Hospital Regulatory Requirements

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Senior Manager, Quality, Safety, and Performance Improvement

Agenda

- Overview of regulatory agencies
- New and problematic standards
- How to stay updated on changes
- Continuous survey readiness
- Survey survival
- Plans of correction and response to complaint
In order to participate in the Medicare program, all hospitals must meet minimum health and safety standards called “Conditions of Participation” (CoPs).

CoPs cover a broad range of operational requirements and represent the foundation for improving quality and protecting the health and safety of Medicare beneficiaries.

Every hospital seeking a Medicare billing number must pass an in-depth survey to demonstrate that it meets all applicable Conditions of Participation.
## Certification Vs. Accreditation

<table>
<thead>
<tr>
<th>Certification</th>
<th>Accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Certification</td>
<td>Accrual</td>
</tr>
<tr>
<td>• Free</td>
<td>• Accreditation is an internationally recognized evaluation process used to assess and improve the quality, efficiency, and effectiveness of health care organizations</td>
</tr>
<tr>
<td>• More stable than other types of regulations</td>
<td>• Marketing advantage</td>
</tr>
<tr>
<td>• One less set of regulations</td>
<td>• Encourages intense focus on performance improvement and attention to error prevention</td>
</tr>
<tr>
<td>• No need for a validation survey</td>
<td>• Dedicated surveyors</td>
</tr>
<tr>
<td>• More flexibility to innovate</td>
<td>• Expensive</td>
</tr>
<tr>
<td>• May lead to a competitive disadvantage</td>
<td>• Additional layer of regulations; need to crosswalk</td>
</tr>
<tr>
<td>• Survey typically performed by state surveyors contracted by CMS</td>
<td></td>
</tr>
<tr>
<td>• Third parties may ask for additional information from non-Joint Commission accredited hospitals</td>
<td></td>
</tr>
</tbody>
</table>

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## Accreditation Is Voluntary. It Is One, But Not the Only, Route to Medicare Participation

### Deemed Status

- To receive payment from Medicare, health care providers must:
  - meet certain statutory requirements
  - comply with regulations established by the secretary of the Department of Health and Human Services (DHHS)
  - Either:
    - seek accreditation from a recognized agency that has been granted deeming authority
      - Must choose this option on application
    - apply directly to the Centers for Medicare and Medicaid Services (CMS) for a review to determine whether they satisfy Medicare’s Conditions of Participation (CoP) for hospitals
Current CMS-Recognized “Deemed Status” Accreditation Programs

• Accreditation Association for Ambulatory Health Care (AAAHC)
• Accreditation Commission for Health Care, Inc. (ACHC)
• American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
• American Osteopathic Association (AOA)
• Healthcare Facilities Accreditation Program (HFAP)
• Community Health Accreditation Program (CHAP)
• Det Norske Veritas (DNV)
• The Joint Commission (JC)

OSHA/DEA/EPA/NFPA
More Requirements!!

• Occupational Safety and Health Agency

• Drug Enforcement Administration

• Environmental Protections Agency

• National Fire Protection Agency
Occupational Safety & Health Administration

• Bloodborne pathogens and needlestick prevention
  ▪ Annual evaluation/product evaluation by staff
• Confined space
• Drugs in the workplace
• Hazard communications
  ▪ MSDS being replaced by SDS
• Latex allergy
• Lockout/tagout
• Violence workplace

Drug Enforcement Administration

• Controlled substance are dispensed pursuant to a valid prescription/medication order
• Doses dispensed (which includes waste) are appropriately accounted for (especially for schedule II controlled substances
• Drugs are stored and secured appropriately
• Loss/diversion of medications reported
**DOT/EPA: Transportation of Hazardous Waste Manifest**

- Joint undertaking by EPA and the Department of Transportation (DOT)
  - EPA - Manifest requirement
  - DOT - Shipping paper requirement
- EPA is responsible for regulating hazardous waste under a federal statute known as the Resource Conservation and Recovery Act (RCRA).
- This act requires that all hazardous waste shipped off-site be tracked from *cradle-to-grave* using a manifest that provides information about:
  - The generator of the waste
  - The facility that will receive the waste
  - Description and quantity of the waste (including the number and type of containers),
  - How the waste will be routed to the receiving facility.

**CMS Adopted the National Fire Protection Agency Codes for Critical and Acute Care Hospitals**

- **Center for Medicare and Medicaid Services (CMS)**
  - Adopted the NFPA codes and incorporated them into their Conditions of Participation for Hospitals as K-Tags
- **National Fire Protection Agency (NFPA) Codes for Life Safety**
  - Based on Regulations 101-2000
  - Other Codes Apply
- All Hospitals under CMS State Regulations must follow K-Tags
- All “Deemed Status” Agents must comply
Recommendations as CMS Regulations

“Standards and recommendations promoted by nationally recognized professional organizations”

- CLIA
- CDC
- ISMP
- AHRQ
- Joint Commission!
- AHRQ
- ACR
- AMA and other professional specialty organization
- APIC
- SHEA
- AORN
- ACS
- ASA
- “Manufacturer’s recommendations”

How Do I Keep Up?

- Periodically check to see you have the most current CoP manual
- Once a month go out and check the survey and certification website
- Once a month check the CMS transmittal page
- Have one person in your facility who has this responsibility – schedule it!
- Accreditation updates
  - Perspectives
  - Manual revisions
Quality Integration: Hospital, LTC, Home Care, and Rural Health Clinics

• Areas subject to CMS/DOH surveys - depends upon the designations under the hospital license
  • Physician practices under a separate corporation is not subject to CMS/DOH surveys

• Standardize policies when appropriate
  • If necessary, add an addendum for specifics

• Identify individuals to represent departments on hospital committees (i.e. patient safety, safety, regulatory readiness)

• Conduct mock surveys of the outside areas

http://www.cms.gov/Transmittals_overview.asp
Regulatory and Accreditation Standards Problematic Across the Country

- Provision of care, treatment, and services
- Leadership / governance
- Medical records/consents
- Credentials and competencies/FPPE/OPPE
- Patient related information and protection
- Quality integration in hospital operations

Leadership and Governing Board Focus

- Organization accountability for patient care, treatment, and services across the enterprise
  - Safety culture
  - Evidence of robust Performance Improvement (PI)
  - Becoming a “learning organization”
  - Focus on prevention through proactive risk reduction strategies and processes
- Integrated patient safety systems and processes that identify all standards and requirements
  - “Report to learn”
# Top 10 Most Scored Standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>EP</th>
<th>Issue</th>
<th>% Non-Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC.02.05.01</td>
<td>6</td>
<td>Air pressure, filtration, and air changes in critical care areas such as the OR</td>
<td>32.78</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Label utility system controls for partial or complete emergency shutdown</td>
<td>21.39</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Design and Installation of utilities to meet patient care and operational needs</td>
<td>10.39</td>
</tr>
<tr>
<td>LS.02.01.20</td>
<td>13</td>
<td>Corridor Cluster</td>
<td>22.41</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Doors unlocked in the direction of egress</td>
<td>16.84</td>
</tr>
<tr>
<td>EC.02.06.01</td>
<td>1</td>
<td>Interior spaces are safe and suitable to care, treatment and services provided</td>
<td>38.8</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>Maintaining ventilation, temperature and humidity</td>
<td>16.84</td>
</tr>
<tr>
<td>EC.02.03.05</td>
<td>25</td>
<td>Lack of documentation related to the maintaining, inspecting and testing</td>
<td>16.5</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Annual testing of smoke detectors, duct detectors, etc.</td>
<td>14.4</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>Automatic air handling unit (AHU) shutdown</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Annual testing of visual and audible fire alarms</td>
<td>11.43</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Water flow device testing</td>
<td>10.3</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Quarterly testing of fire alarm notification to off-site fire responders</td>
<td>10.08</td>
</tr>
<tr>
<td>LS.02.01.10</td>
<td>9</td>
<td>Unprotected openings in fire rated walls and floors</td>
<td>24.21</td>
</tr>
</tbody>
</table>

(Continued)

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<td>9</td>
<td>Unprotected openings in fire rated walls and floors</td>
<td>24.21</td>
</tr>
<tr>
<td>LS.02.01.30</td>
<td>11</td>
<td>Corridor doors</td>
<td>18.67</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>Smoke barriers do not have unsealed penetrations</td>
<td>13.5</td>
</tr>
<tr>
<td>LS.02.01.35</td>
<td>4</td>
<td>Sprinkler piping not to be used to support other materials such as cables</td>
<td>16.84</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Other observations</td>
<td>16.84</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Sprinkler heads not corroded or painted</td>
<td>11.73</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>18&quot; clear under sprinkler heads</td>
<td>10.98</td>
</tr>
<tr>
<td>EC.02.02.01</td>
<td>5</td>
<td>Minimizes risk associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemical</td>
<td>18.22</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Minimize risk associated with selecting and using hazardous energy sources</td>
<td>11.28</td>
</tr>
</tbody>
</table>

Top ten most scored standards with associated Elements of Performance scored at least 10% of the time during survey. Period: 1/1/15 – 6/30/15.
Infection Control and Surveillance: Operative and Invasive Areas of Service

Endoscopes/Instruments

- Not following the proper cleaning process
- Infection prevention - scope cleaning
- Not cleaning all ports
- Scopes dragging on the ground
- Laryngoscope blades
- Storage of the blades in the crash carts
- Must be wrapped or in a separate container
- Use biomed to put scopes on their inventory (other set of eyes)

Laboratory Services

- Laboratories using glucose meters for purposes, or in populations, beyond the “intended use,” shown on the package insert or in device manual, are considered to be engaging in “off-label use.”
- Regulatory controls regarding use of glucose meters
- Definition of “critically ill”
**Medication Management**

- Hospital clinics and ancillary units are key issues
  - Sample medications
  - Recall process
  - Dispensing issues
- Joint Commission
  - MM.03.01.01
  - MM.04.01.01
  - MM.05.01.01
- Changes surrounding glucose meters
  - Define the critically ill
  - Competencies
- Changes surrounding Tramadol and related products
  - August 2014 release of an IV drug
- Back orders
  - Cardiac medications
  - B12

**2015 National Patient Safety Goals**

- No new goals for 2015
- NPSG.15.02.01 on home oxygen safety modified for home care
- Minor language changes for NPSG.03.04.01 (AHC, HAP, CAH, OBS)
- **2014 - Goal 6:** Reduce the harm associated with clinical alarm systems, effective 2016 unless thwarted
- **Sentinel Alert: 8/20/2014**
  ISO Tubing Connector Standards
Operative and Invasive Procedure Locations

- Suspension of CMS and Joint Commission data collection for performance measure SCIP-Inf-4
  - Effective Immediately
- Wrong site surgery
  - Site marking
  - Time out
- Endoscope cleaning
  - Manufacturers’ recommendations
  - Staff turnover

Patient Flow and Throughput

- Boarding of psychiatric patients has significantly increased and has been especially problematic in the ED
- Joint Commission recent revisions were implemented in January 2014, specifically, EP’s 6 and 9 and the role of hospital leadership in using data and measures to identify, mitigate, and manage patient flow issues specifically in the ED
CMS Issues Final Regulation

• Published May 16, 2012

• CMS publishes to reduce the regulatory burden on hospitals-more than two dozen changes
  • Expects to save healthcare providers over $5 billion in five years

• CMS publishes 165 page final regulations changing the CMS CoP

• Most significant changes in the past two decades, modernizing the CoPs

CMS Conditions of Participation

• Governing body
• Patient rights
• Medical staff
• Nursing services
• Medical records services
• Infection control
• Outpatient services
• Transplant center process requirements
Top 10 Challenging Hospital Citations

- Tag A0749: Infection Control Officer Responsibilities
- Tag A0700: Physical Environment
- Tag A0043: Governing Body
- Tag A0450: Medical Record Service
- Tag A0263/A0267: QAPI
- Tag A0083: Contracted Services
- Tag A0118, A0132, A0145: Patient Rights
- Tag A0154: Use of Restraints
- Tag A0396: Nursing Care Plan
- Tag A0490: Pharmacy Services

Infection Control

- 42 CFR 482.42
- Must provide sanitary environment to avoid infection transmission sources and communicable diseases
- Must be an active program for prevention, control, and investigation of infections and communicable diseases
- Not limited to health care associated infections
- Includes community acquired infections
- Flash sterilization- evaluated and used appropriately
Quality Assessment and Performance Improvement

• 42 CFR 482.21

• QAPI activities must be focused on actual care delivered, performance of hospital as an organization, and impact of treatment furnished by the hospital on health status of its patients

• Emphasis on patient safety and accountability

Contracted Services

• Maintain a list of all contracted services

• Segregate list of clinical services

• Ensure each clinical contract service has administrative oversight

• Each clinical contract must define the nature & scope of contract, performance expectations, and integration with QAPI

• Review QAPI and governing body minutes for reporting performance
Governing Body

• 42 CFR 482.12
• Contracted services were not included in QAPI
• Lack of oversight with QA
• Failed to ensure staff develop and implemented effective infection control practices
• Failed to monitor restraint policies and usage

Patient Rights

• 482.13 (a) (1) Standard: Notice of Rights
  ▪ Failure to ensure rights are given in areas (such as psych)
  ▪ Failure to include the state complaint hotline on the notice of rights
  ▪ Failure to provide information in a manner that can be understood (such as not having rights in Spanish in an area that has a lot of Spanish speaking patients)

• 482.13 (a) (2) Standard: Patient Grievances
  ▪ Hospital’s governing body must approve and be responsible for the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee
Patient Rights

• 482.13 (a) (2) Standard: Patient Grievances
  • A-0118 states “if a patient care complaint cannot be resolved at the time of the compliant by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the compliant is a grievance for the purposes of these requirements
  • Grievance Closed vs. Resolved
    o Hospital takes reasonable actions but patient remains unsatisfied, CMS allows case to be closed. Hospital needs to make sure that documentation reflecting efforts exists

CMS Medication Requirements

• List of policies, required by the hospital such as high risk policy, abbreviations, have complete elements of an order, LASA
• Pharmacist on call if not open 24 hours
• Weight based dosing for pediatrics
• Drug recall policy
• Policy to identify potential or actual ADE
CMS Pilot Worksheet Survey - QAPI

- Failure to have the Board approve current, revised QI plan
- Inability to clearly describe selection criteria for current PI projects
- Collection of data after 12 months of meeting or exceeding threshold/goal, yet department continued to collect data and call it a PI project
- Collection of data without turning it into information they could use to make improvements
- Minimal staff participation in PI projects
- Staff not familiar with QAPI terminology
- Failure to share results, including ALL patient satisfaction results, with staff

Provided as attachment for reference

Proprietary & Confidential

Problematic Standards for ALL Areas

<table>
<thead>
<tr>
<th>Standard/NPSG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RC.01.01.01</td>
<td>Signature, Date and time on ALL entries</td>
</tr>
<tr>
<td></td>
<td>Contain information to justify the patient’s care and treatment</td>
</tr>
<tr>
<td></td>
<td>NO stamped signatures</td>
</tr>
<tr>
<td></td>
<td>NO rubber stamps</td>
</tr>
<tr>
<td></td>
<td>Legible signature</td>
</tr>
<tr>
<td></td>
<td>Preferred language</td>
</tr>
<tr>
<td></td>
<td>Race and ethnicity</td>
</tr>
<tr>
<td></td>
<td>Provides language interpreting and translating services</td>
</tr>
</tbody>
</table>

Noncompliance:
2012- 61%
2013- 52%

Proprietary & Confidential
### Problematic Standards for ALL Areas

<table>
<thead>
<tr>
<th>Standard/NPSG</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>IC.02.02.01</td>
<td>Proper cleaning and low level disinfection of medical equipment, devices or supplies (i.e. glucometer, stethoscopes, etc..). Make sure staff understand and comply with the recommended drying time.</td>
</tr>
<tr>
<td></td>
<td>High level disinfection is performed on all surgical implants and equipment</td>
</tr>
<tr>
<td></td>
<td>Proper storage of medical equipment, devices and supplies-separation of clean and dirty</td>
</tr>
<tr>
<td>Noncompliance:</td>
<td>2012 - 42%</td>
</tr>
<tr>
<td></td>
<td>2013 - 46%</td>
</tr>
</tbody>
</table>

### Problematic Standards for ALL Areas

<table>
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<tr>
<th>Standard/NPSG</th>
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</thead>
<tbody>
<tr>
<td>PC.01.02.03</td>
<td>Assess, reassess, and manage the patient’s pain</td>
</tr>
<tr>
<td></td>
<td>H &amp; P: can’t be older than 30 days, must be updated upon admission if done outside the hospital; all patients must have H &amp; P on chart within 24 hours of admission</td>
</tr>
<tr>
<td>Noncompliance:</td>
<td>2012 - 25%</td>
</tr>
<tr>
<td></td>
<td>2013 - 22%</td>
</tr>
<tr>
<td>PC.02.01.03</td>
<td>Before taking action on a verbal order or verbal report of a critical test result, staff uses a record and “read back” process to verify the information</td>
</tr>
<tr>
<td>Noncompliance:</td>
<td>2012 - 16%</td>
</tr>
<tr>
<td></td>
<td>2013 - 18%</td>
</tr>
</tbody>
</table>
### Problematic Standards for ALL Areas

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<thead>
<tr>
<th>Standard/NPSG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM.03.01.01</td>
<td>Storage and security of medications (refrigerator temperature monitoring) (sterile water stored in warmers)</td>
</tr>
<tr>
<td></td>
<td>Removal of expired or damaged medications</td>
</tr>
<tr>
<td></td>
<td>Control between receipt and administration</td>
</tr>
<tr>
<td></td>
<td>Prevent unauthorized people from getting access to drugs (i.e. job description if have limited access to medications)</td>
</tr>
<tr>
<td></td>
<td>Stored medications are labeled with content, expiration date and warning</td>
</tr>
</tbody>
</table>

### Noncompliance:
- 2012: 35%
- 2013: 35%

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### Problematic Standards for ALL Areas

<table>
<thead>
<tr>
<th>Standard/NPSG</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>MM.04.01.01</td>
<td>Medication orders are clear and accurate</td>
</tr>
<tr>
<td></td>
<td>Periodically review preprinted orders</td>
</tr>
<tr>
<td></td>
<td>Look alike, sound alike policy (ISMP and USP)</td>
</tr>
</tbody>
</table>

### Noncompliance:
- 2012: 26%
- 2013: 22%
## Problematic Standards for ALL Areas

<table>
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<tr>
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<th>Description</th>
<th>Noncompliance:</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR.01.02.05</td>
<td>Hospital verifies staff qualifications</td>
<td></td>
<td>16%</td>
<td>19%</td>
</tr>
<tr>
<td>PC.01.03.11</td>
<td>Plans for the patient’s care</td>
<td></td>
<td>25%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Ready for the next patient, not the next survey!!
## Regulatory Responsibility Chart

<table>
<thead>
<tr>
<th>LSTM CHAPTER</th>
<th>CMS COP STANDARD</th>
<th>DISH CHAPTER</th>
<th>PERSON RESPONSIBLE</th>
<th>OTHERS RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership (LB)</td>
<td>Grooming Body (211.12)</td>
<td>Grooming Body Functions (103.3-103.10)</td>
<td>Holly Ranges, Vice President, Chief Quality Officer</td>
<td>Linda Milender, Patient Safety Office, Department of Patient Safety &amp; Risk Management</td>
</tr>
<tr>
<td>Rights and Responsibilities of the Individual (RI)</td>
<td>Patient’s Rights (421.13)</td>
<td>Patient’s Bill of Rights (105.23-105.24)</td>
<td>Karen Augustine, Cancer Care Specialist</td>
<td>Ennette Hallette, Associate Director, Holly Ranges, Vice President, Chief Quality Officer</td>
</tr>
<tr>
<td>Provision of Care, Treatment and Services (PC)</td>
<td>Nursing Services (421.23) and Patient Rights (421.23)</td>
<td>Pharmacy Services (421.23) and Patient Rights (421.23)</td>
<td>Ruth Green, Executive Director, Nursing Services</td>
<td>Karen Erikson, Pharmacy Manager, Clinical Services</td>
</tr>
<tr>
<td>Medication Management (MM)</td>
<td>Medication Services (421.23)</td>
<td>Pharmacy Services (Chapter 111)</td>
<td>Audrey Stans, Pharmacy Manager, Clinical Services</td>
<td>Sue Ann Langley, RN, Manager DF</td>
</tr>
<tr>
<td>Infection Prevention and Control (IC)</td>
<td>Infection Control (142.42)</td>
<td>Infection Control (Chapter 142)</td>
<td>Marilyn Mohn, Infection Prevention</td>
<td>Paul Guglielmi, Infection Prevention</td>
</tr>
<tr>
<td>Performance Improvement (PI)</td>
<td>Quality Assessment and Performance Improvement (421.21)</td>
<td>Holly Ranges, Vice President, Chief Quality Officer</td>
<td>Cindy Longman, Quality Analyst</td>
<td>Pam Marshall, Manager, PI</td>
</tr>
<tr>
<td>Environment of Care (EC)</td>
<td>Physical Environment (422.41)</td>
<td>Safe and Sanitary Services (Chapter 111) and Related Code Requirements and Operating Standards (Chapter 112)</td>
<td>Steve Novak, Director, Safety Operations</td>
<td>Anna Bider, Supervisor, Hospital Police, Domestic, Housekeeping, Biomedical Engineering</td>
</tr>
</tbody>
</table>

### Regulatory Preparedness Committee Sample Agenda Topics

- Standards/regulatory updates
- Chapter leader reports
- NPSG audit results
- Sentinel Events alerts
- Survey reports and plans of correction
- FSA
- Tracer results
- Trends/patterns identified through surveillance
- Building inspection reports
- Safety fair
Focused Standards Assessment (FSA)

• Designed to help hospitals incorporate Joint Commission standards as part of routine operations and ongoing quality improvement efforts, supporting a continuous accreditation process

• Access to the FSA tool on a continuous basis throughout its accreditation cycle

• Noncompliant standards require a Plan of Action/MOS
Continuous Regulatory Readiness

- Regulatory readiness preparation booklets
- Administrative checklists
- Departmental checklists
- Environmental rounds
- Mock survey
- Tracers, tracers, tracers
  - Patient and system

Plan for Arrival of Surveyors

- Greeting surveyors
- Identify leaders and staff who must be notified when surveyors arrive
- Designate a location for the surveyors
- Identify surveyors
- Deliver survey documents for review
- Surveyor escorts
- Access to the electronic medical record
The Big Day

"We're not that well organised, but we know where everybody is."

...FIRST IMPRESSIONS DO MATTER
Individual Tracer Activity

- Participants
- Staff and management involved in care, treatment, and services
- Key to success in tracers
  - Staff being able to navigate computer system and manual system
  - Educate the staff for key areas of chart review

Be Prepared for Second Generation Tracers

- Cleaning, disinfecting, and sterilization
- Patient flow across the care continuum/ED overcrowding
- Contracted services
- Advance diagnostic imaging
- OPPE/FPPE
- Clinical information system
- Therapeutic radiation
Post-Survey Process

• If deficiencies are cited at exit, begin corrections immediately
• Quality Director reports survey findings to the hospital administrative and leadership team
• Quality Director meets with the people/departments to discuss the deficiencies and plan of correction
  • Involve the affected people/areas in the writing of the plan of correction
  • Meet frequently to ensure completion
  • When official report is received, reconcile expected deficiencies with the actual (could be different)

Plan of Correction (POC)

• POC must be submitted to arrive by the due date
• Implement as many corrective actions as possible prior to submission so all actions won’t be planned actions (implement better than planned)
• Be careful with what you say you will do as these things must be done when resurvey occurs
• Many times hospitals promise to implement actions and then they do not occur. Failure to do what is promised will result in possible fines and penalties.
• Hold staff accountable for getting reports to you timely
• Develop a tracking and reporting mechanism
Plans of Correction

- Who
- What
- Where
- How

- Evaluation method for MOS

The Joint Commission Complaints

- Depending on the nature of the complaint, The Joint Commission:
  - may conduct an on-site evaluation of the organization
  - may ask the health care organization to provide a written and/or verbal response to the complaint*
  - may incorporate the complaint into the quality monitoring database that is used to continuously track the performance of accredited health care organizations and certified programs over time
  - may review the complaint at the time of the health care organization's next scheduled survey

* Instructions for submitting a written complaint response included in attachments
CMS Validation of Accrediting Deemed Status Agencies

• CMS still conducts random validation surveys and complaint investigations of organizations with deemed status
  • Randomly selected organization (5%)
  • Survey similar to TJC survey
  • CMS contracted surveyors

Plan for Celebration

• Scribes to document quotes from surveyors to pass on to staff
• Food 😊

Joint Commission Celebration
What We Focus On, We Achieve

Song: Happy (from "Despicable Me 2") - Pharrell Williams
Questions

The Quorum Difference

The Quorum Difference is the extraordinary combination of consulting guidance and operations experience that enables client healthcare organizations to achieve a sustainable future.
THANK YOU

Intended for internal guidance only, and not as recommendations for specific situations. Readers should consult a qualified attorney for specific legal guidance.