Continuous Survey Readiness (pre-during-post)

Accreditation Professional
Orientation Certificate Program

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Vizient: your accreditation partner

A key element of an organization focused on patient safety and performance excellence is Continuous Accreditation Compliance and Survey Management. The previous webinars for the Accreditation Professional Orientation Certificate Program provided you with a foundation of knowledge.

Today, you'll learn about the fundamentals of survey management and responding to unannounced surveys. Recommendations include developing a response plan, implementing that plan during survey, and ensuring a solid process for following up post-survey.

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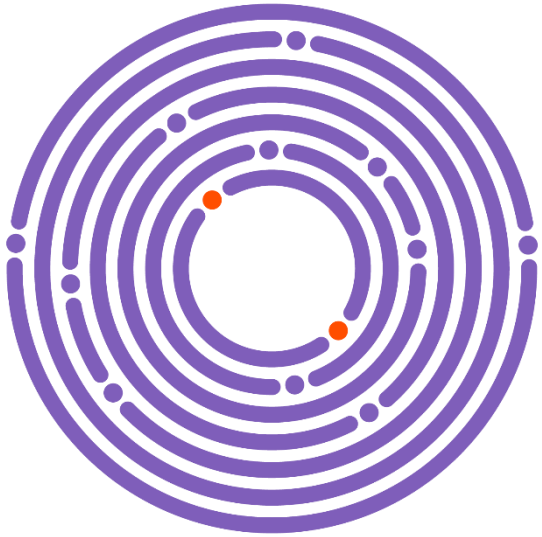

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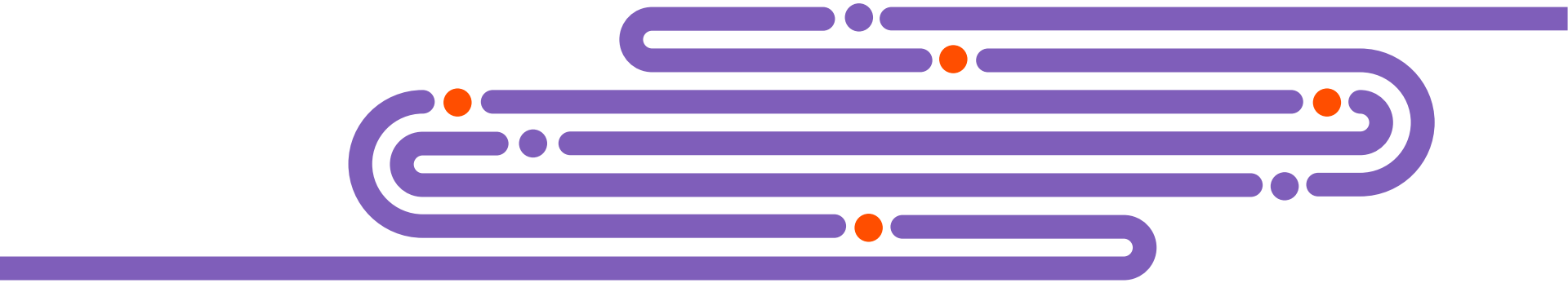
Disclosure information

Natalie Webb and Mitchell Gesinger do not have any relevant financial or nonfinancial relationships to disclose.

Objectives

1. Outline the critical activities of a Continuous Patient Readiness (CPR) model organization undergoing an on-site accreditation survey
2. Define the activities that various CPR model organization staff perform during an on-site accreditation survey
3. Describe the appropriate technique for challenging surveyor findings while surveyors are on-site
4. Outline the critical activities that must occur immediately after accreditation surveyors have left the organization

Survey Management



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Survey success!

Organizational Culture

First impression

- Feel
- Clean
- Organized
- Engaged
- Learning
- Comfortable
- Confidence

Survey Management

Today's discussion

- The interworking of the survey process
- Pre-survey
- Intra-survey
- Post-Survey

Standards Compliance

The Rules

- Law and regulation
- CMS CoPs
- TJC standards and Eps
- OSHA
- Scope of practice
- MIFU
- Professional guidelines

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Survey management

Pre Survey	Intra Survey	Post Survey
–What do you need think about?	–What do you need think about?	–What do you need think about?

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Pre-survey

What needs to happen before the surveyors ever arrive onsite?

Planning-

"If you fail to plan, you are planning to fail"

- Survey Activity Guide (documents)- SAG
- Surveyor touchdown
- Command Center
- Scribes/escorts
- Meeting rooms
- Survey activation
- Opening presentation
- Internal Communication

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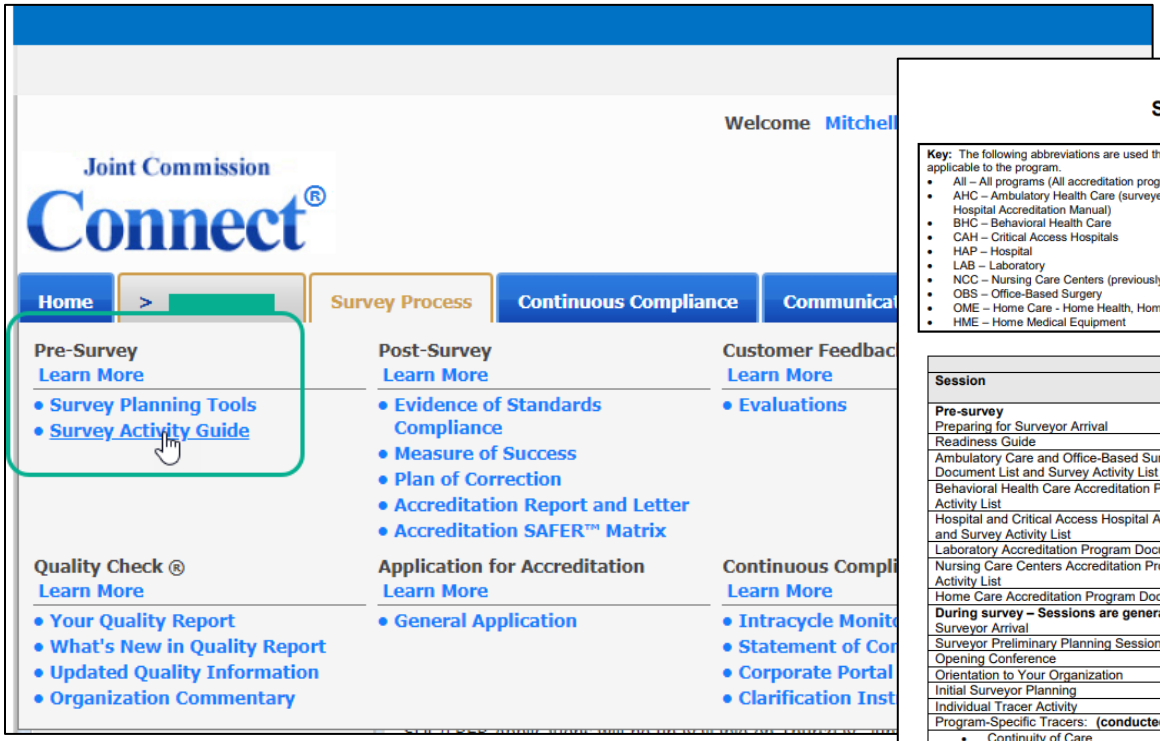
Survey activation guide (SAG)



Health Care Organization
Survey Activity Guide (SAG)

Key: The following abbreviations are used throughout this Guide to identify specific accreditation programs and the survey activities applicable to the program.

- All – All programs (All accreditation programs listed below)
- AHC – Ambulatory Health Care (surveyed from the Comprehensive Accreditation Manual for Ambulatory Health Care and not the Hospital Accreditation Manual)
- BHC – Behavioral Health Care
- CAH – Critical Access Hospitals
- HAP – Hospital
- LAB – Laboratory
- NCC – Nursing Care Centers (previously Long Term Care or Nursing and Rehabilitation Centers)
- OBS – Office-Based Surgery
- OME – Home Care - Home Health, Home Infusion Therapy, Pharmacy, Hospice
- HME – Home Medical Equipment

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Preparing for surveyor arrival

Start at the beginning…Does security and the front desk know what to do and who to contact?

Front Desk Cheat sheet: Survey Activation	
Actions to take when surveyor arrives	Comments:
1) Greet surveyor(s)	Hello, welcome to _____, if I may see your ID to validate your credentials… Thank you, if you would have a seat in the waiting area I will contact the team and let them know you have arrived…
2) Verify identity	Look at picture ID to ensure they are from the Joint Commission
3) Ask them to wait	Location: Waiting area
4) Validate authenticity of survey	Contact: _____ (this individual has a user ID and password to access the organization's Joint Commission extranet site) Phone number:_____

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Pre-survey planning

The first 30 minutes…I just got notified they are here…

Who is…

- Going to meet the surveyors?
- Ordering them coffee and pastries?
- Notifying the c-suite and other stakeholders?
- Or how are we notifying staff and unit leadership?
- Downloading the surveyor agenda and reviewing with lead?
- Downloading census and required documents and delivering them?
- Sending out surveyor bios?
- Coordinating lunch and snacks for surveyors, command center and scribes/escorts?
- Reserving rooms?
- Clearing calendars?
- Completing quick environmental sweeps?
- Notifying Vizient?

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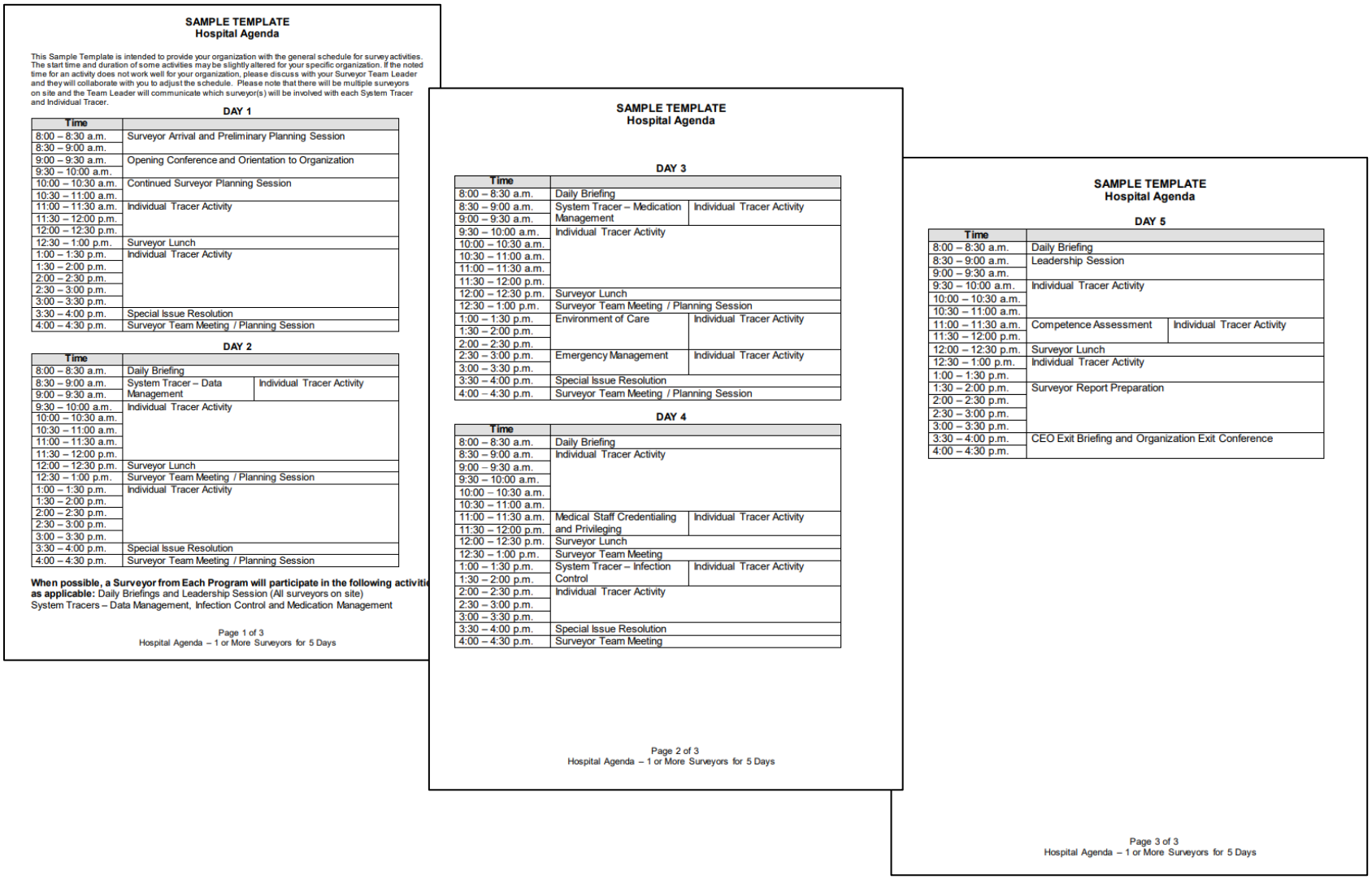
Sample agenda template



SAMPLE TEMPLATE
Hospital Agenda

This Sample Template is intended to provide your organization with the general schedule for survey activities. The start time and duration of some activities may be slightly altered for your specific organization. If the noted time for an activity does not work well for your organization, please discuss with your Surveyor Team Leader and they will collaborate with you to adjust the schedule. Please note that there will be multiple surveyors on site and the Team Leader will communicate which surveyor(s) will be involved with each System Tracer and Individual Tracer.

DAY 1

Time	
8:00 – 8:30 a.m.	Surveyor Arrival and Preliminary Planning Session
8:30 – 9:00 a.m.	
9:00 – 9:30 a.m.	Opening Conference and Orientation to Organization
9:30 – 10:00 a.m.	
10:00 – 10:30 a.m.	Continued Surveyor Planning Session
10:30 – 11:00 a.m.	
11:00 – 11:30 a.m.	Individual Tracer Activity
11:30 – 12:00 p.m.	
12:00 – 12:30 p.m.	
12:30 – 1:00 p.m.	Surveyor Lunch
1:00 – 1:30 p.m.	Individual Tracer Activity
1:30 – 2:00 p.m.	
2:00 – 2:30 p.m.	
2:30 – 3:00 p.m.	
3:00 – 3:30 p.m.	
3:30 – 4:00 p.m.	Special Issue Resolution
4:00 – 4:30 p.m.	Surveyor Team Meeting / Planning Session

DAY 2

Time		
8:00 – 8:30 a.m.	Daily Briefing	
8:30 – 9:00 a.m.	System Tracer – Data Management	Individual Tracer Activity
9:00 – 9:30 a.m.		
9:30 – 10:00 a.m.	Individual Tracer Activity	
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.	Surveyor Lunch	
12:30 – 1:00 p.m.	Surveyor Team Meeting / Planning Session	
1:00 – 1:30 p.m.	Individual Tracer Activity	
1:30 – 2:00 p.m.		
2:00 – 2:30 p.m.		
2:30 – 3:00 p.m.		
3:00 – 3:30 p.m.		
3:30 – 4:00 p.m.	Special Issue Resolution	
4:00 – 4:30 p.m.	Surveyor Team Meeting / Planning Session	

When possible, a Surveyor from Each Program will participate in the following activiti
as applicable: Daily Briefings and Leadership Session (All surveyors on site)
System Tracers – Data Management, Infection Control and Medication Management

Page 1 of 3
Hospital Agenda – 1 or More Surveyors for 5 Days

SAMPLE TEMPLATE
Hospital Agenda

DAY 3

Time		
8:00 – 8:30 a.m.	Daily Briefing	
8:30 – 9:00 a.m.	System Tracer – Medication Management	Individual Tracer Activity
9:00 – 9:30 a.m.		
9:30 – 10:00 a.m.	Individual Tracer Activity	
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.	Surveyor Lunch	
12:30 – 1:00 p.m.	Surveyor Team Meeting / Planning Session	
1:00 – 1:30 p.m.	Environment of Care	Individual Tracer Activity
1:30 – 2:00 p.m.		
2:00 – 2:30 p.m.		
2:30 – 3:00 p.m.	Emergency Management	Individual Tracer Activity
3:00 – 3:30 p.m.		
3:30 – 4:00 p.m.	Special Issue Resolution	
4:00 – 4:30 p.m.	Surveyor Team Meeting / Planning Session	

DAY 4

Time		
8:00 – 8:30 a.m.	Daily Briefing	
8:30 – 9:00 a.m.	Individual Tracer Activity	
9:00 – 9:30 a.m.		
9:30 – 10:00 a.m.		
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.	Medical Staff Credentialing and Privileging	Individual Tracer Activity
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.	Surveyor Lunch	
12:30 – 1:00 p.m.	Surveyor Team Meeting	
1:00 – 1:30 p.m.	System Tracer – Infection Control	Individual Tracer Activity
1:30 – 2:00 p.m.		
2:00 – 2:30 p.m.	Individual Tracer Activity	
2:30 – 3:00 p.m.		
3:00 – 3:30 p.m.		
3:30 – 4:00 p.m.	Special Issue Resolution	
4:00 – 4:30 p.m.	Surveyor Team Meeting	

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Hospital Agenda – 1 or More Surveyors for 5 Days

SAMPLE TEMPLATE
Hospital Agenda

DAY 5

Time		
8:00 – 8:30 a.m.	Daily Briefing	
8:30 – 9:00 a.m.	Leadership Session	
9:00 – 9:30 a.m.		
9:30 – 10:00 a.m.	Individual Tracer Activity	
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.	Competence Assessment	Individual Tracer Activity
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.	Surveyor Lunch	
12:30 – 1:00 p.m.	Individual Tracer Activity	
1:00 – 1:30 p.m.		
1:30 – 2:00 p.m.	Surveyor Report Preparation	
2:00 – 2:30 p.m.		
2:30 – 3:00 p.m.		
3:00 – 3:30 p.m.		
3:30 – 4:00 p.m.	CEO Exit Briefing and Organization Exit Conference	
4:00 – 4:30 p.m.		

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Hospital Agenda – 1 or More Surveyors for 5 Days

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Required documents!

Hospital Accreditation Program
Critical Access Hospital Accreditation Program
Document List

As a Hospital, you will need the following information and documents available for the surveyor to review during the Preliminary Planning Session and Surveyor Planning Session, which occurs on the first day of survey.

In addition to the documents noted below, please be prepared to provide the Life Safety Surveyor, upon arrival, the documents found on the Life Safety and Environment of Care Document List and Review Tool, which is located later in this Guide.

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

1. Hospital license
2. CLIA Certificates
3. An organization chart
4. Name of key contact person who can assist surveyors in planning tracer selection
5. A map of the organization, if available
6. List of all sites that are eligible for survey
7. List of sites where deep or moderate sedation is in use
8. List of sites where high-level disinfection and sterilization is in use
9. List of departments/units/ areas/programs/services within the organization, if applicable
10. List of patients that includes: name, location, age, diagnosis and length of stay, admit date, source of admission (ED, direct admit, transfer)
11. Lists of scheduled surgeries and special procedures, e.g. cardiac catheterization, endoscopy lab, electroconvulsive therapy, caesarian sections, including location of procedure and time
12. List of unapproved abbreviations
13. List of all contracted services
14. Agreement with outside blood supplier *(Not applicable to Critical Access Hospitals unless they operate Rehab and Psych Distinct Part Units)*
15. Organ Procurement Organization agreement
16. Tissue and Eye Procurement Organization agreement
17. Organ, tissue and eye procurement policies
18. Performance improvement data from the past 12 months
19. 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)
20. Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (including reasons for conducting the projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping
21. Analysis from a high risk process
22. Organ donation and procurement conversion rates *(Hospital only)*
23. Environment of Care data
24. Environment of Care Management Plans and annual evaluations
25. Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey
26. Hazard Vulnerability Analysis
27. Emergency Operations Plan (EOP) and documented annual review and update, including communications plans
28. Continuity of Operations Plan*
29. Documentation of completed/attempted contacts with local, state, tribal, regional, federal EM officials in organization's service area*

Hospital & Critical Access Hospital Accreditation Document List
…continued

30. Annual training*
31. Tracking system for sheltered and relocated patients*
32. Emergency Management Policy*
33. Emergency management protocols for Transplant Services* *(Hospital only)*
34. Integrated EM system risk assessments, plan, and annual review*
35. Emergency management drill records and after action reports
36. Infection Control Plan
    - Annual risk assessment and Annual Review of the Program
    - Assessment-based, prioritized goals
37. Infection Control surveillance data from the past 12 months
38. Medical Staff Bylaws and Rules and Regulations
39. Medical Executive Committee meeting minutes
40. The organization's signed and dated agreement with the QIO; in the absence of an agreement with a QIO, the organization's Utilization Review plan *(Not applicable to Critical Access Hospitals unless they operate Rehab and Psych Distinct Part Units)*
41. Governing Body minutes for the last 12 months
42. Autopsy policy *(Not applicable to Critical Access Hospitals unless they operate Rehab and Psych Distinct Part Units)*
43. Blood transfusion policy
44. Complaint/grievance policy
45. Restraint and seclusion policy
46. Waived testing policy and quality control plan
47. ORYX data – *(required only for very small hospitals exempt from submitting this data through vendors)*
48. Available regulatory reports (CMS, State)
49. Medication management policy *(which defines what is a complete medication order and therapeutic duplication)*
50. Abuse and neglect policy for inpatient, and ambulatory sites, if applicable
51. Fall risk assessment and policy
52. Document describing how the organization is using the CDC's Core Elements of Hospital Antibiotic Stewardship Programs
53. Organization approved antimicrobial stewardship protocols (e.g. policies, procedures, or order sets)
54. Antimicrobial stewardship data
55. Antimicrobial stewardship reports documenting improvement (Note: If the data supports that antimicrobial stewardship improvements are not necessary make sure the surveyor is informed.)
56. Final Reports of Certification/Testing for all Primary Engineering Controls and Secondary Engineering Controls associated with Sterile Medication Compounding (including any documentation of remediation/retesting conducted based on reported results) *(Hospital only)*
57. Most recent culture of safety and quality evaluation data

*These documents are related to the CMS Emergency Management Final Rule and will need to be available for surveyor review on all Deemed Status Hospital surveys. Note: Document formats may vary, and many of the documents may be included in the Emergency Operations Plan.

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may ask, on an as needed basis, to see additional documents throughout the survey to further explore or validate observations or discussions with staff.

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Opening presentation…

Organization's 1st big impression

What should you be thinking about?

- Who?
- Where?
- How long?
- What?

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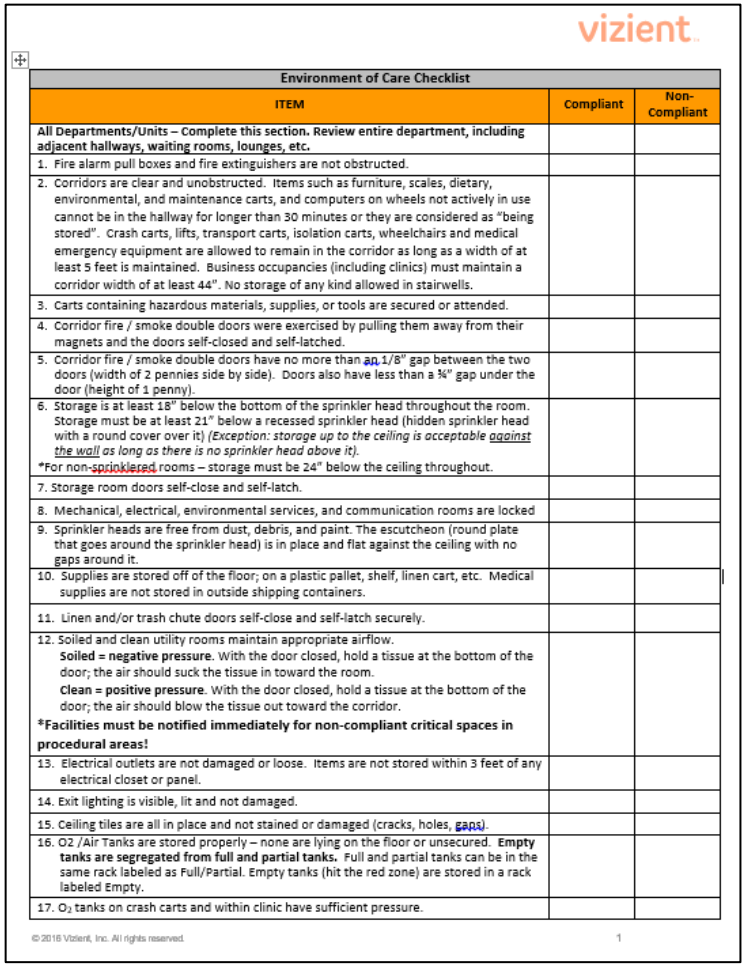
SWAT- environment of care (EOC) checks

What's the SWAT checklist?



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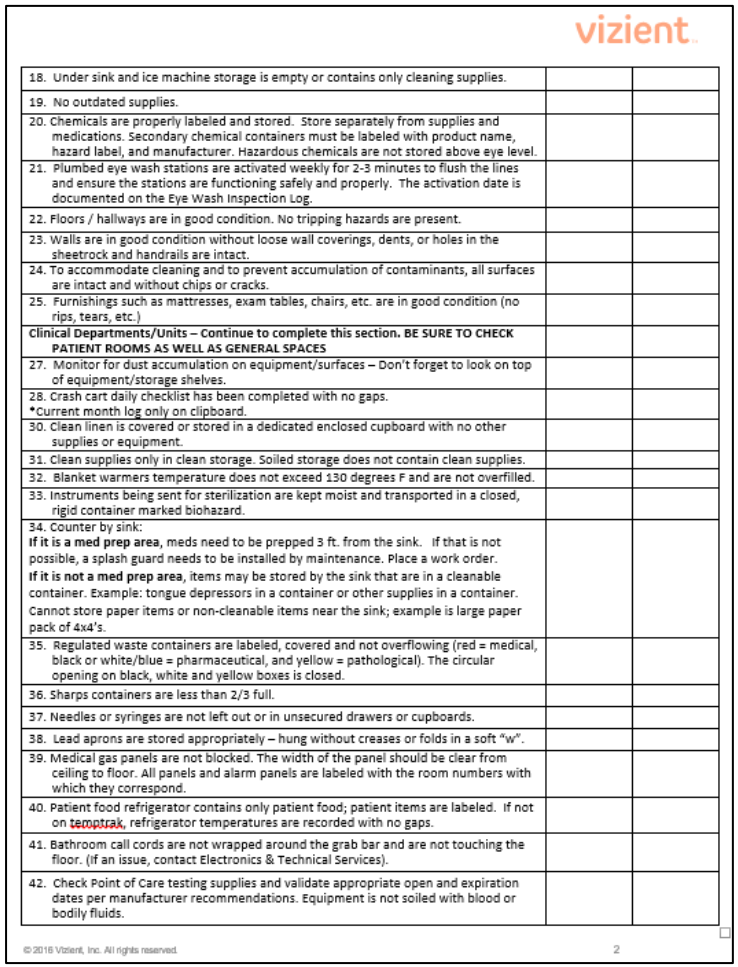
Environment of Care Checklist		
ITEM	**Compliant**	**Non-Compliant**
All Departments/Units – Complete this section. Review entire department, including adjacent hallways, waiting rooms, lounges, etc.		
1. Fire alarm pull boxes and fire extinguishers are not obstructed.		
2. Corridors are clear and unobstructed. Items such as furniture, scales, dietary, environmental, and maintenance carts, and computers on wheels not actively in use cannot be in the hallway for longer than 30 minutes or they are considered as "being stored". Crash carts, lifts, transport carts, isolation carts, wheelchairs and medical emergency equipment are allowed to remain in the corridor as long as a width of at least 5 feet is maintained. Business occupancies (including clinics) must maintain a corridor width of at least 44". No storage of any kind allowed in stairwells.		
3. Carts containing hazardous materials, supplies, or tools are secured or attended.		
4. Corridor fire / smoke double doors were exercised by pulling them away from their magnets and the doors self-closed and self-latched.		
5. Corridor fire / smoke double doors have no more than an 1/8" gap between the two doors (width of 2 pennies side by side). Doors also have less than a ¾" gap under the door (height of 1 penny).		
6. Storage is at least 18" below the bottom of the sprinkler head throughout the room. Storage must be at least 21" below a recessed sprinkler head (hidden sprinkler head with a round cover over it) *(Exception: storage up to the ceiling is acceptable against the wall as long as there is no sprinkler head above it).* *For non-sprinklered rooms – storage must be 24" below the ceiling throughout.		
7. Storage room doors self-close and self-latch.		
8. Mechanical, electrical, environmental services, and communication rooms are locked		
9. Sprinkler heads are free from dust, debris, and paint. The escutcheon (round plate that goes around the sprinkler head) is in place and flat against the ceiling with no gaps around it.		
10. Supplies are stored off of the floor; on a plastic pallet, shelf, linen cart, etc. Medical supplies are not stored in outside shipping containers.		
11. Linen and/or trash chute doors self-close and self-latch securely.		
12. Soiled and clean utility rooms maintain appropriate airflow. **Soiled = negative pressure**. With the door closed, hold a tissue at the bottom of the door; the air should suck the tissue in toward the room. **Clean = positive pressure**. With the door closed, hold a tissue at the bottom of the door; the air should blow the tissue out toward the corridor. ***Facilities must be notified immediately for non-compliant critical spaces in procedural areas!**		
13. Electrical outlets are not damaged or loose. Items are not stored within 3 feet of any electrical closet or panel.		
14. Exit lighting is visible, lit and not damaged.		
15. Ceiling tiles are all in place and not stained or damaged (cracks, holes, gaps).		
16. O2 /Air Tanks are stored properly – none are lying on the floor or unsecured. **Empty tanks are segregated from full and partial tanks.** Full and partial tanks can be in the same rack labeled as Full/Partial. Empty tanks (hit the red zone) are stored in a rack labeled Empty.		
17. O_2 tanks on crash carts and within clinic have sufficient pressure.		



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18. Under sink and ice machine storage is empty or contains only cleaning supplies.		
19. No outdated supplies.		
20. Chemicals are properly labeled and stored. Store separately from supplies and medications. Secondary chemical containers must be labeled with product name, hazard label, and manufacturer. Hazardous chemicals are not stored above eye level.		
21. Plumbed eye wash stations are activated weekly for 2-3 minutes to flush the lines and ensure the stations are functioning safely and properly. The activation date is documented on the Eye Wash Inspection Log.		
22. Floors / hallways are in good condition. No tripping hazards are present.		
23. Walls are in good condition without loose wall coverings, dents, or holes in the sheetrock and handrails are intact.		
24. To accommodate cleaning and to prevent accumulation of contaminants, all surfaces are intact and without chips or cracks.		
25. Furnishings such as mattresses, exam tables, chairs, etc. are in good condition (no rips, tears, etc.)		
Clinical Departments/Units – Continue to complete this section. BE SURE TO CHECK PATIENT ROOMS AS WELL AS GENERAL SPACES		
27. Monitor for dust accumulation on equipment/surfaces – Don't forget to look on top of equipment/storage shelves.		
28. Crash cart daily checklist has been completed with no gaps. *Current month log only on clipboard.		
30. Clean linen is covered or stored in a dedicated enclosed cupboard with no other supplies or equipment.		
31. Clean supplies only in clean storage. Soiled storage does not contain clean supplies.		
32. Blanket warmers temperature does not exceed 130 degrees F and are not overfilled.		
33. Instruments being sent for sterilization are kept moist and transported in a closed, rigid container marked biohazard.		
34. Counter by sink: **If it is a med prep area**, meds need to be prepped 3 ft. from the sink. If that is not possible, a splash guard needs to be installed by maintenance. Place a work order. **If it is not a med prep area**, items may be stored by the sink that are in a cleanable container. Example: tongue depressors in a container or other supplies in a container. Cannot store paper items or non-cleanable items near the sink; example is large paper pack of 4x4's.		
35. Regulated waste containers are labeled, covered and not overflowing (red = medical, black or white/blue = pharmaceutical, and yellow = pathological). The circular opening on black, white and yellow boxes is closed.		
36. Sharps containers are less than 2/3 full.		
37. Needles or syringes are not left out or in unsecured drawers or cupboards.		
38. Lead aprons are stored appropriately – hung without creases or folds in a soft "w".		
39. Medical gas panels are not blocked. The width of the panel should be clear from ceiling to floor. All panels and alarm panels are labeled with the room numbers with which they correspond.		
40. Patient food refrigerator contains only patient food; patient items are labeled. If not on temptrak, refrigerator temperatures are recorded with no gaps.		
41. Bathroom call cords are not wrapped around the grab bar and are not touching the floor. (If an issue, contact Electronics & Technical Services).		
42. Check Point of Care testing supplies and validate appropriate open and expiration dates per manufacturer recommendations. Equipment is not soiled with blood or bodily fluids.		

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And you are are off…

- **The first two hours are over and the actual survey has begun…**
- **Shifting to intra-survey!**

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Organization and logistics

- Surveyor conference room
- Scribe/Escort room
- Command center
  - Location
  - Equipment
  - Supplies

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Essential functions- scribe/escort

Escort: Person who is comfortable and knowledgeable about your organization, operations, locations, and provision of patient care.

Job functions:

- **Build a relationship with the surveyor**
- **Serve as the liaison to aid the surveyor in traveling the hospital.**

Scribe: Person who is detail-oriented, eager to learn and has the time to participate.

Job Functions:

- **Communicate with the command center (never bypass)**
- **Take notes of surveyor questions**
- **Track medical record numbers of records reviewed**
- **Track staff and medical staff personnel for competency files**

Don't forget- Train the escorts and scribes in advance!

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Essential functions- command center

You are the heart of survey management!

Job functions:

- Track and complete objectives
- Mitigate/manage findings
- Track surveyors
- Communicate to the organization
- Coordinate needs
- Notify operations of arrival

Key stakeholders:

- Infection prevention
- Clinical Informatics
- Accreditation/Quality/Risk
- Central support departments
- Policy

Positions:

- Lead
- 1st assist
- Logistics
- Informatics
- IP
- Objective coordinators

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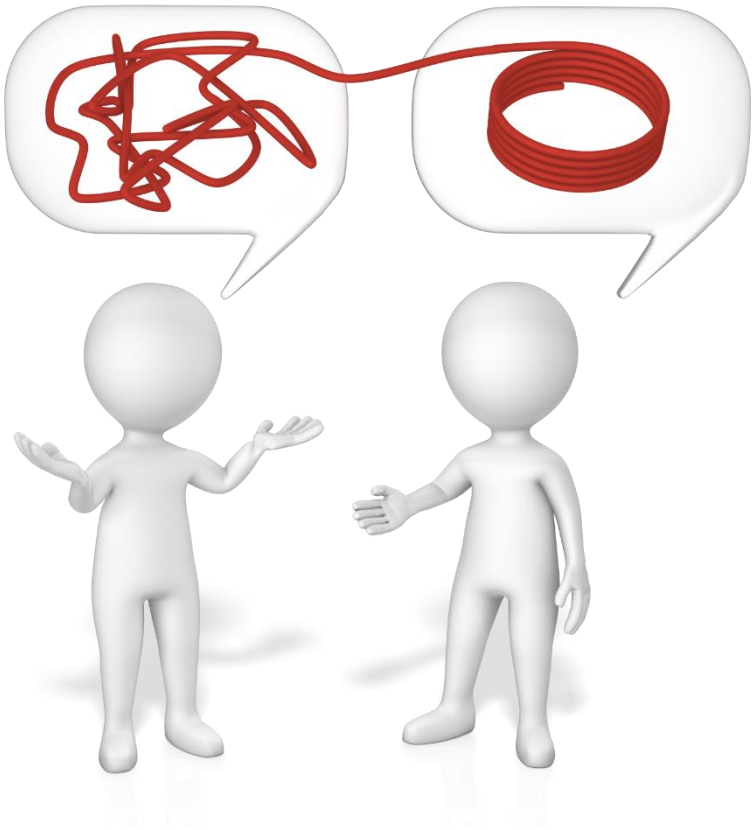
Onsite: Utilize team lead

Interacting with team lead
Maintain ongoing dialogue with team lead; be direct, professional and assertive when necessary
Discuss results and potential deficiencies
Address conflicts with surveyors ASAP with the team lead
Accreditation staff – know standards and your organization's data so as to be able to facilitate real time clarifications of findings with the team lead



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Life safety

Life safety engineer	Survey process
Part of full survey team	Begin to rectify any serious issues immediately
TJC provides agenda and document list	If there are disagreements on issues, involve team lead, call home office, ensure issue is fully clarified before life safety engineer leaves
Life safety exit conference may be held separately from full survey exit conference	
By exit conference, organization should know what the issues are	

Tracer methodology

Focus areas:

- Patient care processes: admission to discharge
- Critical operational processes

Types of Tracers:

- Individual Tracer
  - Specific patient population
- Risk Area Tracer
  - High level disinfection
  - Sedation/Anesthesia
  - Ligature risk
  - Hemodialysis
- System Tracer
  - Tissue management
- Patient Flow Tracer
  - ED and OR / boarding / bed placement

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Tracer methodology

Individual tracer
Taken from patient lists provided
Follow patient through their stay: may focus on complex patients
10% of average daily census or 30 medical records
Will review consents, care plans, orders, medications
May review policies and procedures related to care, treatment and services
Interviews of staff and patients
Identify synergies and collaboration between departments and multidisciplinary team

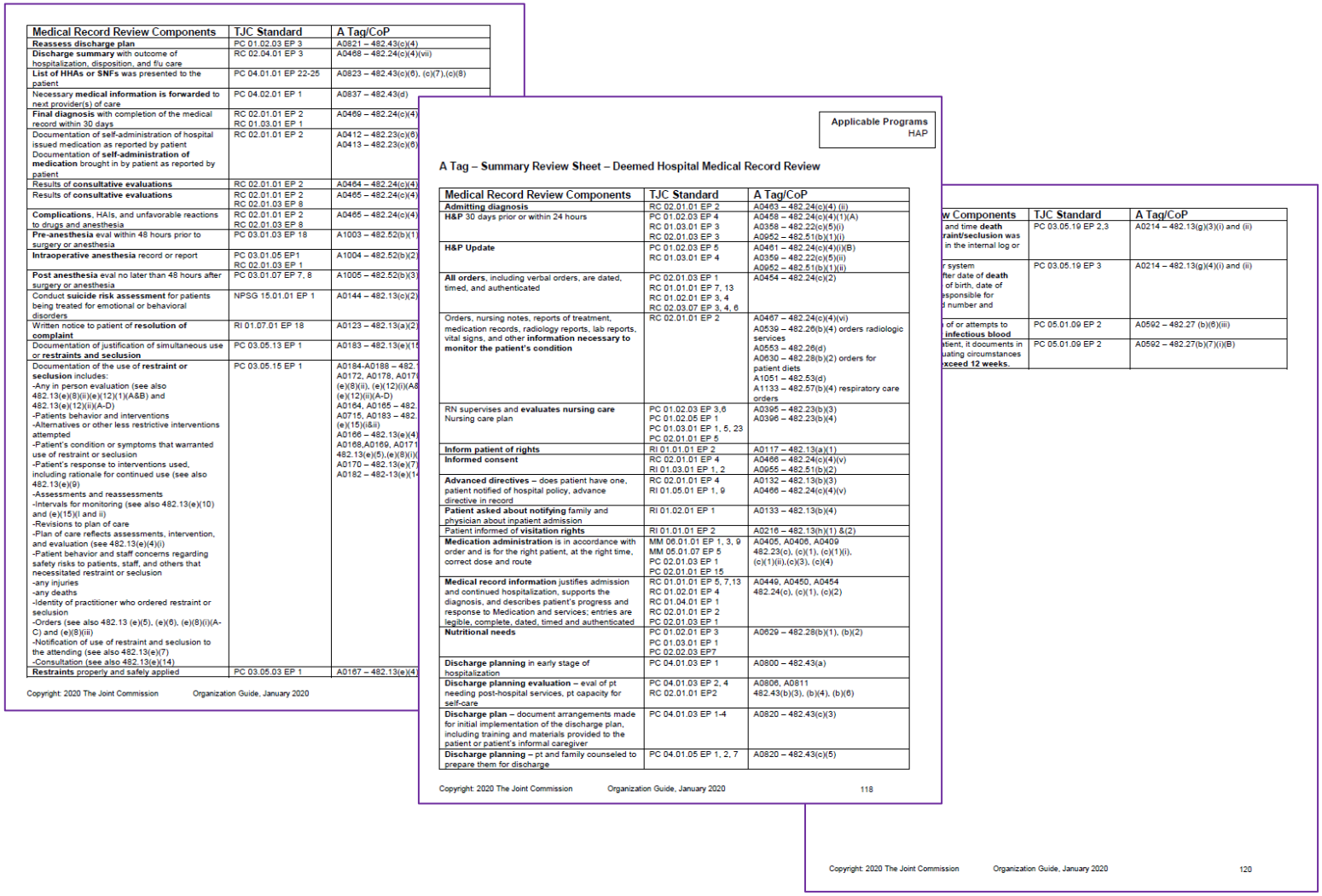
Risk area tracer
Drill into particular organization-wide high risk process
Review of processes that may have a significant impact on patient if gaps exist or errors occur
Examples: • Cleaning, disinfecting, & sanitization • Patient Flow process continuum • Contractual agreements • Diagnostic Imaging • OPPE & FPPE • Therapeutic radiation • Clinical & Health Information

Tracer methodology

System tracer
Exploration of one specific system or process
Surveyor evaluates integration of system or process
Interactive interview session
Process flow, identification of risk points, integration of key information
Communication among team
Baseline assessment of standards compliance
Examples: • Tissue management

Patient flow tracer
Review of patient flow from admission to discharge
Identification of potential treatment delays, unsafe practices during periods of patient congestion (high census)
Examples: • Emergency department throughput – use of hallway beds • Initiation of care • Post-operative recovery unit throughput • Time from discharge to clean bed • Discharge process

A tag review sheet



Medical Record Review Components	TJC Standard	A Tag/CoP
Reassess discharge plan	PC 01.02.03 EP 3	A0821 – 482.43(c)(4)
Discharge summary with outcome of hospitalization, disposition, and f\u/u care	RC 02.04.01 EP 3	A0468 – 482.24(c)(4)(vii)
List of HHAs or SNFs was presented to the patient	PC 04.01.01 EP 22-25	A0823 – 482.43(c)(6), (c)(7),(c)(8)
Necessary **medical information is forwarded** to next provider(s) of care	PC 04.02.01 EP 1	A0837 – 482.43(d)
Final diagnosis with completion of the medical record within 30 days	RC 02.01.01 EP 2 RC 01.03.01 EP 1	A0469 – 482.24(c)(4)
Documentation of self-administration of hospital issued medication as reported by patient Documentation of **self-administration of medication** brought in by patient as reported by patient	RC 02.01.01 EP 2	A0412 – 482.23(c)(6) A0413 – 482.23(c)(6)
Results of **consultative evaluations**	RC 02.01.01 EP 2	A0464 – 482.24(c)(4)
Results of **consultative evaluations**	RC 02.01.01 EP 2 RC 02.01.03 EP 8	A0465 – 482.24(c)(4)
Complications, HAIs, and unfavorable reactions to drugs and anesthesia	RC 02.01.01 EP 2 RC 02.01.03 EP 8	A0465 – 482.24(c)(4)
Pre-anesthesia eval within 48 hours prior to surgery or anesthesia	PC 03.01.03 EP 18	A1003 – 482.52(b)(1)
Intraoperative anesthesia record or report	PC 03.01.05 EP1 RC 02.01.03 EP 1	A1004 – 482.52(b)(2)
Post anesthesia eval no later than 48 hours after surgery or anesthesia	PC 03.01.07 EP 7, 8	A1005 – 482.52(b)(3)
Conduct **suicide risk assessment** for patients being treated for emotional or behavioral disorders	NPSG 15.01.01 EP 1	A0144 – 482.13(c)(2)
Written notice to patient of **resolution of complaint**	RI 01.07.01 EP 18	A0123 – 482.13(a)(2)
Documentation of justification of simultaneous use or **restraints and seclusion**	PC 03.05.13 EP 1	A0183 – 482.13(e)(15
Documentation of the use of **restraint or seclusion** includes: -Any in person evaluation (see also 482.13(e)(8)(ii)(e)(12)(1(A&B) and 482.13(e)(12(ii)(A-D) -Patients behavior and interventions -Alternatives or other less restrictive interventions attempted -Patient's condition or symptoms that warranted use of restraint or seclusion -Patient's response to interventions used, including rationale for continued use (see also 482.13(e)(9) -Assessments and reassessments -Intervals for monitoring (see also 482.13(e)(10) and (e)(15)(i and ii) -Revisions to plan of care -Plan of care reflects assessments, intervention, and evaluation (see 482.13(e)(4)(i) -Patient behavior and staff concerns regarding safety risks to patients, staff, and others that necessitated restraint or seclusion -any injuries -any deaths -Identity of practitioner who ordered restraint or seclusion -Orders (see also 482.13 (e)(5), (e)(6), (e)(8)(i)(A-C) and (e)(8)(iii) -Notification of use of restraint and seclusion to the attending (see also 482.13(e)(7) -Consultation (see also 482.13(e)(14)	PC 03.05.15 EP 1	A0184-A0188 – 482.1 A0172, A0178, A017 (e)(8)(ii), (e)(12)(i)(A8 (e)(12)(ii)(A-D) A0164, A0165 – 482. A0715, A0183 – 482. (e)(15)(i&ii) A0166 – 482.13(e)(4) A0168,A0169, A017 482.13(e)(5),(e)(8)(i)(A0170 – 482.13(e)(7) A0182 – 482-13(e)(14
Restraints properly and safely applied	PC 03.05.03 EP 1	A0167 – 482.13(e)(4)

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Applicable Programs
HAP

A Tag – Summary Review Sheet – Deemed Hospital Medical Record Review

Medical Record Review Components	TJC Standard	A Tag/CoP
Admitting diagnosis	RC 02.01.01 EP 2	A0463 – 482.24(c)(4) (ii)
H&P 30 days prior or within 24 hours	PC 01.02.03 EP 4 RC 01.03.01 EP 3 RC 02.01.03 EP 3	A0458 – 482.24(c)(4)(1)(A) A0358 – 482.22(c)(5)(i) A0952 – 482.51(b)(1)(i)
H&P Update	PC 01.02.03 EP 5 RC 01.03.01 EP 4	A0461 – 482.24(c)(4)(i)(B) A0359 – 482.22(c)(5)(ii) A0952 – 482.51(b)(1)(ii)
All orders, including verbal orders, are dated, timed, and authenticated	PC 02.01.03 EP 1 RC 01.01.01 EP 7, 13 RC 01.02.01 EP 3, 4 RC 02.03.07 EP 3, 4, 6	A0454 – 482.24(c)(2)
Orders, nursing notes, reports of treatment, medication records, radiology reports, lab reports, vital signs, and other **information necessary to monitor the patient's condition**	RC 02.01.01 EP 2	A0467 – 482.24(c)(4)(vi) A0539 – 482.26(b)(4) orders radiologic services A0553 – 482.26(d) A0630 – 482.28(b)(2) orders for patient diets A1051 – 482.53(d) A1133 – 482.57(b)(4) respiratory care orders
RN supervises and **evaluates nursing care** Nursing care plan	PC 01.02.03 EP 3,6 PC 01.02.05 EP 1 PC 01.03.01 EP 1, 5, 23 PC 02.01.01 EP 5	A0395 – 482.23(b)(3) A0396 – 482.23(b)(4)
Inform patient of rights	RI 01.01.01 EP 2	A0117 – 482.13(a)(1)
Informed consent	RC 02.01.01 EP 4 RI 01.03.01 EP 1, 2	A0466 – 482.24(c)(4)(v) A0955 – 482.51(b)(2)
Advanced directives – does patient have one, patient notified of hospital policy, advance directive in record	RC 02.01.01 EP 4 RI 01.05.01 EP 1, 9	A0132 – 482.13(b)(3) A0466 – 482.24(c)(4)(v)
Patient asked about notifying family and physician about inpatient admission	RI 01.02.01 EP 1	A0133 – 482.13(b)(4)
Patient informed of **visitation rights**	RI 01.01.01 EP 2	A0216 – 482.13(h)(1) &(2)
Medication administration is in accordance with order and is for the right patient, at the right time, correct dose and route	MM 06.01.01 EP 1, 3, 9 MM 06.01.07 EP 5 PC 02.01.03 EP 1 PC 02.01.01 EP 15	A0405, A0406, A0409 482.23(c), (c)(1), (c)(1)(i), (c)(1)(ii),(c)(3), (c)(4)
Medical record information justifies admission and continued hospitalization, supports the diagnosis, and describes patient's progress and response to Medication and services; entries are legible, complete, dated, timed and authenticated	RC 01.01.01 EP 5, 7,13 RC 01.02.01 EP 4 RC 01.04.01 EP 1 RC 02.01.01 EP 2 PC 02.01.03 EP 1	A0449, A0450, A0454 482.24(c), (c)(1), (c)(2)
Nutritional needs	PC 01.02.01 EP 3 PC 01.03.01 EP 1 PC 02.02.03 EP7	A0629 – 482.28(b)(1), (b)(2)
Discharge planning in early stage of hospitalization	PC 04.01.03 EP 1	A0800 – 482.43(a)
Discharge planning evaluation – eval of pt needing post-hospital services, pt capacity for self-care	PC 04.01.03 EP 2, 4 RC 02.01.01 EP2	A0806, A0811 482.43(b)(3), (b)(4), (b)(6)
Discharge plan – document arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient's informal caregiver	PC 04.01.03 EP 1-4	A0820 – 482.43(c)(3)
Discharge planning – pt and family counseled to prepare them for discharge	PC 04.01.05 EP 1, 2, 7	A0820 – 482.43(c)(5)

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w Components	TJC Standard	A Tag/CoP
and time **death** **raint/seclusion** was in the internal log or	PC 03.05.19 EP 2,3	A0214 – 482.13(g)(3)(i) and (ii)
r system ffer date of **death** of birth, date of esponsible for d number and	PC 03.05.19 EP 3	A0214 – 482.13(g)(4)(i) and (ii)
of or attempts to **infectious blood**	PC 05.01.09 EP 2	A0592 – 482.27 (b)(6)(iii)
tient, it documents in uating circumstances **xceed 12 weeks.**	PC 05.01.09 EP 2	A0592 – 482.27(b)(7)(i)(B)

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Tracer sessions (system tracers)

- Competency (HR)
- Competency (credentialing/ privileging)
- Infection prevention
- Medication management
- Data
- Leadership

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Role of accreditation professional in tracer methodology

Daily census, surgical and procedure schedules

- Provide list of active patients
- Names, current locations, diagnosis & conditions

Surveyors may request staff to help in selecting appropriate tracer patients

Coach your staff as to the appropriate type of patient to choose

As surveyor navigates your hospital:

- They will interview staff involved in patient's care
- Questions are focused on what those staff have experience in doing every day
- Keep track of patients (for HIPAA purposes) and staff (for personnel file review) who are interviewed

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Our first finding…

Don't panic- it is going to happen…

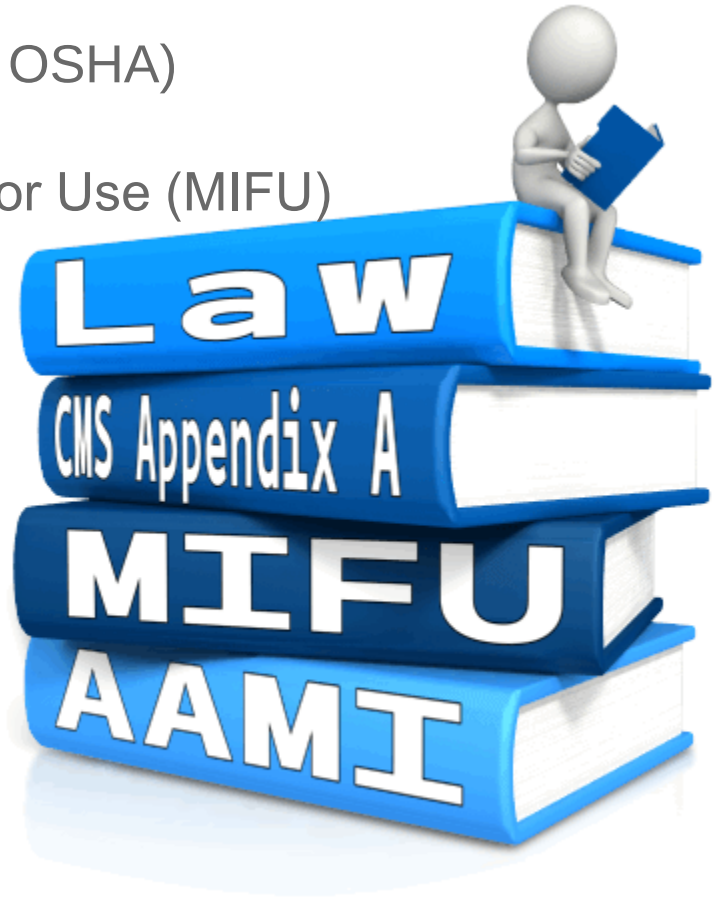
Do…Investigate…Ask…

- Is it a finding?
- Can you find supporting documentation?
- Can you provide clarity?
- Evaluate against the source of truth?

Source of truth

Hierarchy:

- Law or regulation (state law, OSHA)
- CMS (CoP of CfC)
- Manufacturer's Information for Use (MIFU)
- Evidence based guidelines
- Consensus documents
- Policy



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Our first disagreement on a finding…

Special issue resolution…

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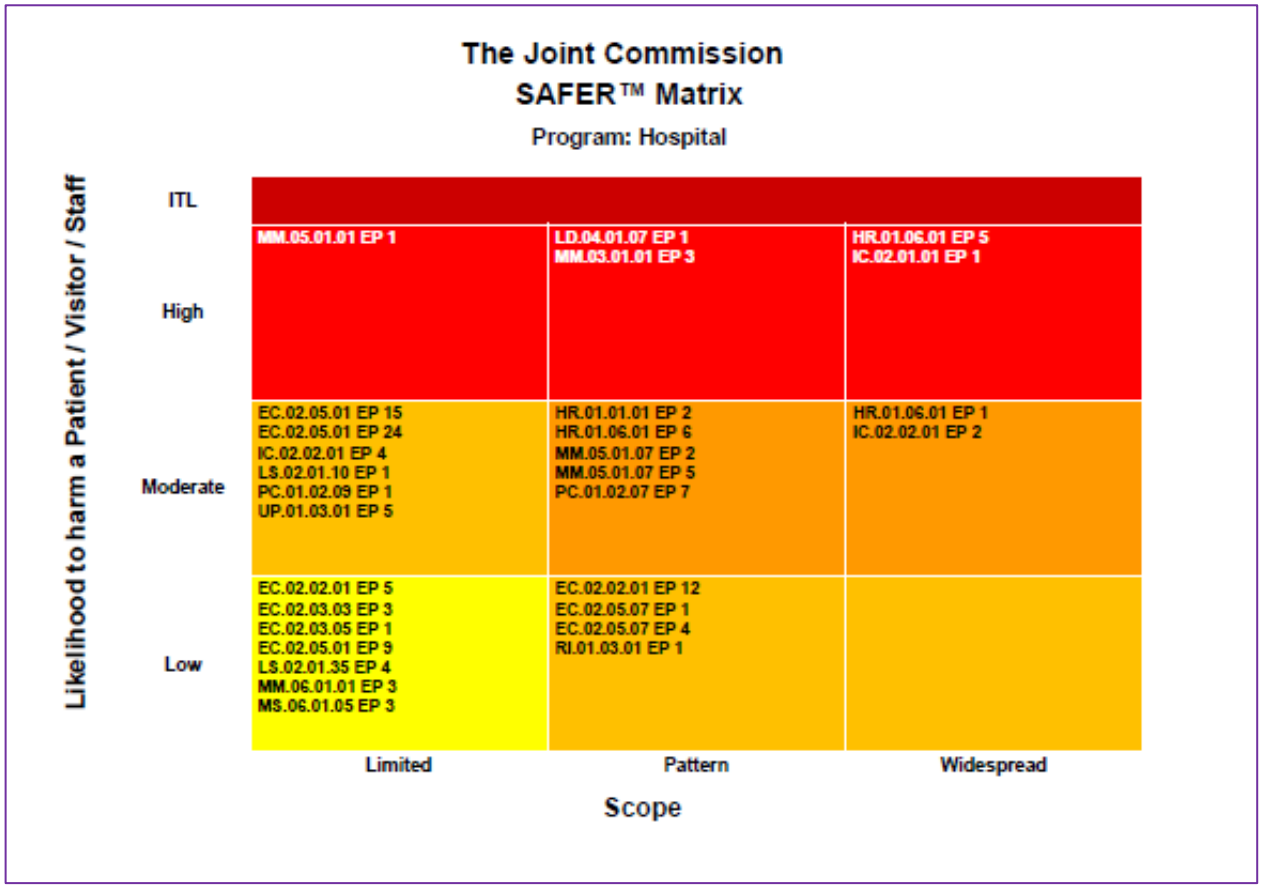
Communicating themes and trends…

SAFER to keep to the left



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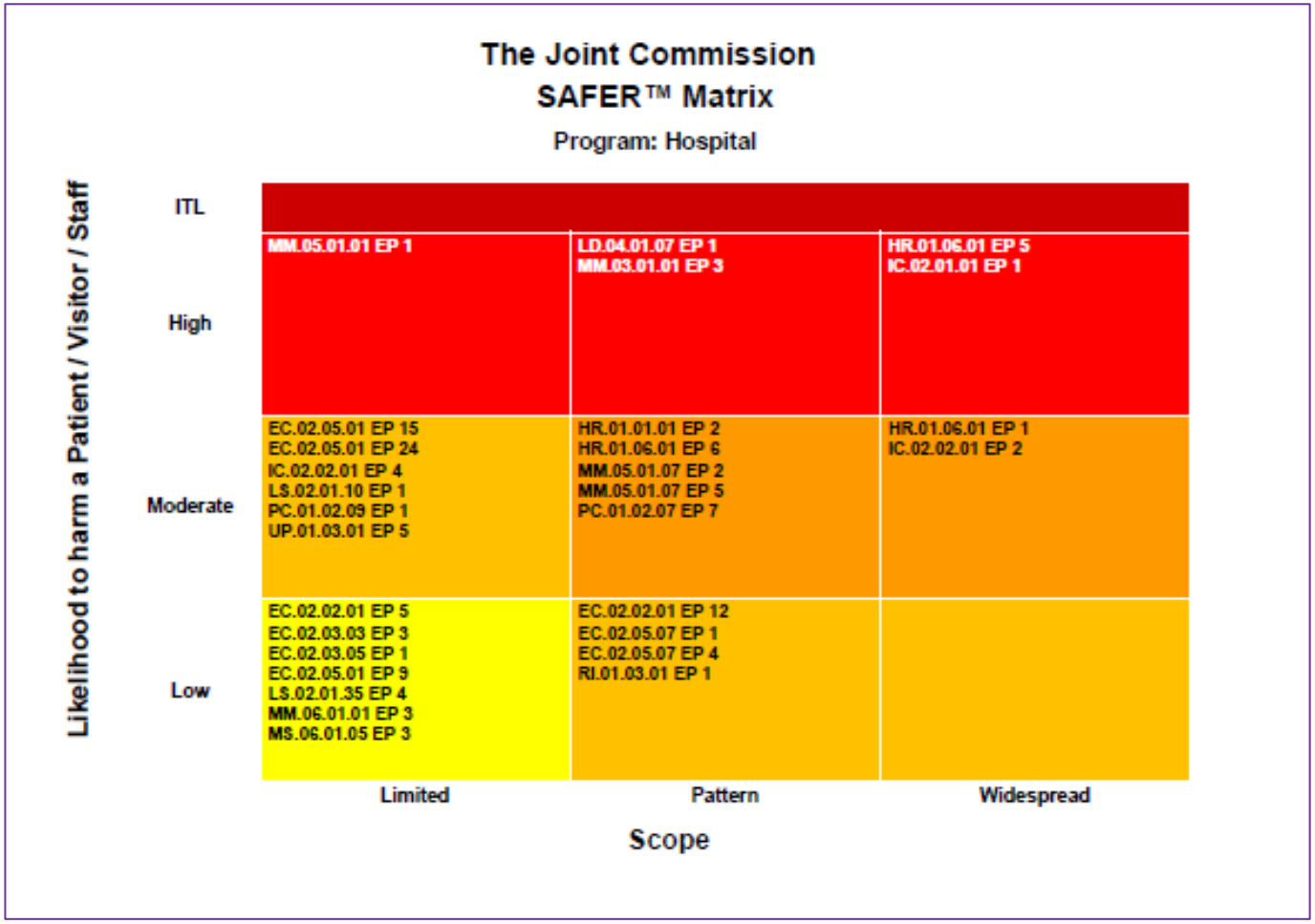
Morning (daily) debriefing…



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Morning (daily) debriefing…

During survey	Post survey
Daily briefing – highlight of significant issues	Begin to rectify any serious issues immediately
Opportunity to identify issues that need to be clarified or resolved	TJC scoring process • Surveyors score elements of performance • Likelihood to harm and scope • Score performance and compliance track record Accreditation decision process • Based on criticality model – RISK • 60 days to respond to a requirement for improvement
Present IOUs from previous day's survey activities	
By exit conference, organization should know what the issues are	

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Exit briefing - executive leadership

Surveyors defer to organization leadership as to whether and how this briefing occurs

Who attends:

- CEO, COO, CMO, CNO, CFO – Board members are welcome
- Accreditation staff should be present to assist with any clarification leaders need from surveyors

Session follows preparation of preliminary survey report

Survey team reviews summary of findings

Organizational exit conference

Leadership	Staff
Organizational leaders determine: • Who attends • What is shared • Whether it occurs	Leaders should consider sharing information with staff at the end of survey
TJC – preliminary report posted to the organizational extranet prior to exit conference	Staff have: Worked hard Experienced anxiety during survey Some organizations hold a separate organizational exit conference or conference call to share results
TJC – final report is posted to the organizational extranet within 10 business days	

Tools

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Document request form

Date Location	Document	Surveyor	Escort	Copies provided Y/N	Copies made by	Comment

Log all documents requested / given to survey team – assists in tracking issued reviewed

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Human resource employee request form

Date Location	Employee name	Employee title (e.g.: RN, OT)	Surveyor	Escort	Copies provided Y/N	Copies made by	Comment

Log all employees interviewed each day – helps begin to build potential list of employee files to be reviewed

Medical records request form

Date Location	Patient name	MR #	Surveyor	Escort	Copies provided Y/N	Copies made by	Comment

Track all records reviewed for HIPAA purposes – record will also be valuable in following up on issues, findings, clarifications (as applicable)

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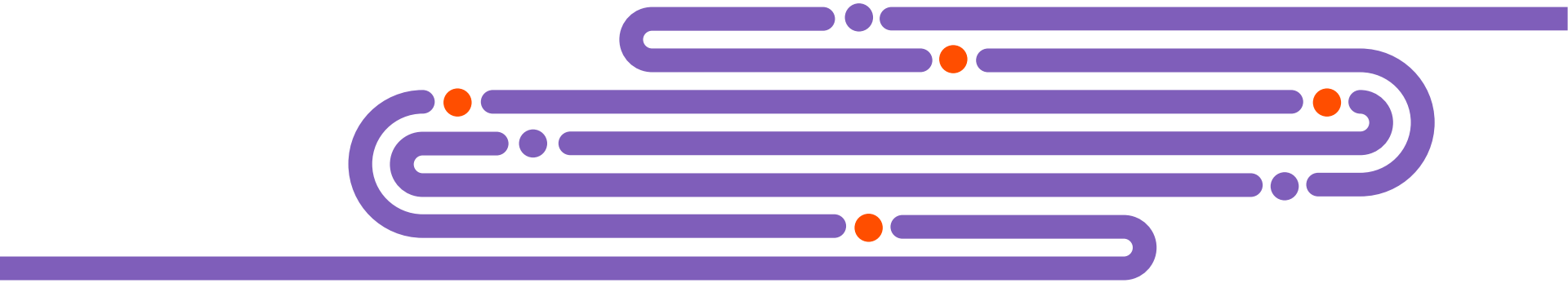
Following the survey



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Immediately post-survey

Celebrate

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Following the survey

Review preliminary report

- Determine impact of findings
- Begin to frame responses before receipt of the final report
- Specific attention should be devoted to those findings that have a direct impact on patients or are scored at the condition-level
- Determine if there are findings that need to be discussed with your account representative (hopefully you will have addressed all issues during survey!)
- Develop a timeline for addressing and correcting findings

Following the survey

Accreditation staff:

- Support, monitor, and coordinate response to survey findings
- Ensure consensus on and approval of the responses and action plans
- Work with operational partners to develop and implement corrective action plans and evidence of standards compliance
- Submit corrective action plan / evidence of standards compliance timely (per voluntary accrediting body or CMS instruction)
- Monitor development of action plans, data collection and monitoring to validate compliance
- Update leadership on progress

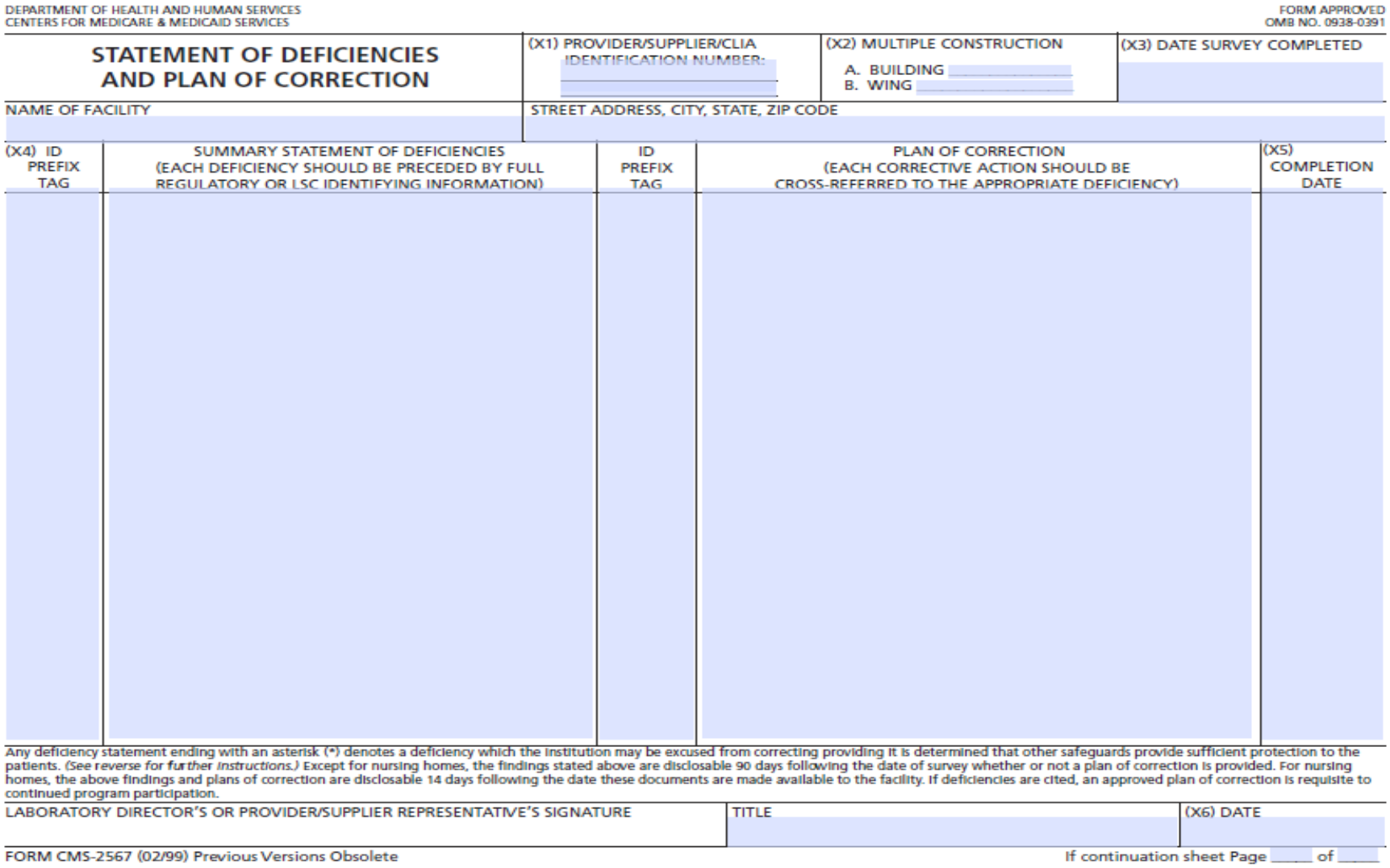
Following the survey

Monitoring action plans:

- Select appropriate sample sizes for tracking compliance
  - Population size < than 30, 100% of cases
  - 30 – 100 cases, 30 cases
  - 101 – 500 cases, 50 cases
  - > than 500, 70 cases

- What is considered compliant?
  - Shoot for 90% or greater
  - Think about the patient – the higher the better

- Based on risk and compliance – determine duration of monitoring



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	A. BUILDING _____ B. WING _____	

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

FORM CMS-2567 (02/99) Previous Versions Obsolete

If continuation sheet Page _____ of _____

CMS 2567Form: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2567.pdf

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CMS plan of correction

- A-Tag and primary issue: Each corrective action should be cross-walked to the applicable deficiency
- Corrective action: High level statement outlining what will be done to correct issue, mitigate/prevent future issues (Potential Root Cause Analysis)
- Policy/Procedure: Is the issue in any way linked to a policy / procedure? If so, list it and delineate whether it will be modified in any way as part of the corrective action
- Training/Communication: If training is part of the action, who will be trained, how will they be trained, and when will training be completed?
- QAPI Measurement/Monitoring: Will there be quality measurement of monitoring to ensure corrective action is sustained? Who will it be reported to and at what frequency?
- Responsible Party: One person who is ultimately accountable for the action
- Completion Date: Date it will be completed

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Summary

- Develop a response plan.
- Be confident in your knowledge of organizational compliance so that you are able to communicate to the survey team and assist organizational staff in conveying compliance.
- Stay connected to team lead during survey to understand issues as they are identified.
- At the end of survey, celebrate your success.
- Ensure your survey report is accurate.
- Assist operational partners in building a valid corrective action plan with appropriate monitoring to validate ongoing compliance.

Questions

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Next steps

1. Complete evaluation

2. Stay connected –
   - Network Members - register for Fundamental and Advanced webinar series and encourage operational partners to listen in to pertinent webinars
   - Attend Vizient conferences to stay up to date with trends and requirements
   - Connect with the colleagues during the course
   - Connect with your Vizient faculty

Contact:

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