



Achieving Accreditation – Survey Preparation (Ready to Review List)

Upon arrival to your organization, the Survey Team will meet with the Organization’s Administrator, or designee, to coordinate the survey process. Kindly provide the following as expeditiously as possible:

1. A small, private meeting room where the team may meet for the duration of the survey;
2. A telephone, preferably in the team meeting room
3. The name of a primary contact person and telephone/pager number
4. A list of department heads with locations and telephone numbers
5. A list of contracted services, if applicable

This survey process involves conducting building tours, observations of patient charts, human resource files, credential files, and interviews with staff and patients. The survey is an information gathering activity to determine organization’s compliance with the HFAP standards.

To facilitate the completion of the survey within the allotted time, the following information and documents should be readily available (**Ready to Review**) for the surveyors to review during survey; the availability of the information will be discussed during the opening conference, which occurs at the beginning of the first day of survey. **The survey is to start promptly at 0800 local time, with leeway until 0815 local time to gather appropriate staff.** Please note that if certain staff members are missing, the team will continue to conduct the survey; the appropriate missing staff members may join when they are available.

Note: The 12-month reference in the following items is not applicable to initial surveys.

LOGS:	✓
Adverse patient events	
Emergency Room, Grievance, Obstetrics, Surgery, and Restraint Logs	
Incidents related to infections and communicable diseases, including those identified through employee health services.	
Maintenance for critically significant medical equipment, e.g., cardiac monitors, IV infusion pumps, ventilators, etc.	
Medication inventory and dispensing	
Pharmacy access: medication withdrawal log; sample drugs for outpatient facilities, if any.	
Preventative maintenance	
Procedure with outcomes that support privilege requests for procedures not attested to in postgraduate references.	
Radiological equipment quality and monitoring, inspections and calibrations, including safety log for exposure meters or badge tests.	
Receipt, storage and issuance log	
Sterilization and testing	
Temperature and humidity tracking, including refrigerator temperature	
Tissue acquisition	
Work-related injuries and illnesses	

CREDENTIALING LIST:	✓
List of Practitioners who are currently on automatic suspension based on incomplete medical records., e.g., H & P, OP's record, discharge summary, etc.	
Medical Director responsible for Anesthesia service (proof of appointment, job description)	
Medical Director responsible for ED service (proof of appointment, job description)	
Medical Staff Bylaws	
Newly credentialed allied health Personnel approved by the Governing Body over the past year.	
Newly credentialed Physicians approved by the Governing Body over the past year.	
Reappointment Active physicians within the past 2 year cycle approved by the Governing Body, including the peer review/quality report card.	
Reappointment allied health personnel within the past 2 year cycle approved by the Governing Body. Bring documentation of physician sponsorship, continuing medical education units, hospital orientation and re-orientation.	

CLOSED MEDICAL RECORDS:	✓
A consultation order, including reason.	
Admission orders for inpatient and outpatient surgery patients.	
Admission orders for non-surgery patients.	
Anesthesia informed consent.	
Anesthesia provider In-patient charts: Post Anesthesia Examination in General Anesthesia charts, including date and time of a provider's last visit, as well as the PACU provider time for the same patient.	
Colonoscopy chart: indicating the H & P, the conscious sedation record, the instructions, and the after discharge phone call.	
Diabetic chart, the historic A1C, the admission A1C, the nutrition consults, the diabetes education consults, and the discharge communication documentation of the primary care provider.	
Discharge date, as well as the date of completion of discharge summary.	
H & P update prior to any surgery or procedure.	
In any orthopedic case, documentation of the use of pneumatic tourniquet.	
Inpatient Intra-Anesthesia Examination in General Anesthesia charts.	
Inpatient Pre-Anesthesia Examination in General Anesthesia charts documenting chest auscultation.	
Medical records policies including safety and security of <u>AND</u> electronic medical record.	
Pneumonia admission that indicates the three components of the Plan of Care reflected in the standard.	
Pneumonia admission with required assessments in standard.	
Post Cardiovascular/Interventional Radiology instructions listed in the standard.	
Preoperative note by surgeon if H & P not authored by the surgeon or interventionist.	
Primary Care Osteopathic Medicine Physician who completed an admission H & P and first progress note	
Surgical Patient Medical Records: Post Anesthesia (Not PACU) document highlight: <ul style="list-style-type: none"> • Cardiovascular function, including pulse rate and blood pressure; mental status; temperature; pain • Respiratory function, including respiratory rate, airway patency, and oxygen saturation • Nausea and vomiting; and postoperative hydration • Post Anesthesia Assessment 	
The attending physician H & P: the admission date/time, date and time when H & P was completed and signed.	
The inpatient and outpatient surgery H & P, the dates performed, and the update note.	

Note: These files may be in paper or in electronic format; however, the information must, at all times, be safe and secure from unauthorized access, up-to-date, accessible and readily retrievable by authorized personnel.

Please note that in order to achieve HFAP accreditation, our surveyors will review each standard within the current manual to ensure that you are in compliance with each standard at time of survey.

VOLUNTARY SUGGESTION

Please note this is NOT required or mandated by neither Central Office nor our HFAP surveyors.

Our Surveyors have found it beneficial to have organizations to prepare Evidence Books (electronic or paper) to help get organized and prepare for survey. Although this process is voluntary, we have provided you some steps to assist in creating Evidence Books:

- Prepare a 3-ring binder with a tab for each standard in “your” chapter.
- Fill each tab as follows
 - Page 1: a highlighted copy of the standard
 - Pages 2-X: the documentation required to prove compliance (P&P, letters of approvals, appropriate minutes, etc.)
- Highlight or sticky tab the relevant portion - so you can find it quickly