Are you ready for inspection every day, any time?

It makes sense, doesn't it? Hospitals should be ready for examination without notice. After all, every patient deserves our best. No one in your organization would disagree with that. But it's not just a matter of doing your best to deliver quality care. The snag is ever-changing regulations. Whether you're accredited by JCAHO or HFAP/AOA (Healthcare Facilities Accreditation Program, a division of the American Osteopathic Association), or subject to a review against the CMS Conditions of Participation, you face a huge challenge in assuring your organization is always ready for an unannounced survey.

From scheduled to impromptu: making the transition

The pressure of last minute survey preparation is no longer a worry. Instead, we now must be equipped for surveyors to present themselves at our doors at any time. Leaders need to understand the importance of maintaining a continuous state of survey readiness.

This paper outlines a six-step plan to get your team knowledgeable about the standards, comfortable with the process and engaged in ongoing education. They'll experience less stress and exhibit more confidence. Your outcomes will show it.

A QHR White Paper: Maintaining Readiness for Unannounced Surveys

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Getting started

If you're JCAHO-accredited, preparation begins with the Periodic Performance Review. You're required to use this process annually to score your compliance with each JCAHO standard and elements of performance. Model the JCAHO survey process itself by validating compliance through tracer activity. Then develop plans of action for correcting any faults, along with measures for success to document progress.

HFAP/AOA-accredited hospitals begin with leadership ensuring that policies and procedures are in place as delineated in the accreditation manual. Supplement policy and procedure development with department visits and staff interviews.

To achieve and maintain compliance with regulations and accreditation standards, leaders and employees must be engaged in the process.

For CMS compliance, get familiar with the interpretive guidelines for the CoP regulations, as these determine the survey process. Use chart review and observation of patient care to check your readiness.

Involve staff: communication and education

These are merely the starting points for ensuring unremitting survey readiness. To achieve and maintain compliance with regulations and accreditation standards, leaders and employees must be engaged in the process. Staff must be knowledgeable of important JCAHO, HFAP/AOA and/or CMS issues. The following six steps will help you get your team enthused about the process, minimize their stress and reduce the potential for poor survey outcomes:

1. Intelligence is bliss: develop staff understanding of standards
2. Who's on first? Assign accountability for evaluation
3. Know the ropes: get familiar with common survey citations
4. Fix flaws: develop plans of action for noncompliance
5. Get creative: evaluate and measure outcomes of action plans
6. Keep it up: ongoing education is the answer

Constant Compliance: how do you know when you're there?

Hospital leaders need to understand what a state of readiness looks like; then create the structure and activities that will allow the organization to achieve it and maintain it.

What does readiness look like?

- Data are aggregated and analyzed
- Results of data analysis are communicated and acted on
- Committee structure is conducive to communication from leaders to line staff and back up the ladder
- Staff members are able to talk about patient safety and quality goals – and what the hospital is doing about them
- Workers are aware of the hospital as a whole, not only their niche
- Your staff members are familiar with the regulations and standards

You're not ready if…

- Your hospital isn't analyzing data, or staff isn't knowledgeable of results
- Your team isn't familiar with the quality and safety goals, or the hospital's efforts
- Workers see only their own department's function; they're not aware of the hospital as a whole
- They don't know the JCAHO, AOA or CMS regulations or language
- Staff members aren't cognizant of changes in regulations; they don't understand why procedures change

Step #1: Intelligence is bliss: develop staff understanding of standards.

We fear what we don't understand. And your staff may have little understanding of CMS' Medicare Conditions of Participation (CoP) and the applicable JCAHO or HFAP/AOA accreditation standards. Key stakeholders must be educated about the regulations and standards and the implication of JCAHO or HFAP/AOA accreditation deemed status with CMS. Education begins with providing the tools the survey is based on (applicable to your facility):

- JCAHO Comprehensive Accreditation Manual for Hospitals
- JCAHO Accreditation Manual for Critical Access Hospitals
- Healthcare Facilities Accreditation Program (HFAP) Requirements for Healthcare Facilities Manual developed by AOA
- CMS Medicare Conditions of Participation

Providing these tools to your department managers and directors is the first step toward realizing continuous survey readiness. They'll need to educate their teams about the standards, both in general for the whole hospital and in particular for their department or function.

The CMS Regulations and Interpretive Guidelines for Hospitals and Critical Access Hospitals are applicable to any facility receiving federal funding through the Medicare program. Both JCAHO and AOA have what is called "deemed status" with CMS. Therefore, organizations accredited by either Joint Commission or the American Osteopathic Association are deemed as essentially meeting the CoPs and are exempt from an annual review against the CoPs. However, it is important to know any organization is subject to on-site CMS review, either on a random basis or as a result of a complaint or public issue. Hence, if you are JCAHO- or HFAP-accredited, you also must be compliant with the nuances of the CoPs.

Any organization is subject to on-site CMS review, either on a random basis or as a result of a complaint or public issue. So, if you are JCAHO or HFAP accredited, you also must be compliant with the nuances of the CoPs.

Step #2: Who's on first? Assign accountability for evaluation.

Who should be responsible for evaluating your hospital's compliance with accreditation and regulatory standards? To decide, first consider your organization's structure: size, scope, culture, services offered, number of staff, etc. Take an inventory of internal and external resources. Review the literature to identify common recent survey citations. And, perhaps most importantly, consider your past survey experiences to get an idea of compliance concerns. This information will help you determine how and to whom accountability should be assigned. It may be that a current team or a new team would best handle the job, or that certain individuals or departments would best manage certain chapters or functions within the standards.

The planning process must involve members of leadership who demonstrate and lend overall support and promote engagement into the process. Once it has been decided how accountability will be assigned, determine which staff members will be selected and educated for evaluating and rating compliance with the regulatory and accreditation requirements that are applicable to your facility's services, programs and populations served. Consider representatives from key departments and areas of care along with a representative sample of department directors and frontline staff. Keep in mind that many improvement processes require medical staff input, so get them involved in the planning process. The key to making it through this developmental phase is not to delegate but to involve the staff.

Finally, determine what sources of data are appropriate for review and analysis. Look at what data are already collected. Typically you will determine that sufficient data exists; however, you may find that you need to accomplish more in-depth aggregation and analysis. The data sources will be the driving force for determining compliance with CMS Interpretive Guidelines, JCAHO Standards and Elements of Performance, and HFAP/AOA Standards and Scoring Procedures.

Step #3: Know the ropes: get familiar with common survey citations.

What are the 'hot topics" on surveyors' minds? The staff who are responsible for evaluating compliance with the regulations and standards need to know. Keep abreast of current literature related to survey findings. Also, consider networking with other organizations that have experienced recent surveys to discover the particular focus of the survey teams.

And don't forget the findings from your previous survey. Surveyors will not only focus on current issues but also the specific citations for your organization from your last survey. Your compliance will be assessed based on the plans of action you submitted, the implementation of the plans and successful maintenance of the outcomes you described.

Attaining this level of understanding, your staff will develop expertise in compliance requirements. They'll begin to take ownership of the process.

12 Most Common Citations

- Medications not secured appropriately
- Assessments not per hospital policy
- Inconsistent implementation of patient safety initiatives
- Monitoring of practitioners' performance not part of medical staff credentialing process
- No PI data aggregated or analyzed
- H&P not done as required by medical staff rules and regulations
- Operative reports not completed as required by med staff rules and regulations
- High medical records delinquency rate
- Inadequate medical records confidentiality
- Lack of orientation for new staff
- Infractions of life safety code issues (fire drills, etc.)
- Patient rights issues (grievance process, advance directives, etc.)

Step #4: Fix flaws: develop plans of action for noncompliance.

Now the rubber hits the road! Action is required to achieve compliance with the regulations or accreditation standards that do not meet compliance expectations. To create an action plan for findings of partial or insufficient compliance, develop a description for each regulation or standard found out of compliance. How was this regulation or standard not compliant? Can we identify the reason?

Then, determine who is responsible for monitoring the implementation of the plan of action and the date compliance is expected. The plan of action must identify the organization's strategy for resolution, who is responsible and how the tactics of execution of the plan will take place. Your plans are easier to measure if you use action words in your plan of correction. Examples of action terminology are educate, conduct, display, list, distribute, amend, revise.

The success of this step is to involve key stakeholders in developing the plan since they most often are the ones who bring the plan to life. Setting the goals, designing the plan and implementing its steps, your staff will begin to buy in to the process.

How Can We Fix This?

Often a plan of action is simply common sense, with follow through.

Noncompliance:	Unauthorized access to medical records
Cause:	Records are left out on the counter when coding staff leaves for the day.
Investigation:	Where else can we put them?
Solution:	Select a file cabinet drawer for work in progress. Put all unfinished files there each day; lock the drawer.
Noncompliance:	Unauthorized access to medication (violation of CMS, JCAHO, federal law)
Cause:	Medications are stored in multiple locations; some are secure, some less so.
Investigation:	Where are medications stored? In PYXIS – who has code? Crash carts in ED, OR, Cath lab, etc. – are they locked or under constant surveillance?
Solution:	Secure all storage sites. Allow access only to individuals such as pharmacists, nurses and therapists (not security or housekeeping personnel).

Step #5: Get creative: measure outcomes of action plans.

It may take various different methods to verify that your plans of action have worked. Determine what evaluation method is needed for each initiative by the nature of the regulation or standard not in compliance and the type of action you took.

Did noncompliance occur because the organization lacked a policy? Then, the outcome of the action plan could be measured by (1) development of a policy and (2) observations to ensure consistent implementation of the policy. Other measures could include systematic random sampling for medical record review, observation of clinical practice, interviews for staff knowledge, or facility and building inspections.

Are we better yet?

To check on medical records confidentiality and medication security, you'll have to get up from your desk and walk around. Use a "mystery shopper" approach to observe who has access to files and medications. Typically, the department with most medication violations is surgery, with anesthesia carts left unlocked. You'll have to get into scrubs to find out.

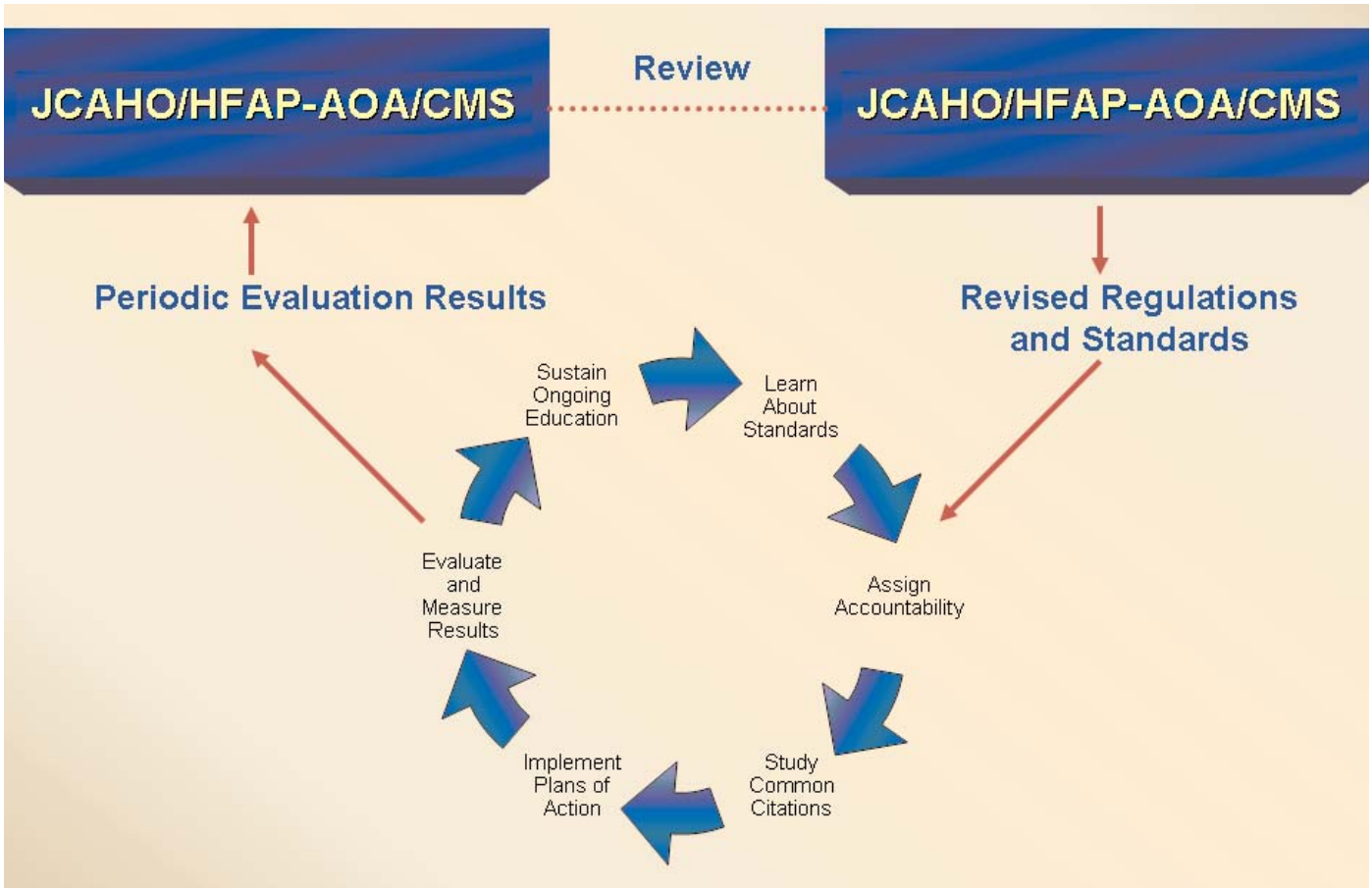
Of utmost importance in attaining conformity with the standards is to communicate and share data to report progress (or lack of it). This key step is often missed, with serious consequences. Without it, staff will lose enthusiasm for the process. They're busy enough without this extra work. Give them a reason – a positive reason – to continue to care about it, and they will. So don't forget to celebrate your successes. When you reach a goal, or get closer to one, recognize staff contributions and accomplishments. Seeing their work valued, staff will take more ownership of the process… and pride in its success. That's when you know you're on the path to continuous readiness.

Step #6: Keep it up: ongoing staff education is the answer.

With your action plan in place, you now have a method to chart your progress toward improved compliance. However, it is important to also keep staff apprised of the ever-changing focus of survey processes as well as new or revised regulations and accreditation standards. To keep up with changes, utilize the resources available from your accrediting organization (i.e., web sites, updates to accreditation manuals, publications, Federal Register, etc.).

Assign responsibility to appropriate staff members to stay abreast of updates and changes. Develop a plan for disseminating the information to the appropriate departments and hospital and medical staff members. Finally, use performance improvement methods to monitor corrections and to determine the need for review and reeducation of staff.

Process for Maintaining Continous Readiness



MAINTAIN YOUR HOSPITAL'S READINESS FOR UNANNOUNCED SURVEYS BY MAINTAINING AN ENVIRONMENT OF LEARNING. SEEK INFORMATION REGULARLY TO KEEP UP WITH REVISIONS TO REGULATIONS AND STANDARDS. REDESIGN EDUCATION AND EVALUATION APPROPRIATELY.

QHR's Accreditation and Regulatory Readiness Services

For more than 17 years, QHR has helped health care providers – from critical access hospitals to tertiary medical centers – achieve successful accreditation and regulatory review results. We can guide you to a state of continuous survey readiness. For more information, call Linda Almond at 1/800-233-1470, ext. 2190, or read about QHR's JCAHO services at www.QHR.com (click on consulting services, then JCAHO services).