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Practical Approaches to Ace Regulatory and Accreditation Surveys: Q&A

Responses to the Top Questions from our
Becker's Hospital Review Webcast

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<https://www.greeley.com/insights/practical-approaches-ace-regulatory-and-accreditation-surveys-qa>

Staffing shortages and pandemic-related process changes have resulted in rising patient safety issues, which has drawn the attention of CMS, state agencies, and The Joint Commission. Not only do health systems have to pass regular accreditation surveys but they must now deal with a rising number of state surveys triggered by patient complaints.

In a June Becker's Hospital Review webinar, our compliance experts discussed the current focus on state survey agencies, practical approaches to addressing common pain points, and how to apply these approaches to improve patient safety.

During our presentation, many attendees had in-depth questions to discuss. Here, we've provided answers to the top questions from our audience. If you missed the webcast or want to revisit the material, please find a link underneath the Q&A.

All of Your Questions, Answered

What items can be eliminated from nursing documentation? Most [registered nurses] spend more time at the computer than at the bedside.

We have found that eliminating unnecessary nursing documentation increases the accuracy and usefulness of the medical record, enhances communication, reduces nursing-associated adverse events such as falls, and improves compliance. It is a

fundamental approach to solving CMS/state agency compliance problems. It is a win-win-win for nurses, physicians, and (most importantly) patients – and survey agencies are the biggest advocates for the change.

Simplification also helps us develop the critical thinking skills of our front-line nurses. When we give in to an ocean of clicks and drop-down menus, we give up individualization. By stripping away unnecessary information we begin to see the patient and their evolving condition and progress.

So, what can be eliminated? Here's a brief outline (hold on to your hats ... there are a lot of myths we're about to bust):

- **Separate nursing care plans:** The necessary elements of planning, intervention, and evaluation being a simple part of—and result from—the nursing assessment/reassessment.
- **Admission assessment:** Some clients can eliminate 85% of the information collected upon admission. Many elements are NOT actually part of a “head-to-toe” physical assessment, and many elements are captured elsewhere by other disciplines (such as in the physician's H&P), or simply do not enhance the true picture of the patient's condition or further the clinician's knowledge about how best to provide care.
- **Shift/ongoing assessment:** Here again we're able to reduce the burden by 75–80%.

At the end of this simplification effort nurses are given back the time to care for patients, the care team can track the progress of the patient by reading the streamlined nursing notes, critical thinking skills are visible and can be reinforced, there are fewer falls and skin breakdowns, and regulators are very, very happy. Remember our goal is to increase communication, support the nursing process, and enhance compliance, all of which are accomplished as a result of simplification.

Additional documentation requirements seem to stem from survey findings. How do we balance documentation and “evidence” of compliance?

The accumulation of corrective actions over the decades has created an (unnecessary) documentation nightmare. This is what we’ve found from helping scores of clients prepare CMS/state agency plans of correction and TJC “evidence of standards compliance” every year:

1. With TJC’s relatively recent elimination of category-C requirements for improvement, the metrics for ongoing monitoring have relaxed significantly.
2. Reviewing a medical record to validate compliance only validates documentation, it does not validate the care process. When the issue is documentation (which is rare), then monitoring for ongoing compliance should indeed be through records review. However, 90% of clinical findings have to do with the care process, not the documentation. When the process of care is the issue, we find the path to correction runs through making a simpler medical record with fewer “clicks.” We validate compliance through a process we call “care facilitation,” which combines monitoring, reinforcement, and skills development. Data are reviewed daily. Improvement is almost instant and sustained.
3. Some surveyors are used to seeing the review of records as part of the plan of correction or ESC submittal. We therefore have effective processes to engage with state, federal, and accreditation decision makers to eliminate non-value-added documentation elements and get to true compliance.
4. Most non-value-added documentation stems from a misunderstanding of the underlying requirement.

What about the expression “if it wasn't documented it wasn't done”?

We can't think of an aphorism more damaging to the care process. This thought stems from professional liability cases and, indeed, it is difficult to prove that a test or a treatment was done without documentation. It also applies to billing: you can't bill for a service that isn't documented. The problem is we tend to require documentation that is not necessary or, even if required, is needlessly detailed.

Failures to document elements you require may well represent a violation of the requirement. But most of the time the documentation you require is excessive or not required at all.

What are the best resources to use to determine unnecessary nursing documentation? Most of the regulations are vague.

Most regulations do not specifically require documentation, and even when required, the extent or detail of the documentation is usually not specified. It is up to you what you require in the record and how detailed the documentation must be. Here are a few tips:

- Read the actual requirement. Does it specifically require documentation?
- If the requirement does not mention documentation, is documentation necessary to facilitate the process of care (including communication between the disciplines and communication during handoffs)?
- If documentation is specified or implied by the requirement, what is the simplest and easiest way to communicate?
- Ask “what is the healthcare team going to do with this information and does the documentation really bring value to clinical communication?”

What are The Joint Commission updates you mentioned in the presentation? Is there anything new with respect to TJC's requirements?

The best source of information about new or changed Joint Commission requirements is its monthly publication, Perspectives. Any new or amended requirements are discussed, and each month there is a column called "consistent interpretation," which highlights how various survey observations fit into the elements of performance.

Recent changes for the hospital accreditation program occurred in two waves: amendments effective January 1, 2022 and amendments effective July 1, 2022. Our analysis is that the workplace violence standards that became effective January 1 have the largest possibility for unpleasant surprises. The new TJC standards go significantly further than OSHA, which has been focusing on workplace violence for several years.

Other standards that were new or revised included:

January

- Water management standards (catching up with CDC)
- Transmittal of patient information (reflecting the federal requirements of the Cures Act)
- Changes to the Performance Improvement chapter clarifying leadership's involvement in performance improvement projects

July

- A completely re-numbered Emergency Management standard that corresponds to the revised CMS Emergency Management Condition of Participation
- Minor changes to clarify certain Environment of Care requirements

- Honoring the patient's decision not to transmit clinical information as specified in the federal Cures Act

Is there any update on the Joint Commission revising medical staff standards to require reappointment every three years instead of two to save on resources and duplication?

Although the issue has been raised many times over the years, we are aware of no active initiative to relax the two-year reappointment cycle in The Joint Commission's hospital standards.

Are you hearing rumblings from [TJC] that there is consideration that titration will be an [Immediate Threat to Life]?

We are not aware of any new guidance for the scoring of titratable medication issues. However, a working group including critical care nursing associations, intensivists, and pharmacists have reviewed titrations very carefully over the last few years resulting in a series of TJC FAQs offering guidance for this very important issue.

Although rare, we have seen one titration-related issue lead to a CMS "Immediate Jeopardy". Titratable medications are, by nature, very high risk. However, most of the citations we see relate to documentation rather than unsafe practices per se (admittedly, documentation, orders, and safety are very closely related). It is very easy to see how, in theory, problems with titrations could lead to a CMS "Immediate Jeopardy" or a TJC "Immediate Threat to Life."

Please note, however, that there were no ITLs cited by TJC over the last two years for the most common element of performance associated with titratable medications: MM.06.01.01 EP03. Regardless, all accreditors and regulators take

issues with titratable medications very seriously and we encourage our clients to put this high on their list for monitoring and, when indicated, sustained improvements.

Is CMS still doing validation surveys post [TJC] surveys?

Yes, to the best of our knowledge, but some states may have difficulty meeting this obligation due to pandemic-related backlogs and staff shortages.

For the last decade CMS has asked state survey agencies to conduct more than 100 “representative sample” full hospital surveys each year to follow within 60 days of a full survey conducted by the hospital’s accrediting organization. This was roughly 3% of the routine (full) surveys conducted by accreditors.

The number of surveys conducted by accrediting organizations (TJC, DNV GL, ACHC, CIHQ) decreased in 2020 and 2021 due to the pandemic, as did the number of sample validation surveys. However, we believe the number of sample validation surveys will return to 100 or more for hospitals in 2022.

Nurses screen our patients for suicide. If positive, the screen is followed by the assessment. Is there a minimum requirement of the practitioners that can conduct this assessment? We require BH practitioners, but resources are scarce. What are you seeing

The standards do not specify a minimum requirement for the individuals conducting the post-screening suicide risk assessment. It is very important that your hospital is clear about who you allow to complete the assessment. What follows is our recommendation in the absence of specific guidance from regulators and accreditors.

Recommendation:

- Structured data collection may be completed by anyone with demonstrated competence in the accurate collection and recording of such data. It may be a psychiatric nurse, but it can also be completed by psychiatric technicians, community workers, or anyone with a background or job duties that would allow them to understand the intent of the data elements collected and communicate with individuals with psychiatric conditions.
- The plan (hospitalize, discharge, precautions, etc.) should be developed or approved by someone with demonstrated behavioral health clinical competencies. That could be a privileged emergency medicine physician or a psychiatric nurse with documented skills in this area.
- Sometimes the individuals performing the assessment are from community-based psychiatric evaluation teams who do not have a contract relationship with the hospital but who are recognized to facilitate involuntary hospitalization decisions.
- Although some hospitals try to craft a contract-like document and track competencies to please surveyors, we recommend that the emergency medicine physician review and sign off on the plan developed by such a community worker and that your policy accommodate the process. Similar to pre-hospital-care practitioners (first responders, fire, police), there is no need for a contract with other governmental representatives who play a role in the implementation of state law applying to involuntary hospitalizations.
- Finally: say what you do and do what you say. Make sure the related policy is clear and concise. Don't make things overly complex.

Are you stating that organizations should not screen all patients presenting for care [using a validated suicide screening tool]?

Yes. TJC's suicide prevention safety goal has never required that all hospital patients be screened for suicidality. Although there are several frequently asked questions on TJC's website to reinforce this notion, one need to look no further than the requirement itself, which states that the hospital must "... screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool."

Although psychosocial issues should always be a component of medical and nursing assessments, the use of a "validated screening tool" should be reserved for behavioral health patients only. Some hospitals choose to perform this screening on all patients, but we strongly recommend against that practice for two main reasons:

1. By screening everyone the process seems to lose focus and clinical credibility.
2. The screening yields several "false positives" and soon exhausts the finite supply of sitters, causing delays in the implementation of high-risk precautions for those who really need them.

We find it far better to focus on the populations that require screening in order to better and more consistently provide the care and services indicated.

Do you see that hospitals have RNs do an attestation at the end of their shift saying that a 1:1 suicide risk patient was constantly observed, versus having the 1:1 sitter document hourly on a piece of paper?

Yes. In fact, we recommend this practice. Continual observation logs by the sitter are not required by the standard and the practice has two drawbacks:

1. It gives the surveyor the obligation to play “gotcha” when a line is missing, or the log is lost.
2. It serves no purpose other than to distract the sitter from observing the patient.

Far better is a note addressing the patient’s behavior and situation in the interval from the previous note along with an indication that continual 1:1 observation was in place (or whatever the situation was during the interval).

Since the standard does not address documentation of observations, the hospital will be bound solely on hospital policy. Beware: paper and electronic medical records forms are often seen as an extension of hospital policy requirements so it is important to be clear about what type of documentation is required and what is not required.

For [policy and procedure] review, is there a requirement for annual review and who should be involved? Does it need to go through the oversight committee (i.e., infection control policies through the IC committee)?

It depends — this is a complex issue.

Some states (e.g., California and Florida) require the periodic review of policies and procedures. Others do not. There is also a handful of “policies” that require a specific review cycle according to federal or CMS requirements (e.g., the Emergency Management Plan and the Quality Assessment and Improvement Plan). For everything else we recommend a review once during every third calendar year unless otherwise specified for individual policies.

Although ECRI and others recommend an annual review of safety-related policies and procedures, in our experience this is too high of a hill for most folks to climb. We typically recommend a bolus of reviews each year with one-third of the policies and

procedures in each bolus.

As for who signs off: it's whatever body ultimately approves the document. But, most importantly, keep it as simple as possible — “consent agenda” item from whoever reviewed the policies, procedures, and guidelines with two lists:

1. List #1 would indicate “the following policies, procedures, and guidelines have been reviewed by me or my designee and do not require amendment at this time.”
2. List #2 would indicate “the following policies have been determined to require amendments, which will be prepared with involvement of appropriate subject matter experts and applicable oversight bodies.”

Your review is now complete, and you can move on to the truly critical part: making sure your policies, procedures, and guidelines are practical, simple, sustainable, and followed.

Do you believe COP 488.26 (c)(2) two inpatient minimum is a fair benchmark as a starting benchmark for a 10-bed hospital vs. a 250-bed hospital?

The two-patient rule is guidance to the state survey agencies and accrediting organizations for the completion of full surveys. The underlying regulation specifies that “patients” must be present in order for the SA or AO to verify compliance with the Conditions of Participation. Two is the lowest number possible to qualify for the plural “patients” (vs. “patient”). So regardless of the overall capacity of the hospital building, at least two patients must be hospitalized when the survey team arrives for the unannounced survey.

A 10-bed hospital likely has far fewer potential inpatients than a hospital designed to accommodate 250 patients and, indeed, this places a greater burden on smaller institutions.

Keep in mind that the CMS regional office has some discretion as to the authorization of certification surveys by state agencies and accrediting organizations. We usually find them to be very helpful in terms of bringing new hospitals online and in re-certification visits, especially hospitals that serve rural or underserved populations.

Feel free to contact us for specific problem-solving advice.

Does safety include compliance with governmental and TJC electrical safety requirements found in NFPA 70E, NFPA 99, and OSHA?

Certainly. One common misconception is that “patient safety” is something different than “environmental safety.”

Indeed, true safety issues identified in environmental oversight groups must be addressed as effectively as medical errors and clinical safety. In our experience, this requires a single oversight authority responsible for resolving all quality and safety vulnerabilities. One of the first things we do with clients facing a significant “safety” challenge is to create or reinforce a “quality and safety oversight committee.” This is a lean and effective group that is serious about accountability and oversight. Led by the hospital’s executive team, the QSOC assigns accountability, provides oversight, and ensures that both clinical and environmental safety issues are identified, the underlying causes understood, and unsafe situations and processes are improved.

We are a [New Hampshire] hospital system that has outpatient clinics. NH is a direct access state that does not require a physician order for OP services. Would CMS or TJC require a physician order for OP therapy services in this situation?

Although CMS references physician orders for outpatient imaging services, the CMS Conditions of Participation and hospital accreditation standards tend to defer to state law. So, if New Hampshire allows a physical therapist to treat patients without a physician's order, then this would generally be accepted by the regulators/accreditors.

However, remember that compliance with the Conditions of Participation does not equate to authorization to bill. Various insurers, including Medicare and Medicaid, may require a physician's order to bill for the services.

Medicine has changed and there are many physicians who no longer admit to the hospital. What are some ways to address competency for no-volume physicians with regards to OPPE?

Our credentialing practice has many years of experience with this issue, and much of it depends on how your bylaws are structured. The following are two possible approaches, but there are more:

1. The medical staff bylaws could recognize that physician members of the medical staff may "refer and follow" their patients when they are hospitalized. This becomes a prerogative of membership, not a "privilege," and ongoing professional practice evaluation (OPPE) is not required. However, although non-privileged physicians can be informed of the patient's progress and follow the patient during their stay, non-privileged physicians do not have the ability to direct care. This approach is in harmony with the intent of the 21st Century Cures Act,

which encourages continuity of medical care following episodes of hospitalization.

2. If the physician requests privileges but they have no volume at the hospital, then their OPPE profile would reflect zero volume and zero issues, and the OPPE obligation would be met. However, the physician would be obliged to show current clinical competence when it comes time for reappointment/reapproval of privileges. The burden is on the applicant to demonstrate adequate volume and comprehensive excellence in the practice of the requested privileges. The applicant may provide appropriate professional references (as allowed by Medical Staff bylaws and credentialing policies) and/or performance data from the ambulatory setting (e.g., A-1-C screening for diabetic patients, immunizations, etc.) to support both volume and excellence at other institutions.

What would you recommend from the Medical Staff Office to be prepared for surveyors?

TJC provides excellent advice in its annually published Survey Activities Guide. They have also developed a Medical Staff Tracer tool. Our guidance is to use this tool as you prepare for survey in meetings with the President of the Medical Staff, the Chief Quality Officer, and the Medical Staff Professionals.

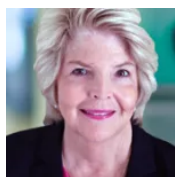
Make sure the requested documentation listed in the SAG and the tracer tool is available and rehearse the participants to be “good witnesses.”

1. Make sure you understand the question before answering it. Don’t be too shy to ask for clarification before answering.
2. Don’t guess. If you don’t know, just say so, but offer to obtain an answer for the surveyor after the tracer (and, of course, fulfill that promise and include the survey management team).

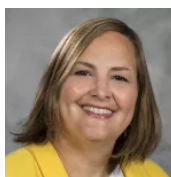
3. Once you understand the question, answer it completely and fully. Do not shade the truth. However:
 1. Don't answer questions that were not asked. Don't volunteer to go into a topic not addressed in the surveyor's question.
 2. Let the surveyor drive. Stop after 30 to 90 seconds in the middle of your answer and verify "is this what you were asking about?" Give the surveyor the opportunity to redirect the conversation.
 3. Clarify near the end of the tracer whether the surveyor has any concerns about what they found during the tracer. This will give the surveyor time to clarify their thoughts and it will give you an idea about whether further information or follow-up is indicated.

Our clients find communicating and rehearsing these points an important approach for putting staff members at ease, supporting optimal survey performance, which is why this front-line education and reinforcement is an important part of our mock surveys.

LEARN MORE ABOUT THE AUTHORS

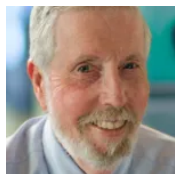


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