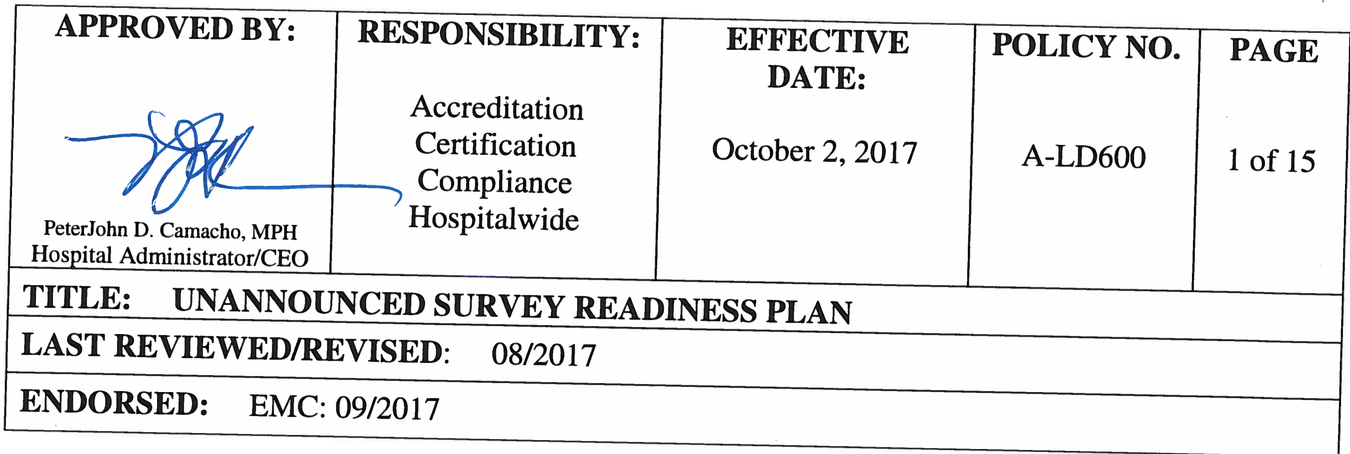
GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL



APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
PeterJohn D. Camacho, MPH Hospital Administrator/CEO	Accreditation Certification Compliance Hospitalwide	October 2, 2017	A-LD600	1 of 15
TITLE: UNANNOUNCED SURVEY READINESS PLAN				
LAST REVIEWED/REVISED: 08/2017				
ENDORSED: EMC: 09/2017				

PURPOSE:

The purpose of this plan is to prepare the organization for an unannounced accreditation/ certification survey from The Joint Commission or the Centers for Medicare and Medicaid Services. The plan will provide direction and facilitate optimal organizational performance during the survey process.

POLICY:

Guam Memorial Hospital Authority (GMHA) is committed to properly planning activities in order to perform optimally during the survey process.

DEFINITIONS:

<u>The Joint Commission (TJC):</u> An independent, not-for-profit, standards-setting, accrediting and certifying body in healthcare. TJC standards address the organization's level of performance in key functional areas, such as patient rights, patient treatment and infection control. Standards set forth performance expectations for activities that affect the safety and quality of patient care. TJC's comprehensive survey process evaluates and organization's compliance with these standards and other accreditation or certification requirements. To earn and maintain TJC's Gold Seal of Approval, an organization must undergo an on-site survey by a TJC survey team at least every three years.

<u>Centers for Medicare and Medicaid Services (CMS)</u>: Previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities through its survey and certification process, and clinical laboratory quality standards

under the Clinical Laboratory Improvement Amendments (CLIA). CMS regulates all hospitals that receive any type of federal reimbursement for care provided. These regulations are described in rules called "CMS Conditions of Participation for Hospitals" which are published in the Federal Register.

Survey: A key component in the accreditation/certification process, whereby a surveyor(s) conducts an on-site evaluation of an organization's compliance with TJC standards and/or the CMS Condition of Participation.

Surveyor: A physician, nurse, administrator, or any other health care professional who meet's surveyor selection criteria set by TJC or CMS, has passed the surveyor certification examination, evaluates standards compliance, and provides education and consultation to surveyed organizations or networks.

PROCEDURES:

I. PUBLIC NOTICE

A. Joint Commission

A notice is posted on the hospital's Web site (www.gmha.org) to inform the public (patients, family members, community representatives, employees, and licensed independent practitioners) of their right to contact the Joint Commission to report concerns relating to the quality of care provided, safety of care provided, or the safety of the environment in which care is provided. This information has also been incorporated into the Patient's Rights and Responsibilities document that is provided to patients.

B. Contact information for the public's right to contact the Centers for Medicare and Medicaid is incorporated into the Patient's Rights and Responsibilities document that is provided to patients.

II. ARRIVAL OF THE SURVEY TEAM

A. The Security Guards Sentry (Emergency Room or Front Entrance) or Administration will be the most likely point of arrival for the surveyor or survey team. The hospital staff member who first greets the surveyor or survey team members should escort and seat them in the Administrative waiting area. **Under NO circumstances should the surveyor or survey team be allowed to walk unaccompanied in the facility.**

B. Upon notification by the Administrative staff of the surveyor or survey team's arrival, a representative from the Compliance Office will formally welcome the surveyors and proceed with the identification check.

1. For Joint Commission surveyors, the verification check will include physically matching the surveyor's Joint Commission Identification Badge against the information posted on the Connect Website. This is to be completed even if the surveyor presents with a letter from TJC. The Joint

Commission posts survey and surveyor information onto the Connect Website by 0730 hours.

Note: ***If individuals claiming to be Joint Commission Surveyors are trying to access the organization, and the Connect Website does not provide information above confirming that they are Joint Commission surveyors, contact the security staff and do not allow them access to the organization. A representative from the Compliance Office will immediately contact The Joint Commission Division of Accreditation and Certification Operations' Manager of Surveyor Planning at 630-792-5855 or the Senior Survey Planning Representative/Mentor at 630-792-5727.***

2. Surveyors from the Centers for Medicare and Medicaid will present their identification upon arrival. The CMS Survey Team Coordinator will announce that a survey will be conducted to the hospital administrative staff that is available at the time of entrance. Per CMS policy, the survey will NOT be delayed if the Hospital Administrator/CEO or designee is not on-site or available. CMS Surveyors must be allowed to being their survey.

C. To alert the staff and any physicians on-site of the arrival of the surveyor or survey team, the operator will be asked to make the following overhead announcement: **Guam Memorial Hospital welcomes the Survey Team from <Insert either "The Joint Commission" or "The Centers for Medicare and Medicaid">.** This will be announced once at the surveyor's time of arrival. In addition, the Compliance Officer will text all Executive Management Leadership and all Department Heads via the established instant messaging system to ensure notification of surveyor(s) arrival has reached them. Department Heads are expected to notify their staff of the surveyors' arrival.

D. A Unit/Department Survey Readiness Checklist is included as *Attachment I* for your reference in conducting a quick screen of your area prior to the beginning of the surveyors' tracing.

III. SURVEY COMMAND POST

A. An administrative assistant from the hospital's Administration Office will be appointed to the Compliance Office for establishing the Survey Command Post and will be responsible for communicating the following:

1. The schedule for system tracers/table-top review sessions (Infection Control, Environment of Care, Data Use, and Medication Management); interviews/discussion sessions, etc.;

2. Any surveyor requests and schedule revisions;

3. Identified focus areas and key findings that require additional attention by managers/division heads.

B. The primary mechanisms for communication from the Survey Command Post will be email, telephone calls, and instant messaging. Communication through the use of the Public Address System will be used as a last resort.

C. In addition to the above responsibility of communication, the administrative assistant appointed to the Survey Command Post will also be responsible for the following:

1. Contacting the Education Department staff on the morning of the surveyor(s) arrival, to clear the schedule for the hospital's meeting rooms.

2. Contacting Dietary Services to make the necessary arrangements for surveyor meals and beverages. If the surveyors have any special dietary requirements that cannot be met/addressed by Dietary Services, a runner will be appointed by the Hospital Administrator for the purpose of obtaining outside food. The runner shall be a separate individual from the administrative assistant appointed to the Survey Command Post;

3. Coordinating any surveyor requests (such as meetings with particular individuals, documents, etc.).

4. Coordinating the assignment of escorts/scribes.

IV. SURVEY TEAM SET-UP

A. The first floor Boardroom will be used as the central meeting place (base) for the surveyor(s). Surveyors will not be given keys to access the conference room. Access to and securing of the room will be coordinated by the administrative assistant assigned to the Compliance Office.

B. Parking passes will be reserved for the surveyors on the subsequent days of the survey. This will be coordinated with the Administrator of Safety and Security.

C. Once the surveyor(s) is escorted to the boardroom, the Compliance Officer, or designee, will make the following information and documents available for them to review during the Preliminary Planning Session and Surveyor Planning Session on the first day of survey. *Note: A 12-month reference applies.*

1. CLIA and CAP certificates
2. An organizational chart
3. Name of key contact person(s) who can assist surveyors in planning tracer selection
4. A map of the organization, if available
5. List of all sites that are eligible for survey
6. List of sites where deep or moderate sedation is in use
7. List of sites where high-level disinfection and sterilization is in use
8. List of departments/units/areas/programs/services within the organization, if applicable

9. List of patients that includes: name, location, age, diagnosis, and length of stay, admit date, source of admission (ED, direct admit, transfer)
10. Lists of scheduled surgeries and special procedures (e.g., cardiac cauterization, endoscopy lab, cesarean sections, including location of procedure and time.
11. List of unapproved abbreviations
12. List of all contracted services
13. Agreement with outside blood supplier
14. Organ Procurement Organization exemption letter from CMS
15. Performance improvement data from the past 12 months
16. Documentation of performance improvement projects being conducted, including the reasons for conducting the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes)
17. Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (including reasons for conducting projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping
18. Analysis from a high risk process
19. Environment of Care data
20. Environment of Care Management Plans and annual evaluations
21. Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey
22. Emergency Operations Plan (EOP) and annual evaluation
23. Hazard Vulnerability Analysis
24. Emergency management drill records and after action reports
25. Written fire response plan
26. Interim Life Safety Measure policy
27. Fire drill evaluations
28. Infection Control Plan
29. Infection Control annual risk assessment and annual review of the program
30. Infection Control assessment-based, prioritized goals
31. Infection Control surveillance data
32. Medical Staff Bylaws and Rules and Regulations
33. Medical Executive Committee meeting minutes
34. The organization's signed and dated agreement with the QIO
35. Governing Body minutes for the last 12 months
36. Autopsy policy
37. Blood transfusion policy
38. Complaint/grievance policy
39. Restraint and seclusion policy
40. Waived testing policy and quality control plan
41. ORYX data
42. Available regulatory reports
43. Medication management policy (which defines what is a complete medication order and therapeutic duplication)
44. Abuse and neglect policy for inpatient, and ambulatory sites, if applicable

45. Fall risk assessment and policy
46. Document describing how the organization is using the CDC's Core Elements of Hospital Antibiotic Stewardship Programs
47. Organization approved antimicrobial stewardship protocols (e.g. policies, procedures, or order sets)
48. Antimicrobial stewardship data
49. Antimicrobial stewardship reports documenting improvement (Note: If the data supports that antimicrobial stewardship improvements are not necessary make sure the surveyor is informed.)
50. List of all Medical Staff members
51. List of all hospital employees
52. List of all new hires within the past four months

In addition to the documents noted above, the documents listed in *Attachment II*, Life Safety and Environment of Care Document List and Review Tool, must be provided to the Life Safety Surveyor upon arrival.

This is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may need to see additional documents throughout the survey to further explore or validate observations or discussions with staff.

If the above information and documentation is not immediately available for surveyors at the Surveyor Preliminary Planning Session, they will begin the survey with an individual tracer.

All requested documents from surveyors are to be brought to the Survey Command Post in the Compliance Office. These will be screened to determine whether the documents can be submitted alone or whether a Department Head or representative will need to accompany their delivery to the requesting surveyor. The exception to this is when a surveyor requests the documents to be brought up to them during an actual tracer. In this instance the document will be submitted to the Compliance Office representative who is escorting the surveyor for screening.

V. ACTIVITIES CONDUCTED AT THE SURVEY COMMAND POST ONCE SURVEYORS ARE SETTLED

A. Obtain a copy of the survey agenda, if available, and disseminate. Note: If the survey is for-cause, dissemination of the survey agenda will be limited to those who are directly involved in the survey
B. Discuss agenda for logistics planning considering room assignments
C. Query division heads for escorts for each surveyor. If none, then scribes will serve in this capacity as well. (See Section VII for more information)
D. Assign scribes for each surveyor
E. Finalize plans for surveyor meals

Additional activities include the coordination of surveyor requests. Department Managers and Division Heads must respond to requests for personnel files, medical record forms/documents, and department-specific policies and procedures. It is important to

make sure that these items are accessible in the event that the Manager is not present during the survey.

VI. THE OPENING CONFERENCE

A. The Joint Commission Surveys:

Upon escorting the Survey Team to the boardroom they will be asked for an estimated time for the Opening Conference. The Leadership of the hospital (members of the Board of Trustees, senior leadership, and members of the Medical Executive Committee) will be contacted and notified of the need to gather in 1st floor boardroom for the Opening Conference at the stated time. The attendees should be prepared to discuss the leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out the hospital's mission and strategic objectives. Surveyors will communicate the structure of the survey at this time, answer questions regarding the survey, and review the hospital's expectations for the survey.

B. Centers for Medicare and Medicaid Surveys:

The CMS Survey Team Coordinator will conduct the opening conference with the hospital administrative staff that is available at the time of entrance. Attendees are determined by the surveyors.

VII. KEY ROLES OF ESCORTS DURING THE SURVEY

The escort accompanies the surveyor through his/her tour of the organization. An important role of the escort is to identify and communicate any key issues or surveyor requests to the survey command post. The escort also serves as a scribe documenting compliance issues identified by the surveyor and the circumstances that surround each issue. The scribe must also document each medical record reviewed by the surveyor during the unit and department visits. To facilitate the documentation of the medical record used, a patient ID sticker may be placed on the notepad. The escort may be called to assist in summarizing key information that must be communicated during the daily briefing.

The Compliance Officer will serve as the escort/scribe for the lead surveyor. Representatives from the Compliance Office will serve as the escorts/scribes for the surveyors. Department Heads from patient care areas may serve as escorts during tracers in areas other than their own department. Escorts will be limited to no more than three in most instances. Further guidance will be provided by the Compliance Officer. The Hospital Administrator/CEO will appoint administrative assistants from throughout the organization to serve as scribes for surveyors, if needed. All scribes and escorts will report to the Compliance Officer for guidance.

Note: CMS surveyors may opt to refuse an escort/scribe. In this instance visited departmental staff are expected to provide on-the-spot directions to these surveyors for

getting from one place to another. All CMS surveyors are expected to have identification that should be validated by staff prior to providing any information or documentation.

VIII. THE SURVEY SCHEDULE (AGENDA)

A survey agenda will be provided to the organization upon the surveyor(s) arrival. It is subject to change on a daily basis by the surveyor(s). The most current information related to the schedule will be communicated by the Survey Command Post.

Note: For-cause surveys may or may not have an agenda. Survey activities are announced at the will of the surveyors.

IX. THE DAILY BRIEFING (per Hospital Administrator/CEO Request)

(Applicable to Joint Commission Surveys ONLY.)

A. A daily briefing will be held each day of the survey. Upon the daily departure of the surveyor(s), all department managers whose area(s) were surveyed, all division heads, and other key staff will gather in the 4th floor education classroom.

B. A member or members of the Executive Management Council will lead the discussion of the day's events with their departments and assist in identifying important follow-up issues that need to be addressed for the following day's survey activities.

X. EXIT CONFERENCE

Once the survey is complete, the Compliance Officer will arrange for appropriate staff and management to attend the exit conference.

REFERENCE:

Joint Commission, February 6, 2017, Survey Activity Guide for Health Care Organizations available at www.jointcommision.org.

RESCISSION:

Policy A-LD600, *Unannounced Survey Readiness Plan*, of the Guam Memorial Hospital Administrative Manual made effective September 19, 2012.

ATTACHMENT:

I. UNIT/DEPARTMENT SURVEY READINESS CHECKLIST

II. LIFE SAFETY AND ENVIRONMENT OF CARE DOCUMENT LIST AND REVIEW TOOL

ATTACHMENT I

UNIT/DEPARTMENT SURVEY READINESS CHECKLIST

Item	Completed
No food or drink in patient care/ drug preparation areas.	
Every employee is wearing an identification badge (no stickers/pins over faces/names).	
Every in-patient is wearing an identification band.	
Medications are secure (medications locked in carts, rooms, etc.). Verify medication station pulldowns are locking properly.	
Multi-dose vials are labeled with expiration date and initials.	
High Alert medications are separated (e.g., insulins)	
Computer screens not visible to public. Staff log-off when walking away from screen.	
Crash carts are locked. Check expiration date of medication and supplies. Check supplies and test defibrillators.	
Logs are accessible: Crash carts, Temperatures, Point of care testing logs, Autoclave, etc.	
White Boards, if used, are up to date.	
Oxygen tanks are secured, segregated, and not excess in number.	
Hallways clear and free of equipment.	
Fire exits/doors/fire extinguishers/pull stations are not blocked. Staff know their location. Staff know RACE and PASS acronyms and evacuation plan.	
Emergency Gas Shut Off panels are not blocked. Staff know which rooms are affected by specific shut off valves.	
Doors are not propped open. No door stops or boxes holding doors open.	
Supplies are not stored on the floor; supplies are not stored in outer shipping box.	
All expired supplies have been removed and sent back to Materials.	
Linen/supply carts are covered.	
Ensure clean environment (sweep/vacuum floors, trash/sharps empty).	
Ensure patient call bell cords are not wound up on the handrails or tied up. They must be within reach of the patient. (Exception: Patients at-risk for suicide with a sitter in place, depending on the plan of care.)	
Ensure 18 inch clearance above stored items (utility/med rooms).	
Ensure 36 inch clearance around electrical panels.	
Isolation precautions posted on doors with isolations carts outside.	
Policy and procedure manuals and Safety Data Sheets (SDS) forms are readily available or staff are able to locate them online.	
Identify an area on your unit/department where surveyors and escorts can have discussions with staff, allowing for confidentiality, privacy, and minimal disruption to care. Be sure it is organized and clean.	
Consider how you can adjust coverage when staff is asked to talk with the surveyors (e.g., charge nurse or unit supervisor to cover patients).	
Now relax, brag about GMHA, and SMILE ☺	

ATTACHMENT I

LIFE SAFETY AND ENVIRONMENT OF CARE DOCUMENT LIST AND REVIEW TOOL

Revised: February 2, 2017

The following pages present documentation required by the Hospital Accreditation program Life Safety (LS), and selected Environment of Care (EC) standards. The Life Safety surveyor will begin review of these documents soon after arrival for the onsite survey.

Surveyors may request other EC and LS documents, as needed, throughout the survey.

Organizations may want to consider using this tool in their continuous compliance and survey readiness efforts.

Life Safety and Environment of Care – Document List and Review Tool

Revised: Feb 2, 2017

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

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	NC	NA	IOU			
LS.01.01.01					Buildings serving patients comply with NFPA 101 (2012 edition)		
EP 1					Individual assigned to assess Life Safety Code® compliance		
EP 2					Building Assessment to determine compliance with Life Safety Code®		
EP 3					Current and accurate drawings w/ fire safety features & related square footage ▯ Areas of building fully sprinklered (if building only partially sprinklered) ▯ Locations of all hazardous storage areas ▯ Locations of all fire-rated barriers ▯ Locations of all smoke-rated barriers ▯ Sleeping and non-sleeping suite boundaries, including size of identified suites ▯ Locations of designated smoke compartments ▯ Locations of chutes and shafts ▯ Any approved equivalencies or waivers		
EP 4					Timely completion of Survey-Related PFIs (SPFI)		
EP 5					Deemed Hospitals: Documentation of inspections and approvals made by state or local AHJs		
EP 6					Removal/maintenance of life safety features		
COMMENTS:							

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy?		Implemented as required?	
	C	NC	NA	IOU		Yes	No	Yes	No
LS.01.02.01					Interim Life Safety Measures (ILSM)				
EP 1					ILSM policy identifying when and to what extent ILSM implemented				
EP 2					Alarms out of service 4 or more hours in 24 hours or sprinklers out of service more than 10 hours in 24 hours in an occupied building - Fire watch / Fire Dept. notification				
EP 3					Signs for alternate exits posted				
EP 4					Daily inspection of routes of egress (See also 19.7.9.2 RE: daily inspections)				
EP 5					Temporary but equivalent systems while system is impaired				
EP 6					Additional firefighting equipment provided				
EP 7					Smoke tight non-combustible temporary barriers				
EP 8					Increased surveillance implemented				
EP 9					Storage and debris removal				

Life Safety and Environment of Care – Document List and Review Tool

Revised: Feb 2, 2017

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy?		Implemented as required?	
	C	NC	NA	IOU		Yes	No	Yes	No
LS.01.02.01					Interim Life Safety Measures (ILSM)				
EP 10					Additional training on firefighting equipment				
EP 11					Additional fire drill per shift per quarter				
EP 12					Temporary systems tested and inspected monthly				
EP 13					Additional training on building deficiencies, construction hazards, temp measures				
EP 14					Training for impaired structural or impaired compartment fire safety features				
EP 15					Other ILSM's				
COMMENTS:									

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	NC	NA	IOU			
EC.02.03.01					Hospital Manages Fire Risk – Fire Response Plan		
EP 9					The written fire response plan describes the specific roles of staff and LIPs at and away from fire including		
					▯ When and how to sound and report fire alarms		
					▯ How to contain smoke and fire		
					▯ How to use a fire extinguisher		
					▯ How to assist and relocate patients		
					▯ How to evacuate to areas of refuge		
COMMENTS:							

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q 1	Q 2	Q 3	Q 4/ Annual
	C	NC	NA	IOU						
EC.02.03.03					Fire Drills					
EP 1					Fire drills once per shift per quarter: Health Care and Ambulatory Health Care (If available, please provide five quarters of fire drill data)	Quarterly				
EP 2					Fire drills every 12 months from date of last drill: Business Occupancies	Annually				
EP 3					When quarterly fire drills are required, at least 50% are unannounced ▯ Drills held at unexpected times and under varying conditions	Quarterly				

Life Safety and Environment of Care – Document List and Review Tool

Revised: Feb 2, 2017

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q 1	Q 2	Q 3	Q 4/ Annual
EC.02.03.03					Fire Drills					
					Drills include transmission of fire alarm signal and simulation of emergency fire conditions					
EP 4					Staff participate in the drills according to the hospital's fire response plan	YES	NO			
EP 5					Critiques include fire safety equipment and building features, and staff response	YES	NO			
COMMENTS:										

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q 1/ Semi	Q 2	Q 3/ Semi	Q 4/ Annual
EC.02.03.05					Fire Protection and Suppression Testing and Inspection					
EP 1					Supervisory Signals-~~including:~~ fire pump running, fire pump failure trouble signals; control valves; pressure supervisory; pressure tank, pressure supervisory for a dry pipe (both high and low conditions), steam pressure; water level supervisory signal initiating device; water temperature supervisory; and room temperature supervisory.	Quarterly				
EP 2					Water flow devices	Semiannually				
					Tamper switches	Semiannually				
EP 3					Duct, heat, smoke detectors, pull boxes	Annually				
EP 4					Notification devices (audible & visual), and door-releasing devices	Annually				
EP 5					Emergency services notification transmission equipment	Annually				
EP 6					Electric motor-driven fire pumps tested under no-flow conditions	Monthly				
					Diesel-engine-driven fire pumps tested under no-flow conditions	Weekly				
EP 7					Water storage tank high and low level alarms	Semiannually				
EP 8					Water storage tank low water temp alarms (cold weather only)	Monthly				
EP 9					Sprinkler systems main drain tests on all risers	Annually				
EP 10					Fire department connections inspected (Fire hose connections N/A)	Quarterly				
EP 11					Fire pump(s) tested – under flow	Annually				
EP 12					Standpipe flow test every 5 years	5 years				

Life Safety and Environment of Care – Document List and Review Tool

Revised: Feb 2, 2017

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q 1/ Semi	Q 2	Q 3/ Semi	Q 4/ Annual
EC.02.03.05					Fire Protection and Suppression Testing and Inspection					
EP 13					Kitchen suppression semi-annual testing	Semiannually				
EP 14					Gaseous extinguishing systems inspected (no discharge req.)	Annually				
EP 15					Portable fire extinguishers inspected monthly	Monthly				
EP 16					Portable fire extinguishers maintained annually	Annually				
EP 17					Fire hoses hydro tested 5 years after install; every 3 years thereafter	5 years / 3 years				
EP 18					Smoke and fire dampers tested <u>to verify full closure</u>	<u>1 year after install</u> <u>At least every 6 years thereafter</u>				
EP 19					Smoke detection shutdown devices for HVAC tested	Annually				
EP 20					All horizontal and vertical roller and slider doors tested	Annually				
<u>EP 25</u>					<u>Inspection and testing of door assemblies by qualified person</u>	<u>Annually</u>				
<u>EP 27</u>					<u>Documentation of maintenance testing and inspection activities for EPs 1-20 and 25 includes: activity name; date; inventory of devices, equipment or other items; frequency; contact info for person performing activity; NFPA standard; activity results</u>					

COMMENTS:

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	YES	NO / Missing Date
EC.02.05.07					Emergency Power Systems are Maintained and Tested			
EP 1					Battery powered egress lights tested monthly – 30 seconds<u>; visual</u> ~~inspection of EXIT signs~~	Monthly		
EP 2					Battery powered egress lights tested annually – 90 minutes<u>; or replace all batteries every 12 months and during replacement, perform random test of 10% of all batteries for 1 ½ hours</u>	Annually		
EP 3					Functional test of <u>Level 1 SEPSS, monthly; Level 2 SEPSS, quarterly</u>, for 5 minutes or as specified for its class Annual test at full load for 60% of full duration of its class	Monthly Quarterly Annually		
					Note 1: Non-SEPSS tested per manufacturer's specifications	Per Mfr.		
					Note 2: Level 1 SEPSS defined for critical areas and equipment			
					Note 3: Class defines minimum time which SEPSS is designed to operate at rated load without recharging			
<u>EP 4</u>					<u>Emergency power supply system (EPSS) inspected weekly,</u> ~~including all associated components and batteries~~	<u>Weekly</u>		
EP <u>5</u>					Emergency generators tested monthly for 30 continuous minutes under load (plus cool-down)	Monthly		

Life Safety and Environment of Care – Document List and Review Tool

Revised: Feb 2, 2017

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	YES	NO / Missing Date
EC.02.05.07					Emergency Power Systems are Maintained and Tested			
EP 6					Monthly load test for diesel-powered emergency generators conducted with dynamic load at least 30% of nameplate rating or meets mfr. recommended prime movers' exhaust gas temperature; **OR**	Monthly		
					Emergency generators tested once every 12 months using supplemental loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes for total of 1 ½ continuous hours	Annually		
EP 7					All transfer switches monthly/12 times per year	Monthly		
EP 8					Fuel quality test to ASTM standards	Annually		
EP 9					Generator load test once every 36 months for 4 hours	36 Months		
EP 10					Generator 4 hour test performed at, at least 30% nameplate	36 Months		
COMMENTS:								

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD	YES	NO
EC.02.05.09					Medical Gas and Vacuum Systems are Inspected and Tested			
EP 1					**Test, inspect and** maintain critical components of piped medical gas systems: Source, distribution, master panels, area alarms, automatic pressure switches, shut-off valves, flexible connectors and outlets No prescribed frequency; recommend risk assessment if < annual	Per policy		
EP 2					Location of and signage for bulk oxygen systems	On Bldg. Tour		
EP 3					Emergency oxygen supply connection	On Bldg. Tour		
EP 4					Review medical gas installation/modification/breech certification results for cross connection, purity, correct gas, and pressure	As applicable		
EP 5					Medical gas supply and zone valves are accessible and clearly labeled	On Bldg. Tour		
EP 6					Handling, transfer, storage, labeling, transfilling of cylinders	Per policy		
COMMENTS:								

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

GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

☐ Bylaws — Submitted by Department/Committee: Administration

☐ Rules & Regulations — Policy No.: ALD-600

■ Policies & Procedures — Title: Unannounced Survey Readiness Plan

	Date	Signature
Reviewed/Endorsed	30Aug2017	[signature]
Title		Danielle Manglona, MSN, MBA, RNC, CPPS, CPHRM Compliance Officer
	Date	**Signature**
Reviewed/Endorsed	09/20/17	[signature]
Title		PeterJohn D. Camacho, MPH Chairperson, Executive Management Council
	Date	**Signature**
Reviewed/Endorsed		
Title		
	Date	**Signature**
Reviewed/Endorsed		
Title		

***Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer.**