CRITICAL ACCESS HOSPITAL

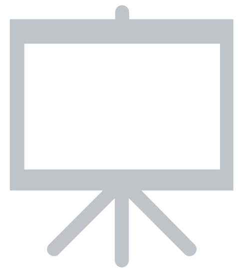
FINANCIAL AND OPERATIONAL VIRTUAL CONFERENCE

June 2024

HOUSEKEEPING

Participants will be muted automatically. If you would like to ask a question or make a comment, please use the chat or Q&A feature.

All sessions will be recorded



Slides and recordings will be made available to all registrants following the webinar

A short survey will follow each conference session. Your feedback is very important to us, and we appreciate your time in helping us improve.

STROUDWATER

Real-world, mission-critical, actionable advisory services as you and your community navigate the dynamic risks of today's healthcare environment.

Stroudwater Associates is a leading national healthcare consulting firm serving healthcare clients exclusively. We focus on strategic, operational, and financial areas where our perspective offers the highest value.

We're proud of our 37-year track record with rural hospitals, community hospitals, healthcare systems, and large physician groups.

- **Strategic Advisory**
  - Strategic Planning
  - Mergers, Affiliations & Partnerships
  - Population Health Strategies
  - Physician-Hospital Alignment
  - Strategic Facility Planning
  - Capital Planning & Access
  - Post-Acute Care Strategy

- **Operational Advisory**
  - Performance Improvement & Restructuring
  - Provider Practice Operations Improvement
  - Revenue Cycle Solutions
  - Post-Acute Care Operations
  - Payor Contracting Advisory
  - Staffing & Productivity Improvement
  - Cost Report Reviews and Analysis

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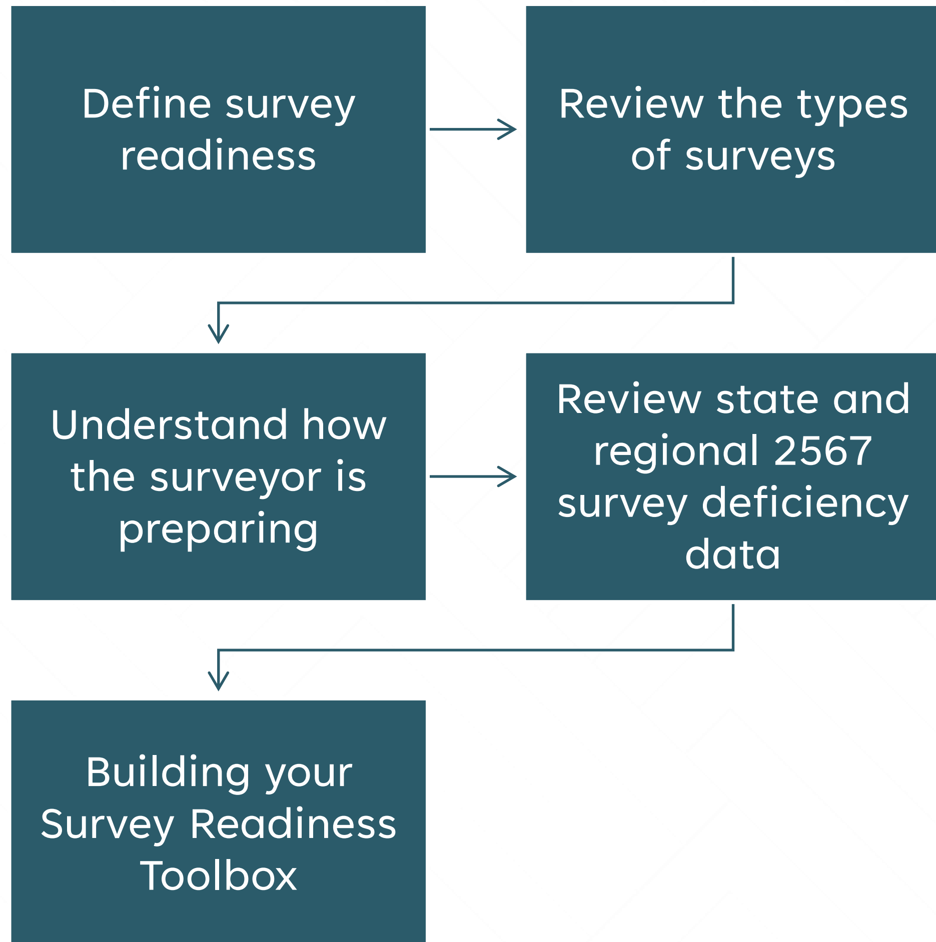
14 16 7 4 11 8 13 6 3 9 17 2 1 12 10 15 5

HOW TO BUILD YOUR SURVEY READINESS TOOLBOX

JUNE 20, 2024

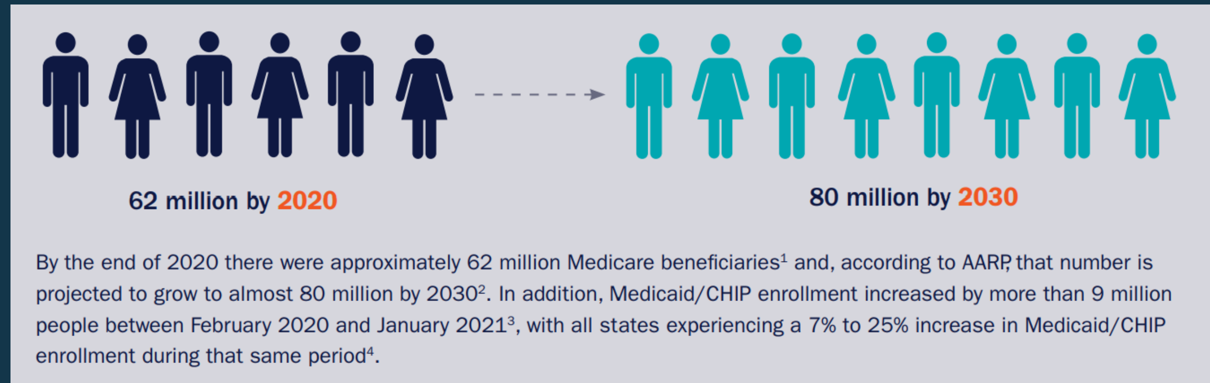
OBJECTIVES FOR TODAY



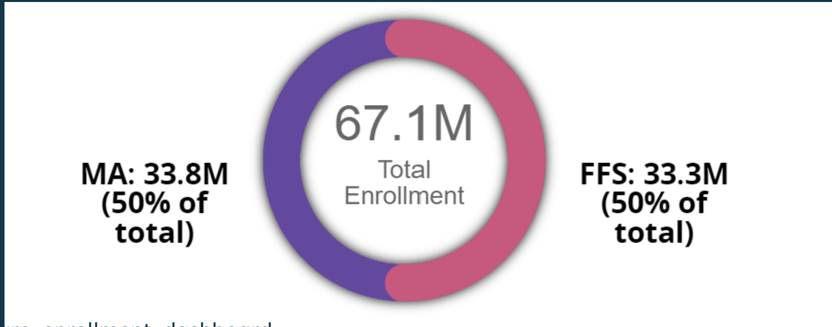
OVERVIEW: SURVEY READINESS

Survey Readiness: Achieving and maintaining an ongoing "prepared" state in which an organization can confidently ensure compliance with regulatory requirements, patient safety, and quality standards.

WHY IS "READINESS" IMPORTANT?



Medicare Enrollment for February 2024



https://www.jcrinc.com/-/media/jcr/jcr-documents/products/advisory-services/cms-survey-whitepaper-final-83021.pdf

TYPES OF CAH SURVEYS

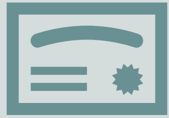
CERTIFICATION SURVEYS

VALIDATION SURVEYS

REVISIT SURVEYS

COMPLAINT SURVEY

CERTIFICATION SURVEY



Certification surveys include both **initial** certification and **recertification** surveys.

CMS describes: “these surveys determine if a prospective or current participant in Medicare and Medicaid meets all applicable requirements for participation and to evaluate the performance and effectiveness of the participant’s care.”

VALIDATION SURVEY

CMS uses validation surveys to validate the performance of an Accrediting Organization, or AO, and to make sure all requirements to participate in Medicare are met.

Currently, there are 4 CMS Approved Accrediting Organizations for CAHs

- Accreditation Commission for Health Care (ACHC)
- The Joint Commission (TJC)
- Center for Improvement in Healthcare Quality (CIHQ)
- Det Norske Veritas- Healthcare (DNV)

CMS selects providers or suppliers for validation surveys on a random basis.

CMS announced in February a Proposed Rule to strengthen the oversight of AOs.

https://qsep.cms.gov/
https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/accrediting-organization-contacts-for-prospective-clients-.pdf

REVISIT SURVEY

- A revisit survey is one in which a survey team re-evaluates a specific deficient area that was cited during a certification survey or during a substantiated complaint survey.
- The revisit survey verifies that the previously cited deficiencies have been corrected.

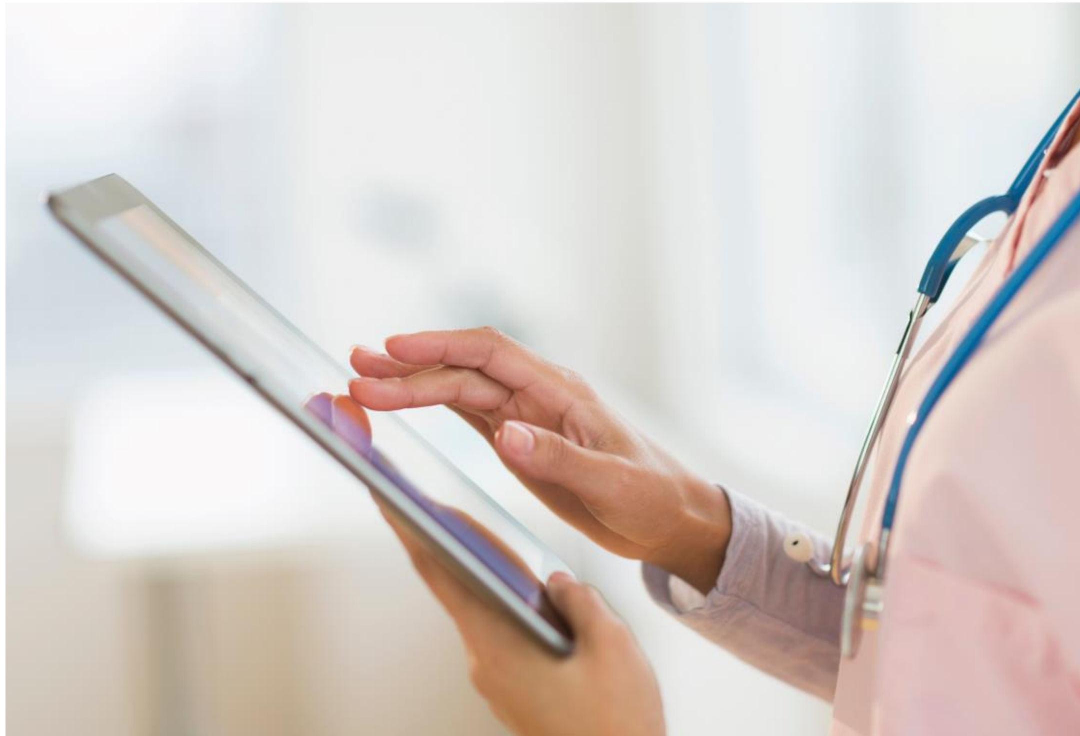
COMPLAINT SURVEY

A complaint survey is conducted after a complaint is filed, which is an allegation of noncompliance with Federal or State requirements or both.

Complaint investigations can be conducted by a State Survey Agency, called an SA, by the applicable CMS location, by an approved State program or State licensure program, or by an Accrediting Organization, or AO.

Investigation into a complaint may or may not result in an onsite survey.

FULL SURVEYS



Certification and validation surveys are always **full surveys that assess an entity's compliance with all CoPs.**

Generally, complaint surveys and revisit surveys are more **focused** though they can be expanded if findings warrant more investigation.

HOW DOES THE SURVEYOR PREPARE?

Surveyors review information about your hospital

- Special features
  - Swing beds, psychiatric, rehabilitation DPUs, off-site locations
- Prior application forms
- Previous survey results
  - POC
- Licensure records
- Media reports
  - Facebook
- Organization website

Surveyors prepare for observations, interviews, record review

During a survey, a surveyor notices a damaged blood pressure machine. A brief interview with nursing staff reveals the machine malfunctions often and has been broken multiple times in the past few months, keeping the staff from using it. One nurse tells the surveyor that staff have submitted multiple requests for it to be fixed, but no one seems to be working on the issue.

During a survey, a surveyor decides to interview a patient regarding a fall. The interview may go something like:

Surveyor: You fell out of bed on Wednesday, is that correct?

Interviewee: Yes, it is.

Surveyor: Would you tell me a little more about how that happened?

https://qsep.cms.gov/

At the beginning of a survey, a surveyor reviews the facility's incident log and finds several reports of medication errors related to antibiotics. Two of the errors were not caught in time and caused harm to the patients. While at the facility, the surveyor conducts interviews with the pharmacy staff and with staff who were involved in patient care. During the interviews, the surveyor learns the pharmacy is using a new label and barcode system, but staff claim they were not trained how to read the new labels prior to implementation.

https://qsep.cms.gov/

STATEMENTS OF DEFICIENCIES (CMS-2567)

Statement of deficiency data is available for Skilled Nursing Facilities, Nursing Facilities, Hospitals & Critical Access Hospitals

2567 is the number associated with the official document used "Form CMS-2567, Statement of Deficiencies and Plans of Correction."

When state survey agencies conduct surveys of acute hospitals, critical access hospitals and psychiatric hospitals on behalf of CMS, they are assessing compliance with Medicare health and safety regulations for the hospitals, the "Conditions of Participation (CoPs)."

The surveyors prepare their survey report on an electronic version of Form CMS-2567 available in a CMS data system that supports survey work. This system contains the text of the regulations, broken down by surveyors into smaller sections called "tags" to facilitate the work of the surveyors to identify regulatory deficiencies and choose the applicable tag.

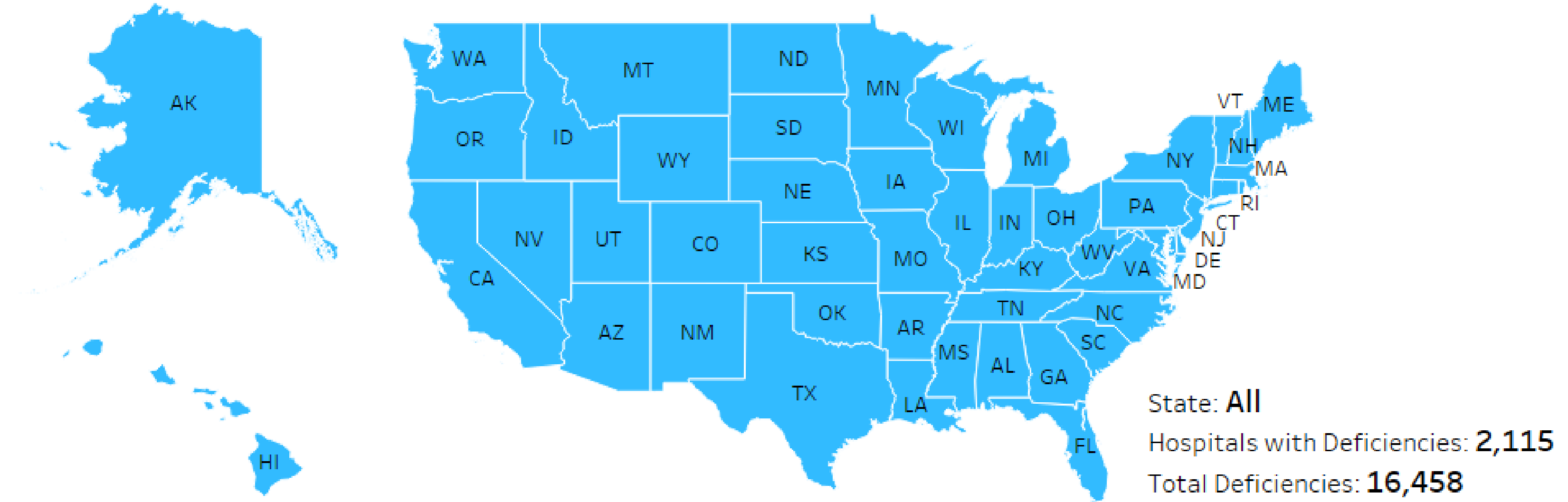
The system generates a Form CMS-2567 with the regulatory text associated with that tag, and then surveyors enter a summary of the evidence for the noncompliance they observed. The survey report is released to the hospital which, depending on the survey findings, may be required to return the Form CMS-2567 with a plan of correction for each area of deficiency.

STATEMENTS OF DEFICIENCIES (CMS-2567)

- There are two different types of citations that CMS can issue.
- A **“standard-level”** deficiency means that the hospital may be out of compliance with one aspect of the regulations but is considered less severe than condition-level.
- The more serious, known as **“condition-level”** means that a hospital is not in substantial compliance with the CoP.
- There is an additional level of noncompliance called **“immediate jeopardy”** that arises when surveyors determine that the hospital’s deviation from regulatory standards constitutes an immediate threat to patients’ health and safety.
  - An immediate jeopardy determination forces a hospital to correct the underlying problems quickly. Termination from participation in Medicare and Medicaid can result in 23 days if the hospital fails to correct the problems.

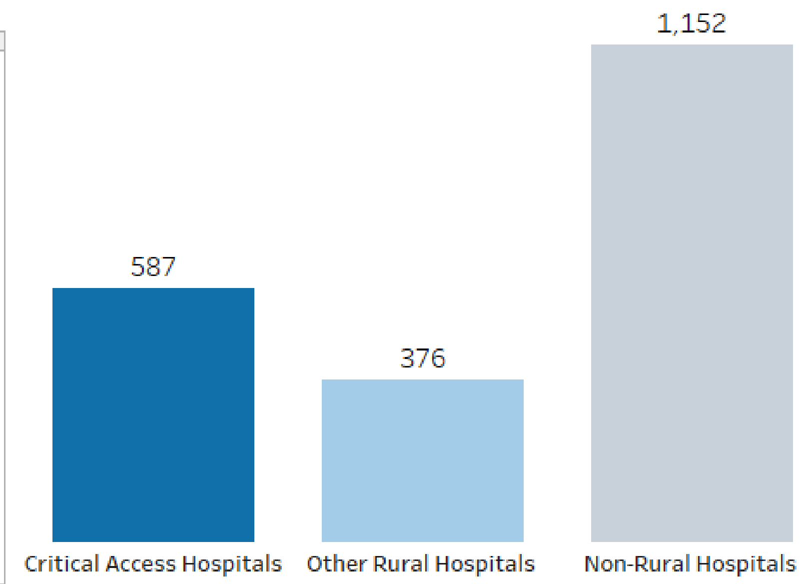
HOSPITAL DEFICIENCIES

Hospital Deficiencies, 1/1/2021 - 12/31/2023



State: **All**
Hospitals with Deficiencies: **2,115**
Total Deficiencies: **16,458**

Description of Deficiency	Hospitals	Total
	2,115	16,458
PATIENT RIGHTS: RESTRAINT OR SECLUSION	266	652
PATIENT RIGHTS: CARE IN SAFE SETTING	407	551
MEDICAL SCREENING EXAM	453	544
COMPLIANCE WITH 489.24	427	539
PATIENT RIGHTS	372	489
NURSING SERVICES	372	484
RN SUPERVISION OF NURSING CARE	318	426
QAPI	208	326
INFECTION CONTROL PROGRAM	244	298
PATIENT CARE POLICIES	200	294
Sprinkler System - Maintenance and Testing	198	228
Electrical Systems - Essential Electric Syste	183	219
SUPERVISION OF CONTRACT STAFF	171	211
STAFFING AND DELIVERY OF CARE	151	190
Hazardous Areas - Enclosure	171	190

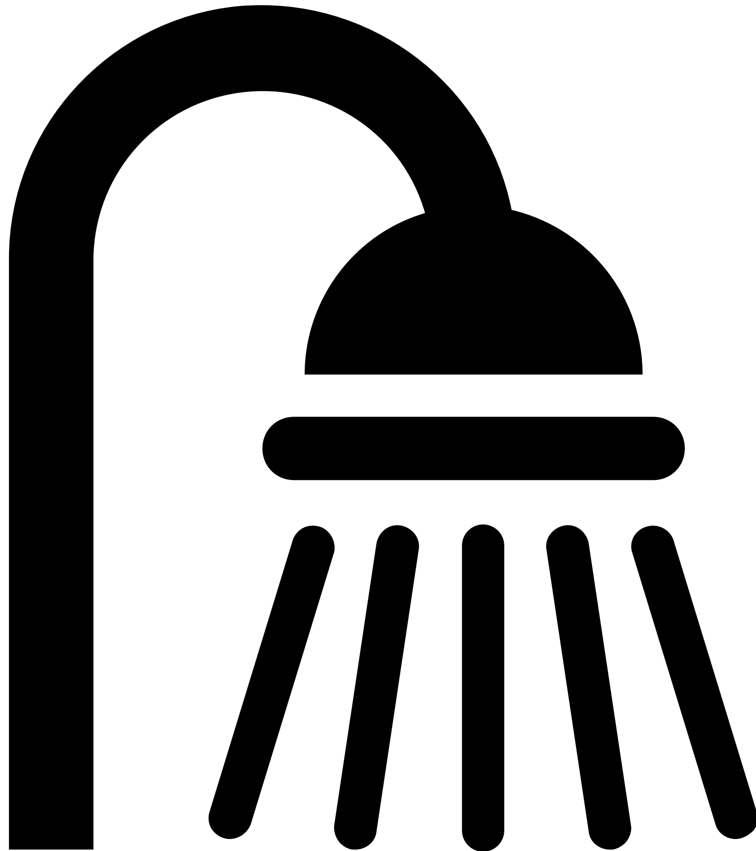


Source: CMS Hospital 2567 Statement of Deficiencies

CMS 2567 TOP TEN RURAL DEFICIENCIES

	Deficiency Tag	Deficiency Description	Distinct Count of CCN	Total Deficiencies
1	K0353	Sprinkler System - Maintenance and Testing	175	199
2	K0918	Electrical Systems - Essential Electric System	158	168
3	K0321	Hazardous Areas – Enclosure	143	156
4	C1208	Infection Prevent Surveil & Control of HAIs	139	153
5	K0712	Fire Drills	128	133
6	C1206	Infection Prevention & Control Policies	114	123
7	C0914	Maintenance	102	108
8	C1016	Patient Care Policies	102	108
9	K0345	Fire Alarm System – Testing and Maintenance	100	114
10	A2400	Compliance with 489.24	97	116

TAG DESCRIPTIONS



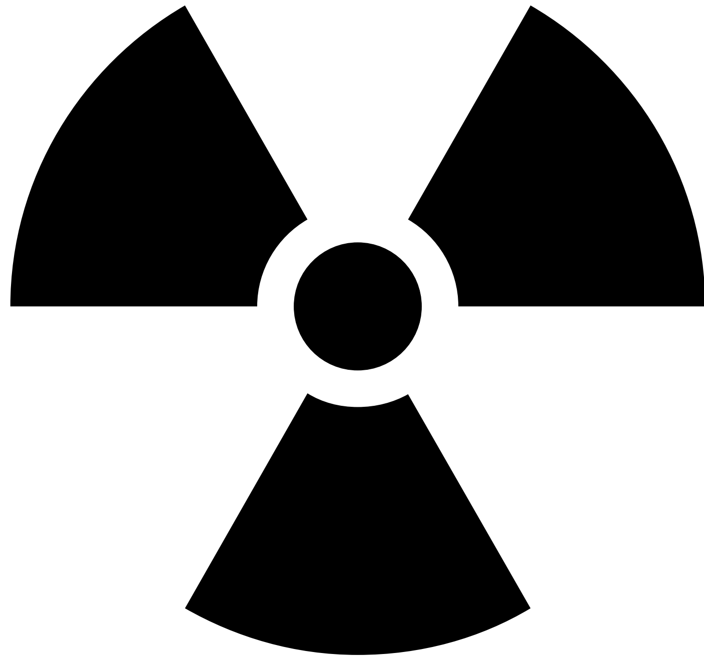
1. **K353 - Sprinkler system**
   - Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.
     - Date sprinkler system last checked
     - Who provided the system test
     - Water system supply source

TAG DESCRIPTIONS

2. K918 - Electrical Systems - Essential Electric System

- The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.
- Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

TAG DESCRIPTIONS



3. **K321 – Hazardous Areas – Enclosure**
   - Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4.

   Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

   a) Boiler and Fuel-Fired Heater Rooms
   b) Laundries (larger than 100 square feet)
   c) Repair, Maintenance, and Paint Shops
   d) Soiled Linen Rooms (exceeding 64 gallons)
   e) Trash Collection Rooms (exceeding 64 gallons)
   f) Combustible Storage Rooms/Spaces (over 50 square feet)
   g) Laboratories (if classified as Severe Hazard - see K322)

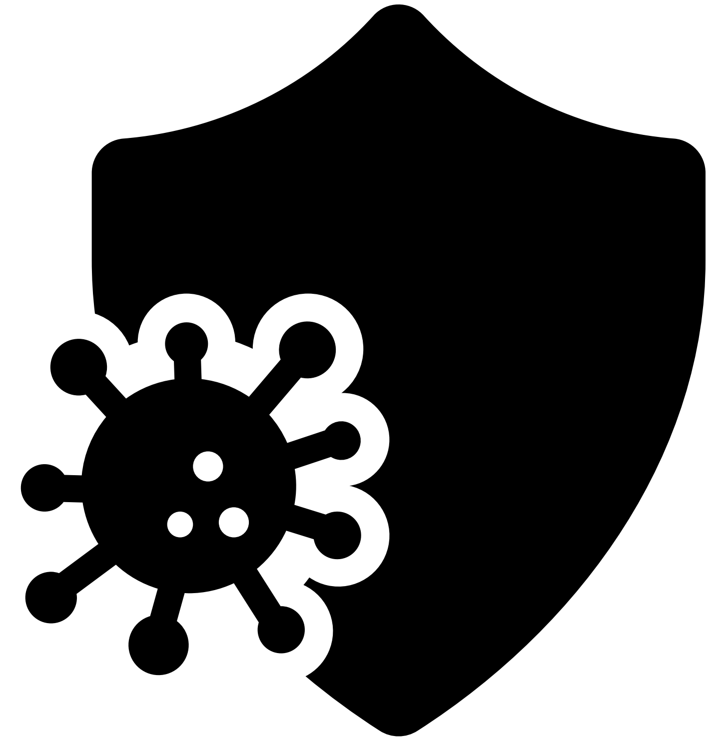
TAG DESCRIPTIONS

4. C1208 – Infection Prevention Surveillance & Control of HAIs

- §485.640(a)(3) The infection prevention and control includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and the program also addresses any infection control issues identified by public health authorities; and

5. K712 – Fire Drills

- Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of an established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.



TAG DESCRIPTIONS

6. **C1206 - Infection Prevention & Control Policies**
   - §485.640(a)(2) The infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the CAH and between the CAH and other healthcare settings
7. **C0914- Maintenance**
   - §485.623(b) The CAH has housekeeping and preventive maintenance programs to ensure that
     - (1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;

TAG DESCRIPTIONS

8. **C1016 Patient Care Policies**
    - §485.635(a)(3)(iv) [The policies include the following:] Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.
9. **K345 Fire Alarm System – Testing and Maintenance**
    - A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.

TAG DESCRIPTIONS

10. A2400 – Compliance with 489.24

- Special responsibilities of Medicare hospitals in emergency cases. EMTALA
- According to John Berry, Specialist Principal Consultant, CMS at Joint Commission Resources, one of the areas in which health care facilities are most often found lacking in a CMS survey is EMTALA.

https://www.jcrinc.com/-/media/jcr/jcr-documents/products/advisory-services/cms-survey-whitepaper-final-83021.pdf

EMTALA FOOD FOR THOUGHT

- **HOSPITAL A:** Failure to provide an adequate medical screening examination and stabilizing treatment.
  - 35-year-old male with chest pain and shortness of breath who presented to the ED accompanied by his girlfriend.
  - Pt. requested to see a physician and became belligerent when a nurse asked him why. That led to the patient being escorted out of the ED by security. Several minutes later, the patient returned to the ED in the girlfriend’s truck. She told staff he had a seizure.
  - She was informed by staff that they would not help get the patient out of the truck. In addition, the security guard told her she had to leave.
  - The patient's girlfriend then took him to another hospital, where he was pronounced dead within 20 minutes of his arrival.

- **HOSPITAL B:** Failed to stabilize an Emergency Medical Condition (EMC)
  - 58-year-old patient who presented to the ED for blurred vision and dizziness.
  - After failing to provide an appropriate EMC, an ED nurse directed the patient to a local eye doctor and failed to provide medical treatment to stabilize the patient's EMC, a cerebral infarction.

EMTALA FOOD FOR THOUGHT

- **HOSPITAL C-**

  - An off-duty volunteer at a hospital presented to the ER and told staff at triage desk he was nauseated and felt like he needed to throw up. He hoped he would get in and home quickly.
  - The ER was nearly empty.
  - His wife and son visited the triage desk repeatedly, and over the next 2 hours he lost his ability to speak or respond to questions. His breathing became labored. During a trip to the bathroom, his legs buckled, and he needed the support of his wife who yelled “I can’t hold him up”. She pounded on the wall separating the bathroom from the triage desk.
  - Noone came so his son dialed 911 asking if they could take his dad to a different ER.
  - Since the operator told the son they couldn’t pick up at the ER and suggested they get his dad to the parking lot so paramedics could pick him up. The wife and son did just that and took the man to the back seat of their car.
  - Paramedics arrived, realized he was too sick to transport, took him back inside through the ambulance entrance where ER personnel began jumping into action.
  - After an hour, the ER staff were performing CPR and the man died.

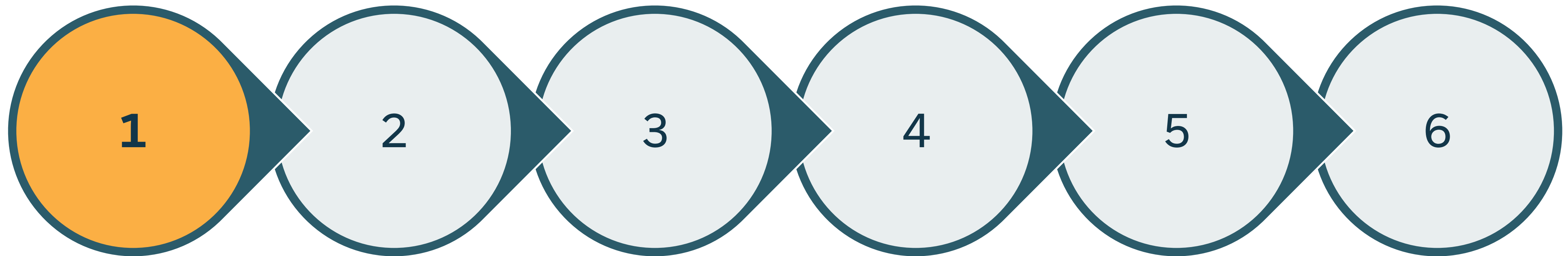
https://www.georgiahealthnews.com/2018/11/investigation-finds-lives-lost-er-violations/

USE THE DATA

Addressing the top CMS deficiencies in a specific state/region				
Provides insights into common areas of non-compliance	Can help you prioritize efforts to address potential organizational compliance gaps	Helps you be proactive and prevent or mitigate these deficiencies before a CMS survey occurs	Tailor training and focus on areas identified as high risk for non-compliance	Develop a targeted action plan to address specific deficiencies and improve overall compliance throughout the hospital

BUILDING YOUR TOOLBOX

SIX KEY TOOLS



1. **Utilize your past survey – plan of correction**
2. Maintain Document Checklist- Assign owners
3. Develop a revolving calendar by month for policy review/revision- Assign owners
4. Conduct internal "Tracers" (Ideally teams are multidisciplinary)
5. Create a "daily checklist" and assign specific areas at the daily huddle
6. Design and print a "pocket guide" for staff

UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation: CMS State Operations Manual § 485.635(d)(3)***
  - *(1) 485.635(d)(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.*
  - *This STANDARD is not met as evidenced by:*
- **Finding**
  - Based on document review, observation, and interview, the facility did not adhere to the protocol used for administering aerosol-generating treatments (a technique for administering medication into the lungs)

➢ **Plan of Correction**

  ➢ It was determined that the Nursing staff needs additional education on the proper administration of aerosol therapy

  ➢ To ensure ongoing compliance, we will develop an audit process to assess whether proper elements of performance are being followed during the administration of aerosol therapy. Beginning in December 2022, audits will continue monthly for 6 months, or longer, if needed to achieve 100% compliance for 3 consecutive months.

    ➢ Audit results are being reported to the Chief Nursing Officer

UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation: Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101***
  - *Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.*
- **Finding**
  - Based on document review and interview, the facility does not ensure that the fire alarm system is tested annually at the Primary Family clinic
- **Plan of Correction**
  - To prevent the recurrence of this issue, we will establish a "planned event" alert in our Total Maintenance System. One month before the due date, Maintenance staff will receive a reminder to schedule a date for the inspection. In addition, we are exploring a change in vendors. Starting in September 2022, we will begin a compliance audit with a goal of 100% compliance. Audits will continue monthly for 6 months, or longer if needed, to achieve 100% compliance for 3 consecutive months.

UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation: Corridors - Construction of Walls CFR(s): NE-PA 101***
  - *Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code.*
  - *Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames.*
  - *If the walls have a fire resistance rating, give the rating if the walls terminate at the underside of the ceiling, give brief description in REMARKS. describing the ceiling throughout the floor area.*
- **Finding**
  - Based on observation and interview the facility did not maintain all corridor walls with a minimum l-hour fire resistance rating

➢ **Plan of Correction**

  ➢ To ensure future compliance we have initiated a bi-monthly above the ceiling inspection process. Starting in September 2022, we will begin a compliance audit with a goal of 100% compliance. Audits will continue monthly for 6 months, or longer if needed to achieve 100% compliance for 3 consecutive months. Audit results are being reported to the Facilities Management Director

    ➢ In addition, staff and contractors will be specifically instructed to ensure proper fire-caulking is completed as part of any work that involves penetration of fire walls and barriers

UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation***
  - *Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lb. is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. 'n sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.*
- **Finding**
  - Observations found on the ground floor, in the corridor leading to the skilled nursing facility, revealed the right leaf of the fire-rated cross corridor doors did not fully close when allowed to swing from the fully open position

➢ **Plan of Correction**

  ➢ The corridor doors have been placed on the Facilities Management bimonthly inspection schedule. The inspections will be audited, beginning June 2022. Audits will continue monthly for 6 months, or longer if needed to achieve 100% compliance for 3 consecutive months.

UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION

- ***Regulation***
  - *Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.*
- **Finding**
  - Observations found on the first floor, above the drop ceiling in front of the main hospital elevator, revealed a vertical wire chase penetrating the underside of floor 2 with the fire stopping pulled away
  - Observations found on the second floor, above the drop ceiling in front of the main hospital elevator, revealed a vertical wire chase penetrating the underside of floor 3 with the fire stopping pulled away

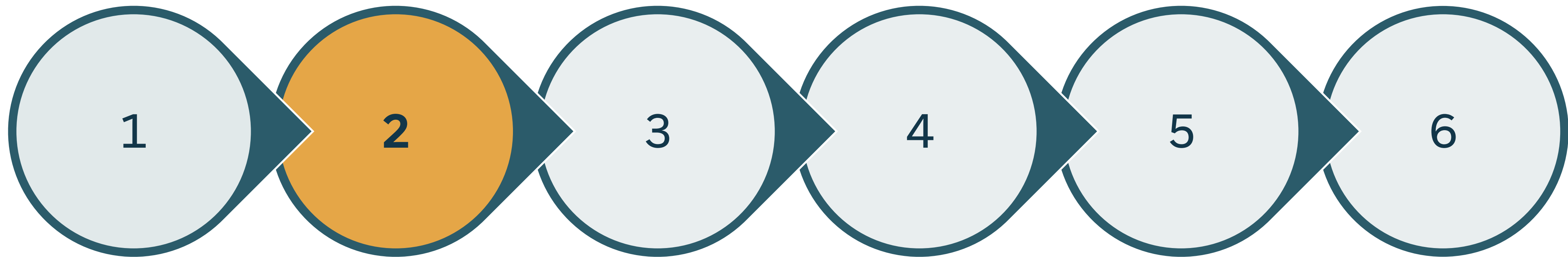
➢ **Plan of Correction**

  ➢ To ensure ongoing compliance, a bimonthly above-the-ceiling inspection plan has been initiated. These inspections will be audited, beginning July 2022. Audits will continue monthly for 6 months, or longer if needed to achieve 100% compliance for 3 consecutive months.

  ➢ Audit results are being reported to the Facilities Management Director

  ➢ In addition, we will educate staff and contractors to complete proper fire caulking as part of any work which involves penetration of fire walls and barriers

SIX KEY TOOLS



- Utilize your past survey – plan of correction
- **Maintain Document Checklist- Assign owners**
- Develop a revolving calendar by month for policy review/ revision- Assign owners
- Conduct internal “Tracers” (Ideally teams are multidiscipli nary)
- Create a “daily checklist” and assign specific areas at the daily huddle
- Design and print a “pocket guide” for staff

MAINTAIN DOCUMENT CHECKLIST

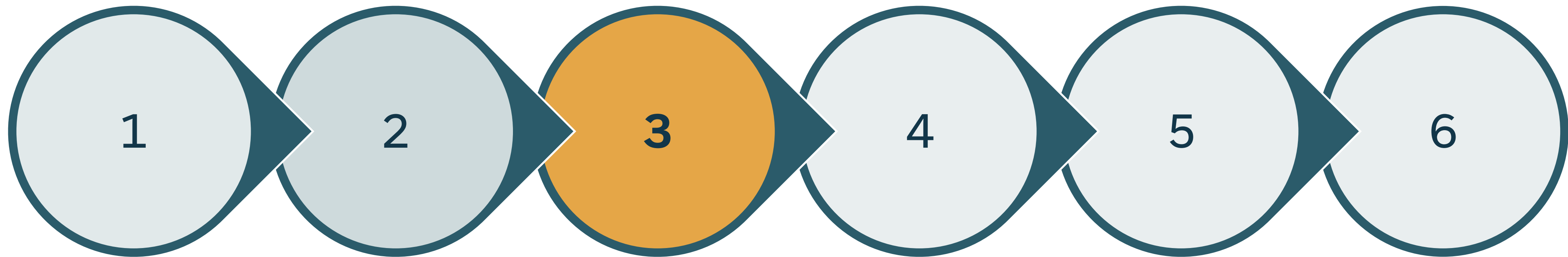
- **Divide into categories and assign an owner to each category.**
  - **General Organizational Detail**
    - Org chart etc.
    - Bylaws
  - **Meeting Minutes and Reports**
  - **Plans and Policies**
    - Emergency Management Plan
    - Medication Management Policy
  - **Contracted Services**
  - **Logs**
    - ED Log
    - Incident
    - Grievances
    - Daily Census
    - Staffing Matrix
  - **Measurement Data, KPIs, Analyses**
    - QAPI
    - Scorecards

EXAMPLE

Meeting Minutes and Reports

- Med Exec meeting minutes
- P&T
- Board meeting minutes
- Quality Committee Meeting Minutes
- Fire Drill Documentation-Evaluations
- Infection Prevention/Antibiotic Stewardship

SIX KEY TOOLS



- Utilize your past survey – plan of correction

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- Create a "daily checklist" and assign specific areas at the daily huddle

- Design and print a "pocket guide" for staff

DEVELOP REVOLVING CALENDAR FOR POLICY REVIEW/REVISION

- Divide into logical categories/departments and assign and owner to each.
  - Human Resources (Jan.)
  - Environment of Care (Feb.)
  - Information Management (Mar.)
  - Life Safety (Apr.)
  - Medication Management (May)
  - Nursing (June)
  - Provision of Care (July)
  - Patient Rights/Responsibilities (Aug.)
  - Document Management (Sept.)

EXAMPLE

Medication Management (May)

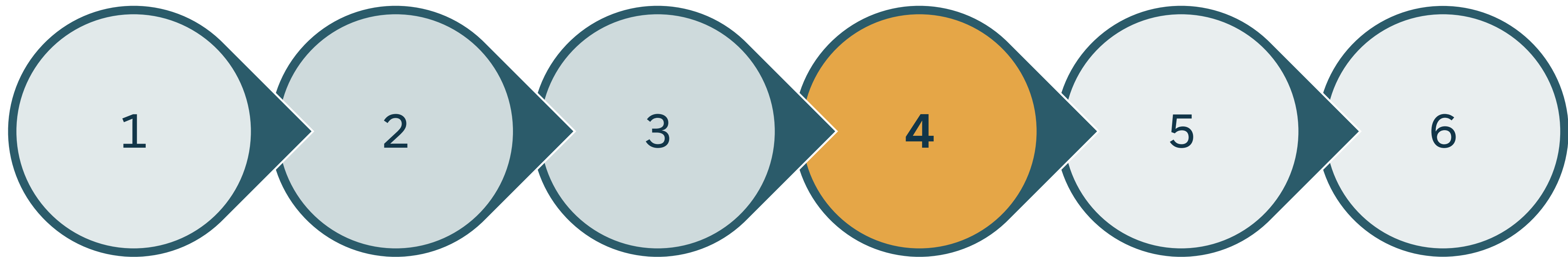
- **Acceptable Medication orders**
- **Medication Administration Process**
- **Disposal of Expired Medication**
- **Wasting of Narcotics**

Ensure Review/Revision Date

Appropriate Signatures

Updated References

SIX KEY TOOLS



1. • Utilize your past survey – plan of correction
2. • Maintain Document Checklist-Assign owners
3. • Develop a revolving calendar by month for policy review/ revision-Assign owners
4. • **Conduct internal “Tracers” (Ideally teams are multidisciplinary)**
5. • Create a “daily checklist” and assign specific areas at the daily huddle
6. • Design and print a “pocket guide” for staff

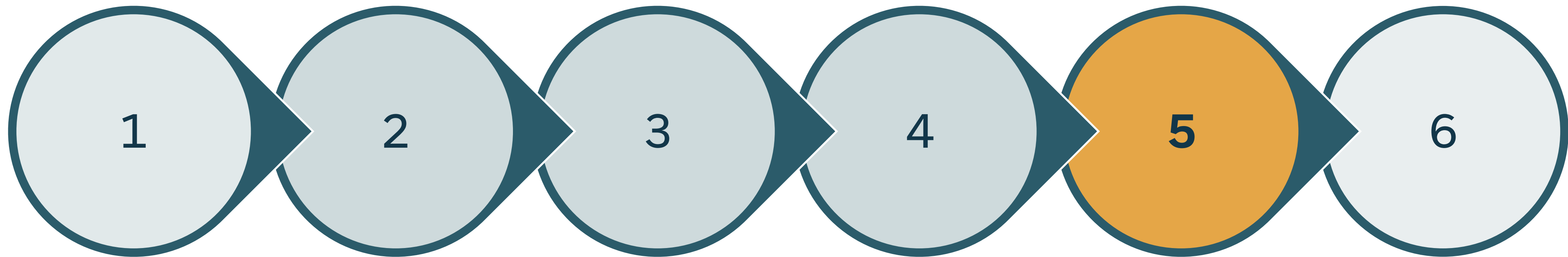
CONDUCT INTERNAL TRACERS

- **Convene "Tracer" Team**
  - *Tracer methodology* —A targeted approach used during hospital surveys to assess compliance with regulatory standards and identify areas for improvement.
  - Follow the path of patient care, from admission to discharge, to evaluate the implementation of policies and procedures.
  - Provides a comprehensive understanding of how policies are translated into practice.
  - Identifies potential gaps in compliance and patient safety.
  - Promotes staff engagement and accountability.
  - Offers actionable insights for quality improvement initiatives.

EXAMPLE

- Leadership — Select tracers **MONTHLY** based on high-risk areas, sentinel events, or regulatory focus.
- Team—Observe patient care processes, including interactions with staff, documentation, and protocol adherence in "real-time."
- Team—Document findings
- Team and key members — Review findings and develop actionable steps for corrective action.

SIX KEY TOOLS



- Utilize your past survey – plan of correction
- Maintain Document Checklist- Assign owners
- Develop a revolving calendar by month for policy review/ revision- Assign owners
- Conduct internal "Tracers" (Ideally teams are multidisciplinary)
- **Create a "daily checklist" and assign specific areas at the daily huddle**
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CREATE DAILY CHECKLIST

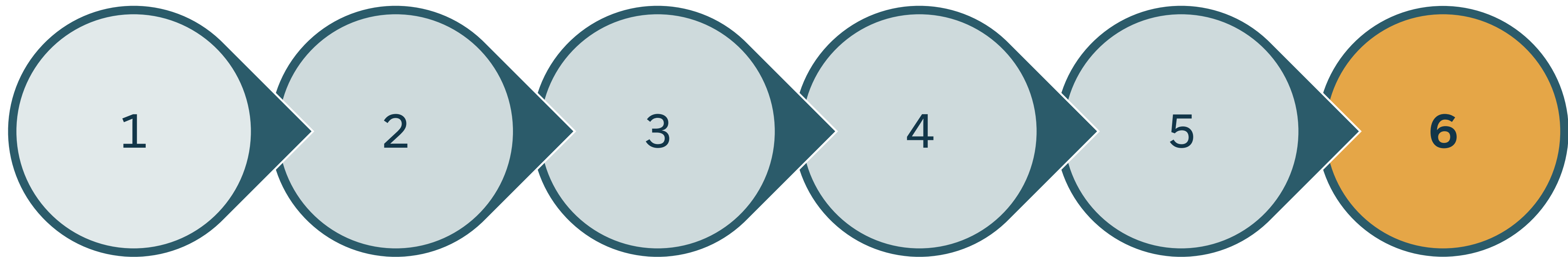
- **Create a checklist of items to be checked daily. Assign a few items to huddle members each morning.**
  - Medications
  - Nutrition area
  - Dirty Utility Room
  - Clean Utility Room
  - Patient Rooms
  - Medical Record Check
  - Equipment Maintenance
  - Egress
  - Warmers
  - Refrigerators
  - Documentation audit

EXAMPLE

Assign Medications to a team member at huddle with the list below

- Medication room locked if in unsupervised area
- Correct medication refrigerator thermometer setting
- Medication refrigerator log complete with actions for any out of-range temperatures documented
- Medications secure with no medications unattended
- Multi-dose vials dated with 28-day expiration date
- No open single-dose vials available for reuse
- Cleaned pill cutters and mortar/pestles
- No unwrapped IV fluids (unless dated with a 24-hour use date)

SIX KEY TOOLS



- Utilize your past survey – plan of correction

- Maintain Document Checklist- Assign owners

- Develop a revolving calendar by month for policy review/ revision- Assign owners

- Conduct internal "Tracers" (Ideally teams are multidiscipli nary)

- Create a "daily checklist" and assign specific areas at the daily huddle

- **Design and print a "pocket guide" for staff**

DESIGN AND PRINT A POCKET GUIDE FOR STAFF

- Organization-specific information
- May include, but not limited to:
  - Mission/Vision/Values
  - Human Resources/Staffing-Orientation
  - Unacceptable abbreviations
  - Medication Management
  - ALL Emergency Codes
  - Environmental Safety
  - Fire Safety Codes and information
  - Infection Prevention
  - QAPI-Quality Measures
  - Patient Safety
  - Patient Rights
  - HIPAA
  - Advance Directives
  - Potential survey questions

"Failing To Prepare Is Preparing To Fail"

Benjamin Franklin

APPENDIX

RESOURCES

- https://www.cms.gov/newsroom/fact-sheets/accrediting-organization-proposed-rule-fact-sheet
- https://www.federalregister.gov/documents/2024/02/15/2024-02137/medicare-program-strengthening-oversight-of-accrediting-organizations-aos-and-preventing-ao-conflict
- https://qsep.cms.gov/
- https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/accrediting-organization-contacts-for-prospective-clients-.pdf

QUESTIONS

COMMENTS

CONCERNS

COMPLAINTS

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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