topics

Introduction of EM Leadership & other Team Members

Interview

- ☐ Ask participants to introduce themselves and briefly describe their role in emergency planning and preparedness and their role in incident command (if applicable). (not scored)
- ☐ Ask who has **authority and oversight of the EM program** and ask them to describe how they support the EM program and program lead. (NPG.03.01.01, EP 1)
- ☐ Ask leaders to describe how the **EM (or similar) committee** is defined and represented (NPG.03.01.01, EP 3) and how the committee plans, evaluates, and maintains the EM program (NPG.03.01.01, EP 4)

Personnel/Credential File

- ☐ Review the EM program leader's job description, qualifications, and responsibilities (NPG.03.01.01, EP 2)

Part 1: EM Program and Hazard Vulnerability Analysis (HVA)
CMS CoP 482.15 & 482.15 (a) 1-2

Interview

- ☐ Ask leaders to describe the hospital's **emergency preparedness program** and how the hospital used an all-hazards approach when developing its program. (EM.09.01.01, EP 1)
- ☐ Ask leaders to **identify the hazards** (for example, natural, human-made, facility, geographic) that were identified in the hospital's **risk assessment** and how the risk assessment was conducted. (EM.11.01.01, EP 2)

Document Review

- ☐ See Part 1 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 2: Emergency Operations Plan (EOP)
CMS CoP 482.15 (a) 3-4

Interview

- ☐ Ask leaders to describe plans for the following:
  - The **patient populations** that would be at risk during an emergency event (EM.12.01.01, EP 2)
  - **Services they will continue to provide**, services that cannot be provided, and plans for continued operations during an emergency or disaster incident. (EM.13.01.01, EP 1)
  - **Succession plans** (EM.13.01.01, EP 3) and process for **delegating authority** (EM.13.01.01, EP 4)
- ☐ Ask leaders to describe their process for **cooperation and collaboration** with local, tribal, regional, state, and federal emergency preparedness officials (EM.12.01.01, EP 6)
- ☐ Ask leaders to describe the **incident command structure** (NPG.03.02.01, EP 1)
  - Activation procedures (NPG.03.02.01, EP 2)
  - Primary and alternate command sites (NPG.03.02.01, EP 3).

Document Review

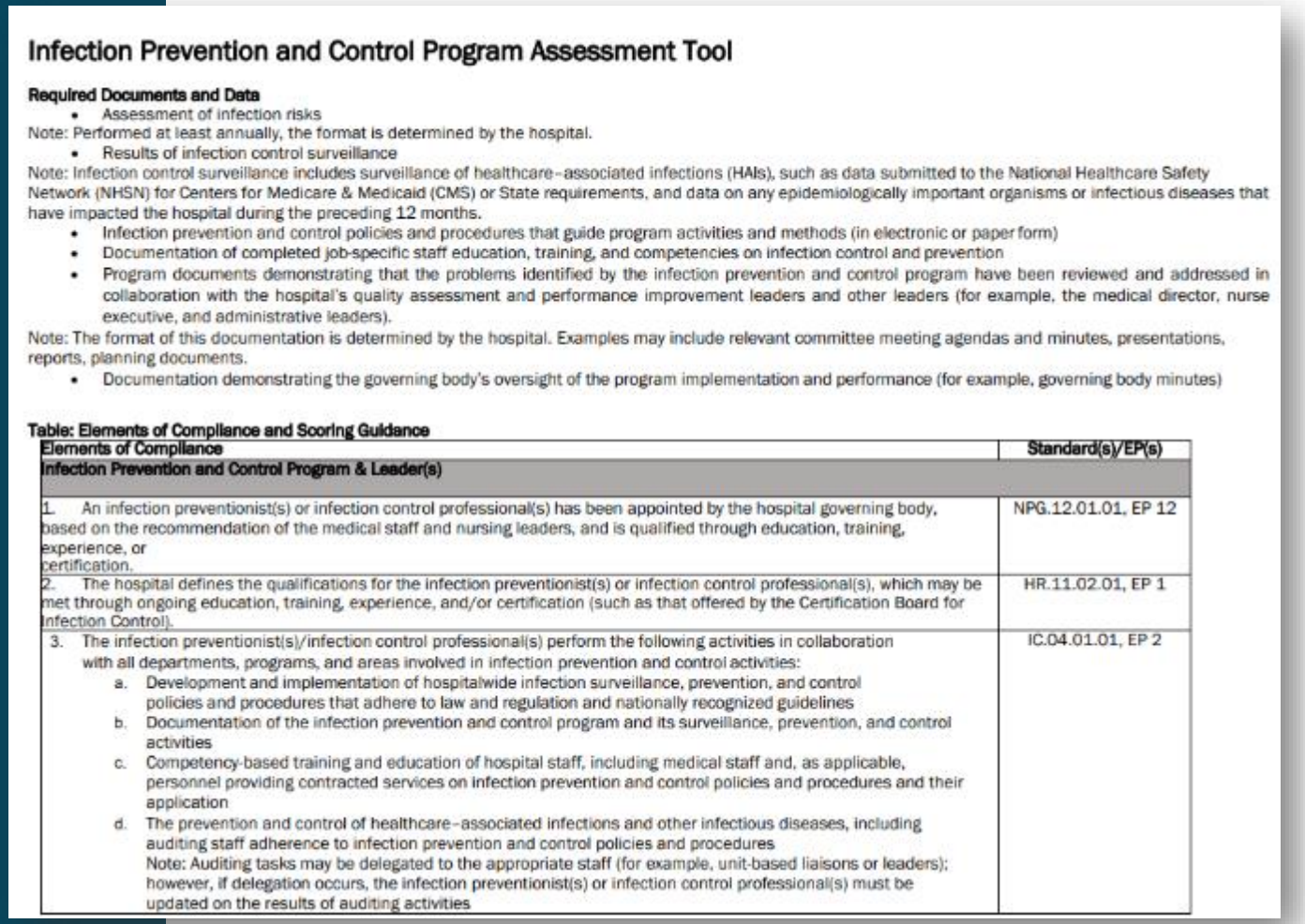
- ☐ See Part 2 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Infection Prevention and Control Program Assessment Tool

- While this is primarily clinical focused it does assess items such as:
  - Water Management Program
  - Construction Infection Control Risk Assessments (ICRA)
  - Alcohol-based Hand Rub (ABHR) Dispensers
  - Resources needed for hand hygiene
  - Environmental cleaning and disinfection
  - Ice machines
  - Furnishing integrity
  - Etc.

- Facilities should review to determine what is in scope or incorporates/impacts the department (i.e., hand hygiene)

- Pages 605 - 619



Infection Prevention and Control Program Assessment Tool

Required Documents and Data

- Assessment of infection risks

Note: Performed at least annually, the format is determined by the hospital.

- Results of infection control surveillance

Note: Infection control surveillance includes surveillance of healthcare-associated infections (HAIs), such as data submitted to the National Healthcare Safety Network (NHSN) for Centers for Medicare & Medicaid (CMS) or State requirements, and data on any epidemiologically important organisms or infectious diseases that have impacted the hospital during the preceding 12 months.

- Infection prevention and control policies and procedures that guide program activities and methods (in electronic or paper form)
- Documentation of completed job-specific staff education, training, and competencies on infection control and prevention
- Program documents demonstrating that the problems identified by the infection prevention and control program have been reviewed and addressed in collaboration with the hospital's quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders).

Note: The format of this documentation is determined by the hospital. Examples may include relevant committee meeting agendas and minutes, presentations, reports, planning documents.

- Documentation demonstrating the governing body's oversight of the program implementation and performance (for example, governing body minutes)

Table: Elements of Compliance and Scoring Guidance

Elements of Compliance	Standard(s)/EP(s)
Infection Prevention and Control Program & Leader(s)	
1. An infection preventionist(s) or infection control professional(s) has been appointed by the hospital governing body, based on the recommendation of the medical staff and nursing leaders, and is qualified through education, training, experience, or certification.	NPG.12.01.01, EP 12
2. The hospital defines the qualifications for the infection preventionist(s) or infection control professional(s), which may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).	HR.11.02.01, EP 1
3. The infection preventionist(s)/infection control professional(s) perform the following activities in collaboration with all departments, programs, and areas involved in infection prevention and control activities: a. Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines b. Documentation of the infection prevention and control program and its surveillance, prevention, and control activities c. Competency-based training and education of hospital staff, including medical staff and, as applicable, personnel providing contracted services on infection prevention and control policies and procedures and their application d. The prevention and control of healthcare-associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures Note: Auditing tasks may be delegated to the appropriate staff (for example, unit-based liaisons or leaders); however, if delegation occurs, the infection preventionist(s) or infection control professional(s) must be updated on the results of auditing activities	IC.04.01.01, EP 2

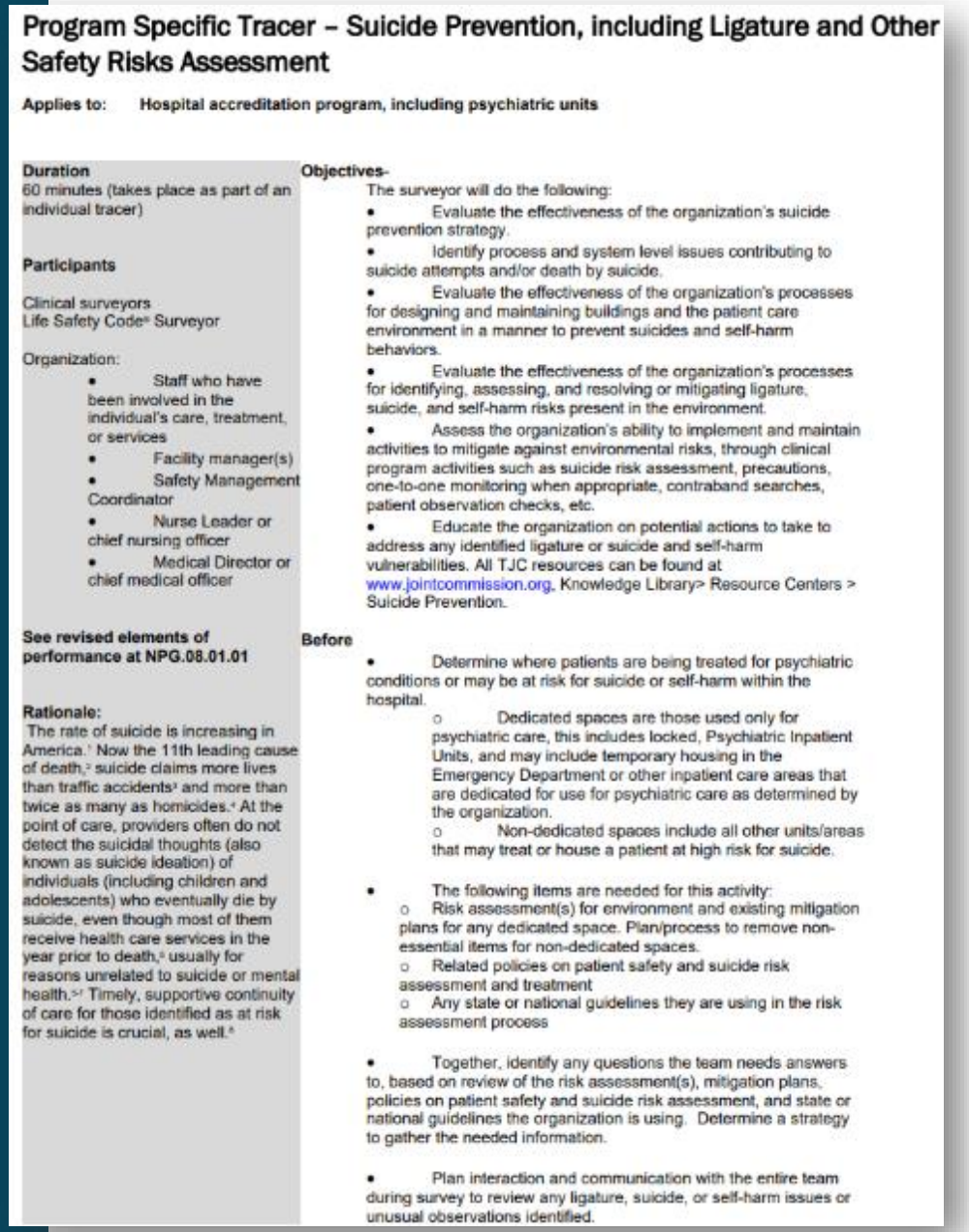
Suicide Prevention, Including Ligature and Other Safety Risk

- While this is primarily clinical focused it does evaluate

  "…the effectiveness of the organization's processes for designing and maintaining buildings and the patient care environment in a manner to prevent suicides and self-harm behaviors."

  "…the effectiveness of the organization's processes for identifying, assessing, and resolving or mitigating ligature, suicide, and self-harm risks present in the environment."

- Pages 642 - 644



Program Specific Tracer – Suicide Prevention, including Ligature and Other Safety Risks Assessment

Applies to: Hospital accreditation program, including psychiatric units

Duration
60 minutes (takes place as part of an individual tracer)

Participants

Clinical surveyors
Life Safety Code® Surveyor

Organization:
- Staff who have been involved in the individual's care, treatment, or services
- Facility manager(s)
- Safety Management Coordinator
- Nurse Leader or chief nursing officer
- Medical Director or chief medical officer

See revised elements of performance at NPG.08.01.01

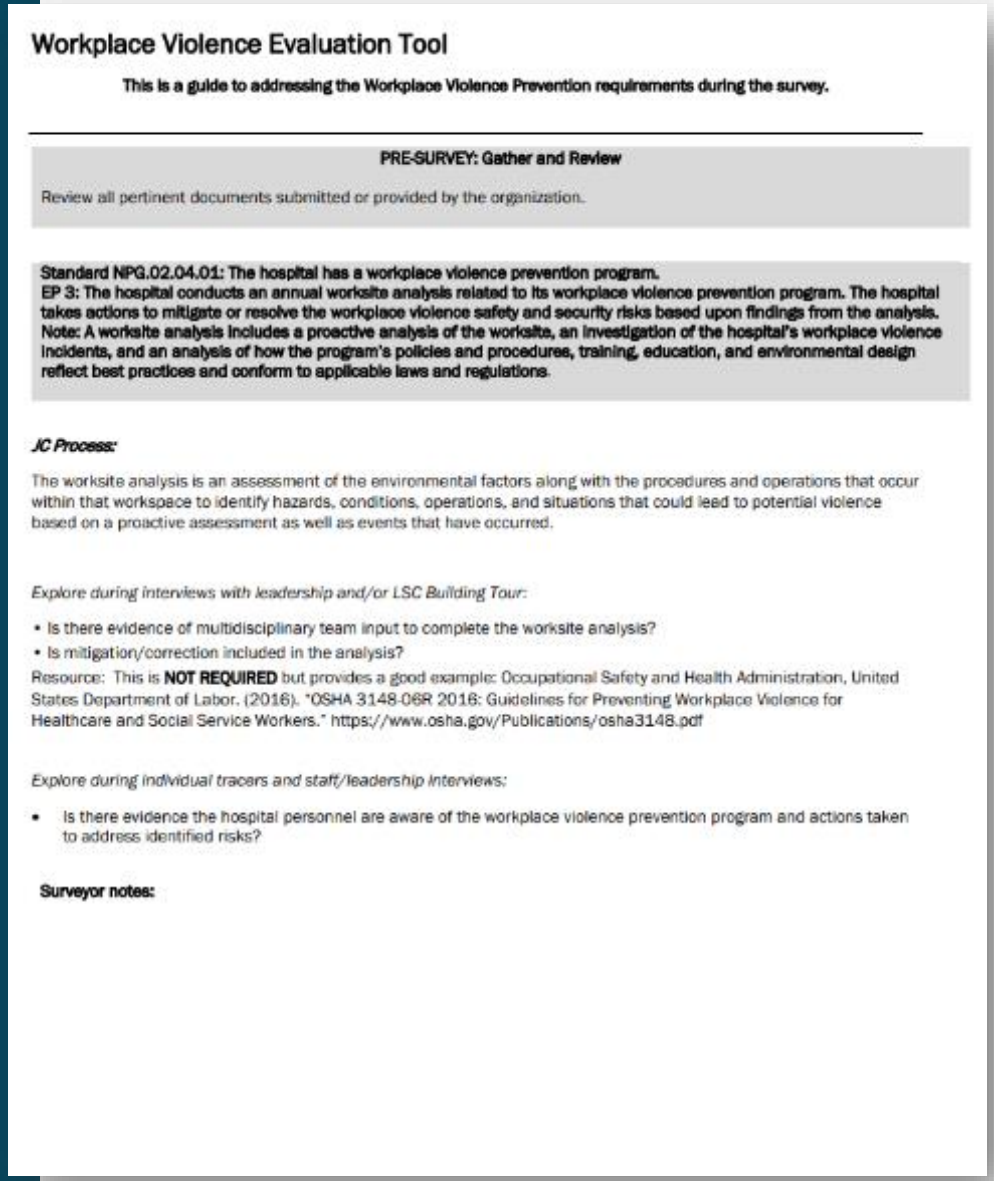
Rationale:
The rate of suicide is increasing in America.[1] Now the 11th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[5-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Objectives-
The surveyor will do the following:
- Evaluate the effectiveness of the organization's suicide prevention strategy.
- Identify process and system level issues contributing to suicide attempts and/or death by suicide.
- Evaluate the effectiveness of the organization's processes for designing and maintaining buildings and the patient care environment in a manner to prevent suicides and self-harm behaviors.
- Evaluate the effectiveness of the organization's processes for identifying, assessing, and resolving or mitigating ligature, suicide, and self-harm risks present in the environment.
- Assess the organization's ability to implement and maintain activities to mitigate against environmental risks, through clinical program activities such as suicide risk assessment, precautions, one-to-one monitoring when appropriate, contraband searches, patient observation checks, etc.
- Educate the organization on potential actions to take to address any identified ligature or suicide and self-harm vulnerabilities. All TJC resources can be found at www.jointcommission.org, Knowledge Library> Resource Centers > Suicide Prevention.

Before
- Determine where patients are being treated for psychiatric conditions or may be at risk for suicide or self-harm within the hospital.
  - Dedicated spaces are those used only for psychiatric care, this includes locked, Psychiatric Inpatient Units, and may include temporary housing in the Emergency Department or other inpatient care areas that are dedicated for use for psychiatric care as determined by the organization.
  - Non-dedicated spaces include all other units/areas that may treat or house a patient at high risk for suicide.
- The following items are needed for this activity:
  - Risk assessment(s) for environment and existing mitigation plans for any dedicated space. Plan/process to remove non-essential items for non-dedicated spaces.
  - Related policies on patient safety and suicide risk assessment and treatment
  - Any state or national guidelines they are using in the risk assessment process
- Together, identify any questions the team needs answers to, based on review of the risk assessment(s), mitigation plans, policies on patient safety and suicide risk assessment, and state or national guidelines the organization is using. Determine a strategy to gather the needed information.
- Plan interaction and communication with the entire team during survey to review any ligature, suicide, or self-harm issues or unusual observations identified.

Workplace Violence Evaluation Tool

- OSHA 3148 – 2016 Regulation, but there is no CoP to apply so scored under National Performance Goal (NPG)
- Collaborative approach by the organization
- Pages 645 - 647



Workplace Violence Evaluation Tool

This is a guide to addressing the Workplace Violence Prevention requirements during the survey.

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

Standard NPG.02.04.01: The hospital has a workplace violence prevention program.
EP 3: The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis. Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.

JC Process:

The worksite analysis is an assessment of the environmental factors along with the procedures and operations that occur within that workspace to identify hazards, conditions, operations, and situations that could lead to potential violence based on a proactive assessment as well as events that have occurred.

Explore during interviews with leadership and/or LSC Building Tour:

- Is there evidence of multidisciplinary team input to complete the worksite analysis?
- Is mitigation/correction included in the analysis?

Resource: This is **NOT REQUIRED** but provides a good example: Occupational Safety and Health Administration, United States Department of Labor. (2016). "OSHA 3148-06R 2016: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers." https://www.osha.gov/Publications/osha3148.pdf

Explore during individual tracers and staff/leadership interviews:

- Is there evidence the hospital personnel are aware of the workplace violence prevention program and actions taken to address identified risks?

Surveyor notes:

Survey Process

Misconceptions

1. These changes are a reduction in standards.
   - While there was a reduction in the EPs, the EC and LS chapters were consolidated into multiple PE and NPG standards.

2. Surveyors will become more lenient during tri-annual surveys.
   - Surveyors will be patient and will not score documents for not stating "PE"

3. Standards / EPs that were deleted can no longer be scored.
   - All deficiencies will still be scored

4. Standards will become clearer and more precise.
   - Not in all cases

What are the Next Steps to Prepare for Accreditation 360?

- Review the Joint Commission Disposition Report and understand where the former standards will be scored.
- Incorporate the various tools and resources available in the Survey Process Guide into tracer, audit, and rounding tools.
- Ensure you are including Business Occupancies in your survey preparedness.
- Continue to educate yourself and your team on the various codes, regulations, guidelines, and CMS interpretations.

Questions?

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