

Hospital Accreditation Program

Survey Methodology

**June 2012
1st Edition**

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Contact Directory

Georgian Hospital Association (GHA)

Address:

Phone:

Fax:

E-mail:

Contact the Georgian Hospital Association:

- To inquire about a completed application for survey, survey date, or schedule
- For assistance with specific problems or information related to accreditation

Georgian Hospital Association Web Site: <http://www.gha.ge/>

Visit the Web site to obtain any of the following:

- General information about accreditation
- Georgian Hospital Association news
- Information about accreditation status for specific hospitals
- Application for survey
- Frequently asked questions (FAQs)
- Revisions to standards
- Standards
- To submit a complaint about an accredited or accredited hospital

Introduction

The Georgian Hospital Accreditation Program (GGHAP) Survey Methodology is designed to provide insight and help understand the process of accreditation for hospitals.

This guide will provide important information about accrediting institution, the GGHAP standards manual, eligibility for accreditation, how to request accreditation, survey preparation, on-site survey, and the accreditation decision.

The Value of Hospital Accreditation Program

Accreditation may benefit hospitals by accomplishing the following:

Giving hospitals a competitive advantage

Accreditation provides evidence of high-quality patient care that helps level the playing field for hospitals providing similar services.

Strengthening public confidence

Achieving accreditation is a visible demonstration to patients and the public that an hospital is committed to providing the highest-quality services.

Obtaining recognition from insurers, associations, employers, and other stakeholders

Increasingly, accreditation in most developed countries of the world is becoming an eligibility prerequisite for reimbursement, association membership, community awareness, and contracts or grants.

Validating high-quality care to patients

Accreditation standards are focused on achieving one goal: raising the quality of care to the highest possible level. Achieving accreditation is a strong validation that an hospital has taken the extra steps to meet a high level of safety and quality.

Helping hospitals organize and strengthen their improvement efforts

Accreditation encompasses state-of-the-art performance improvement concepts that help hospitals continuously improve quality.

Enhancing staff performance

The survey process is designed to be supportive, not punitive. Survey process helps hospitals improve their internal procedures and day-to-day operations.

Facilitating staff recruitment

As staff recruitment becomes more difficult, achieving accreditation as a demonstration of the hospital's commitment to quality and patient safety will enhance recruitment efforts and retention of staff.

Promoting team-building skills for staff

The process of obtaining and maintaining accreditation demands a team approach to good patient care. Establishing processes and systems that support good patient care is achieved through strong team activities.

Who Is Eligible for a Hospital Accreditation Program Survey?

Hospitals which provide clinical care in the areas covered by the GHAP (for the updated list, please visit the GHA web site: <http://www.gha.ge/>) may apply for accreditation if the following requirements are met:

- The health care facility has been in operation for at least 4 months prior to GHAP application;
- The health care facility can demonstrate at least a 2-month track record of consistent compliance with relevant GHAP standards prior to GHAP application;
- The health care facility collected 4 months of data for the selected performance measures;
- The health care facility has monitored at least 4 performance measures.

Standards To Be Used

The standards to be used in the one- or two-day review of the host hospital will be selected from the *Hospital Accreditation Standards, First Edition* (or other applicable standards manual) and will relate to the clinical services provided by the host hospital.

How to Request a Hospital Accreditation Survey

Hospitals that wish to be accredited by GHAP can obtain an application for survey by downloading the application from the GHA web site at <http://www.gha.ge/>

The application for survey should be submitted to GHA at least two months prior to the hospital's preferred on-site accreditation survey dates. Applications should be submitted, in electronic format, by e-mail attachment to <http://www.gha.ge/> . Upon receipt of the application, GHA may request a brief conference call to perform a clinical component review of the application with the hospital leaders and staff for further clarification.

The application for survey is valid for two months from the date it is submitted; this means a hospital can submit its application and still have time to finish preparations before the on-site survey takes place. It is best to submit the application when the hospital is confident it will be able to demonstrate a **two-month track record of compliance** with the standards at the time of the on-site survey.

After the application for survey is received, the accreditation manager for GHA will contact the hospital. The manager will do the following:

- Answer the hospital's questions about survey and help guide individuals through each step of the accreditation process

- Analyze the application for survey and contact the hospital if there are any questions or items requiring clarification

- Update changes to the hospital's information, including the address, contact name(s)

- Schedule the on-site survey and assign the survey team and survey team leader

- Forward the contract agreement for the on-site survey for a signature.

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

One to two months before the survey, the accreditation survey contract agreement will be sent to the hospital leader. The survey cannot be scheduled until the contract agreement is signed. The survey team leader will contact the person responsible for the survey in the hospital approximately one to two 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.

Reporting Changes During the Application Process

If a hospital undergoes a change that modifies the information reported in the application for survey after it submits its application, the hospital **must** notify GHA immediately of the change.

Changes that must be reported include the following:

- Changing the hospital name and/or ownership/ or leadership, including any significant number of changes in the management and clinical staff or operating policies and procedures
- Changing the contact person(s) that the hospital has designated for all accreditation-related communications
- Offering at least 25% of its services at a new location or in a significantly altered building/physical facility
- Significantly increasing the volume of services, such as expanding its capacity to provide services, or use of its services, by 25% or more as measured by beds, patient visits, pieces of equipment, or other relevant measures
- Significantly decreasing the volume of services, such as reducing its capacity to provide services, or use of its services, by 25% or more as measured by beds, patient visits, pieces of equipment, or other relevant measures
- Developing a more intensive level of service
- Merging with, consolidating with, or acquiring an unaccredited site, service, or hospital for which there are applicable GHAP standards

It may be necessary for GHA to schedule an additional survey for a later date if its survey team arrives at the hospital and discovers that a significant change was not reported.

Accreditation Preparation

After GHA accepts the hospital's application for survey, both parties make preparations for the on-site survey.

GHA organizes a team of surveyors to match the hospital's needs and unique characteristics.

On-site accreditation surveys are typically conducted by one or two surveyor(s) depending on the size and complexity of the hospital. The survey follows actual patient care and includes interviews with key personnel, observation of the hospital's administrative and clinical activity, assessment of the physical facilities in which the hospital operates and the patient care equipment, and review of documentation. Some sample survey agendas are presented in this survey methodology document. The actual agenda will be customized by the survey team to fit the needs and services of particular hospital.

The GHA survey team leader will contact applicant hospital's administrator/leader approximately two to three weeks prior to the survey to discuss and coordinate a workable and mutually agreeable agenda. The survey team leader identifies those services/areas which need to be included in the review and suggests the staff who should be involved in each survey activity.

Preparation Timeline

Time	GHA Activity	Hospital's Activity
2 months before preferred month of survey		<p>Review the standards manual to better understand the expectations related to the accreditation policies and procedures.</p> <p>Submit the application for survey to the GHA Office (electronically or by mail).</p>
Upon receipt of the application for survey	GHA accreditation manager will review the application.	

Hospitals Requesting Reaccreditation

Time	GHA Activity	Hospital's Activity
3 months before the due date of the next triennial survey	An application for survey is e-mailed to prepare for the next on-site survey.	
Complete application at least 2 months before the accreditation expires		Hospital staff member(s) with knowledge of the hospital's services, sites, and patient volume will need to complete and submit the application for survey (electronically or by mail). The application should be received by GHA no later than 2 months before the preferred survey dates.

All Hospitals Requesting Accreditation

Time	GHA Activity	Hospital's Activity
1-2 months before survey	A contract agreement is e-mailed to the hospital.	E-mail, fax or directly submit the signed contract to GHA no later than 30 days prior to the survey date.
5 weeks before survey	Verification of survey date(s) and names of surveyor(s) are e-mailed to the hospital.	
4 weeks before survey	The survey team leader contacts the hospital's contact person to finalize the survey agenda and to request presurvey information.	Appropriate staff member(s) will need to discuss the proposed survey agenda and determine whether times are feasible for the hospital, given patient needs and availability of staff.
Survey	Surveyor(s) arrives for the on-site survey. At the conclusion of the survey, the hospital receives a copy of the Exit Report, which details partial or noncompliant areas that need to be addressed. This report is not final until the Accrediting Council has reviewed the report.	As outlined on the survey agenda staff should be available during the survey.
Within 30 days after survey	GHA reviews, approves, and sends the Official Survey Findings Report. A follow-up focused survey may be required prior to the final accreditation decision. If the accreditation is granted, the award letter, report, and accreditation certificate are issued . The Gold Seal publicity kit will also be posted to the GHA Web site, Georgian Insurance Association, Professional Associations websites, medportal.ge and other social media.	After hospital receives the survey findings report, it should begin the follow-up process if the conditions for accreditation were not met : <ul style="list-style-type: none"> • Develop the Strategic Improvement Plan (SIP) • Prepare for the follow-up focused survey.

	The hospital leader will be sent a GHA Accreditation Customer Satisfaction Survey to assist GHA in performance improvement activities.	
Within three days after the certificate is issued	The hospital's name, location, and date of accreditation are added or updated for public viewing on the GHA and other web sites.	
Ongoing	Each accredited facility will have access to the Accredited Hospital Resource Center via the GHA Web site, which contains resources and services that will assist in achieving continuous compliance with the standards.	Staff should review all changes in the developments in the standards and survey process. Compliance with new standards and survey processes is required for accredited hospitals.
Within 30 days of any significant hospital changes		The hospital leader must notify GHA (via letter, fax, or e-mail) of any significant change in the hospital.
Within 18 months of receiving Accreditation		The hospital leader must submit the Intracycle Performance Review data one week prior to the due date to the GHA Office.
3 months before the due date of the next triennial survey	An application for survey is delivered to the hospital leader to prepare for the next on-site survey.	

Survey Scheduling, Postponements, and Cancellations

Initial Schedules for Surveys

Initial surveys (hospitals's first full accreditation survey) should be scheduled within two months from the time GHA receives the application for survey.

GHA tries to honor specific requests for times during which a hospital prefers **not** to be surveyed. The hospital should include these specific dates in the completed application for survey, when possible. There may, however, be circumstances that prevent GHA from accommodating these dates.

Definition of Postponement

GHA also allows the postponement of initial surveys or re-surveys. A *postponement* is a hospital's request to alter an already scheduled survey date or to push back the survey date before it is actually scheduled. A hospital should direct a request for a postponement to the manager for GHA Accreditation Services.

Acceptable Reasons for Postponement

A hospital may postpone scheduled surveys when one or more of the following events occur:

- A natural disaster or another major unforeseen event that totally or substantially disrupts operations

- The hosthospital is involved in a major strike that causes a hospital to cease accepting patients and to transfer patients to other facilities

- Patients, the host hospital are being moved to another building during the scheduled survey.

GHA reserves the right to conduct an on-site survey if the hospital continues to provide patient care services under such circumstances. Prior to postponing a scheduled survey, it is recommended that hospitals contact the GHA accreditation manager.

Cancellation

The survey may be canceled by GHA 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.

Accreditation Standards

The Hospital Accreditation Standards is the place to begin preparing for accreditation. Any hospital considering accreditation can review the relevant to their clinical area standards to better understand the expectations before beginning the accreditation journey. Even if hospitals do not pursue accreditation immediately, the list of standards is an excellent tool to help them evaluate current practices and structures. The standards address patient-focused performance and are organized around functions, processes and clinical care provided by hospital. The standards are designed to be used in self-assessment activities and provides the basis for the accreditation survey.

SCORING GUIDELINES FOR SURVEY CONSISTENCY

SCORING RULES FOR STANDARDS MEASURABLE ELEMENTS

Standards include several measurable elements (ME) Each element is scored as either:

Met - 1

Not Met – 0

Not Applicable – N/A

Determining the Appropriate Score:

1. “MET” Score

A measurable element is scored “MET” if the answer is “yes”, or “always”, or “usually” to the specific requirements of the measurable element.

Also considered are the following:

- Some negative observations may not prevent a score of “met”;
- If 75% or more of observations or records (for example, 8 out of 10) are met, the measurable element is scored met;
- When there are multiple requirements in one measurable element and at least 75% are present, the measurable element is scored met;
- When evidence of compliance is found in majority (75% or 3 out of 4) of areas/departments in which the requirement is applicable (such as in delivery, neonatal care, postoperative but not in postpartum area), the measurable element is scored met.

The track record related to a score of “MET” is as follows:

- A 2 month look-back period of compliance for initial surveys.
- A 6-month look-back period of compliance for triennial surveys.

2. “NOT MET” Score

A measurable element is scored “NOT MET” if the answer is “not usually”, “rarely”, or “never” to the specific requirements of the measurable element. Also considered are the following:

- If 74% or fewer (for example, 1-7 out of 10) records or observations demonstrate compliance
- When there are multiple requirements in one measurable element, 74% or fewer are present.

The track record related to a score of “not met” is as follows:

The requirements of the measurable element are fully met; however, there is only

- A less than 1-month look-back period of compliance for initial surveys.
- A less than 5-month look-back period of compliance for triennial surveys;

If a measurable element of a standard was scored “not met” and some or all of the other measurable elements are dependent on the one scored “not met”, then the remaining measurable elements that are tied to the prior measurable element are scored as “not met”.

3. “NOT APPLICABLE” Score

A measurable element is scored “not applicable” if the requirements of the measurable element do not apply based on the hospital’s services, level of care provided, and so forth.

I. SCORING RULES FOR STANDARDS

Each standard is scored as either:

Met - 1

Not Met – 0

Not Applicable – N/A

Determining the Appropriate Score:

I. “MET” Score

A standard is scored **“MET”** if 50% or more of its measurable elements demonstrate compliance and are scored “met”.

I. “NOT MET” Score

A standard is scored **“NOT MET”** if 49% or fewer of its measurable elements do not demonstrate compliance and are scored “not met”.

3. “NOT APPLICABLE” Score

A standard is scored “not applicable” if the requirements of the standard do not apply based on the hospital’s hospital services, level of care provided and so forth.

ACCREDITATION DECISION RULES

The Accreditation Council considers all information from the initial or triennial full survey and any required follow-up Focused Survey in making its decision regarding accreditation.

The outcome is that the hospital meets the criteria for accreditation or does not meet the criteria and is denied accreditation. The criteria for these two potential outcomes are as follows:

ACCREDITED - this decision results when the hospital demonstrates acceptable compliance with standards, 75 % and more of standards scored met.

ACCREDITATION DENIED - this decision results when the hospital meets one or more of the following conditions at the end of any required Focus Survey subsequent to an initial or triennial full survey

- Hospital does not demonstrate acceptable compliance with standards (fewer than 75% of standards are met).
- A required Focused Survey subsequent to an initial or triennial full survey has not resulted in acceptable compliance with applicable standards.
- One or more of the conditions that place the hospital **At Risk for Denial of Accreditation*** have not been resolved at the time of the Focused Survey to evaluate the condition.
- The hospital voluntarily withdraws from the accreditation process.

***At Risk for Denial of Accreditation**

Conditions that place a hospital At Risk for Denial of Accreditation are the following:

1. An immediate threat to patient/public health or staff safety exists within the hospital .
2. An individual who does not possess a license, registration, or accreditation is providing or has provided health care services in the hospital that would, under applicable law or regulation, require such a license, registration, or accreditation and which placed patients at risk for a serious adverse outcome.
3. Hospital submitted falsified documents or misrepresented information in seeking to achieve or retain accreditation.
4. The hospital does not possess a license, certificate, and/or permit, required by applicable laws and regulations, to provide the health care services for which the hospital is seeking accreditation.
7. The hospital fails to submit the data required for intracycle monitoring within 120 days of the 18-month midpoint of the accreditation period.

ASSIGNMENT OF FOLLOW-UP REQUIREMENTS AS A RESULT OF A FULL SURVEY

INTRODUCTION

Full surveys are conducted at the time of initial accreditation and at the time of reaccreditation, every three years. At the conclusion of the survey, the findings are evaluated against the required conditions for accreditation. When the survey results meet all the conditions for accreditation, the hospital receives an Accredited status. However, when the results of a full survey do not meet one or more of the conditions for accreditation, the hospital will be granted a grace period of time to reach acceptable compliance. The hospital will then be requested to develop a Strategic Improvement Plan (SIP) that defines the improvement strategy(ies) and/or approach to bring noncompliant standards into acceptable compliance.

Acceptable compliance can then be demonstrated by a visit from one or more surveyors to the hospital. The visit is named a follow-up focused survey, as only the noncompliance standards are the focus of the survey.

A. PROCESS

An Official Survey Findings Report is sent to the hospital meeting the accreditation status by GHA within 30 days following the survey.

A Preliminary Survey Findings Report is sent to the hospital by the GHA when the documented findings of the accreditation survey team do not meet one or more of the conditions for

accreditation. The preliminary report is sent to the hospital within 15-30 days after the survey; the report includes all standard(s)/measurable element(s) that were found to be not compliant at the time of the survey.

An SIP will be requested for any not met standard(s)/measurable element(s) cited in the survey report when the hospital does not meet the conditions for accreditation. The SIP explains the hospital's process in defining the improvement strategy(s) and/or approach, including specific actions to bring the cited findings into acceptable compliance. The SIP is due to the GHA for review and acceptance within 15 days after receiving the preliminary survey findings report.

Each of the noncompliant findings will be reviewed for compliance by the surveyors during the follow-up focused survey.

FOLLOW-UP FOCUSED SURVEY

A follow-up focused survey is required within 90 days from the date when the hospital received the Preliminary Survey Findings Report. During the on-site visit, the surveyor(s) will determine the hospital's compliance with the standards 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 follow-up focused survey meet all the conditions for accreditation, the hospital receives an Accredited status.

When the results of the follow-up focused survey do not meet one or more of the conditions for accreditation, the hospital will receive a Denied Accreditation status by the Accreditation Council.

The Accreditation Decision

The final accreditation decision is based on hospital's compliance with Hospital Accreditation Standards. The hospital does not receive a numeric score as part of the final accreditation decision. When a hospital successfully meets standards requirements, it will be awarded a decision of Accredited, which indicates that the hospital is in compliance with all applicable standards at the time of the on-site survey.

Promoting Accreditation

After a hospital received official notification of the accreditation decision, the hospital can publicize its achievement of accreditation by notifying patients, the public and local media.

Information about hospital accreditation status will be posted on the GHA web site.

The Continuing Accreditation Cycle

The accreditation process does not end when the on-site survey is completed. In the three years between on-site surveys, GHA requests ongoing evidence of compliance and corrective actions, such as a self-assessments, periodic submission of compliance data and/or response to complaints. For this reason, it is very important that the hospital maintains compliance with the standards between on-site surveys.

Continuous survey compliance means less focus on the ramp up for survey every three years. Instead, hospitals can and should continually improve their systems and operations, eliminating the need for intense survey preparation. Continuous compliance with the standards directly

contributes to the maintenance of safe, quality care, improved hospital performance and better outcome for patients.

Intracycle Performance Review Requirements

The *Hospital Accreditation Program* is 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 accreditation cycle is to provide a mechanism for assessing the hospital's performance and continuous compliance with accreditation standards.

After the clinical care area has achieved accredited status, each accredited hospital is required to submit the Intracycle Performance Review 18 months after its regular survey to maintain its accreditation.

The required components for the Intracycle Performance Review submission are:

1. Any leadership and personnel updates to the host hospital. A copy of the organizational chart that includes the clinical care area and how it fits within the host hospital's system is highly recommended
2. Any updates to the clinical care area design and scope
4. Performance measure updates including the monthly data points in charts or graphs format and aggregated data summary on performance measures.
6. Attestation of continuing standards compliance or executive summary report of the result from hospital's self-assessment against the standards.

Each accredited hospital is required to submit the intracycle performance report 30 days before the Intracycle Performance Review due date. Upon receipt of the required Intracycle Performance Review information, GHA will schedule a phone conference call to review the submitted information with the hospital's leadership and staff, as well as the surveyor(s) who conducted the hospital's regular survey.

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

- The hospital provides accurate information throughout the accreditation process.
- The hospital reports any changes in the information provided in the application for accreditation and any changes made between reviews.
- The hospital continues to meet all the eligibility requirements for Accreditation.
- The hospital reports its level of compliance with all the applicable standards' measurable elements that are in effect at the time of the intracycle review.
- The hospital demonstrates organized and comprehensive approach to performance improvements.
- The hospital demonstrates accurate and effective use of data and its reporting of the performance measurement results.

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 accreditation survey.

A failure to submit the measure data required for intracycle monitoring within 90 days of the 18-month midpoint of the accreditation period will result for the hospital to be placed under —At Risk for Denial of Accreditation.

The On-Site Survey

The purpose of a Hospital Accreditation survey is to assess the extent of a hospital’s compliance with applicable standards. Hospitals undergoing their first survey need to demonstrate a track record of 2 months of compliance with the standards. Hospitals being re-surveyed need to demonstrate 6 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 surveyor(s)

- Review of documents that demonstrate compliance and assistance in orienting the surveyor(s) to the hospital’s operations

The on-site survey uses tracer methodology to follow a sample of active patients through their experiences of care in the hospital and to evaluate individual components and systems of care.

The on-site review consists of the following steps:

1. Opening conference and orientation to the clinical care provided by hospital

2. Survey planning meeting
3. Document review
4. Closed patient medical record review
5. Patient care and service area visits guided by patient and system tracer activities
6. Credentials evaluation
7. Facility tour
9. Leadership exit conference

Front-Line Staff Ownership of the Process

Involving staff in the initial accreditation process and continuing to involve them in ongoing assessments and process and systems reviews enhance ownership. During the tracer activities, the surveyor(s) will focus his or her discussions on the clinical and support staff and will request manager and leadership staff only to provide clarification, if needed.

Sample Survey Agendas

(Depending on the type and size of the clinical care area, the survey agenda may vary)

Hospital Accreditation Program

Survey agenda

(1 day, 2 surveyors)

Time	Activity
10.00-10.30	Team meeting with facility management, survey coordinator (discussion of logistical support issues and requirements)
10:30-11:00	Opening Conference. Orientation to the Hospital Accreditation Program
11:00-12.00	Performance measurement review, document review. Staff qualification and education review, trainings, license.
12:00-14.00	Individual Patient/Service Tracer Activity: Patient Tracers / Medical Records Review / Facility Tour (Unit Visits) / Patient and Staff Interviews
14:00-15:00	Lunch
15:00-16:00	Individual Patient/Service Tracer Activity: Patient Tracers / Medical Records Review / Facility Tour (Unit Visits) / Patient and Staff Interviews
16.00-17.00	Report preparation
17:00-17:30	Exit report

Hospital Accreditation Program

Survey agenda

(2 days 2 surveyors)

Day I

Time	Activity
10.00-10.30	Team meeting with facility management, survey coordinator (discussion of logistical support issues and requirements)
10:30-11:00	Opening Conference. Orientation to the Hospital Accreditation Program
11:00-12.00	Performance measurement review, document review
12:00-14.00	Individual Patient/Service Tracer Activity: Patient Tracers / Open Medical Records Review / Facility Tours (Unit Visits) / Patient and Staff Interviews
14:00-15:00	Lunch
15:00-16:30	Individual Patient/Service Tracer Activity: Patient Tracers / Open Medical Records Review / Facility Tours (Unit Visits) / Patient and Staff Interviews
16.30-17.00	Undetermined survey activity (if needed)
17:00-17:30	Meeting with survey coordinator and hospital staff: Verbal briefing for the observations of day one Identify needs for the following day

Day II

Time	Activity
10.00-10.30	Daily debriefing
10:30-12:00	Individual Patient/Service Tracer Activity: Patient Tracers / Open Medical Records Review / Facility Tours (Unit Visits) / Patient and Staff Interviews
12:00-13.00	Closed medical records review
13:00-14.00	Staff qualification and education review: trainings, license, personnel files.
14:00-15:00	Lunch
15:00-15:30	Undetermined survey Activity (Optional)
15.30-17.00	Report preparation
17:00-17:30	Exit report

SURVEY AGENDA

Detailed description

I. SURVEYOR PLANNING SESSION

PURPOSE

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

The hospital should provide space for this activity, usually the room designated as the surveyor room.

HOSPITAL PARTICIPANTS

Clinical care area survey coordinator (as needed by team)

SURVEYORS

All surveyors

WHAT WILL OCCUR

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

- Performance measurement data
- A list of departments/units/services within the hospital (if applicable)
- An organization chart, map, staffing
- A current list of patients in the department, including their names, diagnosis, ages, admission dates, physicians, and units/services
- A list of the operative and other procedures scheduled as applicable to the clinical care area; for example (C-section, labor induction etc).
- Clinical practice guidelines if any

- Name of key contact person (such as a supervisor) who can assist the surveyor(s) in planning tracer selection

Selection of Individual Tracers

- Surveyors review the information from the survey application and the list of patients currently available at the facility to guide their selection of patients to trace.
- Surveyors describe to the hospital 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 hospital 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 hospital. For example, the surveyor(s) may choose to trace:
 - Patients seen in the past two months (initial survey) or 6 month (triennial survey) with severe eclampsia developed;
 - Patients seen in the past two months (initial survey) or 6 months (triennial survey) with neonatal Respiratory Distress Syndrome developed.
- In team surveys, tracer selection should be coordinated to avoid overlap of visits to various areas to the extent possible.
- If there are no patients currently being treated by the clinical care area, a list of patients who accessed or progressed through the clinical care area of the hospital will be required as follows:
 - In the past two month for initial survey; and
 - In the past six month for a reaccreditation survey.

II. OPENING CONFERENCE

PURPOSE

During the opening conference, the surveyor(s) describes the structure and content of the survey to the hospital leadership, management and staff.

LOCATION

At the discretion of the hospital

HOSPITAL PARTICIPANTS

- Director of the Hospital/Department
- Clinical Director, when applicable
- Medical personnel designated by management
- Quality Improvement coordinator
- Host hospital's survey coordinator
- Others at the discretion of the hospital.

SURVEYORS

All surveyors.

STANDARDS/ISSUES TO BE ADDRESSED

Introduction and coordination of the survey.

DOCUMENTS/MATERIALS NEEDED

- Final survey agenda
- Other as needed for the introduction, determined by hospital leaders

WHAT WILL OCCUR

Introduction to the Survey Process and Review of Agenda

- Introduction of surveyors
- Introduction of host hospital and hospital/department 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. 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 staff involvement in the patient record review process.
- Surveyors will explain the staff involvement in the staff qualifications and education interview (if applicable).
- Surveyors will explain the purpose and the leaders' involvement in the daily briefing sessions held beginning on day two (if more than one-day survey is done).
- The host hospital and staff will be encouraged to ask questions and seek clarification from surveyors throughout the survey process.
- Facility management 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.

HOW TO PREPARE

- Set up a meeting or conference room large enough for the surveyors to meet with the key host hospital and clinical care area leaders and survey coordinators.
- Have copies of the survey agenda available for all participants in the opening conference.
- Prior to the survey, decide which hospital leaders or staff member(s) will accompany each surveyor throughout the survey day.
- Notify host hospital and clinical care area staff of the survey agenda and expectations.
- Each surveyor will wear a name badge that will identify him or her as a GHA surveyor.

Orientation to the Clinical Care Area

PURPOSE

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

LOCATION

At the discretion of the hospital

HOSPITAL PARTICIPANTS (at the discretion of the hospital leaders)

- Director of the Hospital/Department
- Clinical Director, when applicable
- Nurse executive

- Quality Improvement coordinator

- Host hospital's survey coordinator
- Others at the discretion of the hospital.

SURVEYORS

All surveyors

STANDARDS/ISSUES TO BE ADDRESSED

Introduction to the clinical care area by hospital leaders

WHAT WILL OCCUR

- Hosthospital will provide a brief overview of the clinical care area and relationship to the hospital

- Hospital staff will present an overview of the clinical care area:
Design of the hospital, targeted population, scope of services and continuum of care

- Discuss the program and clarify what was learned from the documentation submitted with the application for accreditation 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 hospital and clinical care area leaders and survey coordinators.

- Provide copies of documents that describe the hospital, such as an organizational chart that includes the clinical care area and how it fits within the hospital;

Daily Briefing

PURPOSE

To facilitate understanding of the survey process and the findings that contribute to the accreditation decision.

LOCATION

At the discretion of the hospital management

HOSPITAL PARTICIPANTS

Hospital survey coordinator and others as determined by hospital management

SURVEYORS

All surveyors on site

WHAT WILL OCCUR

The daily briefing occurs every morning of a multi-day survey, with the exception of the first day. The session is intended to be brief; maximum 30 minutes is suggested depending on the number of surveyors on the team.

During the daily briefing with the hospital, the surveyor(s) will do the following:

- 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
- Emphasize patterns or trends of significant concern that could lead to noncompliance determinations

Inform the hospital management that final findings for any given standard will be possible only when all activities are complete and results are aggregated

- Allow the hospital management to provide information that may have been missed during the previous survey day
- Review the agenda for the survey day ahead (including the identification of individual patient tracers) and make any necessary adjustments based on hospital needs or the need for more intensive assessment of an issue during the undetermined survey activity time
- Conclude the briefing and transition to the next activity(s) according to the agenda

Do not expect the surveyor(s) to do the following:

- Repeat observations made at a previous daily briefing unless it is in the context of identifying a systemic issue
- Discuss in detail each survey activity, specific records, and discussions held with individuals during tracers
- Delay scheduled activities for the current day to have an in-depth discussion of issues from the previous day.

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, discharge summary and instructions. The surveyors will review policies, procedures, forms, educational materials as well as data, 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.

HOSPITAL PARTICIPANTS

Participants should include hospital staff that are familiar with the documents. The designated staff can 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.

SURVEYORS

All members of the survey team

DOCUMENTS/MATERIALS NEEDED

The documents that may be required by the survey team for their review or reference depend on the requirements of particular accreditation program and may include:

- An organizational chart of the hospital/department
- A list of staff members who are involved in particular clinical area to be accredited (including name, title, credentials, and role)
- Required policies and procedures, written documents, or bylaws specific to the hospital; and those relating to sentinel events, adverse events, and near misses;
- Any contractual arrangements that are required based on the standards

- Minutes from any pertinent committee or leadership meetings
- In-service/staff training calendars related to the clinical care area (include past attendance sheets)
- Required Quality Monitors and data; specific performance measures used and brief summary of data collected
- Accurate database /register of patients (current and past) receiving care in the hospital, including diagnosis, age, gender, co-morbidities, and physician.

WHAT WILL OCCUR

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, there should be a staff member readily available, in person or by telephone that can respond to any questions the surveyors may have during the document review session.

The materials should remain available to the survey team throughout the survey for reference purposes. However, if documents are required for use by hospital staff, they can, of course, be removed. Surveyors may schedule a second document review session during the course of the survey. The survey team may also request additional documents throughout the survey to clarify or to become knowledgeable of the hospital's policies and procedures or performance. Clinical care area staff should be as proactive as possible in complying with requests for documents.

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.

Depending on the formulation of the standard, the presence of a policy or procedure alone may or may not determine the score of the standard. If stated in the standard, the survey team will be seeking evidence that the practice related to the policy or procedure is well implemented, as appropriate.

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 often referred to as a *track record*. The survey team will look for a two -month track record for policy-related standards during an initial survey and for a six-month track record during a triennial survey.

Sometimes the standard may require only the presence of the policy or procedure document. In this case the surveyors do not check the implementation of the particular policy or procedure and surveyors score the standard depending on the presence of relevant policy or procedure.

TRACER ACTIVITIES

Tracer Methodology

The tracer methodology is the foundation of the on-site survey and does the following:

- Follows the experience of care for a number of patients through the 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.

Individual Patient Tracer Activity

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.

The tracer methodology is a way to analyze a system of providing care, treatment, and services using actual patients as the framework for assessing 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, areas, 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 hospital.

Patients typically selected are those who have received multiple or complex services and therefore, more contact with various units of the hospital. 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 units within the hospital.

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;

- Patients at different phases of receiving the clinical services that will cover the entire spectrum of services from enrollment to discharge/referral/death.

The surveyor will follow the patient's experience, looking at services provided by various individuals and departments within the hospital, as well as hand-overs between them.

This type of review is designed to uncover systems issues, looking at both the individual units of the hospital, and how the units 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 hospital; an area of care provided to the patient that may be a priority for that hospital; 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 hospital, and the length of the on-site survey. As appropriate to the provision of care being reviewed, the tracer will include the following elements:

- Review of the 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.

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.

Interview with staff

Observation of the environment

Observation of direct patient care

Observation of medication process

Observation of infection prevention and control issues

Observation of maintenance of medical equipment

Review of minutes and procedures as needed

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, clinical care area, 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

Linkages to Other Survey Activities

Issues identified from the individual patient tracer activities may lead to further exploration in the clinical care area based services tracers or other survey activities.

Findings from tracer visits provide focus for other tracers and may influence the selection of other tracers.

Service Tracer Activity

Clinical care area–based service tracers look at a specific set of services defined by the scope of clinical care provided by the hospital.

This includes reviewing all the relevant processes across the entire continuum of care received by the patients.

This differs from the individual tracers in that during individual tracers, the surveyor follows a patient through his or her course of care, evaluating all aspects of care rather than a system. During a service tracer, the surveyor(s) will do the following:

- Evaluate the performance of relevant processes, with particular focus on the integration and coordination of distinct but related processes
- Evaluate the communication/interrelation among disciplines, departments, services provided
- Identify potential concerns in the relevant processes

A service tracer includes an interactive session involving a surveyor and relevant staff members based on information from individual tracers. Points of discussion in the interactive session include the following:

- The flow of the process across the entire care, including identification and management of risk points, communication among staff/units involved in the process
- Strengths in the process and possible actions to be taken in areas needing improvement
- Issues requiring further exploration in other survey activities

The Role of Staff in Tracer Methodology

Staff will be asked to provide the surveyor(s) with a list of patients presently enrolled in the clinical care area and discharged by the hospital, including the patients' names, current locations in the hospital, and diagnosis, as appropriate. The surveyor(s) may request assistance from hospital staff for selection of appropriate tracer patients.

As the surveyor(s) move around the hospital, he or she will converse with a wide variety of staff involved in traced patient's care, treatment or services. This could include nurses, physicians, therapists, case managers, lab personnel (as appropriate) and support staff. If those staff members are not available, the surveyor(s) will ask to speak to another staff member who would perform the same function(s) as the member who has cared for or is caring for the tracer patient. Although it is preferable to speak with the direct care giver, it is not mandatory because the questions that will be asked are questions that any caregiver should be able to answer in providing care to the patient being traced.

Performance Measurement

Performance measurement in health care is an indication of what is done and how well it is done; in other words, an indication of a hospital's or clinical care area's performance in relation to a specified process or outcome.

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:

- 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.
- The measurement strategy must accurately capture whether the evidence-based care has been delivered or the process of interest.
- The measure should have minimal or no unintended adverse consequences.

Although the Hospital Accreditation Program only requires the hospital to monitor four performance measures, the hospital 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.
- Purpose or rationale for the measure** should briefly explain the importance 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 bibliographic source for this measure to demonstrate the evidence-based validity of the measure's specifications defined by the CPGs.
- 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. The numerator should 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 relevant and possible.

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 hospital should track the revision date and make notes in the data aggregation and analysis phase.

Measure reporting interval. The Georgian Hospital Accreditation Program 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 accreditation survey.

Target or threshold should be predetermined or pre-established based on well-documented evidence and/or consensus agreement reached. Attainment or nonattainment should trigger a review of why the threshold/target was not reached or crossed.

System Tracer: Improvement in Quality and Patient Safety

PURPOSE

This session is focused on the hospital's use of data in improving safety and quality of care.

HOSPITAL PARTICIPANTS

Individuals from the hospital selected for participation should be able to address issues related to the use of data for performance improvement. This group should include but is not limited to representation from the following services:

- Clinical staff, including all individuals involved in performance improvement
- Individuals who are knowledgeable about the information systems available for data collection, analysis, and reporting
- A representative from the hospital's leadership

In order to facilitate a beneficial exchange between the surveyor(s) and the hospital, the hospital should identify a relatively small group of active participants for discussions and interviews.

Other staff may attend as observers.

SURVEYORS

All surveyors available to participate will do so.

WHAT WILL OCCUR

During the session, the surveyor(s) and hospital representatives 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

- The basics of data gathering and preparation, including the following:
 - o Selection of measures

 - o Data collection and aggregation

 - o Data analysis and interpretation

 - o Dissemination/transmission of findings

 - o Taking action

 - o Monitoring performance/improvement

 - o For triennial surveys, findings from previous surveys and intracycle data review

NOTE: *Data applicable to the clinical area (for example, Infection Prevention and Control Data Issues; see below) will be determined onsite.*

Infection Prevention and Control Data Issues

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 data are analyzed and interpretation

Results dissemination to physicians, staff, leaders, and external entities

Improvement actions taken based on data findings

Conclusion

As a result of this session, the surveyor(s) and the hospital representatives will be able to do the following:

Identify strengths and weaknesses in the hospital's implementation of the quality improvement 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

Undetermined Survey Activities

PURPOSE

Tracer methodology is used as the primary tool to assess standards compliance. However, other tools, or a focused approach, can be used to gather additional information to evaluate standards compliance that is not directly related to a specific patient tracer. Each of these focused activities is listed on the survey agenda as an Undetermined Survey Activity.

Undetermined Survey Activities are broadly defined and encompass a variety of activities customized to the particular needs of each circumstance. The Undetermined survey activities are selected by the survey team to allow a more intensified assessment of a targeted area when information from any survey activity, such as tracers or discussions, identifies a need to focus on a specific concern or to increase the sample size of a review item.

HOSPITAL PARTICIPANTS

Participants will be identified by the surveyor(s) depending on the activity being evaluated.

STANDARDS/ISSUES TO BE ADDRESSED

Standards related to the specific activity that is being addressed.

WHAT WILL OCCUR

Examples of undetermined survey activities include, but are not limited to, the following:

Focused tracers that are not patient tracers:

— Patient education process

- Blood product infusion processes
- Focused process tracer:
 - Hazardous materials management
 - Laboratory specimen handling in clinics
- Specific site or department visits to review applicable standards:
 - Noninvasive diagnostic areas, such as electrocardiogram (ECG), and electroencephalogram (EEG)
- Specific quality activities:
 - Root cause analysis review
 - Sentinel event review
- Focused document/policy review to close gaps in the usual document review exercise
- Other items as appropriate to the needs of the team

Staff Qualifications and Education Session

PURPOSE

The objective of this interview is to address the hospital's process to recruit, orient, educate, and evaluate all hospital staff. For each clinical care area, it is expected that the hospital's clinical staff will demonstrate the required and/or recommended training and competence.

LOCATION

Small meeting rooms at the discretion of the hospital's leaders

HOSPITAL PARTICIPANTS

Leader of the medical, nursing and other health professional staff who conducts the ongoing professional practice evaluations of the clinical care provided by hospital staff member.

Manager of the human resources/personnel department

Chief nurse

Other representatives who are involved in the orientation, education and training of hospital's staff members.

SURVEYORS

All surveyors

STANDARDS/ISSUES TO BE ADDRESSED

Standards addressing the qualification and competences of the staff

DOCUMENTS/MATERIALS NEEDED:

- The hospital's orientation, ongoing education and training curriculums that are specific to the clinical care area.

- Policy and procedures related to human resources/personnel management and ongoing professional practice evaluations.

- A sample of the hospital's personnel files.

SURVEYORS

The surveyor(s) will provide instructions on the first day of the survey, generally during the document review session, regarding this interview and the preparation of the files for review. The survey team will provide the director of human resources and/or hospital coordinator with a list that identifies the type and number of personnel and medical staff files selected for review later in the survey during the staff qualifications and education interview.

HOW TO PREPARE

The hospital should include a list of all current personnel and medical staff in the document review session on the first day. The list should identify the name, specific discipline, and department or service assigned.

Open/Closed Medical Record Review

This session is held to validate the hospital's compliance with the documentation track record (2 months for initial surveys and 6 months for triennial surveys).

PURPOSE OF THE FORM

The purpose of using the Medical Record Review Tool is to gather and document compliance with standards that require documentation in the patient's record based on additional closed record review beyond the open records that are evaluated during the tracer activities.

ORGANIZATION OF THE FORM

This form will be provided by the survey team and used for the review. It includes the specific standard number and the standard requirement. The form may be revised periodically to reflect approved changes in the standards.

REVIEW PROCESS

The surveyor(s) enters the number of the record being reviewed and the type of record requested (recorded by diagnosis) on the top of the form (Example: Record #5554 Caesarean section).

USING THE FORM DURING THE ACCREDITATION SURVEY

The survey team leader may request 5 to 10 closed records for review. The records will be requested if the surveyor(s) wants to validate the hospital's documentation track record (2-month or 6-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 2 or 6 months. Hospital staff should acquaint the survey team with the hospital's practice and expectations regarding the completion of a patient record following discharge of the patient.
- For the closed patient medical record review, the hospital leaders should provide one staff member for each surveyor involved in the closed patient 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 hospital representative, as needed, to complete the form. One column of the form is completed for each record reviewed. If more than five records are reviewed, the surveyor(s) will use another form.
- For each documentation requirement, the surveyor(s) will check —Y (yes) on the form to indicate that the required element is present, —N (no) if the element is not present, *or* —NA if the element is not applicable to that patient's record.
- The survey team aggregates the completed review forms to score the standards.
- The survey team leader retains the forms to support the survey findings.

Surveyor Team Meeting

PURPOSE

For surveys being conducted by more than one surveyor, scheduled team meetings provide an opportunity for surveyors to share information and observations, plan for upcoming survey activities, and plan for communication and coordination with the hospital representatives.

HOSPITAL PARTICIPANS None

SURVEYORS All surveyors on site

LOCATION Surveyor room

WHAT WILL OCCUR

For surveys lasting more than one day, a 30-minute session is scheduled at the end of each day to allow surveyors an opportunity to debrief and to plan for subsequent survey days and activities.

Surveys lasting longer than two days will include an additional 30-minute session before or after lunch to allow for midday activity planning and observation sharing. During these sessions surveyors will do the following:

- Identify areas that have been visited during tracer activity

- Coordinate locations, services, and other areas that will be visited during continuing tracer activities

- Share observations on hospital performance

- Identify key findings that have surfaced

Identify issues/areas that all surveyors should be exploring during individual patient and system tracers.

Note: When only one surveyor is present, this time is an opportunity to plan upcoming survey activities, including the selection of additional tracers.

Surveyor Report Preparation

PURPOSE

Surveyor(s) will use this time to compile, analyze and organize the data he or she has collected throughout the survey into a report reflecting the hospital's compliance with standards.

HOSPITAL PARTICIPANTS

None

SURVEYORS

All surveyors on site

LOCATION

Designated surveyor conference room.

WHAT WILL OCCUR

This time is reserved on the agenda for the surveyor(s) to review his or her observations and to determine if there are any findings that reflect issues of standards compliance. The surveyor(s) will prepare the report for the leadership exit conference.

The surveyor(s) may ask hospital representatives for additional information during this session to confirm or disprove a finding.

Leadership Exit Conference

PURPOSE

The purpose of this conference is to report the findings of the survey to hospital leadership and to resolve any issues of interpretation that may have been identified during the survey.

LOCATION

At the discretion of the hospital's leaders

HOSPITAL PARTICIPANTS

- Hospital Director
- Head of Department
- Clinical Director, when applicable
- Quality Improvement coordinator
- Host hospital's survey coordinator
- Others at the discretion of the hospital.

SURVEYORS

All surveyors

STANDARDS/ISSUES TO BE ADDRESSED

Survey findings

DOCUMENTS/MATERIALS NEEDED

None

WHAT WILL OCCUR

This session includes the following two components:

1. Discussion with key leaders of the hospital about the survey findings report and discuss the post-accreditation follow-up process, including review of the Strategic Improvement Plan (SIP).

The discussion will cover the following:

- Purpose of the conference

- Summary of findings related to standards

- The expected follow-up to the survey findings, for example, the SIP or a follow-up focused survey if required.

2. Education:

- The surveyor(s) will provide education to assist the hospital in developing the SIP based on the not met findings from the survey report. The surveyor(s) will explain the survey follow-up process regarding communication of the accreditation decision by the Accreditation Council.
- The surveyors will provide education on accreditation decision rules and scoring guidelines. They will cover the following:
 - Explanation on each of the decision rules for the hospital accreditation
 - Scoring criteria for “met”, “not met”, and “not applicable” logic based on the surveyor’s scoring guidelines.

The team leader will select one or two of the surveyors' observations that were reported at the daily debriefing to use as examples in illustrating how the findings would be scored based on the scoring guidelines.

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