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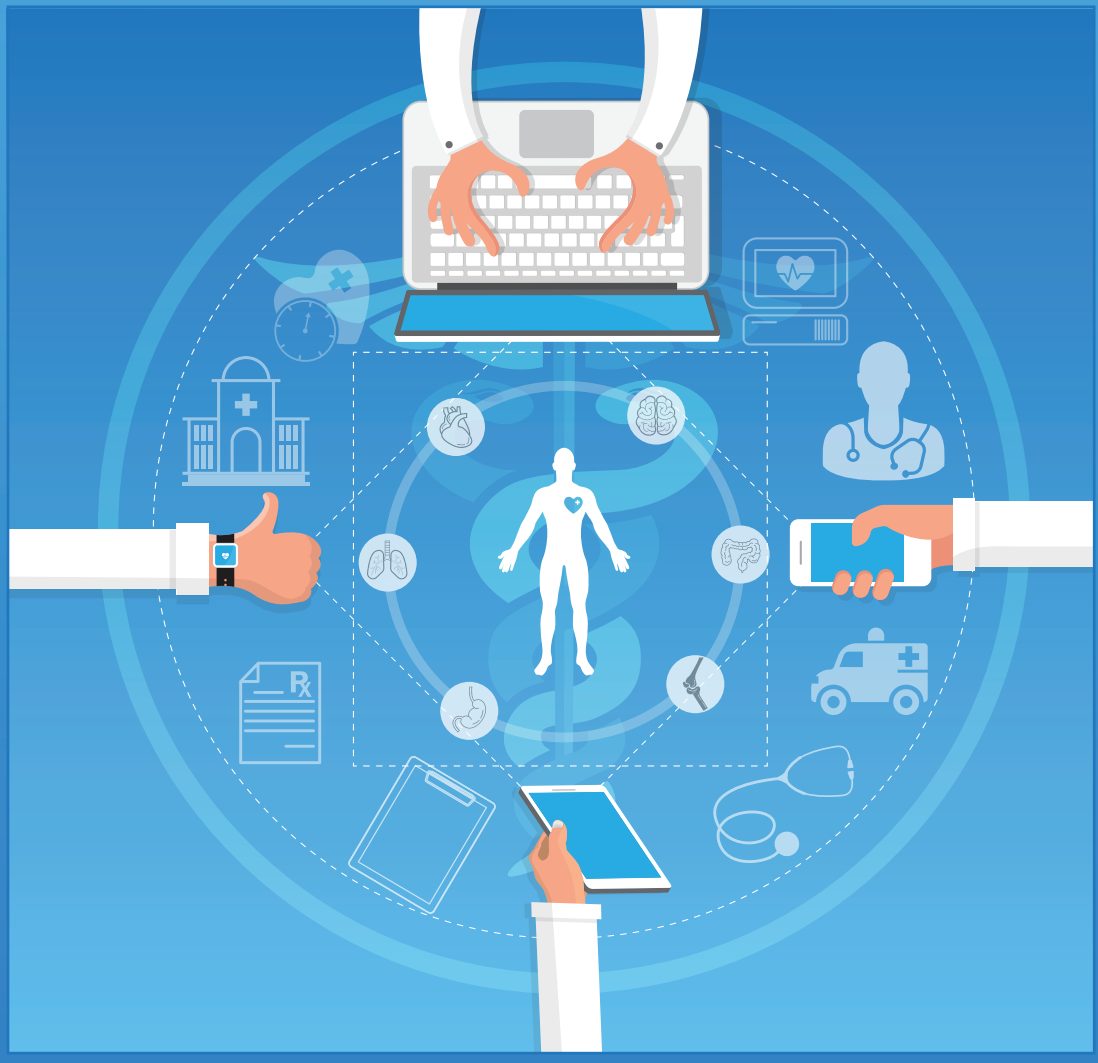
The Survey Coordinator's Handbook

21st Edition



Jodi L. Eisenberg, MHA, CPHQ, CPMSM

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About the Author

Jodi L. Eisenberg, MHA, CPHQ, CPMSM

Jodi L. Eisenberg, MHA, CPHQ, CPMSM, is the senior director of leader connections at Vizient™, an alliance of hospitals and healthcare organizations including academic medical centers, community hospitals, ambulatory care, and other healthcare providers. She leads efforts to evaluate, develop, and deliver education to member organizations with a focus on continuous patient readiness, approaches for improving compliance with foundational regulations and standards, and strategies to ensure an ongoing focus on quality and patient safety across the continuum.

Prior to this role, Eisenberg was the system lead manager of accreditation, clinical compliance, and policy management at Northwestern Medicine in Chicago. She was responsible for leading the full range of Joint Commission and other accreditation and regulatory compliance activities, including the organization of continuous compliance activities for The Joint Commission and other regulatory agencies. Also under her purview was the programmatic direction for the design, development, and oversight of the hospital and departmental policy and procedure management system. She also served as faculty to the HCPro Accreditation Boot Camp.

Additionally, Eisenberg served as an editorial advisor for *Briefings on Accreditation and Quality* (now known as *Inside Accreditation and Quality*), published by HCPro, a Simplify Compliance brand. She is the original author of the *Survey Coordinator's Handbook* and the coauthor of *Performance Improvement: Winning Strategies for Quality and Joint Commission Compliance,* published by HCPro, which won the National Association for Healthcare Quality David L. Stumph Award for Excellence in Publication in its second edition in 2000. She has authored, edited, and contributed to several other HCPro publications over the past 20 years.

Eisenberg's evolution in healthcare administration began in medical staff services and quality. She holds a master's degree in healthcare administration from the University of St. Francis, as well as certifications as a professional in healthcare quality, a professional in medical staff management, and a specialist in healthcare accreditation.

Acknowledgments

Who knew I would still be on this adventure 20 years later! The success of this book is definitely in the rich contributions of many experts. As in past editions, I would like to thank those experts who have contributed to the content and whose input continues to be part of the building blocks of this handbook: Brad Keyes, CHSP; Elizabeth DiGiacomo-Geffers, RN, MPH, CNAA(r); Gayle Bielanski, RN, BSN, CPHQ; Maureen Connors Potter, RN, BSN, MSN; and Donna Woodkey-Dinsmore, RN, MBA. The resources provided in previous editions continue to appear as part of the structure of this book.

To past handbook authors Laure L. Dudley, RN, MSN; Patricia Pejakovich, RN, BSN, MPA, CPHQ; and Jean S. Clark, RHIA: Thank you for your work on earlier editions of this book. While the standards and survey process have changed and coordination and continuous readiness have evolved over the past 20 years, success can be obtained when the focus remains on patients, their care, and their outcomes.

Finally, to all of you who are reading this book, remember, the next visit will happen … whether it is The Joint Commission, the Centers for Medicare & Medicaid Services, the Department of Public Health, or another regulatory body with an acronym. Just take a deep breath and keep your focus on the patient. You are doing great work at the bedside, and that will shine through!

Introduction

Since the original publication of this book, we have seen the oversight process for healthcare organizations evolve. The Institute of Medicine's 1999 report *To Err Is Human* brought to light the potential depth and breadth of medical error. Scrutiny by the Centers for Medicare & Medicaid Services (CMS) and the voluntary accrediting bodies on ensuring patient safety and identifying the issues that present potential harm to patients has increased. Due to this increase in oversight, the number and frequency of unannounced surveys by all accrediting bodies with deemed status have increased, and we are seeing the number of condition-level findings increase as well.

This book is intended for those who will serve as the primary points of contact and liaisons between their healthcare organizations and the regulatory agency. It provides an overview of the history and evolution of the accreditation process, along with suggestions for establishing a culture of continuous readiness for patients each and every day.

Understanding the foundational requirements within the CMS *Conditions of Participation* is critical to this process. Based on that understanding, the survey coordinator can make a positive impact on patient care each day, partnering with operational leaders and effectively managing time, resources, and staff. The goal should not be to comply simply because CMS or the accrediting body requires it; rather, the goal should be to provide effective, efficient, and safe patient care and, as a byproduct, comply with the rules and regulations. To bring this shift in mindset to the organization, leaders must employ keen listening skills, understand the sources of truth, collaborate with frontline staff members and operational leaders, and be open to continuous learning and improvement.

In addition to providing an overview of the regulations and the process, this handbook contains suggestions for managing the process prior to, during, and after regulatory visits. It also contains helpful figures and forms, many of which are currently in use by survey coordinators across the country. Although they are merely illustrations from selected settings, we believe that they will help clarify the recommendations and provide you with a running start in establishing a continuous readiness program within your healthcare organization.

CHAPTER 1

Accreditation at a Glance

Accreditation started as a minimum set of healthcare standards developed by a group of surgeons for the hospital inpatient setting. From there, it evolved into standards promoting optimal quality and then to those focused on patient safety and outcome measurement and management. This evolution began in the early 1900s and continues today. The current focus is as much on the hospital inpatient setting as it is on the settings across the continuum. Just as medicine is changing across the continuum and innovative and virtual delivery platforms are being introduced into the market, so too will regulations, standards, and the survey process continue to evolve. Preventive care and wellness, continuity and communication among providers, and consistent care of the chronically ill are areas where we are seeing changing standards and regulations.

The simplest reason that accreditation matters is that most healthcare organizations need it in order to be eligible to receive Medicare reimbursement. Its primary intent is to ensure that the hospital adheres to basic standards and provides consistent, quality care, and it has become a symbol of credibility to insurers, health plans, and patients. When we put the patient at the forefront, these requirements are foundational to safe, efficient, effective care.

This chapter provides an overview of the accreditation process to help you understand its evolution and its influence on healthcare policy and practices. For those who are new to the field of accreditation, this chapter summarizes the types of services that accrediting agencies provide and includes an overview of the accreditation and certification programs available. It also provides a fundamental overview of the issues facing most organizations every day as they work to integrate continuous readiness into daily operations. Acknowledging the many challenges that hospitals face, this chapter offers practical advice, tools that can be easily implemented, and perhaps new insight into identifying solutions and opportunities for improvement.

Figure 1.1 | Accreditation evolution

1913	American College of Surgeons (ACS) formed
1917	ACS establishes *Minimum Standards for Hospitals*
1918	ACS conducts its first hospital inspections
1945	American Osteopathic Association (now Healthcare Facilities Accreditation Program) forms
1950	More than 3,000 hospitals receive the ACS seal of approval
1951	Joint Commission on Accreditation of Hospitals forms
1965	Medicare Act "deemed status" created—American Osteopathic Association and Joint Commission receive deeming authority
1987	Joint Commission expands scope from hospital accreditation to healthcare organization accreditation
1993	Joint Commission changes to focus on functional standards rather than departmental-based standards
1999	Institute of Medicine's *To Err is Human* report of medical errors in healthcare
1999	Center for Improvement in Healthcare Quality (CIHQ) formed
1999	Joint Commission introduces ORYX performance measures
2003	Joint Commission introduces National Patient Safety Goals
2006	Centers for Medicare & Medicaid Services requires accreditation organizations to conduct unannounced surveys
2008	Det Norske Veritas Health Care Division formed—integration of ISO 9001 standards with Medicare *CoPs* receives deemed status
2010	Affordable Care Act and introduction of Pay for Performance Measures
2013	CIHQ receives deemed status

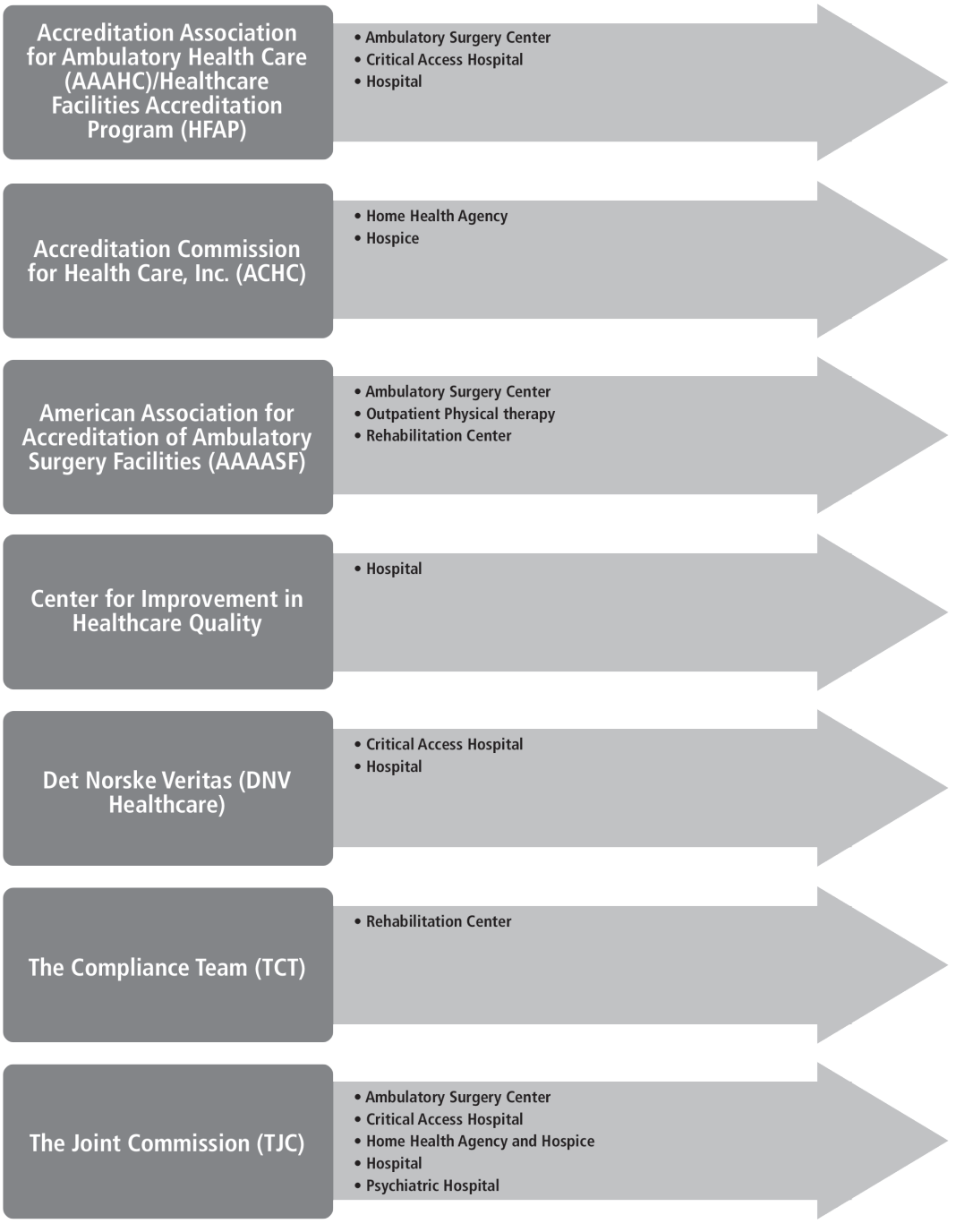
History of Accreditation

The timeline in Figure 1.1 offers a glimpse into how the foundational healthcare standards came into being. Accreditation followed, and actually predated the Medicare *Conditions of Participation* (*CoP*).

In 1910, Ernest Codman, MD, an innovative surgeon of his time who made contributions to anesthesiology, radiology, surgery, and medical outcomes, proposed that hospitals develop procedures for tracking patients long enough to determine whether treatment was effective. By reviewing outcomes, he felt

risk reduction, and greater ease of staff (especially nurse) recruitment. The most important issue for hospitals, however, is that deemed status from successful accreditation allows them to receive reimbursement from Medicaid and Medicare as third-party payers. As the reimbursement landscape evolves under the Affordable Care Act, we may see changes in the accreditation or certification requirements for other types of healthcare organizations as well.

Figure 1.2 | CMS deemed status agencies as of 2019



CHAPTER 2

Sources of Truth

Chapter 1 provided an overview of the Centers for Medicare & Medicaid Services (CMS) Medicare and Medicaid certification process, the voluntary accreditation process, and the accrediting agencies that are currently approved to survey on behalf of CMS. This chapter highlights the critical resources and sources of truth that are available to the survey coordinator.

Whether your organization is facing a survey by CMS, The Joint Commission, one of the voluntary accrediting organizations, or any other type of regulatory survey, first and foremost, you must understand what the source of truth is so that you can begin to understand the rules. In this age of information, there are many resources available, but it is important to understand what the sources of truth are and where they are located. Sources of truth include the CMS *Conditions of Participation* (*CoP*) and specific accreditation and certification standards. All resources that you use should link directly to those resources.

Too often, however, we hear people point to information that they obtained from a source that may not be reliable and say, "CMS says we have to do this or The Joint Commission says we have to do this." For example, although listservs and consultants can be great resources, survey coordinators must be careful to ensure that they understand the rules. Any recommendations for compliance must align with the rules. More importantly, they need to ensure that these recommendations are linked to the source of truth. Remember, the healthcare organization is being held to the regulation and the standard, not to the consultant's recommendation.

The following is information on the specific sources of truth and links to navigating the internet resources.

These regulations apply to the following healthcare organizations:

- Ambulatory surgical centers (ASC)
- Clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers (CMHC)
- Comprehensive outpatient rehabilitation facilities (CORF)
- Critical-access hospitals (CAH)
- End-stage renal disease facilities
- Federally qualified health centers
- Home health agencies
- Hospices
- Hospitals
- Hospital swing beds
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- Long-term care facilities
- Organ procurement organizations (OPO)
- Portable X-ray suppliers
- Program of All-Inclusive Care for the Elderly (PACE) organizations
- Psychiatric hospitals
- Religious nonmedical healthcare institutions
- Rural health clinics
- Transplant centers

Additionally, each state has its own agency and set of rules. Organizations must be able to access and understand the differences between the federal and state regulations. Each organization will be held to the most stringent rule.

Another important factor relates to the on-site surveys. In many states, the state surveyors also conduct the federal surveys. CMS provides them with instructions on how to conduct the surveys as well as how to interpret the *CoP*s. Survey coordinators have access to this information as well, and they should use it to understand how to establish compliance and continuous readiness.

Below are some links to help you navigate your state survey agencies and identify appropriate contacts for each office.

State survey agency directory

A comprehensive list of state survey agencies, locations, and contacts can be accessed via the link below:

State Department of Public Health: *https://healthfinder.gov/FindServices/SearchContext.aspx?show=1&topic=820*

- Establish expectations in corporate bylaws, policies, and medical staff bylaws
- Establish a code of ethics and a code of conduct for all members of the hospital
- Coordinate and integrate compliance, planning, integration, and performance improvement into daily operations
- Establish consistent methods of providing patient care (including policies, procedures, protocols, and evidence-based practices)
- Establish methods for quality control, quality assurance, and performance improvement (e.g., consistent methodology, annual quality planning, annual goals, ongoing measurement, and display of measurement)
- Establish vigorous performance management, compensation, and other support programs

Your leaders must be knowledgeable and aware of the sources of truth. During and in preparation for survey, the leadership team must be able to address their structure and responsibility for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your organization's mission and strategic objectives. Knowing the sources of truth will help leaders articulate how they connect and integrate with the regulations and standards and ultimately support them in achieving their mission, visions, and goals. More importantly, though, knowing and embedding the foundational requirements as outlined in the sources of truth will help any organization provide consistent and safe care for their patients.

Chapter 2 Quiz

1. What are the two sources of truth that provide information on changes to the CMS *CoP*s and survey procedures?

   a. *Federal Register* and the *Joint Commission Perspectives*
   b. *Journal of Healthcare Quality* and regulatory alerts
   c. Transmittals and Quality, Safety, and Oversight memoranda

   Answer: c

2. True or false: The goal of the survey process is to validate the basic regulatory requirements and ensure the provision of safe, quality care.

   Answer: True

3. True or false: Regardless of which agency a healthcare organization uses, if the organization is seeking accreditation to fulfill Medicare certification, the accrediting agency must align their standards with the CMS *CoP*s.

   Answer: True

CHAPTER 3

Functional Approach to Continuous Readiness

Knowing the sources of truth is critical to the success of a continuous readiness program. However, knowing where to focus your attention and limited resources is just as important, and there are several ways to do that. As accreditation professionals, we should stay abreast of the frequently cited standards, so staying connected to information released by the Centers for Medicare & Medicaid Services (CMS) and the accrediting bodies can help you stay informed on important topics and any problematic standards. Additionally, reviewing the history of your own organization may help identify consistent areas of noncompliance.

To outline the process of continuous readiness, we will use The Joint Commission (TJC) functional chapters, a focused review of each functional chapter, and TJC's Intracycle Monitoring process as examples. Whether the focus is on The Joint Commission chapters, CMS *Conditions of Participation* (*CoP*), Healthcare Facilities Accreditation Program (HFAP) standards, or ISO 9000 standards, the process includes the same elements: continuous assessment, intervention, and reassessment. The intent of the process is to bring focus to the issues within each of the categories, identify operational partners (those who own the issue or process), highlight high-risk and problem-prone standards, and focus your resources on sustaining compliance and making improvements, hardwiring compliance, and ensuring safe, quality care. For each functional category that follows, consider these activities:

- Identify the operational partners within your organization that have the content expertise about and responsibility for daily operations related to specific functions, requirements or processes.
- Ensure that you have a process in place to identify and address high-risk issues or issues that, if left unresolved, could have an adverse impact on patients—not because of the regulatory consequences but because it is the right thing to do.
- Partner with the risk management professionals to understand the adverse events and near

misses that are being reported within your organization.

- Partner with the person or team conducting ongoing hazard surveillance rounds to understand the facility and environmental issues that they identify.
- Partner with the infection prevention professionals to understand the outcome of their surveillance as well as the work they are doing to raise awareness and prevent infections during patient care.
- Ensure that you have a process in place to stay abreast of the changes in regulations and standards. Review those changes and integrate them into your functional approach on an ongoing basis.
- Align your policies and procedures with the requirements, but do not make your policies and procedures overly complex and unnecessarily burdensome. Policies and procedures need to be written so they can be read and understood by a new nurse on the first day of work. Remember, you will be held to your policies and procedures, so say what you do and do what you say!
- Focus your limited resources on the issues that will make a difference in patient care, make and monitor improvements, and ensure ongoing compliance.

As a survey coordinator, you have many roles: You are a facilitator and a team builder, an educator, a collaborator, a change manager, a conflict manager, and, sometimes, a politician. Mostly, though, you need to be an advocate for your patients. In order to develop expertise and credibility, focus on what is right and appropriate for patient care. Think quality and patient safety. Understand the "what" and the “why” behind the requirement, and engage your operational partners in helping you to understand their workflow. By doing this, you become the liaison—connecting the regulations to the operations of the organization and ultimately to the provision of patient care.

A functional approach to continuous readiness can provide the survey coordinator and leadership with a road map for improvement. To get leadership and staff on the same page, establish a process (gap analysis) to conduct a thorough and accurate assessment along with an inventory of evidence of compliance. Doing so can also help promote the building and integration of compliance into daily operations. This process is not much different from the care process. It involves assessment, diagnosis, planning, implementation, and reassessment. Putting it into that framework can help you to connect with clinicians, who understand the care process.

While undertaking this functional assessment, ensure that your process captures true operations and practices. Don’t simply review the requirements from memory, and don’t conduct the assessment alone. Use a multimodal team approach, view the actual process or practice and take an active role in assessing compliance. Involve the operational partners and frontline staff. Observe practice, audit data, and processes, conduct risk assessments, and conduct tracers to validate compliance.

Organizations must be able to produce an inventory of contracts. While there may be more focus on clinical contracts, the requirement doesn't differentiate. Figures 3.1 and 3.2 provide a sample checklist and annual evaluation for clinical contracts utilizing the TJC standards and elements of performance. It is important to remember that all contractors must understand the performance expectations and the organization must be able to monitor and measure that the expectations are being met.

Tips for success: Get comfortable with whether your organization can demonstrate oversight of contracted services to ensure that the care being delivered is satisfactory. The first step is to ask administration for a centralized list of contracted services and determine whether it is current. For example, at a management meeting, review the accuracy of this list against the services you offer to determine whether all contractors are accounted for. Doing so is especially important if oversight of contractors is distributed among various leadership staff members. Next, review the contract language to see whether there is a requirement to meet all hospital, Joint Commission, and state or federal requirements. If your contractors are doing business in multiple hospitals, they are aware of what is required. Review all the data elements that are being collected and how they are reviewed.

IMPORTANT NOTE

Many times, when asked about oversight, hospitals will be told that the contractor provides data to the organization on a regular basis, and this is the extent of the conversation. Although hospitals can use performance measures the contractor provides, this must be discussed and agreed upon, and you need to be sure that someone is actually looking at the information and determining whether it is necessary to take action on it. For example, in one organization, consultants found that every physical therapy consult noted during record review was not conducted for five or six days, even though the contractor had a policy stating that physical therapy consults had to be conducted within 48 hours. This information was a surprise to the organization. Think about the impact to operations and patient care in this scenario. Don't put yourself in this position: Rather than accepting canned criteria from the vendor, determine what is important for you to know regarding the vendor's performance to meet your quality expectations on a regular basis. In this case, the time from referral to consult was added as a measure to report. Face-to-face meetings with leadership are a time to discuss issues from both ends to try to avoid magnification of problems down the road.

Patient flow and capacity management

The Leadership and Provision of Care chapters include requirements addressing patient flow not only in the ED but also throughout the organization. Under the leadership standards, the organization is required to measure and set goals for the patient flow process throughout the organization and include the available supply of patient beds; other clinical areas that provide care, treatment, and services to patients (e.g., the laboratory); the efficiency of nonclinical services, such as housekeeping; and access to support services, such as case management.

Figure 3.3 | FPPE: Keep it simple

Introduction

In 2007, The Joint Commission issued the FPPE standard as a way to evaluate the privilege-specific competence of a practitioner who does not have documented competency in executing the privilege. The October 2008 FAQs on FPPE (often referred to as "proctoring") identify two components:

1. "A period of focused professional practice evaluation is implemented for all initially requested privileges." This would include all privileges for new practitioners and all new privileges for existing practitioners.
2. FPPE is also employed when there is a concern regarding the practitioner's current competency, generally identified through a sentinel event, serious complaint, or trend in ongoing professional practice evaluation (OPPE) data. (The 2006 standard MS.4.90 that addressed "peer review" has been eliminated, but the intent shifted to this standard.)

Establishing the Process

The intent of the requirement is that the organization determines the competence of practitioners who request specific privileges, and that these privileges are granted only to practitioners who demonstrate the ability to provide high-quality, safe patient care.

Establish criteria

Evaluation of the competence of a new or an existing practitioner requesting a new privilege must be criteria-based. The medical staff must develop criteria that are relevant to the specialty (new practitioner) or privilege and are used to evaluate the competence of the new practitioner or privilege. The criteria can include general acceptable practice standards and behavioral expectations or triggers (in the case of a new practitioner) and privilege-specific criteria (in the cases of a new practitioner and of a new privilege for an existing practitioner).

Triggers

Triggers could include issues or events that would lead to a case review process with any credentialed practitioner, such as serious complaints; failure to follow medical staff rules and regulations, practice-based guidelines, and hospital policy; and sentinel events, such as unexpected death. Triggers can also include trends and patterns of care, such as diagnosis-specific readmission rates, long lengths of stay, postoperative infection rates, and unexpected admissions following outpatient procedures. These events and patterns of care are applied to all practitioners within the organization and often include the OPPE indicators. For a new practitioner, these triggers would be monitored on a more frequent basis than for an established practitioner.

Privilege-specific criteria

The medical staff must develop privilege-specific criteria, whether for the new practitioner or for a new privilege granted to an existing practitioner. These criteria are generally procedure-based, such as in the following cases:

- A new gastroenterologist applying for privileges. In addition to the triggers established for all new practitioners, the medical staff determines the criteria for monitoring the invasive procedures. Such criteria may include procedure complications, documentation (history and physical [H&P], postprocedure note), use of reversal agents (if the practitioner is responsible for the moderate sedation process), unplanned admission following procedure, and procedure-appropriateness criteria.
- An existing surgeon requesting privileges to perform bariatric surgery. The criteria for this practitioner may include demonstration of education and training for performing bariatric surgery, including oversight of the procedure by a peer (a surgeon experienced in bariatric surgery) and monitoring of five cases by an identified department of surgery proctor.

CHAPTER 4

Risk Reduction Strategies Contribute to Continuous Readiness

What is the best way to prepare for patients each and every day? The best way is to create a safe, effective, and efficient system for providing patient care. It is to become knowledgeable and identify issues in an effort to minimize risks and maximize best outcomes. It is to be prepared. As a survey coordinator in partnership with operational leaders, you know best what your organization does and what patient population it serves. You have a distinct advantage in ensuring that the survey team understands your organization and how you operate to maintain compliance and minimize any risk that might be identified. Demonstrating to the survey team that your organization has given thoughtful consideration to issues that may present risks to the patient and the patient care process is an important aspect of the survey.

Basic Risk Assessment

A basic risk assessment is a process to proactively evaluate the potential for adverse impacts associated with systems and processes, both internal and external to the organization, and related to patients, staff, visitors, and others with regard to patient care and safety or as required by law or regulation.

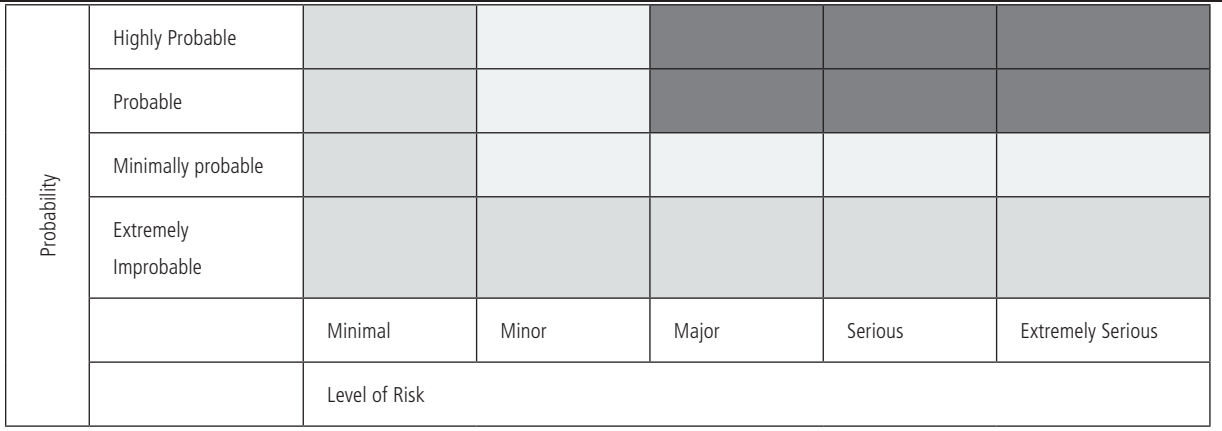
Conducting a basic risk assessment would likely include the following (or a variation of the following) steps:

1. Identify the issue

2. Identify arguments in support of the issue
3. Identify arguments against the issue
4. Evaluate both arguments
5. Come to a conclusion
6. Document the process
7. Monitor the conclusion to ensure that it is correct

When conducting a basic risk assessment, there are several elements of focus. These include an assessment of the valuables that need to be preserved or protected, identification of any threats that might be present or possible, identification of any potential areas of vulnerability or loss, and identification of the controls currently in place. The primary goal is to identify the probability of risk. See Figure 4.1 for more information.

Figure 4.1 | Risk assessment model



Required Risk Assessments

There are "required" risk assessments included in Centers for Medicaid & Medicare Services (CMS) and other voluntary organization standards and requirements. The Joint Commission specifies some required organizational risk assessments as well. National Patient Safety Goal (NPSG) 15.01.01 requires a risk assessment for addressing suicide prevention as well as emergency management and infection control. Note that risk assessments as reviewed here are not the same as the failure modes and effects analysis (FMEA), which is a much more complex study of a process or an issue.

The following are the required Joint Commission risk assessment topics:

- Suicide
- Safety and security: violence in the workplace

Chapter 4 Quiz

1. True or false: The main purpose of taking a multidisciplinary approach to conducting tracers is that it allows all staff members to participate in the process.

   Answer: False. The real value of taking a multidisciplinary approach to conducting tracers is in obtaining a fresh look at your day-to-day practices. For example, staff members from other departments may be unfamiliar with your department's process and can raise issues with practices that other staff members would accept because they are familiar with the practice on the unit.

2. True or false: Not only can a risk assessment support your existing process, but conducting one can also expose vulnerabilities in your practice as you go through your analysis.

   Answer: True.

3. Which of the following is true regarding data management? Circle all that apply.

   a. Data should be organized so that they are easy to sort through to find specific documents requested by the surveyor

   b. Data should be actively managed

   c. All key hospital personnel should be included in the data management system tracer session

   d. The building of a new facility should be included in your PI data because construction and moving will be a huge challenge for the staff

   Answer: a and b. Only key personnel involved in the frontline management of data should be invited to the system tracer, and PI plans should ideally include projects reaching conclusion within a year or so.

CHAPTER 5

Life Safety Compliance for the Non-Engineer

Editor's note: The following chapter was written by ***Brad Keyes, CHSP,*** *of Keyes Life Safety Compliance. He is the contributing editor of HCPro's* **Healthcare Life Safety Compliance** *newsletter and author of several life safety–related books.*

Hospitals have had to comply with the *Life Safety Code*® (*LSC*) for nearly 50 years, since the forerunner of the Centers for Medicare & Medicaid Services (CMS) formally adopted it in 1971. The *LSC* was created by the National Fire Protection Association (NFPA) (which writes codes for other agencies and authorities to adopt but does not enforce them), and its goal is to protect lives from the harmful effects of fire. Created in 1913 as a standard on the proper method of maintaining building exits, the *LSC* has evolved into a proactive code that today involves all facets of building safety, from the type of construction used to the requirements for fire detection and suppression. All of its codes are created by consensus, by committees made up of people who work with the codes on a daily basis.

All hospitals that receive Medicare and Medicaid reimbursements must be in full compliance with the *LSC*, and CMS does not permit any deviations without a CMS-approved waiver. Even though there have been more recent revisions, accreditation organizations (AO) that receive deeming authority from CMS (i.e., who may assess hospitals for compliance with CMS standards) are required to enforce the 2012 edition of the *LSC*. The AOs are not permitted to adopt a more recent edition until CMS decides to do so.

CHAPTER 6

Preparation for Survey

Preparing for the on-site survey and trying to ensure that the survey process runs smoothly can be overwhelming. Although it is everyone's responsibility to make sure that your organization is ready for patients every day, the reality is that when it comes to the survey, your staff depends on you to guide them through the process and toward a successful outcome. Let's look at how to prepare for survey by developing a readiness plan tailored to your organization.

Planning Tools and References

Accreditation application

Make sure that you, as the survey coordinator, have access to your organization's application on The Joint Commission's extranet site. If you don't, identify the person who does. The application is updated on an ongoing basis, at least annually, and you need to ensure that all of your services are accurately accounted for and included. Or In the case of an organization that discontinues services, those changes need to be accurately accounted for.

Electronic application

The voluntary accrediting organizations provide electronic applications. For example, hospitals have access to their e-app, which is available 24/7 on The Joint Commission Connect extranet. It is important to keep your organization's data current and update it any time that there are changes. This information determines the types of surveyors you will receive and how many will conduct the on-site survey.

CHAPTER 7

After Your On-Site Survey

The Joint Commission states that your official survey report will be posted to your extranet site within 10 business days of your survey. Today, many reports are turned around in 24 hours. The final report includes the manual chapter, standards, and elements of performance (EP) found to be noncompliant during the on-site review.

If your organization uses The Joint Commission for deemed status, the report also provides a summary of the noncompliant standards and the Centers for Medicare & Medicaid Services (CMS) *Conditions of Participation* (*CoP*), including A-tags. This summary allows you to match the findings to both the CMS and Joint Commission requirements.

Evidence of standards compliance (ESC) is due within 60 days for all requirements for improvement.

Scoring the Standard

It is important to understand the scoring methodology. For Joint Commission–accredited organizations, based on the EP scores, a standard is scored as either compliant or noncompliant. At the conclusion of the survey, standards determined to be noncompliant are tagged as such and an RFI is generated.

IMPORTANT NOTE

Scoring occurs at the EP level. When a single EP is scored as noncompliant, the standard is designated as noncompliant. The number of EPs located under a standard is irrelevant. It takes only one EP to be noncompliant and to potentially have the standard scored out of compliance. Don't risk the chance of increasing your RFIs by not paying attention to the EP level of a standard.

The Introduction of Criticality

In 2009, The Joint Commission introduced four levels of criticality as a method of focusing on the EPs that have the greatest impact on patient care and safety. To understand these levels, first understand that The Joint Commission defines criticality as the immediacy of risk to patient safety or quality of care as a result of noncompliance. The EPs with high criticality levels are also (in most cases) connected to the square R risk icon. They are EPs that include the following:

- Immediate threat to health and safety (ITHS)—A situation identified during a survey that represents an immediate risk with a potentially serious adverse effect on health or safety of patients. Such a situation has a high level of criticality. These include inoperable fire alarm, adult-strength medications on a pediatric crash cart, lack of master alarms for medical gas systems, and patients with known antibodies receiving transfusions without the units being typed for the corresponding antigen.
- Situational decision rules (SDR)—These decision rules are applied when a situation represents a pattern or trend that may have serious consequences. The SDR situation isn't clear-cut and includes subjective review by the surveyor. Often, Joint Commission surveyors will consult the home office to determine how to proceed with a survey should they identify a potential issue. Examples include a facility without a license, an individual without a license when a license is required, failure to implement *Life Safety Code*® corrective actions.
- Although this categorization is going away, the distinction between direct impact requirements and indirect impact requirements can help you understand the risk level. EPs that were categorized as direct impact were deemed to create an immediate threat to patient safety and quality of care; they represent situations in which very few processes and/or protective defenses stand between noncompliance and a direct impact on patients.

Indirect impact requirements were those that, if noncompliant, carry little or no risk of directly impacting the quality or safety of care. In some cases, noncompliance over time (a pattern or trend) could increase the risk of impact to the patient. Surveyors use SDR to determine the status of any issue they observe.

The SAFER Matrix

In 2015, The Joint Commission introduced the Survey Analysis for Evaluating Risk (SAFER) matrix to assist organizations in visualizing the level of risk represented by each requirement for improvement. The SAFER matrix is a 3-by-3 grid that helps to identify the level of risk and harm observed by the surveyor for a particular EP.

CHAPTER 8

Ongoing Compliance Readiness

Since 2006, hospitals accredited by The Joint Commission have experienced unannounced surveys. Regardless of the accrediting agency, however, hospitals and healthcare organizations need to know whether they are in compliance with The Joint Commission's standards and the Centers for Medicare & Medicaid Services' (CMS) *Conditions of Participation* (*CoP*). Continuous readiness and tools such as the tracer methodology introduced by The Joint Commission have proven useful in assessing both the patient care process and other supportive processes in a hospital to determine gaps in compliance, knowledge deficits, and exemplary practices.

Continuous readiness, including a mock survey approach that fully integrates the tracer methodology, is a good way to take a snapshot of the organization's compliance, remind staff of the survey process so that they maintain a comfort level should an unannounced survey occur, and work on improving any items identified to maintain and improve the state of readiness.

This chapter aims to outline an organized and systematic way of monitoring compliance continuously. In order to successfully prepare for survey and, more importantly, meet patients' needs, integrate the activities described into the operations and infrastructure of the organization's quality process. Doing so will make this process less of a compliance assessment activity and more of a quality assessment, monitoring, and improvement activity.

Chapter 4 introduced the idea of using the tracer methodology to assess risk. Remember, each tracer is a snapshot in time that can reveal areas for improvement as well as areas of exemplary practice. To be continuously compliant or at least continuously aware of compliance status, your organization needs to measure and monitor compliance regularly.

As the survey coordinator, do you know at any given time what the compliance issues are in your organization? Your goal is to know the organization inside and out so that when the actual survey occurs, there are no surprises. Integrating ongoing compliance readiness into daily operations allows you to identify deficiencies and build action plans that lead to compliance on a day-to-day basis rather than once every three years just prior to survey.

This chapter outlines some key steps to consider in maintaining ongoing survey readiness.

Obtain Leadership Commitment

As referenced throughout this book, leadership commitment is essential. In order to maintain a successful continuous readiness program, you must secure senior leadership's commitment to providing the resources and support that the ongoing readiness process will require. You will encounter varying degrees of interest in the accreditation process, but if leadership is not involved and does not openly support the process, you may face barriers when it comes to addressing and resolving issues that are identified. Your first step, therefore, is to determine who the leadership champion or executive sponsor will be for the ongoing process. Who takes the lead on accreditation issues in your organization? Typically, leaders who do so are the chief executive officer (CEO), chief nursing officer (CNO), chief medical officer (CMO), and chief quality officer (CQO) or senior vice president, depending on your organization's size and complexity.

Determining the Approach

You can't ensure survey readiness single-handedly, but you can improve your chances of success by involving the right people. These people should be able to assess current policies and procedures, be able to challenge practices in your organization, and be in a position to leverage change and improvement related to identified issues. You'll also want to match their skills and expertise to the focus of the standards. For example, the director of pharmacy can be your lead counterpart for medication management.

Remember to consider participation across the organization. Don't limit your approach to the inpatient units. Consider ambulatory clinics such as respiratory clinics, ambulatory care clinics, wound clinics,

homecare, and other off-site locations. You want to be able to obtain the best picture and assess the consistency of practices across and throughout your organization.

You can organize your approach according to the sources of truth discussed in Chapter 2. As you think about where to start or what to focus on, you can refer to the functional focus areas discussed in Chapter 3.

It is important to know and understand who the key stakeholders are in any ongoing compliance readiness approach. Most likely, they will include the following:

- You, the survey coordinator
- The performance improvement (PI) director
- Senior managers such as the CEO or chief operating officer (COO), CMO, CQO, vice president, medical director, and physician leaders
- Frontline managers from the multidisciplinary care team (nursing, pharmacy, respiratory, dietary, etc.)
- Staff and management involved in education and competency assessment

The size and complexity of your organization and your team's skill set will help you determine the best approach.

Tips for success: Some organizations have found success in implementing a compliance oversight group. This group, which should include key leadership and PI management, reviews the work of the ongoing compliance readiness team and its findings, action-plan development, and progress toward meeting improvement goals. It is also charged with providing direction to the ongoing readiness teams and removing any roadblocks the teams encounter. The compliance oversight group raises, discusses, and, ideally, resolves issues. If an issue can't be resolved because of concerns such as budget constraints, the group can at least offer guidance as to how to proceed.

Ongoing compliance should not be considered to be its own silo in the organization. If your organization chooses a stand-alone oversight model, the oversight group should have a reporting mechanism through the organization's quality leadership structure. Another option is to assign these responsibilities to a standing quality committee. Whatever the structure, ensure that any issues raised are integrated into the hospital's quality process as appropriate.

Organization of teams by standards chapter

Many organizations decide to organize by chapter because this seems to be a logical approach, and it is often easier for them to operationalize internally, especially when new standards are released. They

APPENDIX

Figure 1 | TJC individual tracer unit survey information sheet

Unit: _____

Date of Visit: _____

Place Patient Identification Sticker Here

_____
Name of Patient

_____
Medical Record Number

_____
Date of Admission

Primary Diagnosis:

Male or Female **Age:**

Secondary Diagnoses:

Special Issues with Patient (i.e., dialysis, chemotherapy, postoperative pt, infections)

Specific Issues Under Review (what is the surveyor looking for/at or discussing)

Surveyor Findings (what did the surveyor say was good or not good)

Surveyor Comments (quotes are always helpful):

Individuals Interviewed (include all)

Any Issues or special comments from Individuals Interviewed

Figure 2 | Inpatient medical record review tracer tool

ED Number/Patient Name: _____

Date: _____ **Time:** _____

Unit Name: _____

Circle issues or deviations from policy/standard; put a line through unproblematic areas.

Emergency Care

Triage

- Delayed wait
- Triage protocols evident
- Medical screening timely/complete
- Pain assessment
- Inpatient process used when admitted/bed delayed

Advance Directives

History & Physical

- Within 30 days prior to admit
- Updated within 24 hours of admit
- Updated on postadmit/prior to surgery

Operative Documentation

- Postprocedure note complete prior to post-anesthesia care unit discharge or to other care
- Pre- and postanesthesia evaluation (plan pre-anesthesia eval; within 48 hours post-OR)
- Immediate reevaluation prior to sedation/anesthesia

Initial Nursing Assessment

- Elements completed per policy
- Within 24-hour time frame
- Falls risk per policy
- Abuse/neglect screening
- Suicide risk assessment, if indicated

Initial Pain Assessment

- Comprehensive per hospital policy if pain present

Education

- Barriers to communication, religion, culture
- Learning preferences/readiness
- Needs identified and resolved
- Patient/family involvement in condition management
- Risk/infection/isolation
- Treatment
- Discharge (includes medications)

Orders

- Orders clear, accurate
- Complete: name, dose, route, frequency
- Unapproved abbreviations
- PRN indications complete
- Range orders complete per policy
- Titration for wean protocols
- Reorder/resume appropriate/legible

Verbal and Telephone

- Verbal or telephone orders taken and read back
- Documented appropriately in record
- Authentication/countersignature within 48 hours (or state)
- MD written orders: date, time, signature

Behavioral Health/Physical Rehab

- Interdisciplinary treatment plan
- Measurable goals

The Survey Coordinator's Handbook
21st Edition

Jodi L. Eisenberg, MHA, CPHQ, CPMSM

The Survey Coordinator's Handbook, 21st Edition, is the ultimate resource in survey prep for all accreditation professionals no matter their experience level. This handbook walks through every step of preparation, explaining key problem areas and highlighting major areas of focus for surveyors.

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