Ann & Robert H. Lurie Children's Hospital of Chicago®

Joint Commission experience – March 2026

Ann & Robert H. Lurie Children's Hospital of Chicago
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Senior Director, Surgical & Procedural Services
April 14th, 2026

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT RANKED IN 11 SPECIALTIES 2025-2026

MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

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Disclosure

- I have no financial or commercial interests to disclose

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Learning Outcomes

- Gain insight into different organization's recent experiences in Joint Commission inspections
- Observe anecdotal experiences that helped one organization successfully prepare for an inspection performed March 17th-20th 2026
- Gain insight into different organization's plans to better prepare for future inspections

Slides & forms available at: johnolmstead.org

The manager makes the difference

Chicago, Illinois, United States

HOME ABOUT JOHN PUBLICATIONS PAST PRESENTATIONS INSPECTION PREP GUIDE APRIL 2026 CHA SLIDES

The Nurse Manager

Past survey results

November 2019 results – SPD:

- Widespread incidences of surgical instruments with degraded / compromised / non-intact identification tape
- Transporting used instruments in containers without biohazard designations
- BI logs not complete in instances of IUSS use
- Multiple sterilized surgical trays found without appropriate filters in place to protect sterility
- TOSI tests for instruments washers performed weekly instead of daily.
- Pass-through window in dis-repair

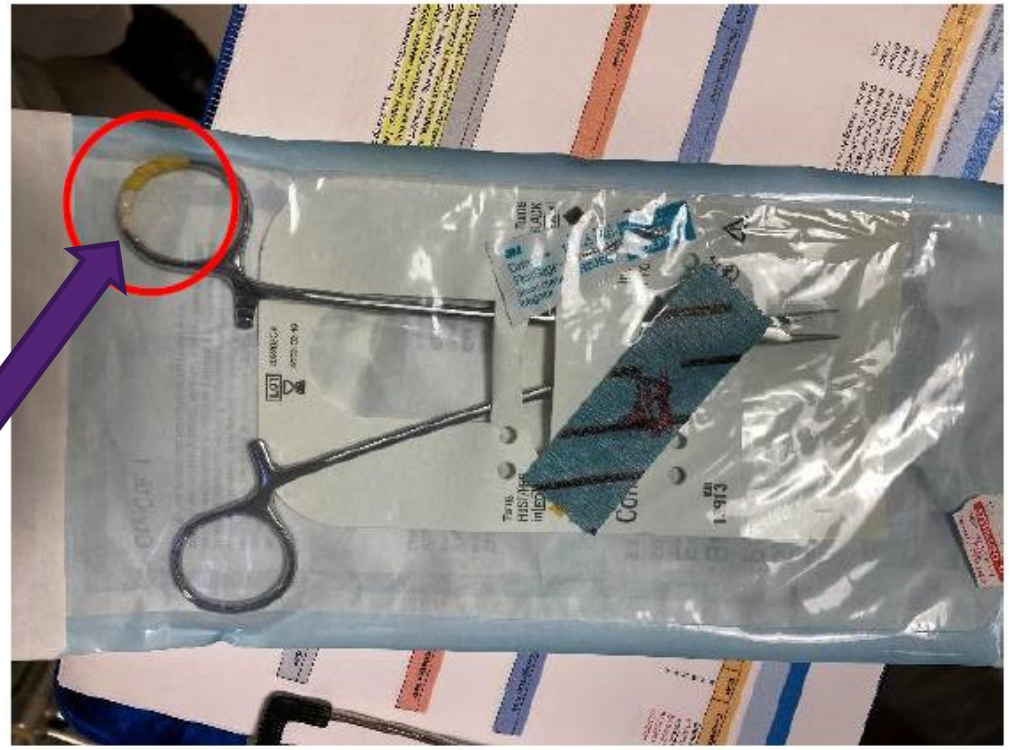
OR area:

- Daisy-chaining power strips in the OR
- Limited amounts of equipment missed annual inspections
- Full / empty oxygen cylinders stored together

Denigrated tape picture

The way things OUGHT to be…

The way things are…



Past survey results

March 2023 results (“Easy” survey)

- **SPD: perfect survey!!!**
- OR:
  - Limited incidence of surgical instruments with degraded / compromised / non-intact identification tape
    - A few in the OR
    - 1 in clinic
  - Time-out error: anesthesia tech kept preparing for the case during the time-out
  - Transporting used instruments in containers without biohazard designations
- ASC:
  - Unlocked anesthesia cart in-between cases

February 2025 Mock Inspection survey

- Joint Commission inspectors double as “mock inspectors” giving extremely thorough advice on inspection preparation
- Room-by-Room inspection performed
- Heavy emphasis on:
  - Surgical instruments with damaged identification tape
  - Expired items on carts (not managed by Supply Chain)
  - Logs
  - Environment of care in all areas
- See appendix for notes samples from
  - Feb 2025 Mock inspection
  - Notes from other hospitals identifying inspected issues

General approach used by Mock Inspector in general inspection of any healthcare area:

1. What is this
   - (piece of equipment, a process, etc)
2. How do I know this is safe?
   - Equipment - training, orientation in use?
   - Processes: appropriate orders or policy
3. How do I know this will not hurt / infect patients?

ESC Action Plan Overview: EOC

John Olmstead & Department directors/ managers

Inspection findings:

- 34 Environment of care findings
- 4 Practice findings
- 2 points of advice for upcoming Practice observations

Common cause

- Lack of double-checks on departmental performance logs
- Lack of routine inspection of all rooms and contents.

Quality & Safety enhancement partners:

- Accreditation & Readiness
- Infection Prevention
- Environmental Services
- Physician leadership
- Vendor partner STERIS

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Physical Room inspections:

- Entered 150 Environment of Care workorders between all departments
- All environmental issues identified in Mock Inspection were openly obvious to observers, examples:
  - Stained ceiling tiles
  - Ripped upholstery in OR equipment
  - Massive amounts of tape residue on IV poles, OR tables, etc
  - Dent / damage to walls due to heavy OR equipment impact

STERIS IMS
https://www.steris-ims.com

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Rust and Bioburden Regulatory Citation Risks

Other equipment repairs include

With no project too large or too small, STERIS IMS is committed to providing solutions to keep your SPD and OR moving.

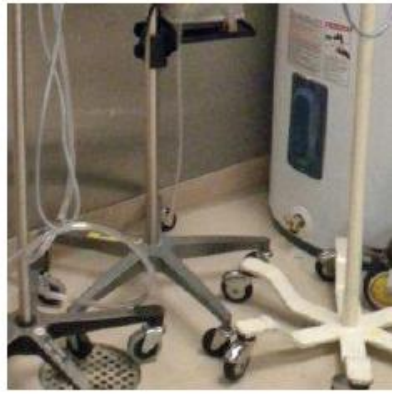

Melted caster


Dirty cart with tape


Rusty caster


Poor weld


Corroded caster


Broken IV stand lock

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Single biggest citation

Chapter	Standard EP	Number	Findings	Recommended Actions
Infection Prevention and Control (IC)	IC.06.01.01, EP 3	15 of 29	**Immediate-Use Steam Sterilization** Arthrex and Depuy surgical instruments/trays had been reprocessed by immediate-use steam sterilization (IUSS), not following MIFU.	Ensure all MIFUs are followed when reprocessing sterile instruments in relation to time, temperature, and dry time. Educate staff and audit for compliance.

+ 8. Does your company have anything in writing from the FDA allowing the extended shelf life?

+ 9. What is the difference in validation and verification?

— 10. What happens if a surveyor wants to cite our facility for using ONE TRAY®?

ONE TRAY® has received information from customers stating that their facility is being cited by a surveyor as part of an accreditation assessment. Upon further discussion, we often see that the commentor is a consultant working with their facility who is not an actual surveyor. In any event, chances are this citation or statement reflects a misunderstanding of the use of **ONE TRAY®**.

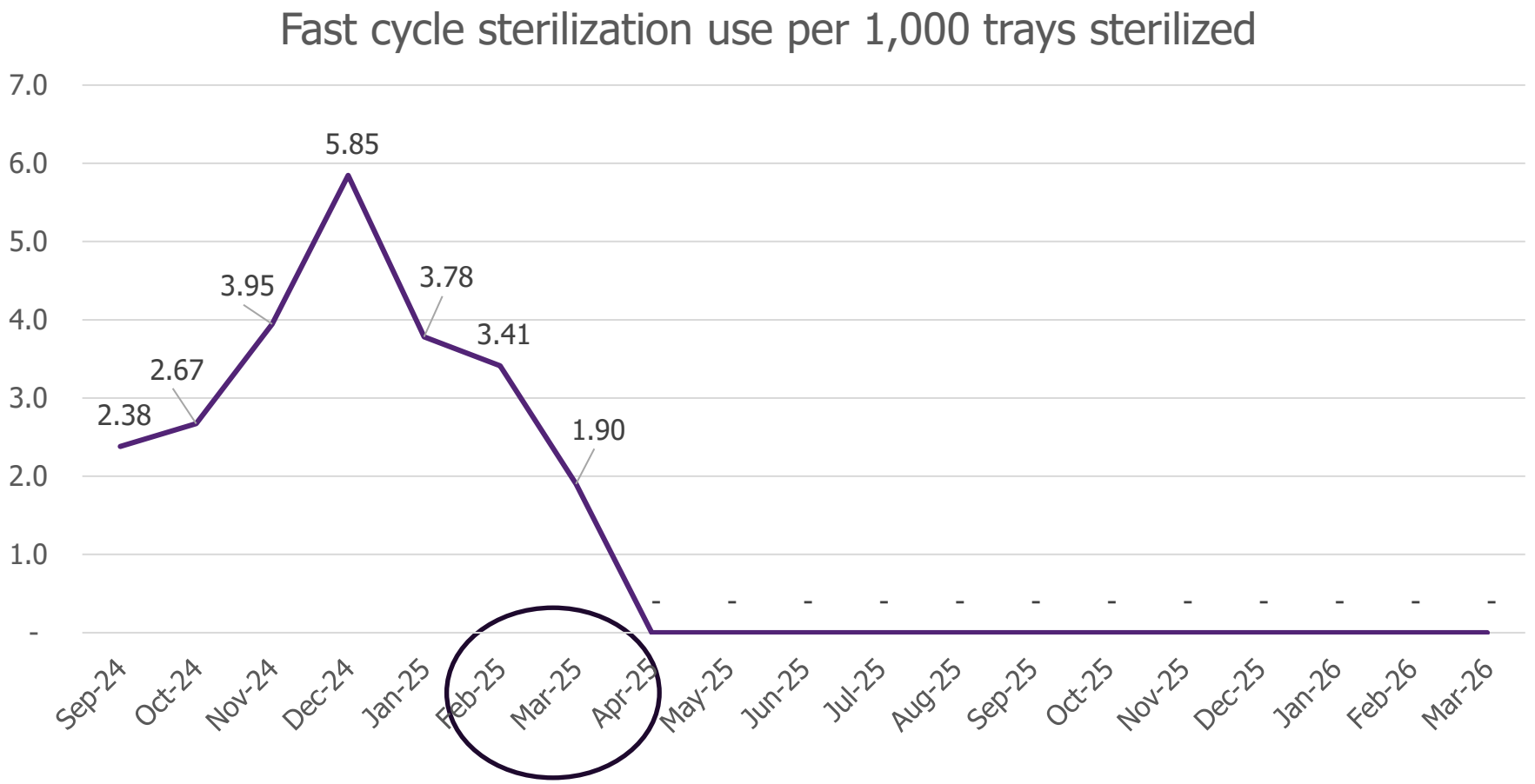
If it is an actual survey, then the first question should be "what are you citing us for?" Secondly, "what information can you provide to support your position?" Attempt to have a polite yet confident and professional conversation that what is being cited is a discrepancy. Explain your position, but then seek out the individual that you report to make him/her aware of what is transpiring.

The areas of concern for a surveyor/inspector are usually:

1. Moisture in the tray
2. Elimination of dry time in the medical device manufacturer's IFU
3. Storing a tray beyond 48 hours
4. Calling the tray IUSS
5. and Sterilizing implants in a **ONE TRAY®**

If you do not have the explanation for any of the listed areas, we can provide that for you. To correct the inaccurate information, **ONE TRAY®** will need the consultant's name, the organization's name, and the date that the conversation occurred. Contact **ONE TRAY®** before your next survey occurs and be prepared! Remember, we are also available if you would like to reach out to our VP of Clinical services Barbara Ann Harmer, MHA, BSN, RN (with 25 years experience in surveying) ***DURING*** a survey for further explanation. She can be reached at bharmer@onetray.com.

Incidence graph post-intervention



Multi-faceted Preparation goal

- Perpetual preparedness
- Decreased stress & workload involved in maintaining preparedness
- Work environment created while preparing for inspection resembles reality
- Emphasis on SAFETY, not “rule-following”

Inspection Preparation Plan

Components

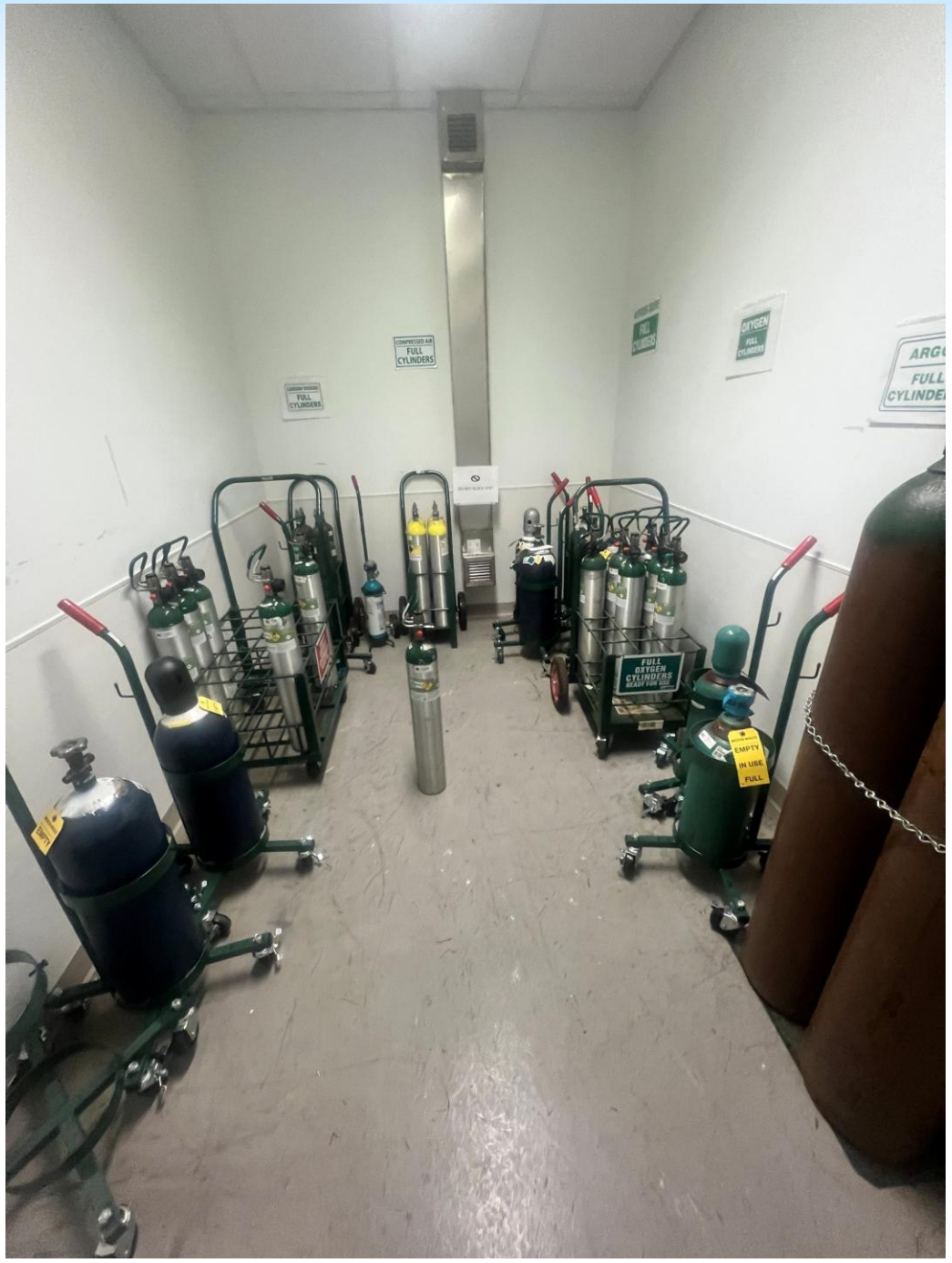
- Human Resource Department file expectations
- Comprehensive department log review
- Routine Physical room inspections
- Critical Patient care / department process monitoring
- Tracer question / answer guide review

Replaced with Laser Labeling


LC Case Cart 36
10050-036


Steam
SPD Ortho Cart
LCMain
orthoped – 000
10/23/2023
LCMain
CsCrt – 075
Loaner Depuy Steam – 000

Why so serious?



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HR Records standard

Practice issue: the manager should be able to produce these records within 15 minutes.

	Record	Retention Period	Comments
Mandatory	Current job description	Keep permanently	Also required for contract / agency staff
	Current Primary source Verification of all required Licensure, Registration or Certification as per the job description	Most recent	
	Department orientation checklist	Keep permanently	
	Initial competency assessment (orientation skills checklist / flowsheet / record of completion)	Keep permanently	
	Annual Competency Validation (not applicable for new-hires)	Keep permanently	
	Recent Mandatory education records	Keep permanently	
	Performance evaluations	Ensure ability to review if requested	
	Any Performance Improvement Plans / Corrective Action notifications	Keep permanently	
Optional	Initial job offer letter	If available	
	Payroll correction forms	Most recent 2 years	
	Attendance records	Most recent 2 years	
	Scheduling requests	Most recent 1 year	
	Recognitions/ awards	Optional	

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Log reviews performed monthly

Pre-Post, PACU & OR logs

1. Code cart logs
2. Code cart defibrillator check log
3. Refrigerator logs
4. Room temperature & humidity logs (non-BAS monitored)
5. Blanket warmer logs
6. Fluids stored in blanket warmers
7. Tissue tracking log
   - Package integrity check
   - Package temperature check
   - Freezer temperature control
   - Date / time tissue received
   - Date / time tissue removed
   - Date / time tissue implanted

Sterile Processing Department logs

1. Autoclave Steam Sterilizers
   - Daily Biological Indicator test
   - Individual load testing
   - Biological Indicator validation test
   - Leak test
2. Low temperature sterilizers
   - Individual load testing
   - Test strip validation
3. High level disinfectors
   - Individual load testing
   - Test strip validation
4. Instrument / Cart washers
   - Washing process indicator test
5. Ultrasonic washers,
   - Cleaning indicator daily test
6. Enzymatic Dosing system
   - Daily testing
7. Endoscope flushing system
   - Daily testing performed?
8. Drying cabinet,
   - Cleaning schedule
9. Room temp & humidity logs
   - Daily testing
10. Positive/Negative air pressure logs
    - Daily testing

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Sterile Processing Dept logs

Log	Test	Expectation	Completed?
Autoclave Steam Sterilizers	Daily Biological Indicator test	Bowie Dick test done before the sterilizer is used for the day	Y / N
	Individual load testing	Biological indicator test done on each load sterilized	Y / N
	Leak test	Test done weekly	Y / N
Low temperature sterilizers (STERRAD, VPro)	Individual load testing	Biological indicator test	Y / N
	Biological Indicator validation test	Test done to ensure the BI used in individual loads are valid	Y / N
High level disinfectors	Individual load testing	Test strip indicators done on each load sterilized	Y / N
	Test strip validation	Test strips are checked for validation for use	Y / N
Instrument / Cart washers	Washing process indicator test	Done on each washer daily	Y / N
Ultrasonic washers	Cleaning indicator daily test	Test done daily to ensure cleaning efficacy (NA if no ultrasonic in use)	Y / N / NA
Decontamination sink; Enzymatic Dosing system (AccusInQ & TBJ Doser	Daily testing	TO include detergent dose and water temperature	Y / N
Endoscope flushing system (Scope Buddy)	Daily testing performed?	Flow validation test is to be done each day before use	Y / N
Eyewash station log	Weekly testing performed	Testing to be charted weekly	Y / N
Drying cabinet	No daily testing expectation; weekly cleaning schedule should be in place	Cleaning schedule in place and adhered to?	Y / N
Room temperature & humidity logs	Daily testing	Charted daily (N/A if tracked by Facilities)	Y / N / NA
Positive / Negative air pressure logs	Daily testing	Charted daily (N/A if tracked by Facilities)	Y / N / NA

Example: Hard form, 6th floor OR

Lurie Children's Hospital Operating Room Logs

6th Floor Log types	Log locations	Completion Frequency	Completed per expectations?
Code cart logs	6-West Core	Monthly	Y / N
	6-East Core	Monthly	Y / N
	Procedural Suite: 06-C32	Monthly	Y / N
Defibrillator checks:	6-West core, Procedural Suite: 06-C32	Daily	Y / N
	6-East Core	Daily	Y / N
	Procedural Suite: 06-C32	Daily	Y / N
Blanket warmers:	6W Core	Daily	Y / N
	6E Core	Daily	Y / N
	Specimen Room	Daily	Y / N
	06-414A between OR 14 &15	Daily	Y / N
	Procedural Suite 06C32	Daily	Y / N
Fluids stored in blanket warmers:	6W Core	Daily	Y / N
	Trach Room 06455	Daily	Y / N
	6E Core	Daily	Y / N
	Procedural Suite 06C32	Daily	Y / N
Eyewash station log	6th floor Scope Intake Room 06-431 (Adjacent to the GI Scope Room)	Checked weekly by Facilities	N/A
Tissue storage refrigerator / freezer:	Kept on 7th floor in Sub-sterile 07-367	Continuous centralized monitoring by facilities	N/A
Specimen storage refrigerator:	Room 06-414A (between OR 14 and 15)	Continuous centralized monitoring by facilities	N/A
	Procedural Suite Rm: 06338	Continuous centralized monitoring by facilities	N/A

Example: SPM Log review guide

Sterile Processing Department: Log tracking guide v 11.10.2025

Log	Question	Answers	Steps
Autoclave Steam Sterilizers	Daily Biological Indicator test	Bowie Dick test done before the sterilizer is used for the day	Management; reprocessing; Load History; select sterilizer/washer to be viewed; select date range; in the Cycle column, click on the Pinpoint and select Bowie Dick or IUSS Spore Test
	Individual load testing	Biological indicator test done on each load sterilized	Management; reprocessing; Load History; select sterilizer/washer to be viewed; select date range; in the Cycle column, ensure all options are chosen; review the "BIs" column, Green checkmarks indicate successful BI load status
	Biological Indicator validation test	Test done to ensure the BI used in individual loads are valid	BI can be found in "test Results" report. Management>reports>run reports> test results (select date range, recommend this done daily or weekly) and will show all tests in on section. This will have bios and leaks!
	Leak test	Test done weekly	Management; reprocessing; Load History; select sterilizer/washer to be viewed; select date range; in the Cycle column, click on the Pinpoint and select Leak
	DART test	Test to be done daily before Bowie Dick test	Need to ensure this is in SPM
	Chamber cleaning	Performed bi-annually	Logged by Facilities
Low temperature sterilizers (STERRAD, VPro)	Individual load testing	Biological indicator test	Management; reprocessing; Load History; select sterilizer/washer to be viewed; select date range; in the Cycle column, ensure all options are chosen; review the "BIs" column, Green checkmarks indicate successful BI load status
	Biological Indicator validation test	Test done to ensure the BI used in individual loads are valid	BI can be found in "test Results" report. Management>reports>run reports> test results (select date range, recommend this done daily or weekly) and will show all tests in on section. This will have bios and leaks!
	Leak test (Not done in STERRAD)	Test done weekly	Management; reprocessing; Load History; select sterilizer/washer to be viewed; select date range; in the Cycle column, click on the Pinpoint and select Leak
High level disinfectors	Individual load testing	Test strip indicators done on each load sterilized	Download data from Medivator until data is available in SPM
	Test strip validation	Test strips are checked for validation for use	Review strip bottles against file of certifications at website: Certificates of Analysis (COA) | STERIS

Inspection Preparation Plan

Components

- ~~Human Resource Department file expectations~~
- ~~Comprehensive department log review~~
- Routine Physical room inspections
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- Tracer question / answer guide review

List of individual room inspection forms:

- Operating Room
- Endoscopy Procedure Room
- Pre-Post-Recovery bays
- Nurse's Station
- Medication Room
- Lab area
- Oxygen storage room
- Supply Storage room
- Clean Utility Room
- Dirty Utility Room
- IUSS Room
- Non-patient care areas
  - lobby, waiting area, break rooms, locker rooms

Non-Patient Care Areas: • Lobby • Waiting Room • Staff Break Room • Staff Locker Room		ROOM NUMBERS
Ceiling	• Clear of water stains / damage? • Air vents: dusty / dirty?	YES Compliant? NO
Walls	• Intact? • Clear of dust / dirt / cobwebs?	YES Compliant? NO
Handwashing sinks	• No patient care materials should be stored under sinks as they can be affected by moisture 3 feet space or solid barrier shield from supplies?	YES Compliant? NO
Areas open to the public	• Is any PHI (Patient Health Information) protected so privacy is not violated?	YES Compliant? NO
Surfaces / countertops	• No chips / damage that would prevent cleaning? • Patient care surfaces torn / laden with tape residue	YES Compliant? NO
Floors	• Intact?	YES Compliant? NO
Area care	• What is the room cleaning schedule? • How is cleaning monitored for completion? • Single-use supplies disposed of?	YES Compliant? NO
Hallways	• 8-feet clearance available?	In patient care areas, any object blocking an 8-feet clearance should be mobile, and moved at least every 30 minutes
	• Medical gas valves clear?	No item should be stored or placed to block open access to medical gas safety shut-off valves.

Example: Room inspections

Room:	Operating/Procedure Room	LIST ROOM #'S INSPECTED
Air:	• Humidity / temperature: **see footnote* • What is the acceptable range? • How is it monitored, and on what frequency? • Actions to be taken when measures are out of acceptable range?	YES Compliant? NO • Call Facilities
Air	Pressures: Positive / Negative • How is it monitored, and on what frequency? • Actions to be taken when measures are not complaint with expectations?	YES Compliant? NO • Call Facilities
Ceiling	• Clear of water stains / damage? • Air vents: dusty / dirty? • OR lights: dusty / dirty?	YES Compliant? NO

Walls	• Intact?
	• Clear of dust / dirt / cobwebs?
	• Stored supplies kept within 18 inches of ceiling?
	• Cabinets:
	  ○ Dented/damaged edges / surfaces that prevent cleaning?
	  ○ Dusty found inside?
	  ○ Expired supplies?
	  ○ Cleaning schedule?
		YES Compliant? NO

Supplies	• Storage containers: items stored in corrugated cardboard shipping containers?
	• Check:
	  ○ Package integrity
	  ○ Expiration dates
	  ○ Have staff describe any applicable inventory rotation process
	  ○ Any applicable temperature storage expectation
	• Single-use supplies disposed of?
		YES Compliant? NO

Doors	• Is door blocked from functioning ○ Barriers blocking door; door jam in place to keep door from closing during a fire • Does the spring-hinged door latch as expected?	YES Compliant? NO

Inspection Preparation Plan

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- ~~Human Resource Department file expectations~~
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- ~~Routine Physical room inspections~~
- Critical Patient care / department process monitoring
- Tracer question / answer guide review

Tracers • Hospital

Status: Published

My Recent | Favorites | All Tracers

Search

	Tracer Name	Details	Date Updated	Actions	Type	Observation Actions
★	Surgical Counts (v2)		07/01/2025	Print - Email - Export	JC	Add View
★	Dress Code		06/13/2025	Print - Email - Export	JC	Add View
★	Specimen Handling		04/21/2025	Print - Email - Export	JC	Add View
★	Time Outs		04/21/2025		JC	

AMP modules

OR

- Dress code
- Time Outs
- Surgical counts
- Specimen handling

SPD

- Dress code
- Scope cleaning / sterilization
- Peel packs
- Rigid / wrapped trays

Joint Commission Resources

Tracer Observation Form

Surgical Counts (v2)

06/05/2025 03:14 PM

Site: 7269 Ann & Robert H. Lurie Children's Hospital of Chicago

Program: Hospital

Observation Header	
Tracer Instructions:	If question is marked as not compliant, auditor is to include details in Notes on why action was not compliant. Real-time corrective action/feedback is suggested when a non-compliant action is observed.
Observation Title:	**Site:**
Observation Date:	**Floor/Dept.:**
Total Completed Observations:	**Department:**
Survey Team:	**Staff Interviewed:**
Medical Staff:	**Unique Identifier:**
Location:	**Equipment Observed:**
	Contracted Service:
Note:	

Questions (* = Required)

1.* Initial count was completed ☐ N/A

Instructions: Initial Count: performed BEFORE the procedure or prior to skin incision to establish a baseline.

Compliant? ◯Yes ◯No | Num: _____ Den: _____

2.* Relief count, as required, was completed ☐ N/A

Instructions: Relief Count: required at the time of relief (temporary or permanent) of either the scrub person or circulating nurse by the incoming team.

Compliant? ◯Yes ◯No | Num: _____ Den: _____

3.* Subsequent counts were completed: *to be audited via count sheet document following final count* ☐ N/A

Instructions: All subsequent counts are performed as follows:
a. All sponges added to the field are done so and documented in groups of 5 or 10 (Each lap/sponge added to field initialed on count sheet).
b. All sponges used (Raytec and Laps) placed in count bag.
c. All sutures are added as a continuous addition or subtraction (Each suture added to field initialed on count sheet).
d. All used sutures are placed in a suture counter (Do not place used suture in a basin). All sutures removed from surgical field placed in the suture counter and removed from the count sheet (DO NOT THROW AWAY).

Compliant? ◯Yes ◯No | Num: _____ Den: _____

4.* Final count(s) were completed. ☐ N/A

Joint Commission Resources

Tracer Observation Form

Surgical Counts (v2)

06/05/2025 03:14 PM

Instructions: This is the last count performed during a procedure. This count takes place at skin closure or the end of the procedure. This count should reflect all counted items are removed from the patient and have been visualized by the scrub and circulator. The 'final' count will be verbalized to the entire procedure team using active communication and 'repeat back confirmation' should be verbalized by the surgeon.
Order of final count proceeds as follows:
1. Surgical field
2. Mayo Stand
3. Back Table
4. Count stand or count bags
Note: Instruments are counted per tray in same sequence

Compliant? ◯Yes ◯No | Num: _____ Den: _____

5.* Sponge count bag was used for ALL used sponges and laps ☐ N/A

Instructions: All used sponges and laps were disposed of in the sponge count bag, that is to be hung on the count bag tower pole

Compliant? ◯Yes ◯No | Num: _____ Den: _____

6.* Two people actively participated (one counting, one verifying) in all required parts of counts ☐ N/A

Compliant? ◯Yes ◯No | Num: _____ Den: _____

7.* All required fields of count documentation in patient chart were completed. ☐ N/A

Compliant? ◯Yes ◯No | Num: _____ Den: _____

8. If counts are not accurate, standard process was followed. ☐ N/A

Instructions: In the case of an incorrect count due to the misplacement of a sponge, sharp and accessory:
a. Search surgical field, back table, floor, garbage, mayo stand and linen.
b. Notify the charge nurse / clinical manager and ALL attending surgeons involved in procedure of the incorrect count.
c. Obtain an X-Ray of the operative site.
d. Have the Radiologist read the X-Ray.
e. Fill out a Safety Event Report (SERS) noting the incorrect count, what is missing, name of attending surgeon notified, that an X-Ray of the procedural site was obtained, and the result(s) of the attending X-Ray findings.
f. Mark the patient's intra-procedural record Count section as incorrect and make a note in the Nurse's Note.
g. All attending surgeons confirmed with circulator the resolution of incorrect count.

Compliant? ◯Yes ◯No | Num: _____ Den: _____

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Monthly Quality, Safety & Inspection Preparation Dashboard

			# audits goal	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
LC Main Hospital	AMP Audits	Dress Code	10	81	320	653	306	236	158	167	115
	AMP Audits	OR: Hand Hygiene	10	work in progress	work in progress	work in progress	work in progress	work in progress	5	work in progress	17
	AMP Audits	Specimen Handling	10	work in progress	12	14	15	13	23	18	10
	AMP Audits	**Surgical Counts**	**68 (4.5%)**	7	11	27	63	47	112	50	36
	AMP Audits	Time Outs	5	8	11	28	26	16	23	30	19
	OR Log checks	6th floor	100%	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed
	OR Log checks	7th floor	100%	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed
	Cart inspections	57 wandering carts inspected	100%	25%	Completed	Completed	Completed	Completed	Completed	Completed	Completed
	OR rooms inspected	6th floor: rooms:	100%	Completed	Completed	Completed	Completed	*Due in Jan*	*Due in Jan*	Completed	*Due in April*
	OR rooms inspected	7th floor: rooms:	100%	Completed	Completed	Completed	Completed	*Due in Jan*	*Due in Jan*	Completed	*Due in April*
SPD	AMP Audits	Dress Code	10	30	140	88	383	219	83	198	167
	AMP Audits	SPD: Peel Packs	10	2	141	548	475	558	328	385	484
	AMP Audits	SPD: Scopes	5	n/a	2	11	12	15	19	14	22
	AMP Audits	SPD: Trays	100/week	122	406	490	580	431	446	420	487
	SPM / visual	SPD Logs	100%	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed

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High risk measures: OR Time Outs

Q#	Question Text	Dec-25	Nov-25	Oct-25
1	Time out was completed immediately before starting the invasive procedure or making the incision	91.7% (33/36)	100.0% (24/24)	100.0% (44/44)
2	All immediate members of the surgery/procedure team actively participate in the time-out?	97.2% (35/36)	100.0% (24/24)	100.0% (44/44)
3	All members of the procedural team were introduced	80.6% (29/36)	100.0% (24/24)	93.0% (40/43)
4	The right patient, right procedure, and right surgical side/site was confirmed.	100.0% (36/36)	95.8% (23/24)	95.5% (42/44)
5	Site is marked and marking is visible.	100.0% (16/16)	100.0% (14/14)	95.7% (22/23)
6	Patient allergies were reviewed	100.0% (36/36)	100.0% (24/24)	100.0% (42/42)
7	Risk of blood loss was reviewed	86.1% (31/36)	95.8% (23/24)	88.1% (37/42)
8	Medications were reviewed (antibiotics/local)	97.2% (35/36)	95.8% (23/24)	100.0% (43/43)
9	Equipment/Implants availability were reviewed.	94.3% (33/35)	100.0% (24/24)	93.0% (40/43)
10	Expected specimens were reviewed	88.6% (31/35)	95.7% (22/23)	92.9% (39/42)
11	Medical imaging was reviewed	89.3% (25/28)	100.0% (23/23)	94.3% (33/35)
12	Airway and IV status were reviewed	97.1% (33/34)	91.7% (22/24)	97.7% (43/44)
13	Postoperative location was reviewed	97.2% (35/36)	100.0% (24/24)	95.5% (42/44)
14	Fire safety was reviewed	100.0% (36/36)	100.0% (24/24)	100.0% (42/42)
15	**During each "time out process" all other activities were suspended**	71.4% (25/35)	83.3% (20/24)	82.9% (34/41)

Tracer Compliance:

Green indicates department scored 100% (or better)

Yellow indicates department scored between 90 and 100%

Red indicates department scored 90% or less

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AMP compliance details – High risk measures

#	SPD: Wrapped Trays	Compliance
1	Tray wrap checked for holes, integrity checked and validated	100% (373/373)
2	Check external indicator	100% (373/373)
4	Check for filters as appropriate (hold to light for holes)	100% (373/373)
5	Check for two integrators and appropriate change	100% (373/373)
6	Check for bioburden prior to placing on sterile field	100% (373/373)
7	Check for tape on any instruments	100% (373/373)
8	Check instruments to make sure they are open/not fully assembled	100% (373/373)

	SPD: Scopes	Compliance
1	Ask staff to describe the process required after removal of the endoscope from the reprocessor. Do manufacturer's instructions for use match the process, as described?	100%)16/16)
2	Observe the location where endoscopes are stored following high-level disinfection. Are endoscopes stored in a manner to prevent contamination?	100%)16/16)
3	Discuss with staff the process for reprocessing endoscopes when they not been used for an extended period of time after disinfection. Does the practice, as described, match the policy for defined reprocessing intervals?	100%)16/16)

#	SPD: Peel Packs	Compliance
1	Check package for integrity, opened, any evidence of moisture	100% (289/289)
2	Check to make sure indicators have changed	100% (289/289)
3	Check instruments to make sure they are open/not fully assembled	98.3% (284/289)
4	Open in a sterile fashion to the sterile field	100% (289/289)
5	**Check for tape on instrument**	99.7% (288/289)
6	Check for bioburden	100% (289/289)

Inspection Preparation Plan

Components

- ~~Human Resource Department file expectations~~
- ~~Comprehensive department log review~~
- ~~Routine Physical room inspections~~
- ~~Critical Patient care / department process monitoring~~
- Tracer question / answer guide review

Inspection Preparation Calendar

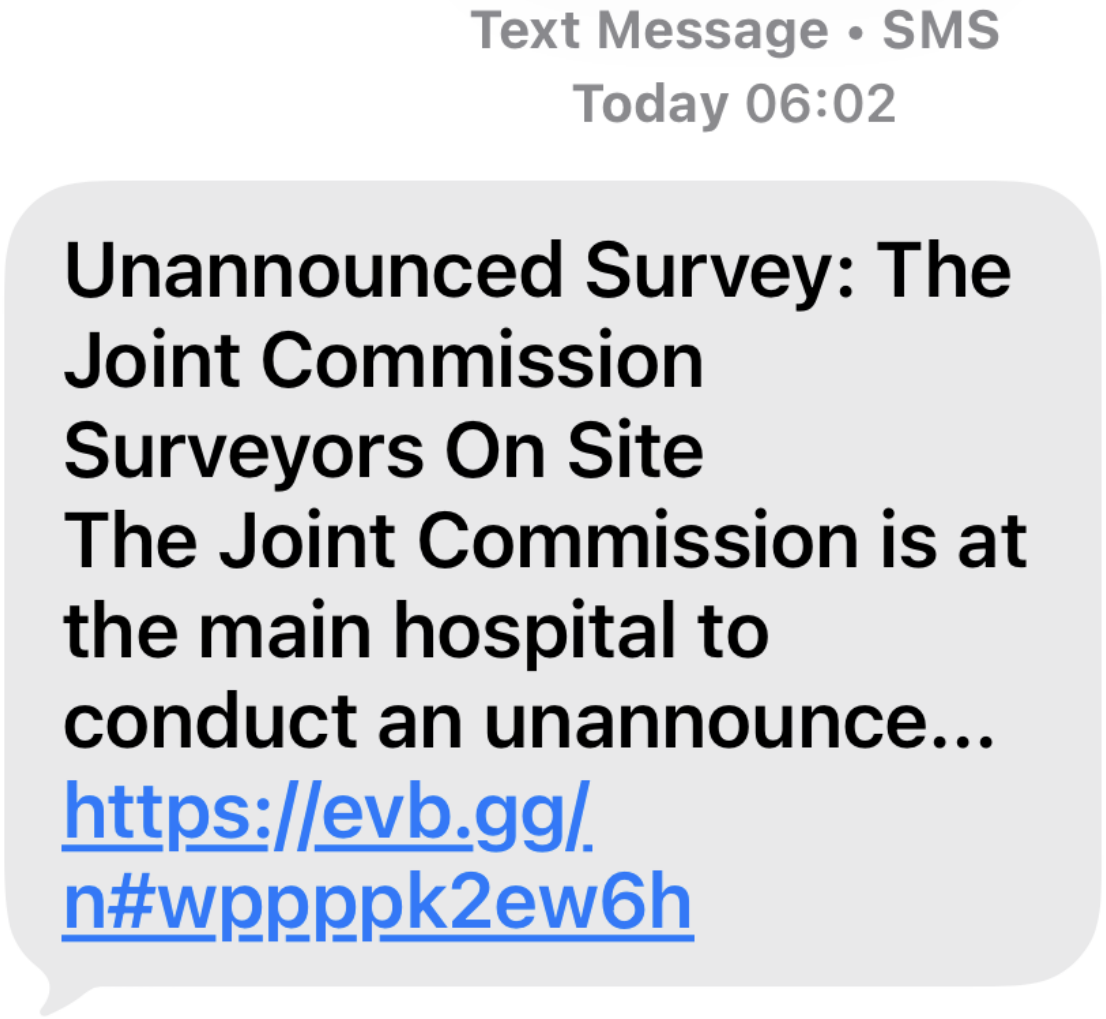
Joint Commission check calendar	Cadence	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Dept log checks	Monthly	**Done**	**Done**	**Done**	**Done**	**Done**	**Done**	**Done**	**Done**
Critical function monitoring: Time-outs	Monthly	**Done**	**Done**	**Done**	**Done**	**Done**	**Done**	**Done**	**Done**
Laser Safety meeting	Monthly				**Done**			**Done**	
Dept physical environment reviews	Quarterly		**Done**			**Done**			**Done**
HR file readiness review	Annually						**Done**		
Department Policy review:	Annually						**Done**		
Staff preparedness: Common Questions & Answers	Monthly	not set up yet	not set up yet	not set up yet	not set up yet	not set up yet	not set up yet	not set up yet	not set up yet

Advances in Quality

- Log issues:
- ASTCs:
  - SPD scope process tracking lapses
  - Tissue tracking practices missed expectations
- Mis-understanding follow-up expectation on warmer failures
- Laser Safety Program enhancement
- Equipment maintenance expectations
  - Recognition of massive tape residue problem
  - Minor Procedure Cleaning procedure
    - Revised policy
- OR Practice issues
  - Dress code compliance
  - Surgical Count process detail compliance
  - Time Out process compliance
  - Specimen Handling process compliance
- SPD Practice issues
  - High level disinfection practice competency monitoring
  - Dress code compliance
  - SPD tray inspection process
  - Peel pack instrument inspection process
  - Instrument transport process from Clinic to SPD for sterilization

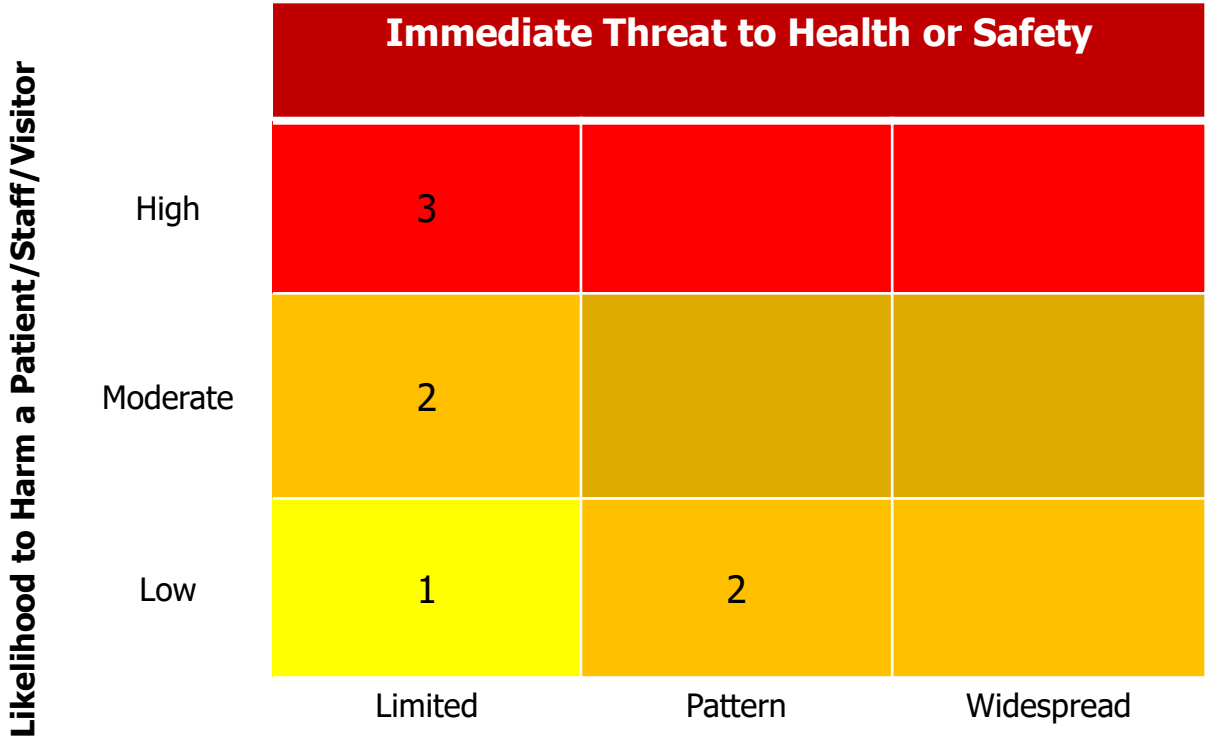
So….How did we do???

Tuesday March 17th, 2026 Opening Statement



- Primary sources of high-level citations given at recent hospitals
  - Surgical Tissue management tracking
  - Surgical instruments displaying degraded / non-sterile identification tape
  - General environment of care deficiencies in ORs :
    - Ripped surgical table upholstery
    - Rusted / unclean tables / carts
    - OR attire violations
- Inspection of Procedural areas to commence immediately!

How did we do?



SAFER Matrix Placement	Required Follow-up Activity
High/Limited, High/Pattern, High/Widespread	Within 60-days of findings: • Evidence of Standards Compliance (demonstration of compliance) • Compliance evidence must include evidence of leadership involvement and preventative analysis • Finding will be highlighted to be included in follow-up surveys
Moderate/Pattern, Moderate/Widespread	
Moderate/Limited, Low/Pattern, Low/Widespread	Within 60-days of findings: • 60-day Evidence of Standards Compliance (demonstration of compliance)
Low/Limited	

Limited Pattern Widespread

High level

IC.06.01.01, EP 3	Lack of hand hygiene prior to sorting sterile instruments	Observed SPD technician not perform hand hygiene prior to sorting sterile instruments into designated tray.
IC.06.01.01, EP 3	Lack of hand hygiene when processing GI endoscope	While processing GI endoscope on the clean side of the scope processing area the SPD staff donned gloves without conducting hand hygiene and subsequently changed gloves twice without conducting hand hygiene in between the glove changes.
IC.06.01.01, EP 3	Not utilizing SPD test strips according to MIFU	Staff demonstrated use of the test strips while verbally talking through the process. • For the Rapicide PA test strips used with the Medivator AER the staff demonstrated that the process is a 30 second dip and immediate read. MIFU states the process is a 1 second dip followed by a read at 30 seconds.
NPG.01.06.03, EP2	Activities were not suspended during OR time out	During tracer activity it was identified that the surgical tech did not stop performing activities during the preprocedural time out. The HCO policy "Universal Protocol Procedural Services Department" states that "during each time out process all other activities are suspended".

Medium – Low level

PE.03.01.01, EP 3	Improper bed storage in corridor	In 1 of 30 corridor observations for egress obstruction, there was a sign on the wall that stated "Nothing stored against this wall" that had a bed stored below the sign.
PE.04.01.01, EP 1	Improper power strip usage	It was identified that the OR cautery unit was plugged into a mounted outlet connection/power strip on the cart positioned next to it. When using a cart mounted power strip, only the items on that cart are to be plugged into those outlets.
LD.13.03.01, EP 22	Expired medication and supplies in malignant hyperthermia kit	It was noted that the malignant hyperthermia kit contained a vial of sodium bicarbonate that was expired.
PE.02.01.01, EP 4	Blocked eyewash	In 1 of 8 emergency eyewash/shower checks, the eyewash was blocked by several carts.
No standard identified	Scope Drying	Surveyor observed process of HLD of scope. Scope was not wiped with a lint free cloth after removing from the Medivator.

What SHOULD have been reviewed?

- ASC tissue use / tracking
  - Need better education to Charge RN / staff
- Clinic use of STERIS System E sterilizers
  - Need better inspection prep for clinic staff to ensure higher confidence in survey readiness
- Time durations in between scope usage &
  - case completion
  - manual cleaning

What's next? Program continuation

KEEP:

- Continue Inspection Preparation Calendar

FINE-TUNE:

- AMP monitoring plans:
  - Finetuning critical function monitors
    - OR measures: set individual service monthly monitor expectations
    - SPD measures:
      - Keep all current measures as KPIs
      - Add in "OR interruption" measures - to start May+

ADD:

- Arrange weekly review of Inspection Preparation general knowledge questions
- Train managers in using the Mock Inspector general inspection process:
  1. What is this (equipment, process, etc)
  2. How do I know this is safe?
  3. How do I know this will not hurt / infect patients?
- Train staff in handling Inspection "breakdowns"
  - Interruptions while a staff member is "in-process"
  - Mis-directions / persistent questioning staff while performing a task

Appendix contents

- Feb 2025 Mock Inspector notes
  - OR
  - Pre-Post-Recovery
  - SPD
- Local Adult Hospital Feb 2026 survey results
- CHA Listserv Joint Commission inspection focus notes – 2025

Feb 2025 Mock Inspector notes – OR (slide 1 of 3)

- Fire drill – how often, who has documentation
- Pressure from doors/rooms
- What to do with stretchers in hallway in a fire – needs a designated spot/plan
- Medical gas – rule is that you can turn it without delay, need consistent signage
- Eye wash pressure (??? This is a rule, apparently)
- Formalin safety
- Asset tag and PM on power strips
- Sanitizer cannot be directly over an outlet – needs to be 1 inch to the right or left
- Propofol wastage (not in sharps)
- Fire doors – do they close?
- Oxygen chains need to be across body of tank, not neck
- PMs for anesthesia machines
- How to look up surgeon privileges
- Prep dry time – how long do you wait?
- Anesthesia timeout – important to do only the things pertinent to anesthesia so that people don't tune out the surgical timeout when it comes time for that
- How to know if instruments are sterile
- Watching counts
- Airway equipment
- MH cart
- Decontamination process (spraying instruments following a case)
- PIV/medication labeling
- Check radiology lead for cracks; is it tracked?
- Are refrigerators centrally monitored?
  - How often do you check it?
- Tape on instruments
- Medivator maintenance
- Scope logs
- Documentation of scopes and linking to patient

Feb 2025 Mock Inspector notes – Pre-Post-Recovery

(slide 2 of 3)

- All H&P elements and signed and completed in appropriate timeframe
- Patient flow from preop – OR – PACU
- Who gives versed (premed)
  - Review associated orders
- NPO protocol
- CHG wipe warmer
- Who does dental H&P
- Documenting interpreter
- Consents
- Anesthesia notes
- Education
- Education
- Anesthesia discharge education with family
- PACU orders – orders to give oxycodone before discharge
- Crash carts
- Sharps in preop rooms
- Ceiling tiles
- Storage areas (equipment and oxygen)/clean supply/Soiled utilities
- Food storage
- POC QC checks

Feb 2025 Mock Inspector notes – SPD (slide 3 of 3)

- Tosi test – it is daily now!
- Chemicals –appropriate cleaners for washers
- Asked about the concentration of the detergent in the sink
- Indicators – expiration of the indicators
- Letter of performance with Medivator indicators
- Asked several SPD techs to use OneSource to pull up individual instrument IFUs, and review sterilization performance compared to IFU
- Walk through sterilization process and looked at several loads
- SPM log documentation
- Good cleaning behind & inside the steam sterilizers
- Airflows (negative & positive)
- Sprinkler heads
- IUSS review

Local Adult Hospital Feb 2026 survey results (slide 1 of 2)

Day 1 –

- Surveyors said peel packs looked very good.
- No double peel packing or folded peel packs.
- Looked over all sterilization documentation. Looked at one date in January, biological results documented, lot # documented, counts documented.
- Surveyor asked about elements of inspecting trays and instruments. She demonstrated the use of the borescope for cannulated instrument inspection. Nice work!
- He asked about proper chemical indicator placement.
- Decontam – discussed process flow and use of sinks
- Detergent, rinse, RO rinse. Detergent dispensing dosage and how to test if working properly.
- Tosi and Sonic testing process.
- Use of brushes and disposal process. Sanitizing automated canula flusher process.
- Endoscope process went very well. Staff did a great job explaining process and discussing Medivators filters and maintenance required.
- IFU requested for Intercept detergent.
- Discussed drying cabinets, cleaning, hanging times.

Local Adult Hospital Feb 2026 survey results (slide 2 of 2)

Day 2 –

- Concerned with instrument tape on NICU/OB instrument – taped more than 1 ½ times around.
- Concerned with CVR Cath Pacemaker tray – had tarnishing of instruments, labels falling off tray.
  - A corrective issue will most likely be required.
- Gomco issue – IFU requires all parts to be separated for sterilization.
  - We have been putting together loosely due to issues in OB putting them back together correctly.
- Multiple trays opened and inspected by surveyors in other departments. All good!

CHA Listserv Joint Commission inspection focus notes - 2025

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OR	SPD	Pre-Post / PACU
• All logs • Fire safety: extinguisher locations, fire drills, medical gas valve access/responsibility, oxygen tank storage / safety	• All logs • SPM documentation • Environment of care cleanliness • Equipment maintenance	• All Logs • Consent, H&P, site marking • Orders for scheduled drugs
• MH / crash carts		• Discharge criteria / orders
• Monitoring of timeouts • Monitoring of counts		• Environment of care cleanliness • Hand hygiene practices / monitoring
• Medication labeling • Equipment maintenance & use of extension cords		
• Scope handling, cleaning & storage		