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Survey Hot Topics for Critical Access Hospitals

Carolyn St.Charles

April 2023

Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals to develop and strengthen Swing Bed programs. St. Charles earned a master's degree in Business Administration from the Foster School of Business at the University of Washington and a bachelor's degree in Nursing from Northern Arizona University.

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About HealthTech

HealthTech has been supporting community hospitals for over 50 years. We are focused on improving financial, operational and clinical performance, while increasing patient and community engagement.

Nationwide Client Base

HealthTech provides award-winning hospital management, and consulting services to over 100 community, district, non-profit, and critical access hospitals across the country.

Preferred vendor for

- California Critical Access Hospital Network
- Western Healthcare Alliance

Consulting Support to:

Illinois Critical Access Hospital Network

Montana Flex Program

Member of Vizient Group Purchasing Organization

Education Courses
Information at www.health-tech.us

Swing Bed Basic Certification Course

Swing Bed Advanced Certification Course

Transitional Care Management

Behavioral Health Integration

Lean Practitioner

Advance Care Planning

Annual Wellness Visit

January – July webinars

All webinars are recorded for on-demand viewing.

Choosing an EHR for your hospital: A roadmap

Presenter: Amy Lowe – Senior Recruiting Director, HealthTech
Date: February 8, 2023 | **Time:** 12pm CST
URL: https://bit.ly/3YQvNGq

COVID fraud

Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE, will be a facilitator for Scott Shanker, an attorney from Bass, Berry & Sims PLC
Date: March 10, 2023 | Time: 12pm CST
URL: https://bit.ly/3jmTwOh

Part 1: Survey hot topics for Critical Access Hospitals

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer, HealthTech
Date: April 14, 2023 | Time: 12pm CST
URL: https://bit.ly/3HXDdBL

Improving health system operations – One step at a time

Presenter: Scott Manis – Regional Vice President.
Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer, HealthTech
Date: May 10, 2023 | Time: 12pm CST
URL: https://bit.ly/3G5HIsp

Part 2: Survey hot topics for outpatient care settings and Rural Health Centers

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer, HealthTech
Date: May 19, 2023 | Time: 12pm CST
URL: https://bit.ly/3jR9G2o

How creativity drives advertising effectiveness for your hospital + Building a brand voice

Presenter: Dominic Symes – EVP Staffing Solutions & Chief Revenue Officer, HealthTech
Date: June 16, 2023 | Time: 12pm CST
URL: https://bit.ly/3WXT0oB

Diversity and inclusion service management

Presenter: Kevin Hardy - Director of Interim and Executive Recruiting, HealthTech
Date: July 12, 2023 | Time: 12pm CST
URL: https://bit.ly/3FNRii6

Instructions for Today

You may type a question in the text box if you have a question during the presentation

We will try to cover all your questions – if we don't get to them during the webinar, we will follow-up with you by e-mail

You may also send questions after the webinar to our team (contact information is included at the end of the presentation)

The webinar will be recorded, and the recording will be available on the HealthTech web site: www.health-tech.us

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Agenda

1) Regulatory Sources – Types of Surveys – Scope of Surveys – Classification of Findings – Validation Surveys
2) Surveyor Work Flow
3) Reading / Interpreting Regulatory Standards
4) TJC National Patient Safety Goals
5) Health Equity
6) Environment of Care and Life Safety
7) Emergency Preparedness
8) Infection Prevention
9) Human Resources
10) QAPI
11) Restraints and Ligature Risk
12) Documentation Audits
13) Surveyor Acumen
14) Leader Responsibilities

Objectives

1. Identify at lest three survey focus areas.

2. Identify at least three strategies for maintaining continuous survey readiness

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Regulatory Sources
Type of Surveys
Scope of Surveys
Classification of Findings
Validation Surveys

Regulatory Sources

State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs
(Rev. 200, 02-21-20)

State Operations Manual Appendix I - Life Safety Code
(Rev. 209, 12-09-22)

State Operations Manual Appendix Q - Guidelines for Determining Immediate Jeopardy
(Rev. 187, Issued: 03-06-19)

State Operations Manual Appendix V - EMTALA
(Rev. 191, 07-19-19)

State Operations Manual Appendix Z - Emergency Preparedness
(Rev. 204, Issued: 04-16-21)

YOUR State Administrative Code

Regulatory Sources

- Health Survey
  - Initial
  - Recertification
  - Revisit
- Complaint
- Life Safety
- Validation Surveys of Accrediting Organizations
- Federal Monitoring Surveys

Mock Surveys

Let us know if you're interested in a mock survey and we will be glad to send you a proposal. We survey:

- Critical Access Hospitals
- Hospitals
- Hospital-Based Provider Clinics
- Rural Health Clinics
- Long Term Care
- Home Health & Hospice
- Focus Surveys
  - Swing Bed
  - Environment of Care, Life Safety, Emergency Management
  - QAPI
  - Infection Control

Scope of Surveys

Surveyors assess CAH compliance with the CoPs for :

- all services, areas and locations in which the provider receives reimbursement for patient care services billed under its CMS Certification Number (CCN),
- as well as certain entities that provide services to the CAH on a contractual basis.

These areas **include**

- all inpatient and outpatient services and practice locations
- buildings and facilities (including, but not limited to, generators, electrical rooms, food services, HVAC, supply areas, sterilization areas, etc.).

CMS Classification of Findings

When noncompliance with a condition of participation is noted, the determination of whether a lack of compliance is at the standard or condition level depends upon the degree (how severe, how dangerous, how critical, etc.) and manner (how prevalent, how many, how pervasive, how often, etc.) of the lack of compliance. The cited level of noncompliance is determined by the interrelationship between the degree and manner of the noncompliance.

Condition Level: A deficiency at the condition level may be due to noncompliance in a single standard or several standards, or parts of standards within the condition, or because of noncompliance with a single part (tag) representing a severe or critical health or safety breach. Even a seemingly small breach in critical actions or at critical times can kill or severely injure a patient, and represents a critical or severe health or safety threat.

Standard Level: A deficiency is at the standard level when there is noncompliance with any single requirement or several requirements within a particular standard that are not of such character as to substantially limit a facility's capacity to furnish adequate care, or which would not jeopardize or adversely affect the health or safety of patients if the deficient practice recurred.

CMS Immediate Jeopardy

Three key components that are essential for surveyors to use in determining the presence of Immediate Jeopardy.

• Noncompliance: An entity has failed to meet one or more federal health, safety, and/or quality regulations;

AND

• Serious Adverse Outcome or Likely Serious Adverse Outcome: As a result of the identified noncompliance, serious injury, serious harm, serious impairment or death has occurred, is occurring, or is likely to occur to one or more identified recipients at risk;

AND

• Need for Immediate Action: The noncompliance creates a need for immediate corrective action by the provider/supplier to prevent serious injury, serious harm, serious impairment or death from occurring or recurring.

Source: State Operations Manual Appendix Q – Core Guidelines for Determining Immediate Jeopardy Table of Contents (Rev. 187, Issued: 03-06-19)

TJC Classification of Findings

Likelihood to harm a Patient / Visitor / Staff	TJC SAFER MATRIX			
	Immediate Threat to Life			
	High			
	Moderate			
	Low			
		Limited	Pattern	Widespread
			SCOPE	

DNV Classification of Findings

Condition Level: Nonconformities where there is a broken process with a patient safety component.

Level 1 Nonconformity: There is no process or there is a significant variation in the process being followed.

Level 2 Nonconformity: There is an established process, but there is opportunity to ensure consistency of following process.

CMS Validation Surveys

The Centers for Medicare & Medicaid Services (CMS) has responsibility for oversight and approval of accrediting organization (AO) accreditation programs used for Medicare certification purposes, and for ensuring that providers or suppliers that are accredited under an approved AO meet the quality and patient safety standards required by the Medicare Conditions of Participation

CMS has indicated in the report that the validation redesign pilot (VRP) program, in which a SA surveyor has direct observation of AO surveyors during survey activity, is tentatively scheduled to restart in FY 2022.

In Section 5 CMS reported that the **physical environment (PE) and infection control conditions** are the top disparate citations for hospitals, psychiatric hospitals, ambulatory surgery centers and CAHs.

Source: Center for Clinical Standards and Quality/Quality, Safety & Oversight Group
Ref: QSO-22-06-AO/CLIA
December 15, 2021
FY 2020 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program

CMS Validation Surveys

Critical Access Hospital	2017	2018	2019
60-Day Validation Sample Surveys	32	17	13
SA Surveys with Condition-Level Deficiencies	12	7	7
AO Surveys with Missed Comparable Deficiencies	11	7	6
Disparity Rate	**34%**	**41%**	**46%**
Sampling Fraction	0.19	0.08	0.09

SA = State Agency (conduct validation surveys)

AO = Accrediting Organization

Validation Surveys

Critical Access Hospitals 2019 Validation Surveys	Cited by SA	Missed by AO	Disparity Rate
Physical Plant and Environment	10	5	55.6%
Provision of Services	3	1	11.1%
Surgical Services	2	1	11.1%
Organizational Structure	1	1	11.1%
Swing Bed	1	1	11.1%

SA = State Agency (conduct validation surveys)

AO = Accrediting Organization

CMS Validation Surveys DNV & TJC

Critical Access Hospital	2019 DNV	2019 TJC
60-Day Validation Sample Surveys	7	88
SA Surveys with Condition Level Deficiencies	3	43
AO Surveys with Missed Comparable Deficiencies	3	37
Overall Disparity Rate	**43%**	**42%**
Health and Safety Disparity Rate	43%	31%
Physical Environment Disparity Rate	31%	23%
Sampling Fraction	0.05	0.08

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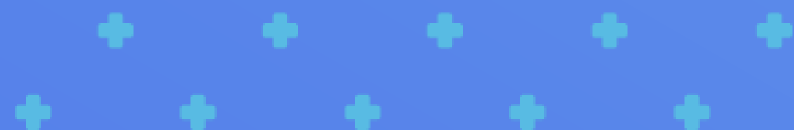
Surveyor Work Flow



Information Reviewed Prior to Survey

The objective of this task is to analyze information about the CAH in order to identify areas of potential concern to be investigated during the survey and to determine if those areas, or any special features of the CAH (e.g., provider-based clinics, specialty units, services offered, etc.) require the addition of any specialty surveyors to the team. Information obtained about the CAH will also allow the SA (or the RO for Federal teams) to determine survey team size and composition, and to develop a preliminary survey plan. The type of CAH information needed includes:

- Information from the **provider file** (to be updated on the survey using the Hospital/CAH Medicare Database Worksheet, Exhibit 286), such as the facility's ownership, the type(s) of services offered, whether the facility is a provider of swing-bed services, any distinct part units, the number, type and location of any off-site locations; and the number and categories of personnel.

- **Previous Federal and state survey results** for patterns, number, and nature of deficiencies, as well as the number, frequency, and types of complaint investigations and the findings;

- Information from **CMS databases** available to the SA and CMS. Note the exit date of the most recent survey;

- **Waivers and variances**, if they exist. Determine if there are any applicable survey directive(s) from the SA or the CMS RO; and

- Any **additional information** available about the CAH (e.g. the **CAH's Web site, any media reports about the CAH**, etc.)

On-Site Request – within 3 hours

- A location (e.g., conference room) where the team may meet privately during the survey
- A telephone for team communications, preferably in the team meeting location
- A list of current inpatients, providing each patient's name, room number, diagnosis (es), admission date, age, attending physician, and other significant information as it applies to that patient
- A list of department heads with their locations and telephone numbers
- A copy of the CAH's organizational chart
- The names and addresses of all off-site locations operating under the same CCN
- A list of employees
- The medical staff bylaws and rules and regulations
- A list of contracted services; and • A copy of the CAH's floor plan, indicating the location of patient care and treatment areas
- The CAH's infection control plan

Surveyor Instructions
They are always watching!

Observations provide first-hand knowledge of CAH practice and the provision of care and services to inpatients and outpatients.

The regulations and interpretive guidelines offer guidance for conducting observations.

Observation of the care environment provides valuable information about how the care delivery system works and how CAH departments work together to provide care.

Surveyors are encouraged to make observations, complete interviews, and review records and policies/procedures by stationing themselves as physically close to patient care as possible.

While completing a chart review, for instance, it may be possible to also observe the environment and the patients, staff interactions with patients, safety hazards, and infection control practices.

Surveyor Instructions
They are always watching!

When conducting observations, particular attention should be given to the following:

- Patient care, including treatments and therapies in all patient care settings
- Staff member activities, equipment, documentation, building structure, sounds and smells
- People, care, activities, processes, documentation, policies, equipment, etc., that are present that should not be present, as well as, those that are not present that should be present
- Integration of all services, such that the CAH is functioning as one integrated whole
- Whether quality assurance (QA) is a CAH-wide activity, incorporating every service and activity of the provider and whether every facility department and activity reports to, and receives reports from, the CAH's central organized body managing the facility-wide QA program
- Storage, security, and confidentiality of medical records.
- Environmental risks. Examples may include, but are not limited to, unattended cleaning carts, unattended hazardous cleaning solutions, unlocked medications, and ligature risks in areas where psychiatric patients may have care provided

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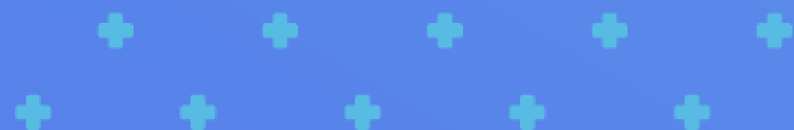
Reading / Interpreting Regulatory Standards



Standards may be released prior to CoPs

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Ref: QSO-20-07-ALL
DATE: December 20, 2019 **We still don’t have CoPs**
TO: State Survey Agency Directors FROM: Director Quality, Safety & Oversight Group
SUBJECT: Burden Reduction and Discharge Planning Final Rules Guidance and Process

Memorandum Summary
On September 30, 2019, the Centers for Medicare & Medicaid Services (CMS) published the Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction Final Rule, as well as the Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies Final Rule.

This policy memorandum provides guidance to the CMS Regional Offices (ROs), the State Survey Agencies (SAs) and the Accrediting Organizations (AOs) regarding the changes to the regulations and our approach for updating the State Operations Manual (SOM) and applicable surveyor systems.

QSO20-07 01 Burden Reduction-Discharge Planning SOM Package121919 (1).pdf

CoPs Structure

C-1050 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) **Number / Date**

§485.635(d)(4) A nursing care plan must be developed and kept current for each inpatient. **Description**

Interpretive Guidelines §485.635(d)(4) **Detail**

There must be a nursing care plan for every CAH inpatient. Nursing care planning starts upon admission. It includes planning the patient's care while in the CAH as well as planning for transfer to a hospital, to a post-acute care facility or for discharge. A nursing care plan is based on assessing the patient's nursing care needs (not solely those needs related to the admitting diagnosis). The assessment considers the patient's treatment goals and, as appropriate, physiological and psychosocial factors and patient discharge planning. The plan develops appropriate nursing interventions in response to the identified nursing care needs. One resource for information about nursing care plans is The American Nurses Association http://www.nursingworld.org/EspeciallyforYou/StudentNurses/Thenursingprocess.aspx.

The nursing care plan is kept current by ongoing assessments of the patient's needs and of the patient's response to interventions, and updating or revising the patient's nursing care plan in response to assessments. The nursing care plan is part of the patient's clinical record and must comply with the clinical records requirements at §485.638. CAHs have the flexibility of developing the nursing care plan as part of a larger, coordinated interdisciplinary plan of care. This method may serve to promote communication among disciplines and reinforce an integrated, multi-faceted approach to a patient's care, resulting in better patient outcomes. The interdisciplinary plan of care does not minimize or eliminate the need for a nursing care plan. It does, however, serve to promote the collaboration between members of the patient's health care team.

Survey Procedures §485.635(d)(4)
Select a representative sample of nursing care plans based on the number of inpatient records reviewed.

- Are the care plans created as soon as possible after admission for each patient?
- Are the care plans based on the nurse's assessment of the individual patient?
- Is there evidence that the care plans are reviewed on an ongoing basis?
- Is there evidence that the nursing care plan is revised as needed and is there documentation of nursing reassessment?
- Verify that there is evidence that the nursing care plans have been implemented

What surveyors should look for. Use this internally to conduct your own reviews / tracers

Sometimes there are NO Interpretive Guidelines or Survey Procedures

§485.640 Condition of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs

The CAH must have active facility-wide programs, for the surveillance, prevention, and control of HAIs and other infectious diseases and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic-resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in coordination with the facility-wide quality assessment and performance improvement (QAPI) program.

Interpretive Guidelines §485.640
Guidance is pending and will be updated in future release.

Survey Procedures §485.640
Survey Procedures are pending and will be updated in future release.

Sometimes References to Other CoPs

C-1626 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§485.645(d)(8) Nutrition (§483.25(g)(1) and (g)(2) of this chapter).

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident—
(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;
(2) Is offered sufficient fluid intake to maintain proper hydration and health.

Interpretive Guidelines §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures

Sometimes References to Other Requirements

Interpretative Guidelines § 491.9(a)(3) & (c)(2)
Basic laboratory services must be provided in the RHC by RHC staff in order to facilitate the immediate diagnosis and treatment of the patient. To the extent permitted under State and local law, the 6 basic laboratory services listed in § 491(c)(2) are considered the minimum laboratory services the RHC must have available within the clinic, provided by RHC staff. If any of these laboratory services cannot be provided at the RHC due to a State or local law prohibition, that laboratory service is not required for Medicare certification.

These laboratory services must be provided in accordance with the Clinical Laboratory Improvement Act (CLIA) requirements at 42 CFR Part 493 operating under a current CLIA certificate appropriate to the level of services performed. However, compliance with CLIA requirements is not assessed by surveyors conducting RHC surveys. Surveyors should, however, ask to see the RHC's CLIA certificate.

Sometimes Text in Red (NEW)

§485.640 Condition of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs

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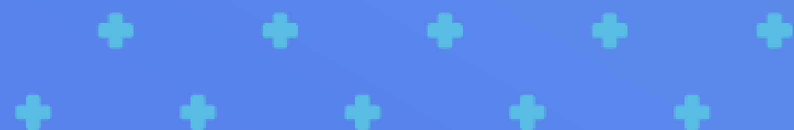
National Patient Safety Goals - 2023



NPSG for 2023

NSPG.01.0.01.01: Identify patients correctly. Two patient identifiers

NPSG.02.03.01: Improve staff communication. Critical Test Results

NPSG.03.04.01: Use Medicines Safely. Before a procedure label medications that are not labeled.

NPSG.03.04.01: Use Medicines Safely. Precautions for patients on blood thinners

NPSG.03.04.01: Use Medicines Safely. Medication Reconciliation

NPSG.06.01.01: Use alarms safely. Alarms on medical equipment are heard and responded to

NPSG.07.01.01: Prevent Infection. Hand Hygiene

NPSG.16.01.01: Improve Healthcare Equity

UP.01.01.01: Prevent mistakes in surgery: Correct surgery on correct patient and correct place
UP.01.01.01: Prevent mistakes in surgery: Mark surgical site
UP.01.01.01: Prevent mistakes in surgery: Pause before surgery

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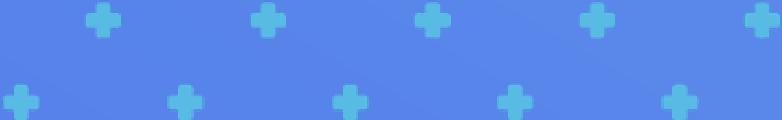
Health Equity



TJC Healthcare Equity NPSG 16.01.01

EP1: The CAH designates an individual(s) to lead activities to improve health care equity for the CAHs patients

EP2: The CAH assesses the patient's health-related social needs and provides information about community resources and support services

EP3: The CAH identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the CAH's patients. This may include age, gender, preferred language, race, and ethnicity

EP4: The CAH develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population

EP5: The CAH ats when it does not achieve or sustain the goals in its action plan to improve health care equity

EP6: At least annually, the CAH informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity

CMS Healthcare Equity Goals

April 10, 2023

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity

CMS Healthcare Equity Goals Potential Impact for CAHs

1) Expand data collection to include race, ethnicity, preferred language, sexual orientation, gender, identity, disability, income, geography, and other factors across CMS programs.

2) Development of health equity-focused measures.

3) Propose a “birthing-friendly” hospital designation.

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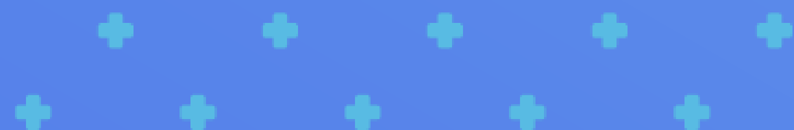
Environment of Care and Life Safety



TJC Frequent Deficiencies

LS.02.03.10 EP 14: **Penetrations** sealed with appropriate fire rated sealant.
Use the same type and color of sealant each time. Also replace if cracked or falling out of a penetration.

EC.02.02.05 EP 6: **Utility systems** are maintained.
Example is finding an open electrical junction box when checking above the ceiling.
Another would be not changing air filters when due.

EC.02.05.01 EP 9: **Electric circuit breakers** not properly labeled.
Spare breakers should be in the off position.
This also includes utility shut offs not labeled, for example the gas shut off valve for the kitchen gas stove, along with other emergency shut offs for water, gas, electricity throughout the hospital.

LS.02.01.35 EP 4: **Cables** on sprinkler lines

TJC Frequent Deficiencies

Life Safety

- Fire extinguishers blocked and not accessible.
- Exit pathway partially blocked (especially in the rear corridors with cabinets and supplies stored in the corridor).
- Battery powered egress lights inspected monthly and annually.
- Annual fire drills: If the building a fire alarm system, Joint Commission wants it activated during the fire drill. If you rent a portion of a building, get that requirement included in the lease agreement.

Focus Area – Fire Drills

Fire Drills – Surgery and Hyperbaric Units now require annual fire drills (TJC)

- **Surgery** fire drills (EC.02.03.03 EP7) are for oxygen enriched fires on a patient and include putting out and removing drapes. The drill includes evacuation and education on preventing surgery fires. Since this drill must be announced, it does not count as a quarterly fire drill (which are unannounced.)

- **Hyperbaric** fire drills (EC.02.02.03 EP 8) include time to activate everyone from the chamber room, prevention training, and staff response both inside and outside the chamber.

- **Kitchen** fire drills – although not an annual requirement, it is suggested to do them each year to reinforce training. On half of our EOC/Life Safety surveys the cook points to the fire extinguisher to use in case of a fire, instead of pulling the pin to activate the hood suppression system.

Other Focus Areas

1. **Temperature and Humidity** in Surgical Suites
   - If you adopted the 20% categorical humidity waiver, there must be a risk assessment that includes documentation that supplies and equipment can function properly at 20%
   - If your operating room temperature drops below the recommended levels of 68-73 degrees F, a risk assessment is required for each surgery case.
2. **Airflow** must be appropriate for the specific area (negative or positive) including operating rooms, IV rooms, central sterile.
3. **Egress clear at all times**
   - Corridor exits, electrical panels, medical gas shut of valves, fire extinguishers
4. **Fire Extinguisher** testing must be current and documented. Must include surgical suites and MRI. (MRI must have an extinguisher safe to enter MRI).

EOC & Infection Control Rounds Critical for maintaining Compliance

Life Safety

- ☐ Oxygen stored in appropriate containers
- ☐ No door stops
- ☐ All exits and hallways clear
- ☐ Nothing blocking fire extinguishers or electrical panels
- ☐ No items stored within 18 inches of ceiling
- ☐ Oxygen cylinders secure in tank holders
- ☐ Oxygen cylinders labeled (Full / Partial / Empty)
- ☐ Adequate egress (hallways are clear of clutter)
- ☐ No space heaters unless approved by Facilities
- ☐ No extension cords unless approved by facilities – and – attached to wall

EOC & Infection Control Rounds Critical for maintaining Compliance

Equipment

- ☐ All equipment has current sticker for preventative maintenance. If broken, take out of use and follow policy for repair.

General Environment of Care / Safety

- ☐ Cleaning agents out of reach of patients/ visitors and labeled appropriately
- ☐ All areas uncluttered
- ☐ Report any building repairs needed such as wall holes, chipping paint, etc.
- ☐ Sharps containers not more than ¾ full

Outdates / Cart Checks

- ☐ Check for outdated medications and supplies. All outdated / expired items discarded (Check drawers and carts)
- ☐ Crash carts locked
- ☐ Refrigerator / Freezer / Fluid Warmer / Blanket Warmer / Crash Cart / Eye Wash Station checks completed per policy
- ☐ Check test strips for outdates (Dietary, Point-of-Care tests)

EOC & Infection Control Rounds Critical for maintaining Compliance

Infection Control

- Bottom shelf of wire racks has a solid barrier – plastic cover
- No items stored under sinks
- Only "clean" items in clean areas and "dirty" items in dirty areas
- Refrigerators are clean and all food items thrown away that are outdated. All food items are covered, dated and labeled.
- Employee food and / or beverages out of patient care area except in staff lounge / break room. Drinks with lids may be allowed per department policy.
- Clean linen covered
- Linen hampers covered when transported
- Nothing stored on top of linen carts
- Staff can demonstrate or discuss "*5 Moments for Hand Hygiene*"
- Appropriate use of cleaning products
- Appropriate isolation processes
- Appropriate processes for mixing medications
- Appropriate high-level disinfection processes

Testing Frequency

Inspection	Frequency
Eyewash Inspection	Weekly
Vaneometer	Weekly
Fire Alarm Panel Trouble	Weekly
Generator no-load	Weekly
Haz-waste storage	Weekly
Exit Sign	Monthly
Generator load test	Monthly
ATS	Monthly
Line Isolation Monitor	Monthly
Haz-Waste Disposal	Monthly
Line Isolation Monitor	Monthly
Em. Batt. Lights	Monthly
Fire Extinguisher	Monthly
Water Test	Monthly
Fire Insp. Activity update	Monthly
Valve tamper switch	Monthly
FDC Connection	Quarterly
Fire Alarm Inspection	Quarterly
Sprinkler Inspection	Quarterly
Generator PM	Quarterly
Fire Drill	Quarterly
Water Safety Management	Quarterly
Filters	Quarterly
Medical Air Compressor	Quarterly
Panic Button	Quarterly
Blood Bank	Quarterly

Inspection	Frequency
Em. Batt. Lights	Annual
Generator 2hr. SEPSS	Annual
Fuel Cleaning	Annual
Backflow	Annual
Med Gas	Annual
Vent Testing	Annual
Legionella	Annual
Gas Manifolds	Annual
Equipment Risk Assess.	Annual
Hepa Filters	Annual
Fire Marshal	Annual
Plan Review	Annual
Boiler	Annual
Fire Extinguisher	Annual
Fire Doors	Annual
Line Isolation Monitor	Annual
Biomed inspection	Annual
Phar. Fridge Calibration	Annual
Generator	Tri-Annual
Fire Dampers	4 Year
Fire Valve Internal	5 Year

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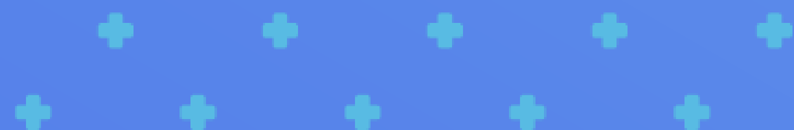
Emergency Preparedness



Emergency Preparedness Appendix Z 2021

State Operations Manual Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance Table of Contents

(Rev. 204, Issued: 04-16-21)

Emergency Preparedness Appendix Z E-001 Documentation

The emergency preparedness program must be in writing. (We are not requiring a hard copy/paper, electronic or any particular system for meeting the requirements.)

We would also recommend, but are not requiring, facilities to develop a crosswalk as applicable for where their documents are located.

Providers and suppliers are encouraged to keep documentation and their written emergency preparedness program for a period of at least 2 years for inpatient providers and at least 4 years for outpatient providers.

Inpatient providers are required to have 2 exercises per year, therefore surveyors will review the current year and the previous year to determine compliance.

For outpatient providers, testing exercises are required annually, however require full-scale exercises every other year, with the opposite years allowing for the exercise of choice.

Additionally, we are not requiring approval of the Emergency Program or official “signoff,” however, we do recommend facilities check with their State Agencies and local emergency planning coordinators (LEPCs) as some states require approval of the emergency preparedness plans as part of state licensure.

Emergency Preparedness Appendix Z 2021 E-007

The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years.

The plan must do the following:]
(3) Address [patient/client] population, including, but not limited to**, persons at-risk**; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

Emergency Preparedness Appendix Z E-001

Emerging Infectious Diseases (EIDs)

As facilities develop or make revisions to their emergency preparedness plans, **EID's are a potential threat which can impact the operations and continuity of care within a healthcare setting and should be considered.**

The type of infectious diseases to consider or the care-related emergencies that are a result of infectious diseases are not specified.

Adding EID's within a facility's risk assessment ensures that facilities consider having infection prevention personnel involved in the planning, development and revisions to the emergency preparedness program, as these individuals would likely be coordinating activities within the facility during a potential surge of patients.

Some examples of EID's may include, but are not limited to: o Hazardous Waste o Bioterrorism o Pandemic Flu o Highly Communicable Diseases (such as Ebola, Zika Virus, SARS, or novel COVID-19 or SARS-CoV-2) EID's may be localized to a certain community or be widespread (as seen with the COVID-19 PHE) and therefore plans for coordination with local, state, and federal officials are essential. Facilities should engage and coordinate with their local healthcare systems and healthcare coalitions, and their state and local health healthcare systems and healthcare coalitions, and their state and local health departments when deciding on ways to meet surge needs in their community

Emergency Preparedness Appendix Z 2021 E-0039

(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:

(i) Participate in a full-scale exercise that is community-based every 2 years; or

(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or

(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.

(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B)

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed

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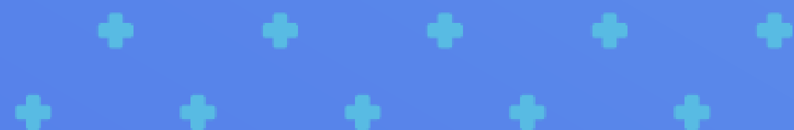
Infection Prevention



Infection Control Basics

1) Job Description for IC Practitioner reflects duties and qualifications

2) Infection Control Plan current

3) IC Risk Assessment current (annual)

4) IC P&Ps current including policies for:
    1) Isolation Precautions
    2) COVID

5) Data Collection and Reporting (minimum)
    - Hand Hygiene
    - HAIs
    - Third party organizations (CDC)
    - Reportable communicable diseases to Health Dept.

6) Construction and Remodeling
    - Risk Assessment
    - Permit
    - Monitoring

7) Appropriate use of cleaning products
    - Appropriate for what is being cleaned, contact time, and dwell time

8) Collaboration with Antibiotic Stewardship Program (must be documented)

High Level Disinfection & Sterilization

1) Important to <u>observe high-level disinfection on a regular basis</u>

2) Review all areas high level disinfection occurs
   - Central Processing
   - **Ultrasound** (Intra-cavity probes)
   - Sterilizers in clinics or other areas of hospital

3) Review transportation of items for sterilization (must be covered)

4) Review how items are cleaned prior to transport (in dirty area – not co-mingled with clean area)

5) Sterilize hinged instruments in open position

Infection Control Rounds Critical for Maintaining Compliance

- Bottom shelf of wire racks has a solid barrier – plastic cover
- No items stored under sinks
- Only “clean” items in clean areas and “dirty” items in dirty areas
- Refrigerators are clean and all food items thrown away that are outdated. All food items are covered, dated and labeled.
- Employee food and / or beverages out of patient care area except in staff lounge / break room. Drinks with lids may be allowed per department policy.
- Clean linen covered
- Linen hampers covered when transported
- Nothing stored on top of linen carts
- Staff can demonstrate or discuss “*5 Moments for Hand Hygiene*”
- Appropriate use of cleaning products
- Appropriate isolation processes
- Appropriate processes for mixing medications
- Appropriate high-level disinfection processes

Infection Control Worksheet

Guidance for the Hospital Infection Control Worksheet used during on-site survey in order to determine compliance with the Infection Control Condition of Participation.

References are to Appendix A – but applicable to Appendix W.

https://www.hhs.gov/guidance/document/hospital-infection-control-worksheet

Infection Control Worksheet Examples

- ❑ The Infection Control Officer can provide an updated list of diseases reportable to the local and/or state public health authorities.
- ❑ The Infection Control Officer can provide evidence that hospital complies with the reportable diseases requirements of the local health authority
- ❑ The hospital has infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair, including the requirement for an infection control risk assessment (ICRA) to define the scope of the project and need for barrier measures before a project gets underway.
- ❑ The Infection Control Officer(s) can provide evidence that problems identified in the infection control program are addressed in the hospital QAPI program (i.e., development and implementation of corrective interventions, and ongoing evaluation of interventions implemented for both success and sustainability).
- ❑ After pre-cleaning, items are appropriately wrapped packaged for sterilization (e.g., package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).
- ❑ A chemical indicator (process indicator) is placed correctly in the instrument packs in every load.
- ❑ A biological indicator is used at least weekly for each sterilizer and with every load containing implantable items

https://www.hhs.gov/guidance/document/hospital-infection-control-worksheet

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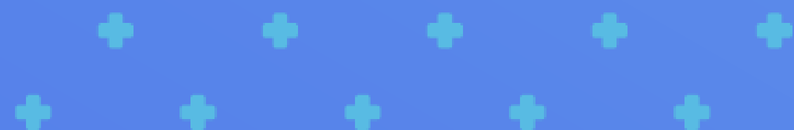
Human Resources



Human Resources

1. **ALL staff, <u>including contract staff,</u> have basic orientation to the organization and their department <u>BEFORE</u> they begin work.** At a minimum this should include:
   - What to do in case of a fire
   - What do in case of a disaster
   - Basic Infection Control (Hand washing, no eating in patient care areas, etc.)
   - Where P&P are located and how to access them
   - How to recognize and report potential abuse (internal and external)
   - Orientation to department (What to do if a patient has a respiratory or cardiac arrest, Location of emergency equipment / supplies, location of fire extinguishers, location of eye wash stations, etc.)

2. **ALL staff, <u>including contract staff</u>, must have employee health requirements met <u>BEFORE</u> they start work** (TB skin test, immunizations, physical if required, FIT test, etc.)

3. **ALL staff, <u>including contract staff and providers</u>, must have a clear criminal background check <u>BEFORE</u> they are allowed to start work.**

Human Resources

Competency is not the same as Education

Competencies must be based on role – responsibility – job description (i.e. YES Vital Signs if CNA – NO Vital Signs if RN)

Competencies should be chosen based on

- **Criticality** (High level disinfection) (Terminal Cleaning Surgical Suites) (Sepsis) (STEMI) (Moderate Sedation)
- **Low Volume** (Ventilator Management (Post Partum Hemorrhage)
- **Problem Prone** (Restraint) (Blood Transfusion documentation)
- **Regulatory Requirements** (Antibiotic Stewardship) (Opioids)
- **Departmental Processes** (Proper positioning X-Ray) (Calculating weight based medication doses) (IV compounding)

Competency Example

	Observation: Verifier observes that employee is proficient in competency, skill or task in real life scenario.	Simulation: Verifier observes that employee is proficient in competency / skill / task in a controlled environment.	Verbal: Verifier has employee demonstrate competency, / skill / task through a verbal response.	Written: Verifier has employee demonstrate competency / skill / task through a written test.
GENERAL EXAMPLES				
Hand Washing	X			
CPR		X		
Report a Fire			X	
Recognizing Abuse				X
DEPT. SPECIFIC EXAMPLES				
Apply restraints	X			
Creating Ligature Safe Room	X		X	
Difference between restraints for harm to self and others AND restraints for no harm to self or others			X	X
Documentation for patient in restraints	X		X	X
SEPSIS Protocol		X	X	X
Terminal Cleaning OR	X			
Moderate Sedation	X			X

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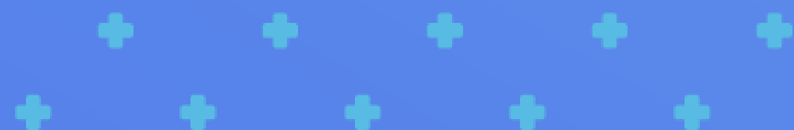
QAPI

Quality Assurance Performance Improvement



QAPI

1. QAPI plan is current.
   QSO20-07 01 Burden Reduction-Discharge Planning SOM Package121919 (1).pdf

2. Priorities established, based on prioritization criteria.

3. Corrective actions / follow-up when indicators don't meet target.

4. All departments involved in improvement, including contract staff/contract departments.

5. Governing board actively involved in overseeing quality.

6. Collaboration / Oversight Infection Control Program.

- **Update QAPI Plan including criteria for projects**
- **Minimize number of QC and focus on improvement**
- **ALWAYS make sure there is a corrective action**

Prioritization - Example

Criteria Area:	Problem Prone (weight: 4) Defined a the level to which this issue has the potential to prevent or reduce medical errors, adverse patient outcomes, or CAH-acquired conditions.	State, Federal or Accreditation Requirement (weight: 4) Defined as mandated improvement initiative or overall inadequate performance on requirement.	High Volume (weight: 4) Defined as high volume population or service. Percent of patients Impacted	High Risk - Likelihood of potential harm (weight: 4) Defined as the level to which this issue poses a risk to patients, providers, visitors, staff.	Community Priority e.g. Community Needs Assessment or other input (weight: 3)	Addresses multiple other priorities e.g. Adverse drug events and HCAHPS medication communication (weight: 4)	Staff/Provider Enthusiasm (weight: 2)
Clinical Care							
Falls with Injury.							
Sepsis							
Hand Hygiene							
Client Experience							
Care Transitions							

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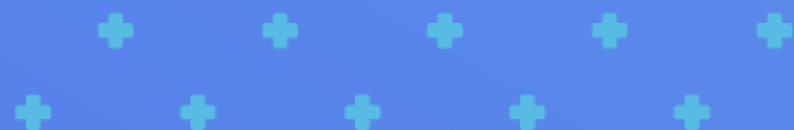
Restraints and Ligature Risk



Restraints and Ligature Risk

High Priority for Surveyors

TJC has formally defined the term "ligature resistant" as "without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life."

Restraints and Ligature Risk Appendix C-1612

§485.645(d)(3) Freedom from abuse, neglect, exploitation, misappropriation of property

§483.12(a)(1) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.(a) The facility must—

(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints

Restraints and Ligature Risk Appendix A-0144

Although all risks cannot be eliminated, hospitals are expected to demonstrate how they identify patients at risk of self-harm or harm to others and steps they are taking to minimize those risks in accordance with nationally recognized standards and guidelines. The potential risks include but are not limited to those from ligatures, sharps, harmful substances, access to medications, breakable windows, accessible light fixtures, plastic bags (for suffocation), oxygen tubing, bell cords, etc.

1) Identify patients at risk.

2) Implement environmental risk assessment strategies appropriate to the specific care environment and patient population.

3) Hospital staff must be trained to identify environmental safety risks regardless of whether or not the hospital has chosen to implement the use of an environmental risk assessment tool to identify potential or actual risks in the patient care environment.

4) Hospitals must provide the appropriate level of education and training to staff regarding the identification of patients at risk of harm to self or others, the identification of environmental patient safety risk factors and mitigation strategies. Staff includes direct employees, volunteers, contractors, per diem staff and any other individuals providing clinical care under arrangement.

Chemical Restraints Appendix F-605

When any medication restricts the resident's movement or cognition, or sedates or subdues the resident, and is not an accepted standard of practice for a resident's medical or psychiatric condition, the medication may be a chemical restraint.

Even if use of the medication follows accepted standards of practice, it may be a chemical restraint if there was a less restrictive alternative treatment that could have been given that would meet the resident's needs and preferences or if the medical symptom justifying its use has subsided.

Use of Restraints

Challenge – Infrequent use so low volume / high risk. Staff and providers forget!

Challenge – Understanding chemical restraints

Challenge – Tracking restraint use

Challenge – Inadequate audits

Challenge – Staff and providers do not recognize the difference between restraints for “non-violent or non self-destructive behavior” and restraint for the management of “violent or self-destructive behavior”

Restraints – Strategies for Consideration

1. Hard-wire the process with algorithms and documentation templates.
2. Audit as much as possible “real-time” (Notify shift supervisor immediately when restraint applied).
3. Educate staff and providers “immediately” after restraint event.
4. Educate staff and providers that the type of restraint is <u>NOT BASED ON DIAGNOSIS.</u>
5. Educate on definitions of chemical restraints.

Strategies for Reducing Harm

1. Risk Assessment (now required by TJC)
2. Develop policy for assessing patient’s at risk of suicide – and in what locations.
3. Develop and implement policy for making a room **SAFE** for a patient at risk of harm to self or others.
4. Observers: family / friends <u>should not</u> be allowed to act as observers.
5. Implement training program for observers
6. Implement training program for staff that includes de-escalation
7. **<u>Focus on Hand-Off Communication</u>**

YES – IT CAN HAPPEN IN YOUR ORGANIZATION

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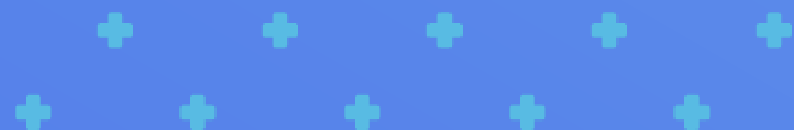
Documentation Audits Tracers



Tracers

Surveyors spend a lot of time reviewing medical records (as you know)

Strongly recommend conducting medical record tracers specific to the practice in every unit and department.

Tracers / chart audits should be done with staff and with current records if at all possible.

Medical Record Tracer Medication Administration

Medication Tracer

1) What medications is the patient receiving?

2) Is there a complete order for every medication?

3) Are the medications given on time?

4) If there are parameters (i.e. blood sugar, pain scale, etc.) for when the medication is to be given, are the parameters followed and documented?

5) For pain medication is there a pain scale before and after the medication?

6) If oxygen is being administered is there an order? Is oxygen being administered at the appropriate liter flow. If it is being titrated are there orders for titration? (oxygen is a drug)?

7) Review orders and administration for IV drug titration. Is the order being followed? Is the drug(s) titrated appropriately?

Medical Record Tracer
Plan of Care

Plan of Care Tracer

1) Why was the patient admitted?

2) Does the patient have any risk factors? And are they included on the plan of care?
- Nutritional Risk
- Fall Risk
- Braden Scale

3) Are there specific areas that need to be assessed / monitored by nursing?
- Observation for risks of anti-coagulants?
- Observation related to adjustment / changes in cardiac medications?
- Observations related to titration of oxygen?

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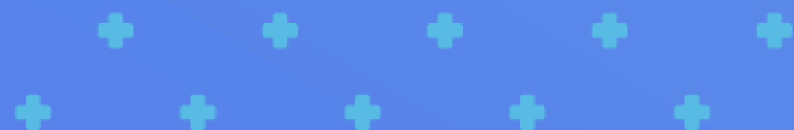
Surveyor Acumen



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HELPFUL

- STOP, Smile, take a deep breath
- Ask for clarification and standard reference
- Ask the surveyor to discuss in private – away from staff
- Ask the surveyor to discuss with the CNO/COO/CEO (move yourself out of the conflict)

NOT HELPFUL

- Argue
- Get angry

IF NECESSARY

Contact the survey agency and speak to person in authority over surveyors

NEVER ALLOW surveyors to VERBALLY ABUSE staff. Call an immediate time-out.

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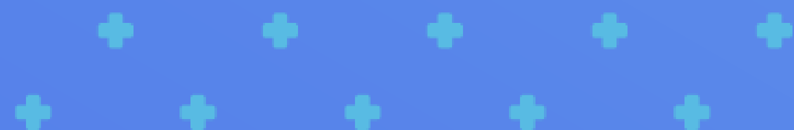
Leader Responsibilities



Leader Responsibilities

1. **KNOW THE STANDARDS THAT APPLY TO YOUR DEPARTMENT!**

2. Educate your staff on standards that apply to your department.

3. Promote, “**WHY**” survey readiness is important for safe patient care thru-out the organization ---- **NEVER SAY** because “**they**” make us do it this way.

4. Conduct regular patient and system tracers
   - Immediate feedback to staff
   - Document findings and follow-up

5. Incorporate survey readiness as part of leader rounding.

6. Focus on areas identified during (your) most recent survey.

7. Focus on new / revised standards.

8. Focus on areas of significant non-compliance identified by CMS or deeming authority.

9. Implement EOC/IC rounds – at least once per department per quarter.

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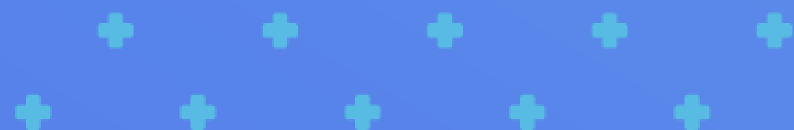
Questions from Webinar



Questions - General

Will we have access to a recording?

May we use that recording and share with others in our organization? I believe this would be great for orientation?

Is there going to be a Part II: Survey Hot Topics for CAH's? Since this is labeled Part I: Survey Hot Topics for CAH's. As this was extremely helpful.

Questions - Human Resources

Also they (surveyors) did check our employee files for background checks and if the company doing the background check is certified by the State Police in your state

Questions - IC

Is a IC Risk Assessment required by CMS or best practice?

Wee recently had a mock survey - a huge IC talking point was ttape on sterile instruments - the type we use to track different clinics/facilities, etc. Just FYI.

We just had state survey in February – we are CAH. HEAVY FOCUS ON INFECTION CONTROL!!!
Ex: Deficiencies were found for staff not washing hands, finding furniture, items, not cleaned between patients (inpatient and outpatient depts – lab, therapy)

Ligature Risk - Questions

How often to you perform ligature/suicide risk assessment? IS it for inpatient only or all OP areas (we have many, many OP areas)?

Is having an observer for highrisk SI/HI patient required? We struggle with having appropriate resources to do so.

We have good clinical and non-clinical sitter training Powerr Points if it would be helpful feel free to reach out: mrobertson@gvh-colorado.org

Should tracer/safety rounds include review of ligature/suicide harm ?

Tracers - Quesitons

Where would we find tracers for other areas?

Your Questions

Let me know if you are interested in a proposal for a mock survey

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