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CMS

Will TJC get tougher? CMS okays AO status but outlines concerns

by A.J. Plunkett (aplunkett@decisionhealth.com)

Expect The Joint Commission (TJC) to get tougher on some areas of survey, particularly with the physical environment and off-campus facilities, and to change the level of detail in its daily briefing about what surveyors are finding.

In mid-July, CMS confirmed that TJC—one of the nation's longest-running accrediting organizations (AO) and a longtime standard-setter in patient safety—has earned CMS approval as an AO for hospitals.

But only for two years.

The Federal Register *announcement of the approval* noted that CMS had concerns about TJC's ongoing performance, saying the AO may not be tough enough.

A former TJC accreditation executive says the notice could lead to more condition-level findings and more on-site follow-up surveys.

CMS outlines problems

The last time TJC was renewed as a hospital AO was in 2014, for a six-year period. That ran out as of July 15, 2020.

In a special filing in the July 15, 2020, Federal Register, CMS published a notice that TJC had been approved as a hospital AO through July 15, 2022.

The federal announcement made a point of saying that the approval was only two years, instead of the six-year maximum allowed by regulation. CMS most recently approved four- or six-year terms for TJC's competitors.

"This shorter term of approval is based on our concerns related to the comparability of TJC's survey processes to those of CMS, as well as what CMS has observed of TJC's performance on the survey observation. Some of these concerns stem from the level of detail TJC provides in the daily briefings it provides to facilities, as well as TJC's processes surrounding its staff interview practices. Additionally, we are concerned about TJC's review of medical records and surveying off-site locations, in particular for the Physical Environment *Condition of Participation (CoP)*," said CMS in the notice.

In the last few months, TJC has revised or expanded standards to meet CMS demands related to its application for reapproval, along with updates to conform to *CoP* revisions for burden reduction and discharge planning. Among other things, according to the notice, TJC also increased surveyor training to meet CMS demands.

Still, CMS said it remains "concerned about the thoroughness of review conducted within the facilities." The agency acknowledged all the changes TJC has made, but "we will continue ongoing review of TJC's survey processes across all their approved accrediting programs to ensure that all our recommended changes have been implemented. In keeping with CMS's initiative to increase AO oversight, and ensure that our requested revisions by TJC are complied with, CMS expects more frequent review of TJC's activities to avoid any continued inconsistencies."

TJC leads AOs in hospital deeming

TJC is the *chosen AO* for more than 4,400 general, pediatric, long-term acute, psychiatric, rehabilitation, and specialty hospitals in the United States, including Puerto Rico. That's roughly 85% of about 5,200 community hospitals total in the U.S., according to the *American Hospital Association*.

The rest of those community hospitals are deemed safe enough to bill Medicare by three other AOs—HFAP, DNV-GL Healthcare, and the Center for Improvement in Healthcare Quality (CIHQ)—or by CMS surveyors spread through regional and state offices.

Both *CIHQ* and *HFAP* accredit about 125 hospitals apiece, while *DNV-GL*—the only for-profit AO for hospitals—says it has accredited about 600 facilities since entering the accreditation market in 2008.

CMS approved CIHQ for continued status as an AO in 2017 for six years, while DNV-GL and HFAP were approved for four years, in 2018 and 2019, respectively.

The approval terms for both HFAP and CIHQ said only that the organizations met or exceeded CMS expectations. DNV-GL also met expectations, but CMS said it would conduct a follow-up site visit at the organization's corporate headquarters within 18 months to "verify DNV GL's continued compliance with the provisions of *this final notice*."

CMS unhappy with all AOs for awhile

For several years, *CMS has cracked down on TJC and all the AOs*, even separating out a performance report on AOs to Congress that had previously been part of the agency's annual financial report.

Then in December 2018, CMS *issued a request* for comment on possible conflicts of interest by AOs that also offered consulting services for a fee.

In February of this year, CMS sent the Office of Management and Budget (OMB) a *proposed rule* to review on "Strengthening Oversight of Accrediting Organizations (AO) and Related Provisions." While that proposal was expected to be published in the spring, it still is before the OMB, presumably backlogged because of the coronavirus pandemic.

In 2019, CMS also published a *proposed rule* adding new requirements and a specific process "to address changes of ownership in the sale, transfer, or purchase of assets of Accrediting Organizations (AOs) for the Centers for Medicare & Medicaid Services (CMS) approved accreditation programs." The change was designed, said CMS, "to provide CMS the ability to receive notice when an AO is undergoing or negotiating a change of ownership (CHOW) and the ability to review the AO's capability to perform its tasks after a CHOW has occurred, in order to ensure the ongoing effectiveness of the approved accreditation program(s) and to minimize risk to patient safety."

That proposal is not expected to be finalized until at least 2022 now.

In the most recent performance report on AOs to Congress, the fiscal year 2018 "*Review of Medicare's Program for Oversight of Accrediting Organizations and the Clinical Laboratory Improvement Validation Program*," CMS was particularly critical of what it called the disparity rate in *CoP*-level problems found by CMS surveyors in follow-up site visits several weeks after an AO survey.

To get a more accurate look at AO performance, CMS said it was redesigning its AO validation surveys to put CMS observers on-site at the same time as the AO survey.

While the AO report to Congress pointed to disparities, TJC did not do much worse than the other AOs, especially given that TJC conducted so many more surveys than the others.

Expect tougher TJC surveys

The concerns CMS voiced about TJC in this latest public notice almost certainly means the long-time accreditor will make more changes and get even tougher on surveys.

The previous concerns about disparity rates and AO performance is likely "the underlying reason for desiring a change in performance," says **Kurt Patton, MS, RPh**, a former director of accreditation services for TJC and founder of Patton Healthcare Consulting.

He says he found a significant section of the approval outlining differences between TJC's standards and requirements for accreditation and CMS' conditions and survey requirements (see excerpt, page 4) "to be misleading relative to TJC changing its standards. As written, it makes it seem as if there was some longstanding defect in TJC's standards, and that is not the case."

"These changes relate to the federal burden reduction initiative, and TJC took a leadership role in drafting standards before CMS had published new interpretive guidance. Yes, they are now consistent, but TJC was ahead of the curve on this issue," says Patton.

"The changes in survey process seem most significant and unfortunately may make TJC more like CMS. In particular, it sounds like CMS wants them to provide less details during the morning briefing. That is one of the nice features about the TJC process today," notes Patton. "They tell you exactly what they are finding, and where they found it. Nothing in the detailed briefing goes away, but the client has a clear awareness of what was wrong. The CMS exit briefing is much less detailed, almost obscure, and the organization is less informed about what to fix until the detailed printed report is mailed."

Asked to clarify the wording in the approval notice, CMS responded that it was indeed concerned that TJC surveyors provide too much information. "Providing too much detail or having extensive discussions before or during a facility inspection survey can potentially compromise the integrity of the survey process. Based on the level of detail shared, a facility could correct potential deficiencies mid-course, which would skew the findings and final outcome of the investigation," said CMS in an email. (See additional CMS statement on page 5.)

"There is also a required change to no longer interview frontline staff in front of their supervisors," notes Patton. "This seems to assume that frontline staff are intimidated by their supervisors and will tell the surveyors where the defects are only if supervisors are not present."

"The approach discounts all the active listening, shared governance, and leadership training that hospital managers and staff have today to work collaboratively. TJC surveyors have always been attentive to overly zealous managers who answer for staff, and surveyors have politely gotten them to back off without acting like secret police."

Patton draws particular attention to a couple of items in the approval in which CMS discusses how TJC determines the severity of a deficiency.

"The last item I noticed in changes to the survey process is a commitment to better train surveyors about the 'severity' of deficiencies. This is where the link occurs to the AO disparity rate. CMS wants the AOs to find the same condition-level findings that they find. However, this is the most subjective part of the survey process because there is no published, clear guidance or bright line of demarcation from CMS establishing what is a standard-level finding and what is a condition-level finding," says Patton.

"The advice is to use 'manner and degree,' which requires hundreds of different surveyors to uniformly decide it is only a standard-level finding or it is a condition-level finding. The only way to win at this game is to up-score to a condition-level finding more often than not."

Warns Patton: "That last issue may result in more condition level findings and more on-site follow-up surveys."

What was TJC's reaction?

For its part, TJC took a conciliatory stance on the short approval period.

TJC released this statement from **Mark R. Chassin, MD, FACP, MPP, MPH**, TJC's president and CEO, in response to the notice:

"The Joint Commission is pleased that the Centers for Medicare & Medicaid Services (CMS) recognizes the value of continuing to grant hospital deeming authority to The Joint Commission. The deeming authority designation allows The Joint Commission to evaluate our nation's hospitals for compliance with CMS health and safety requirements, while also surveying for adherence to our own rigorous quality performance standards. All issues raised by CMS about comparability of our respective processes were adjudicated during the deeming authority application process, as noted in CMS' public notice granting approval of our application.

"The Joint Commission appreciates that CMS began an initiative last year to increase its oversight of all hospi-

tal accrediting organizations. We will continue to demonstrate that Joint Commission accreditation provides the nation's most state-of-the art and effective evaluation of hospitals. We look forward to our ongoing work with CMS to improve patient safety and quality of care." ■

CMS

Notice outlines CMS differences with TJC requirements

In an announcement that The Joint Commission (TJC) has been approved for two years as a Medicare accrediting organization (AO), CMS outlines what it sees as the differences between TJC standards and its own requirements. (More on announcement, page 1.)

Hospital *Conditions of Participation (CoP)* in Medicare are under the Code of Federal Regulations for Public Health, beginning with *Part 482*.

The following, edited lightly for style, is excerpted from the notice published in the Federal Register, which can be found at *https://www.federalregister.gov/documents/2020/07/17/2020-15599/medicare-and-medicaid-programs-application-from-the-joint-commission-for-continued-approval-of-its*.

CMS: Provisions of the final notice

A. Differences Between TJC's Standards and Requirements for Accreditation and Medicare Conditions and Survey Requirements

We compared TJC's hospital accreditation requirements and survey process with the Medicare *CoP*s of parts 482, and the survey and certification process requirements of parts 488 and 489. Our review and evaluation of TJC's hospital application, which were conducted as described in section III. of this final notice, yielded the following areas where, as of the date of this notice, TJC has completed revising its standards and certification processes in order to:

- Meet the standard's requirements of all of the following regulations:
  - Section 482.21(b)(2)(i), to incorporate language related to using patient care data to monitor the effectiveness and safety of services and quality of care.
  - Section 482.22(c)(5)(ii), to include comparable language, which requires that the updated examination of the patient including any changes in the patient's condition be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
  - Section 482.23(c)(6)(i)(A), to address patients' self-administration of hospital-issued medications that may be allowed by a hospital pursuant to a practitioner's order (specifically to incorporate a comparable standard to ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting such self-administration of medications).
  - Section 482.26(d)(2), to address timeframes related to records retention of accredited hospitals.
  - Section 482.41(c)(2), to include reference to the NFPA Health Care Facilities Code (NFPA 99) (2012 edition).
  - Section 482.57(b)(1), to incorporate language related to written documentation requirements for personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out such procedures.
  - Glossary adjustment to incorporate language to include the caregiver or support person within the definition of family member.

In addition to the standards review, CMS also reviewed TJC's comparable survey processes, which were conducted as described in section III. of this final notice, and yielded the following areas where, as of the date of this notice, TJC has completed revising its survey processes in order to demonstrate that it uses survey processes that are comparable to state survey agency processes by:

- Providing additional clarity to how TJC determines the size and composition of the organization's survey teams for hospitals as required under § 488.5(a)(5) including Life Safety Code (LSC) surveyors.
- Modifying TJC's accreditation award letter to facilities to remove the term "lengthen" to eliminate potential conflict as it relates to survey cycle length not to exceed 36 months, as survey cycles for deeming purposes do not exceed this timeframe.

- Adding references to the 2012 edition of the (NFPA) Health Care Facilities Code (NFPA 99) within its Accreditation Process and Surveyor Activity Guide.
- Providing clarification to its Surveyor Activity Guide indicating that the 2012 edition of the NFPA Life Safety Code and NFPA 99 applies at hospital outpatient surgical departments, regardless of the number of patients served.
- Providing clarification to its Surveyor Activity Guide indicating that surveys must consider all hospital provider-based locations.
- Requiring additional training for TJC's surveyors and adjusting TJC's survey processes as they relate to off-site locations, to include surveying for LSC and other physical environment standards.
- Making adjustments to TJC's survey processes as they relate to leading and probing questions during interviews.
- Making adjustments to TJC's survey processes as they relate to providing a setting, which promotes ease of sharing information with surveyors during interviews, in particular placing restrictions on interviewing staff in front of first line supervisors.
- Requiring additional training for surveyors and making modifications instructing surveyors regarding the level of detail provided to the facility during TJC's daily briefing, to ensure it does not change the integrity of the survey process.
- Requiring additional training for TJC's surveyors and adjusting TJC's survey processes as they relate to in-depth review of medical records.
- Making modifications to TJC's survey processes as they relate to the "Governing Body" Condition of Participation (§ 482.12). Specifically:
  - Clarifications to TJC's governing body Tracer and Leadership sessions, as they relate to discussion-based investigation techniques and record reviews.
  - Determinations of deficiencies and TJC's preliminary decision making processes, such as determining the severity of deficiencies, and TJC's process for citing the governing body based on the deficiencies found at a facility.
  - Citing the governing body for deficiencies within a facility's physical environment based on the severity of deficiencies.
- Clarifying timeframes for Plans of Corrections to be submitted by the facility to TJC and TJC's performance of Evidence of Standard Compliance (ESC) processes, as well as onsite follow up surveys as part of TJC's ESC survey activities.
- Modifying TJC's survey process related to providing each patient in the sample a unique identifier in deficiency reports and for TJC surveyors to have appropriate identifiable information on a separate identifier list which can be provided to the facility upon exit.
- Clarifying and providing additional training to surveyors related to survey processes and procedures for review of credentialing and human resources and/or personnel file reviews. ■

CMS

CMS clarifies some concerns about longtime accreditor

by A.J. Plunkett (aplunkett@decisionhealth.com)

Given The Joint Commission's (TJC) more than 60-year presence in hospital accreditation, *Inside Accreditation and Quality* went to CMS for some clarification on its concerns that led to only a two-year renewal for TJC as an accrediting organization.

Those concerns included a statement that "some of these concerns stem from the level of detail TJC provides in the daily briefings it provides to facilities." *IAQ* asked whether that meant too much or too little detail.

Here is the response from CMS:

"Consistent with our strong commitment to patient care, quality and safety requirements, the Centers for Medicare & Medicaid Services (CMS) approved The Joint Commission's (TJC) deeming authority renewal application for hospital accreditation for a period of two years; the agency has the discretion under applicable regulations to approve accreditation organizations for up to the maximum allowed time period of six years.

"CMS' decision-making is guided by systemic concerns surrounding TJC's hospital survey process and how they compare to CMS' hospital survey processes

established by federal regulations and program guidance. These and other quality of care concerns [were] publicized in media outlets, citing a need for greater consistency. The agency believes, in this case, a shorter time period between renewals is necessary [to] provide CMS with an opportunity allowing for additional review and to obtain evidence of TJC's effective oversight processes. The agency will work with TJC to help sustain its ability to assure compliance with federal accrediting organization (AO) requirements. This decision to reduce the length of TJC's approval period for deeming authority builds on earlier steps CMS has taken to strengthen federal oversight of AOs and to ensure that patients are receiving high quality, safe care in the nation's healthcare facilities."

CMS added this as additional background:

"Deeming authority is a public trust responsibility that CMS takes seriously.

"CMS review found flaws and a lack of continuity in TJC's hospital program renewal application, and compliance with Medicare requirements. Although CMS review found flaws and noncompliance with some of the Medicare requirements, CMS worked with TJC to address and make corrections. However, continued oversight is needed to ensure that changes are implemented and put into action in upcoming surveys.

"Problems in TJC's application were found during CMS' review of TJC's renewal application for hospital deeming authority. CMS found that TJC's survey processes were inconsistent with federal survey processes followed by the state survey agency, including: 1) the level of detail included during a daily exit conference; 2) the adequacy of TJC's investigations and analyses of CMS's hospital "governing body" requirements (42 C.F.R. § 482.12); and 3) compliance with CMS' requirements for monitoring its accredited hospitals."

When asked again to clarify the concerns about "level of detail," CMS sent this reply:

"In this application's case it means too much detail. Providing too much detail or having extensive discussions before or during a facility inspection survey can potentially compromise the integrity of the survey process. Based on the level of detail shared, a facility could correct potential deficiencies mid-course, which would skew the findings and final outcome of the investigation." ■

You be the surveyor

What deficiencies would you cite and why? And how would you correct them?

by A.J. Plunkett (aplunkett@decisionhealth.com)

You be the surveyor.

The following information was taken from a CMS Form 2567 "Statement of Deficiencies" posted online by the federal agency under its Quality, Certification and Oversight Reports (QCOR) group.

The website—https://qcor.cms.gov/hosp_cop/HospitalCOPs.html—*was announced in 2018 as a way for Medicare to put more pressure on accrediting organizations (AO) and healthcare providers to improve patient safety by highlighting facilities with what it calls "recent substantial deficient practice."*

The reports are usually from within the previous six months, and the search matrix shows whether the surveyors declared an immediate jeopardy and if the survey was because of a complaint, a recertification, or a validation of an AO's performance.

Read the following information. See if you can cite the same A-tag deficiencies that CMS surveyors did using the federal agency's State Operations Manual (SOM), *Appendix A, with interpretive guidelines to enforce Medicare* Conditions of Participation. *The report findings are included at the end of this article.*

The survey

One morning in late March, almost two weeks after the national pandemic emergency was declared because of the 2019 novel coronavirus, CMS surveyors visited an acute care community hospital in a Chicago neighborhood with 168 employees and a patient census of 69. The surveyors observed the following:

At the hospital entrance, there was no screening of visitors walking into the building. At the security desk, visitors signed the log and walked to the area of the hospital they needed, including pharmacy, laboratory, radiology services, or other areas.

The hospital's "Visitor Registration Log" showed 32 visitors between 5:30 a.m. and 12:15 p.m. "The document did not include any type of questionnaire or screening done to the visitors walking into the hospital building," noted the surveyors.

The surveyors reviewed a hospital document, entitled "Visitor Policy Update for COVID-19," dated two days after the national emergency was announced. The policy said, among other things, that "effective immediately until further notice, we are not allowing visitors in any [of] our inpatient and outpatient areas." The document did not outline screening of visitors walking into the building.

Surveyors interviewed three people, including the hospital's public safety officer, who stated, "I do not do any screening. I just have them sign the visitor log;" the hospital's infection control practitioner, who said, "Definitely, we must be screening the visitors walking into the building. I am not sure why they are not doing the screening;" and the hospital's chief experience officer, who stated, "We do not have any screening done for the public or [visitors that walk] into the building."

Surveyors also reviewed the hospital's policy on "Respiratory Protection Program COVID-19," which stated that the hospital was to ensure "staff are trained, equipped, and capable of practices needed to: Prevent the spread of respiratory diseases including COVID-19 within the facility," and included a provision for healthcare personnel that if the hospital had even one patient test positive for coronavirus, "all healthcare workers that had close contact with a patient [who] tested positive for 2019 novel coronavirus will be screened for symptoms daily before shift for 14 days."

Surveyors then reviewed the hospital's "Employee Health-Exposure to COVID Form," which included "an algorithm required to follow when employees have been exposed to 'Person Under Investigation' (PUI). The algorithm included [risk] categories (low, medium, or high) that provided guidance post-exposure. If the employee is categorized as low risk, then they are to self-monitor temperatures for 14 days. If the employee is considered medium or high risk, then they are required to wear a mask and [undergo] active monitoring through Employee Health for 14 days."

The hospital was then presented with a list of employees who had been exposed to two patients who'd tested positive for COVID-19: Of them, 19 were exposed to patient one and 46 were exposed to patient two. "The list indicated the employees who were on self-monitoring or active monitoring of their temperatures, as required twice a day for 14 days."

Surveyors then reviewed a hospital log that included the active and self-monitoring sheets received from the employees. There were only seven active monitoring sheets and two self-monitoring sheets out of the 65 total employees exposed.

The surveyors returned to the hospital the following day and reviewed staff time sheets that "indicated that 43 of the 65 exposed staff are currently working. However, there is no consistency of how these staff are being monitored."

That same morning, the hospital's chief clinical officer showed surveyors an "Employee Temp Log 2020" that the officer said was from the hospital's Employee Health department. The temperature log included employees that were on active-monitoring status and were required to have their temperatures taken upon arrival for duty. The log included 22 employees with dates starting from CMS' arrival on-site—but lacked any employee temperatures before that.

Surveyors interviewed one employee exposed to one of the COVID-19–positive patients, who said he was told that "if he had a thermometer at home then, he would check his temperature," but was not told to keep a log. However, the employee told surveyors "I have been keeping some temperatures in my phone."

Another employee, a nurse practitioner, told surveyors that employees exposed to the COVID-19–positive patients were either on self-monitoring if they had been exposed but were wearing personal protective equipment (PPE), or on active monitoring if they were not wearing PPE upon exposure. "If they are on active monitoring, this requires them to monitor their temperatures twice a day, and they also have to be monitored by either Employee Health, the nursing supervisor, or ED upon entering the building," the nurse practitioner said.

How say you?

After reading this summary, take a moment to decide: What deficiencies, if any, do you think the hospital faced?

And how would you and your team cite this if you were a surveyor? What CoP *tag would you use, or what standard would you cite from your AO?*

What were the findings?

The hospital was found to be out of compliance under two A-tags, both related to §482.42 *Condition of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs:*

- **A-0747 states**: "The hospital must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program."
- **A-0772 emphasizes leadership responsibilities and states**: "The infection preventionist(s)/infection control professional(s) is responsible for: (i) The development and implementation of hospital-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines."

CMS found that the hospital failed to follow its own infection control and prevention program by both failing to screen visitors and by failing to track and monitor employees after they were exposed to COVID-19–positive patients. "This could affect and potentially expose 69 patients on the current census and 168 staff members with the COVID-19 virus," CMS noted.

Was immediate jeopardy called?

Because the hospital failed to follow its exposure plan for employees, CMS found the hospital in immediate jeopardy (IJ). According to CMS' *State Operations Manual, Appendix Q*, an IJ "represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death."

How would you correct the deficiencies?

Tell us how you would correct the deficiencies and we'll print a summary of your answers in the next issue of *Inside Accreditation and Quality*.

Please email your answers to *IAQ* editor A.J. Plunkett at aplunkett@decisionhealth.com.

Emergency preparedness

Tool: Use agenda template to keep your HICS meetings on track

Modify this template of an incident command meeting agenda for your organization, to help you keep your hospital incident command system (HICS) planning on track, especially if you are managing multiple campuses.

The agenda was developed by the Jacksonville, Florida–based Renaissance Behavioral Health System (RBHS) as part of its lessons learned after several tropical storms moved through the state's panhandle in the last few years. RBHS manages a variety of behavioral health and social services organizations, including 24-hour behavioral health emergency services, inpatient services, and a variety of outpatient programs for several communities throughout Florida.

The incident command meeting agenda ensures that the planning teams cover all information necessary to prepare for a storm, says **Leah Guthrie, MSN, MBA/HCM, BA, RN**, director of quality improvement/risk management for RBHS.

With so many moving parts to track, "having the agenda helps the ICS [incident command staff] when we are meeting face-to-face or via teleconference ensure we have considered every potential issue and have a pulse on what is occurring throughout the organization and areas of impact," Guthrie *told Inside Accreditation and Quality* last year.

The template has been edited slightly for easier adaptation.

ICS meetings should be scheduled during hurricane watches or warnings, and throughout the duration of the event, as well as afterward. This document should be completed during each meeting or teleconference.

Questions Comments & Ideas

– AJ Plunkett, Editor
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INCIDENT COMMAND STAFF WATCH MEETINGS			
LOCATION/METHOD:	**DATE:**	**TIME:**	
ATTENDANCE:			
DISCUSSION ITEMS	**ACTION**	**PERSON RESPONSIBLE**	**COMPLETION DATE**
1. Current status: ☐ Watch ☐ Warning ☐ Post			
2. Potential impact/area(s) affected:			
3. Generator fuel levels: [Facility name, location] Current fuel level: Delivery date: Other concerns:			
4. Notification of staff regarding sheltering-in option [facility name]:			
5. Hotline updates:			
6. Website updates:			
7. Vehicles: Where to locate: Fueled: Where to secure keys: Drivers:			
8. Dietary preparations/food/water inventory [facility name, location]:			
9. Facility closure assessment: Which need to be closed? Modified schedule? Remain open?			
10. Staffing:			
11. Census: [Facility name] [Facility name] [Facility name]			
12. LIP coverage:			
13. Number of individuals sheltering-in at facilities: (Facility name, location] Staff: Families: Pets:			
14. Facility reopening: When? Who will check facilities prior to opening?			
15. Damage assessment:			
16. Immediate issues/remediations:			
17. Other:			
18. Next call/meeting:			

Recorded by: _____

Book excerpt

Risk reduction strategies for continuous readiness: The tracer

Always being ready for survey can be one of the greatest challenges, but there are tools. In the following excerpt from Chapter 4 of HCPro's recently published *Survey Coordinator's Handbook, 21st Edition,* we offer you a look at using tracers to assess how well your team is doing on compliance. (To learn more about the book, by author **Jodi Eisenberg, MHA, CPHQ, CPMSM**, go to *https://hcmarketplace.com/survey-coordinators-handbook.)*

Tracers: Another Method for Assessing Risk

Tracer methodology remains a primary tool for assessing compliance and can also be a valid tool for assessing risk. Having an organized and continuous readiness process with integration of tracers throughout the triennial cycle is an excellent way to stay prepared for a survey and identify and mitigate risk.

This process, introduced several years ago, is borrowed from the manufacturing industry, where a product is followed from start to finish and process and system issues are identified while following the product. In healthcare, the tracer involves the patient care process or a procedure or system used in the organization. Use the daily census lists, operating room schedules, procedure schedules, and other data sources for a selection of patients to trace. Identify processes and systems that support patient care and operations, and use existing procedures to develop a tracer; alternatively, create a process map of the system and use it as a tracer guide.

The tracer process may include the following:

- Observation of care delivery
- Observation of medication-related processes
- Observation of care planning
- Patient or family interviews
- Reviews of medical records as indicated
- Discussion with staff about performance improvement (PI) and patient safety activities, their daily duties and clinical practice, and their orientation and training

Review of policies and procedures

It is worth the time to use the tracer process and involve frontline staff in it. Frontline staff are the keys to your organization's success in patient care delivery. They all play an important role in your facility's care, and incorporating them into the compliance and risk assessment process can only benefit overall patient care. Therefore, consider taking the time to conduct individual patient care tracers and systems tracers so that staff members can not only help identify risks but also become familiar with the survey process. The advantage of conducting tracers is that you can work on issues that are identified during the activity, such as holes in the handoff communication, medication management, or nursing documentation process. It also allows the staff to feel more comfortable with the types of questions that will be asked during an on-site survey.

Tips for success

Here are some suggestions to go about this process:

- To start, identify a core team of individuals to initiate the individual tracer process. Once you have the process down, you can use these staff members to train others.
- Make sure that all disciplines are involved or interviewed. For example, pharmacy and lab staff play a key role in the patient care process. Team them with a nurse to conduct a tracer. By conducting tracers, staff members also gain an appreciation for the complexities involved in caring for a patient. Consider utilizing those groups that are already conducting surveillance, including safety officers, nurse educators, IC practitioners, security officers, and leadership, to name a few.
- Assign staff members from other units to conduct the tracers with which they are less familiar. They will ask questions. In fact, they will ask more questions because they won't "assume" or "know" the established process.
- Plan to conduct a comprehensive tracer. That is, just as a surveyor would while on-site, be sure to include or interview all relevant staff members, including the unit clerk, dietary personnel, rehab therapists, wound care personnel, and care management personnel. Don't forget the appropriate physicians as well.
- Notify staff members, such as the charge nurse or manager, of missing or incomplete information in real time. Take the time to provide education during the process. When you address an issue immediately, while you have the staff's attention on a specific issue, the staff will be more likely to remember the discussion. Remember, the purpose of the tracer is also to provide a learning experience for the staff.

- Identify the staff member(s) conducting the tracer to minimize disruptions while conducting the activity. Some organizations do this by providing an identification badge or button in a bright color that states, "I'm on a tracer." Staff members can immediately identify the purpose of this person's presence on the floor and understand that they may be selected to be interviewed.
- Consider offering a reward for staff members who are selected to participate. One organization printed little coins that stated, "I've been traced." Each coin was worth a free beverage in the cafeteria.
- Aggregate your findings. This allows you to identify patterns across the organization, as well as unit-specific issues. When you see patterns, it's time to reexamine your policies or determine whether staff education is warranted.

Examples of an individual inpatient tracer, as well as sample process tracers, are included in the [book's] appendix for your consideration. Remember, though, that you don't need to create a special tool or checklist. Pull one of your procedures, and use that as a template to determine whether the steps were followed appropriately. This approach allows you to truly match your practice to your procedure.

Enough can't be said about the value of mock tracers to an organization. Staff members who undergo this process are able to identify what is and isn't working. They are key to identifying gaps in practice so that improvements can be made that can have a positive impact on care for all patients. Using the process consistently also helps staff feel more poised and comfortable with answering questions about what they do every day. More importantly, if this process is used to identify and correct potential risks to the patient, staff will be able to see the actual benefit of the tracer process. ■

For the sample process tracer and other tools, get your copy of the book here.

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– AJ Plunkett, Editor
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Lab safety

Three signs that nobody is paying attention to laboratory safety

by Dan Scungio, MT(ASCP), SLS

A safety officer walked into the satellite laboratory and saw an employee scrolling through social media on her phone. Another employee was chewing gum while wearing mesh sneakers in the department. In the storeroom, chemicals were stacked on high shelves and the aisles were blocked off with empty boxes.

The safety officer had come to perform an audit, but it was clear in a minute that the safety culture here wasn't great. Visual cues are a fast way to see that no one is paying attention to safety, but there are other methods as well, and it's important to use them. Not paying attention to safety has consequences.

First sign takes practice

Visual cues are the obvious first sign of safety problems in a laboratory but picking up on these cues isn't easy without practice. It takes time and focus to immediately recognize safety issues.

Lab leaders get the blame for not paying attention to safety lapses in the department, but when they are conducting day-to-day operations, noticing those issues is not something that happens naturally. If you oversee safety or are in leadership, learning how to notice visual problems is key.

Practice using your "safety eyes." Look for personal protective equipment issues for a week, then move onto chemical safety, then electrical safety, etc. Focus on one area at a time and you will hone your ability to notice visual safety issues.

Second sign: No response to safety audits

A second sign that there is a safety culture problem is a lack of response to safety audits. If there is no follow-up to safety audits, then there is no point in performing them.

The person who completes the audit should write a full report and submit it to the appropriate stakeholder, usually the manager or director, as soon as possible. A delay in results makes the audit seem less impactful.

Once the audit results are turned in, provide a deadline to lab leadership for responses. Make sure the report has a space for responses to any safety concerns

documented. The audit program should require the manager to document all responses and submit them to the safety officer within a given time frame. If there is no requirement to respond, it is unlikely management will pay attention to the audit, and in turn lab safety will be ignored.

Check the accident data

A third sign that nobody is paying attention to safety is an increase in incidents and accidents in the lab. Let's go back to our beleaguered satellite lab in the introduction.

The lab technologist scrolling on her phone in the department became ill with a bacterial pneumonia.

The employee wearing mesh sneakers dropped a dirty needle and it went into his foot.

A third employee reached up to grab chemical reagents from the shelf, but the container opened and splashed into her eyes.

While all these injuries and exposures probably wouldn't occur at the same time, in the unsafe lab described above, each event is certainly possible.

See something, stop now to solve it

Ignoring safety will lead to increased employee harm— something that should be avoided at all costs. If departmental safety indicators show an increase in injuries, exposures, spills, or other safety events, a review of lab safety practices is overdue.

If you notice any one of these three signs of poor attention to safety in your department, stop what you are doing right now and think of at least one way to solve the safety problem. If you notice all three signs in your lab, you have a larger problem—one that will require planning to make changes.

Focusing on safety in a lab that hasn't previously done so is challenging, but achievable. Recruiting safety champions and leaders, providing new education, and communicating regularly with staff lets them know this topic carries weight. Fix safety issues that you notice immediately and show the employees that maintaining their safety should always be everyone's priority. Your new focus will affect the entire department, and it will improve all aspects of your lab safety program. ■

Scungio is the laboratory safety officer for Sentara Healthcare in Virginia. This was originally published in Medical Environment Update, a Simplify Compliance brand.

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