Hospice Day 2
Home Health Day 1
Accreditation Intensive
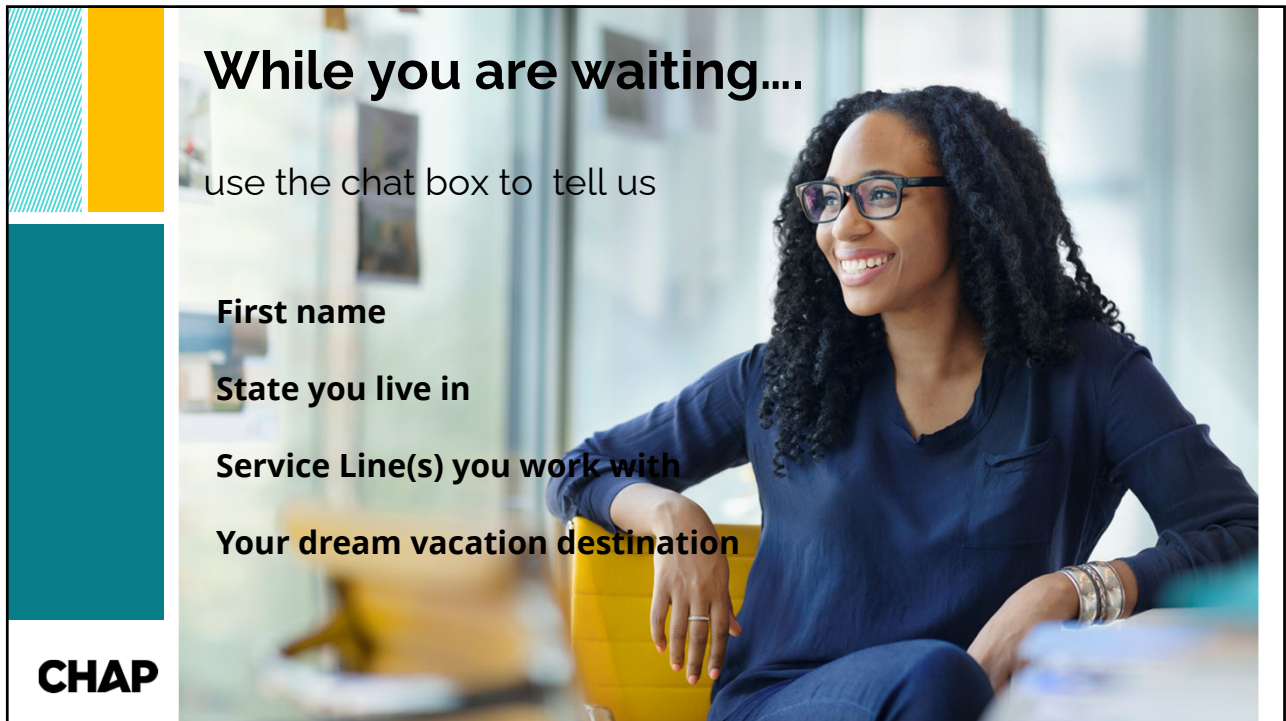
An Interactive Training

Bobbie Warner RN, BSN & Linda Lockhart, BSN, MPH

CHAP Community Health Accreditation Partner

1

While you are waiting....

use the chat box to tell us

First name

State you live in

Service Line(s) you work with

Your dream vacation destination

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2

polls

Which of the following best reflects your organization…
We provide home health only
We provide hospice and home health
We provide hospice only

How long have you worked in community-based services?
0-5 years
5-10 years
10-15 years
15-20
over 20

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3

Housekeeping

⟩⟩⟩⟩⟩

- Introductions

Agenda
and
Handouts

- Muting
- Use of Chat
- Raise and
  lower of hand

4

Disclosures/Conflict of Interest

This nursing continuing professional development activity was approved by the Virginia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

There are no conflicts of interest for any individual in a position to control content for this activity.

How to obtain CE contact hours:

Criteria for successful completion includes attendance at the entire event (both days), participation in engagement activities, completion of an evaluation and completion of the consulting exam.
:

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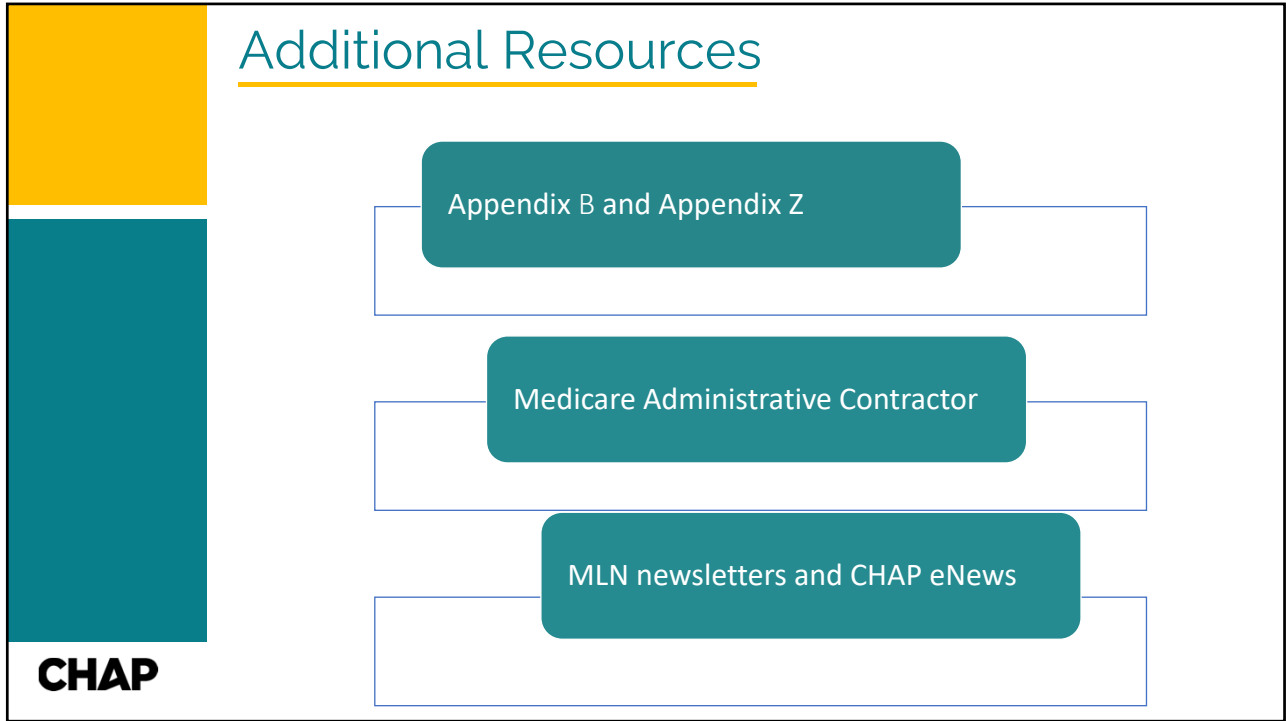
CHAP Standards of Excellence

Revisions

Version

Evidence Guidelines

6

Additional Resources

Appendix B and Appendix Z

Medicare Administrative Contractor

MLN newsletters and CHAP eNews

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7
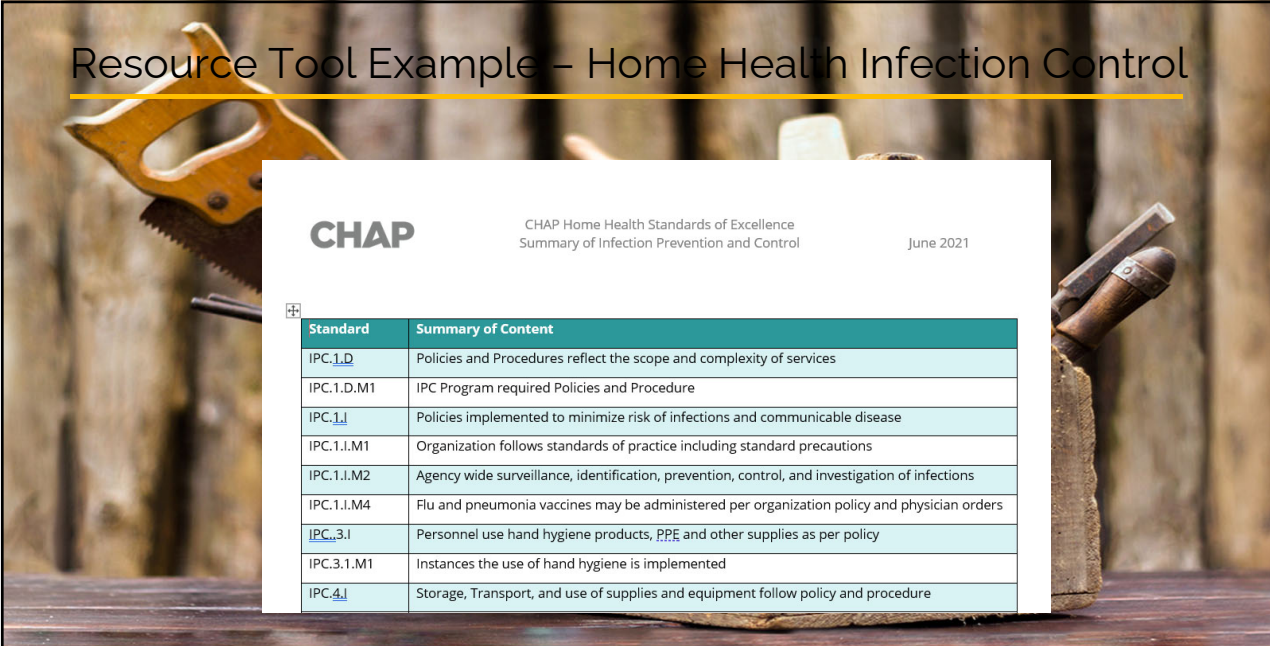
Different yet Alike Hospice and Home Health

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Resource Tool Example – Home Health Infection Control

9

Resource Tool Example

Standard	Summary of Content
HPFC 1.D	The hospice has a **Patient Bill of Rights** and Responsibilities
HPFC 2.D	**Required elements** of the Patient Bill of Rights
HPFC 3.I	**Provision** of the Bill of Rights during the initial assessment and **prior to care provision**
HPFC 4.I	**Patient right to exercise** their rights without discrimination or reprisal
HPFC 5.I	Addressing **patients not competent** to exercise their rights
HPFC 6.D	**Complaint** management process including policies and procedures
HPFC 7.D	Addressing **allegations** of verbal, mental, sexual, physical **abuse/mistreatment**
HPFC 8.D	Hospice **response to alleged** violations of **abuse/mistreatment** per policy
HPFC 9.D	Patient is informed and provided written instruction regarding **advanced directives**
HPFC 10.I	Advance Directive information provided at initiation of care and **documented**

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Infection Prevention and Control

Hospice- HIPC Home Health- IPC

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Program Goal

Each organization must maintain and document an effective infection control program that protects patients, families, visitors, and agency personnel by preventing and controlling infections and communicable
diseases.

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Prevention (CDC Healthcare Infection Control Practices Committee)

Six Standard Precautions
- Hand Hygiene
- Environmental Cleaning and Disinfection
- Injection and Medication Safety
- Appropriate use of Personal Protective Equipment
- Minimizing Potential Exposures
- Reprocessing of reusable medical equipment between each patient and when soiled.

Foundation Needed
- Policies and Procedures
- Protocols for education of staff/patients/caregivers
- Monitoring for compliance

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Control

Coordinated agency-wide program
- Surveillance
- Identification
- Prevention
- Control
- Investigation of infectious and communicable diseases

QAPI
Includes:
- Identifying infectious and communicable disease problems;
- A plan to result in improvement and disease prevention.

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Education

Employees

Contracted Providers

Patients

Family

Caregivers
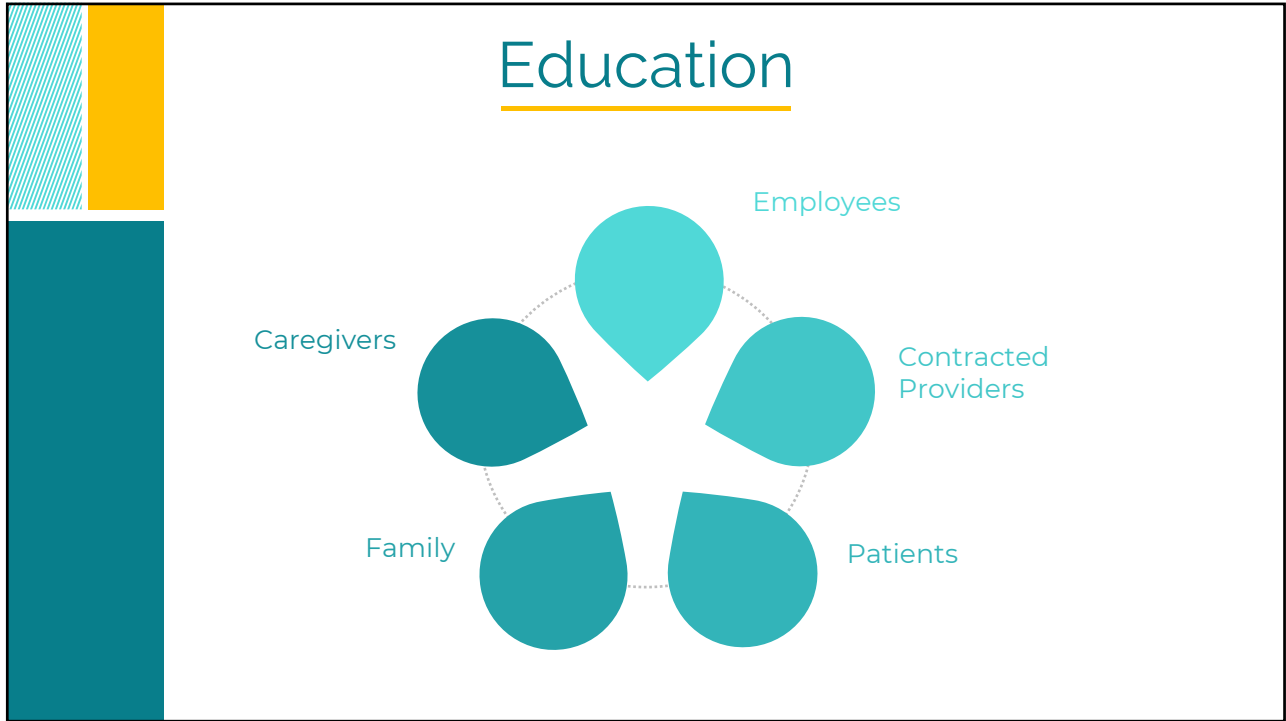
15

Review the Handouts

Handwashing

Bag Technique

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16

17

Discussion

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Focused Infection Control Survey
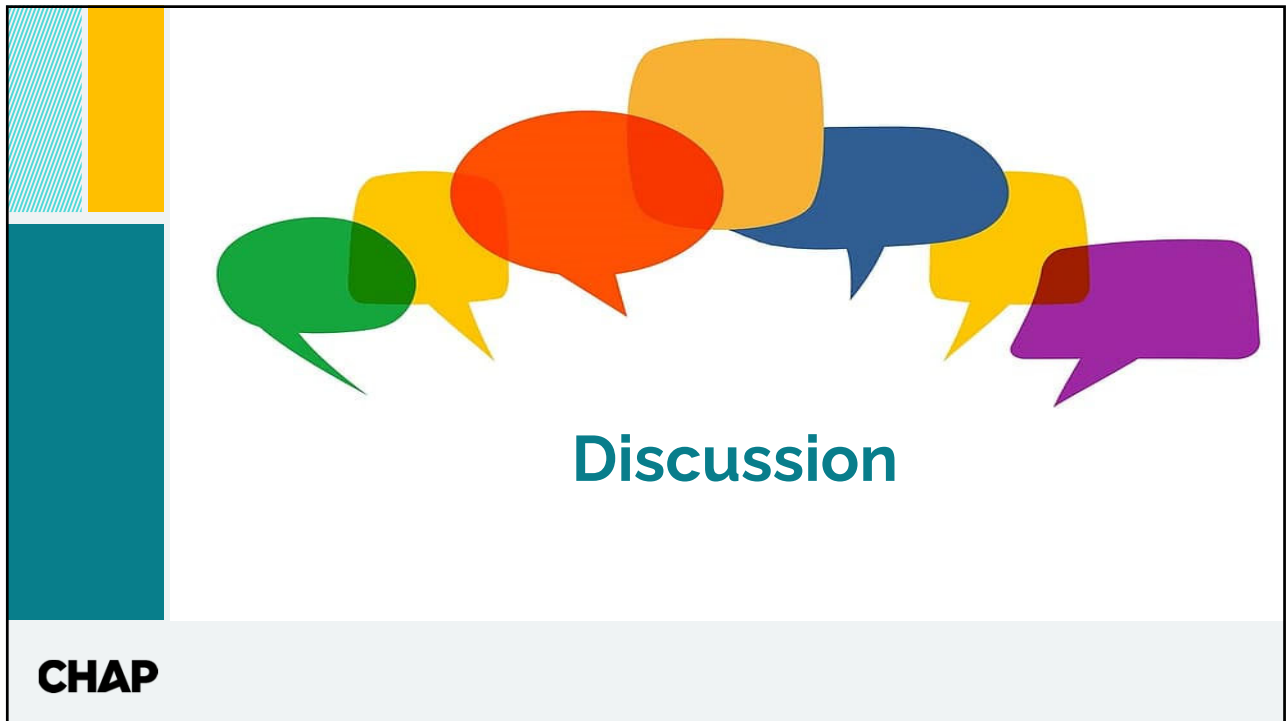
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Focus- Operational Elements

- Infection Prevention and Control Plan
- Communication
- PPE Availability
- Staffing in Emergencies
- Handling Staff Exposure or Illness

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Focus- Agency Location

- Screening process for those entering location
- Internal office staff/visitor processes
- General standard precautions
- Transmission Based Precautions

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Focus- Field Practices

- Screening

- Hand Hygiene

- Use of PPE appropriately

- Aerosol-generating procedures

- Education

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QSO-22-07-ALL
QSO-22-09-ALL
QSO-22-11-ALL

Guidance for the Interim Final Rule - Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination

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Standard Revisions 2021
Hospice and Home Health

Hospice	Home Health	Content Summary
HIPC.11	IPC.15	Who the vaccination requirement applies to
HIPC.12	IPC.16	Process elements defined in policy for those eligible to be fully vaccinated
HIPC.13	IPC.17	Policies related to request for exemption
HIPC.14	IPC.18	Acceptable reasons for delay in vaccination
HIPC.15	IPC.19	Two acceptable job responsibility exemptions
HIPC.16	IPC.20	Policy and procedure addressing process for medical exemption and/or spiritual exemption
HIPC.17	IPC.21	Documentation evidence
HIPC.18	IPC.22	Requirement to ensure nationally recognized IPC guidelines are followed

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100% Compliance Requirements

For those eligible to be fully vaccinated

Policies and Procedures:

- Establish who is eligible to be fully vaccinated
- The process for tracking and documenting each individual's receipt of single dose or series prior to the provision of care
- The process for tracking and documenting completion of series;
- The process for tracking and documenting receipt of booster doses
- What vaccination documentation is accepted;
- Who receives, reviews, accepts or rejects vaccination documentation
- How everyone's vaccination information is securely maintained.

Staff Vaccination Compliance

- Documentation is present to validate 100% of staff eligible to be fully vaccinated ***are fully-vaccinated.***

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100% Compliance Requirements

Eligible for a delay, exception, or exemption

Policies and Procedures:

- The process for an individual to request a temporary delay, an exception due to job responsibilities, or a medical/spiritual exemption
- Who receives and reviews the documentation for above requests
- The process to track the documentation received the acceptance or denial of request
- The contingency plan(s) for an individual not fully vaccinated for COVID-19 and its documentation;
- A process to implement precautions intended to mitigate the transmission of COVID-19
- How each individual's information is securely maintained.

Staff Vaccination Compliance

- Documentation is present to validate 100% of staff requesting a delay, exception or exemption ***have submitted documentation and been approved for the request.***

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Top Findings in HIPC and IPC

Standard	Hospice Content	Tag	%
HIPC 9.I	Addressing risk for occupational exposure to TB	NONE	25%
HIPC 2.I	Appropriate use of standard precautions	L 579	23%
HIPC.4.I	Bag Technique	L579	11%

Standard	Home Health Content	Tag	%
IPC.3.1.M1	Instances in which the use of hand hygiene is implemented	G 682	31%
IPC.4.1.M1	Bags that carry equipment/supplies used consistent with policy	G 682	21%
IPC 8.1	TB screening per state local regulation or CDC	G 684	8%

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Top Findings HIPC-Hospice

HIPC 9.1; Addressing risk for Occupational Exposure to TB

No tag; Staff are screened and tested

L579- Prevention- 418.60(a): Standards of Practice

HIPC 2.I - Use of standard precautions –handwashing, gloves, waste disposal, PPE

HIPC 4.I - Bags used to carry medical equipment (e.g., BP cuff) or supplies into or out of the care environment

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Top Findings IPC-Home Health

IPC3.I.M1; 484.70(a) Prevention

G682- *Hand Hygiene: 5 elements*

IPC4.1.M1

G682-*Bags are transported and used in a manner consistent with organizational policy to prevent the spread of infections and communicable disea*s*es.*

IPC8.I

G684-*personnel are screened and tested according to P/P*

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Tips for Success

⟫⟫⟫⟫

Conduct Observation in the field

Infection control should be an important part of your quality program

Include the trunk and field bag in the review

Teach your RN's best observation practices for Aides

Know state specific requirements

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Human Resource Management

Hospice- HSRM Home Health- HRM
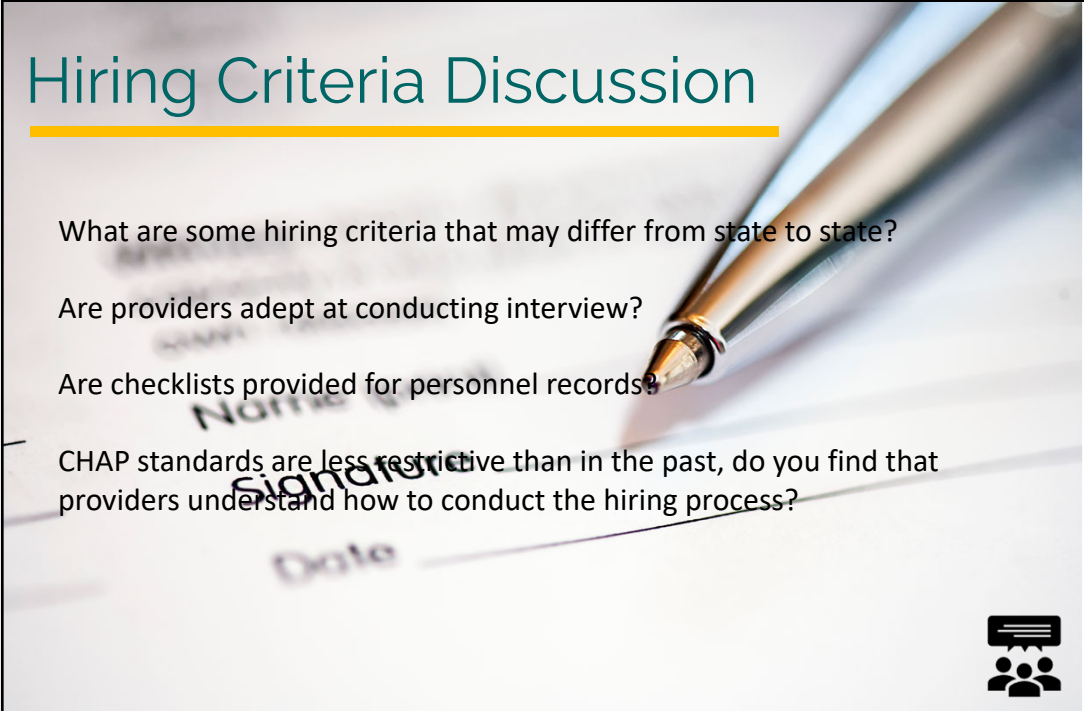
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Hiring Criteria Discussion

What are some hiring criteria that may differ from state to state?

Are providers adept at conducting interview?

Are checklists provided for personnel records?

CHAP standards are less restrictive than in the past, do you find that providers understand how to conduct the hiring process?

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Employee Requirements

Documented policies and procedures

Each position defines
- Duties, roles and responsibilities
- Qualifications, required experience, education, certifications, licensure

Hiring criteria are met
- Per applicable CHAP standards and Conditions of Participation
- As per policy
- In accordance with local, state, and federal law and regulation

All personnel
- Are provided orientation
- Demonstrate competency
- Are supervised by qualified staff
- Are evaluated per agency policy and/or state and federal law and regulation
- Participate in ongoing in-service

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NP scope of Practice

Full practice
- Evaluate
- Diagnose
- Manage treatment
- Prescribe medications

Reduced practice
- Reduces
- At least one element of NP practice
- Requires
- Collaborative agreement

Restricted practice
- Restricts
- At least one element of NP practice
- State requires supervision**,** delegation, or team-management

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NP Scope of practice variation

STATE	PRESCRIPTIVE AUTHORITY	BOARD OF NURSING	PRACTICE ACT	DETAILS AND RESOURCES
Arizona	Full authority with DEA registration	**AZ Board of Nursing**	**AZ Nursing Statutes**, **AZ Nurse Practice Act**	Must complete a Controlled Substance Prescription Monitoring Program (CSPMP) application
Florida	Requires supervision of a physician or surgeon	**FL Board of Nursing**	**FL Nurse Practice Act**	NPs must have proof of malpractice insurance or an exemption
South Carolina	Requires an approved written protocol with a collaborating physician	**SC Board of Nursing**	**SC Nurse Practice Act**	"In addition to those activities considered the practice of registered nursing, an APRN may perform delegated medical acts"

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Top Findings in HSRM and HRM

Standard	Hospice Content	CMS Tag	% Cited
HSRM 16.I	Requirement for criminal background checks	L 795	26%
HSRM 2.D	Requirements for hire and organizational chart	NONE	22%
HSRM 14.I	Assess skills and competency of all staff/in-services	L 663	12%
HSRM 29.D	Professionals participate in QAPI and in-services	None	12%

Standard	Home Health Content	CMS Tag	% Cited
HRM.3.I	Personnel meeting the organization's hiring criteria	G848	33%
HRM.10.I	Personnel are evaluated per organizational policy	N/A	11%
HRM.7.I	Personnel demonstrate competency	G768	11%

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Top Findings HSRM-Hospice

HRSM16.I; 418.114(d)(1); Background checks

L795- *criminal background checks on all hospice employees who have direct patient contact or access to patient records*

HSRM14.I- 418.100(g)(3);

L663- *Assess the skills and competence of all individuals furnishing care, including volunteers and, as necessary, provide in-service training and education programs*

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Top findings HRM- Home Health

HRM 3.I484.100: Compliance with Federal, State, and local laws and regulations

G848 -not currently licensed per State requirements; other state/federal regulatory issues

HRM 7.I; 484.80(c)(1); Competency

G768- Home Health Aide competency

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Tips for Success

1. Know state specific requirements

2. Focus audit on specific HR timeframes
   - Orientation
   - Annual requirements
   - Performance evaluations
   - Hiring criteria

3. Checklists guides are helpful

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Home Health Continuous Quality Improvement (CQI)

Hospice Quality Assurance and Performance Improvement(HQPI)

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Program Similarities

Hospice	Home Health	Content
HQPI 1.D-2.I	CQI.1I	Governing Body Involvement agency wide, data driven, reflects complexity of organization and services
HQPI 3.I – 6.1	CQI.2D	Types of data collection
HQPI 7.I	CQI.3	Analysis of data
HQPI 8.I	CQI.3.I.M4	Action taken
HQPI 9.I	CQI.5	Annual performance improvement project requirements
	CQI.6	Sustainability

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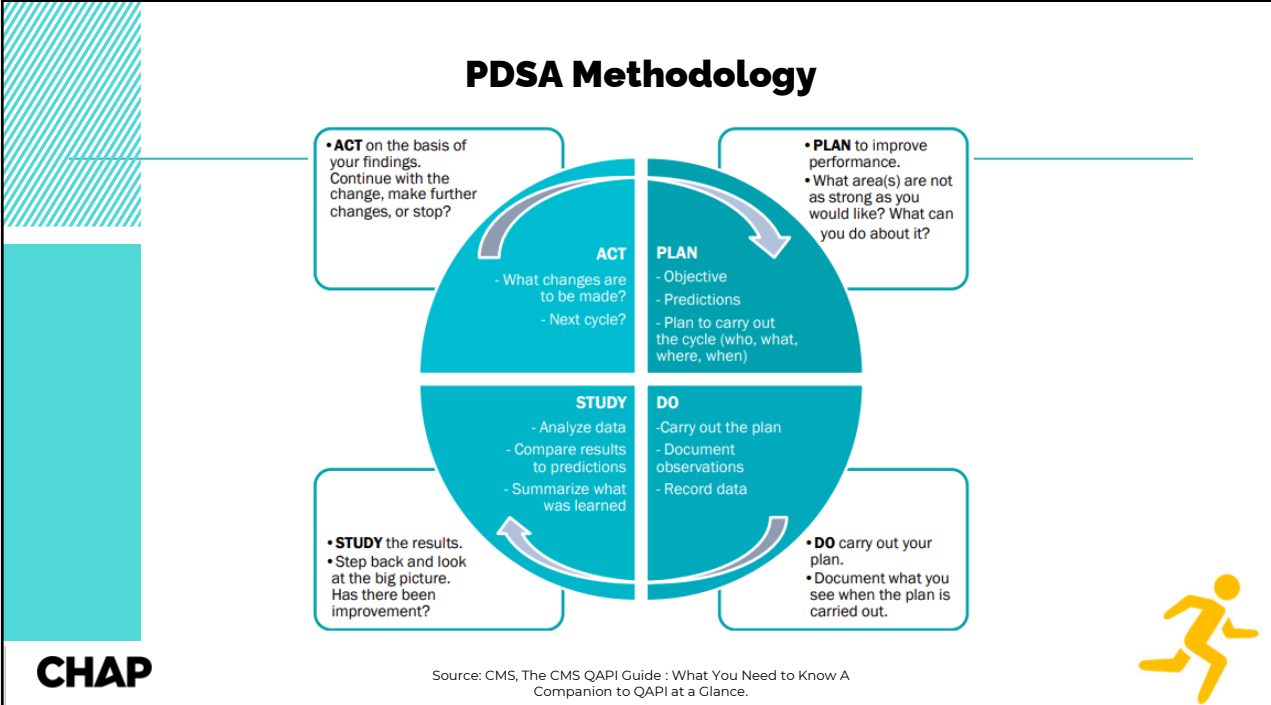
Goals

Specific

Measurable

Attainable

Relevant/**R**ealistic

Time-based

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PDSA Methodology

- **ACT** on the basis of your findings. Continue with the change, make further changes, or stop.

ACT
- What changes are to be made?
- Next cycle?

- **PLAN** to improve performance.
- What area(s) are not as strong as you would like? What can you do about it?

PLAN
- Objective
- Predictions
- Plan to carry out the cycle (who, what, where, when)

STUDY
- Analyze data
- Compare results to predictions
- Summarize what was learned

DO
- Carry out the plan
- Document observations
- Record data
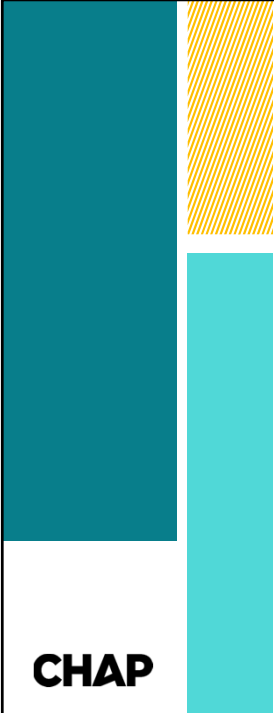
- **STUDY** the results.
- Step back and look at the big picture. Has there been improvement?

- **DO** carry out your plan.
- Document what you see when the plan is carried out.

Source: CMS, The CMS QAPI Guide : What You Need to Know A Companion to QAPI at a Glance.

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Group Activity- Develop a PDSA

Break into 8 groups-each group will be assigned an element of PDSA for their scenario
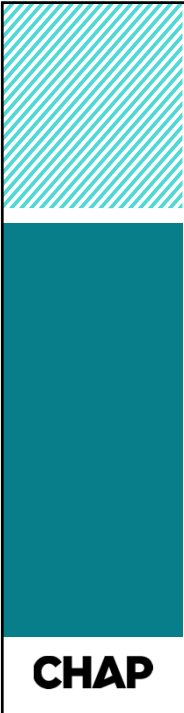
-Groups 1-4 will address -Scenario 1

- Groups 5-8 will address Scenario 2

Elect a spokesperson to report after the breakout session

-*You will have 15 minutes*- 5 min and 2 min warnings

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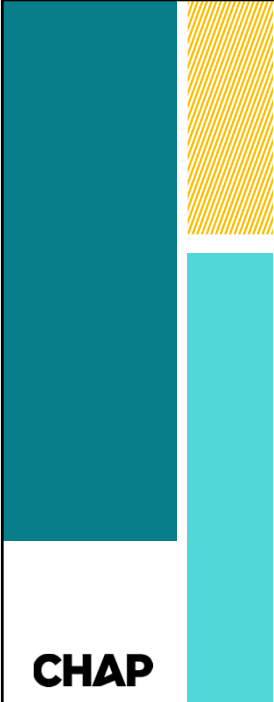
Quality Activity

Scenario A (4 groups) - <u>PIP for wound infections</u>
Scenario B (4 groups) - <u>PIP for bag technique and hand washing</u>

- Groups 1A/B: Develop a SMART GOAL

- Group 2A/B: Develop a plan to address the deficiency – determine a multifaceted plan

- Group 3A/B: Implementing corrective steps – what action steps are being implemented

- Group 4A/B: Develop monitoring for improvement. What will they monitor; what action will they take if there is no improvement

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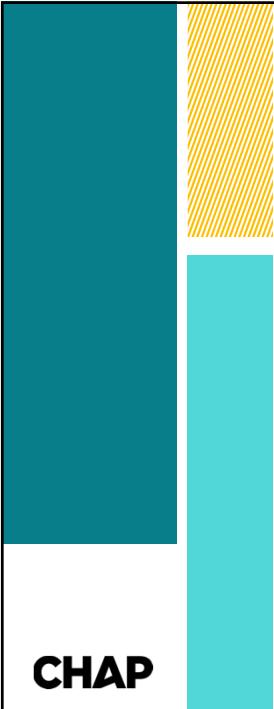
Scenario A - Infection Control- Groups 1-4

Over 3 sequential quarters an agency
identified a progressive increase in
their Potentially avoidable events for
hospitalizations due to wound infections
that occurred during an active Plan of Care.
The infections were both surgical and non-
surgical.

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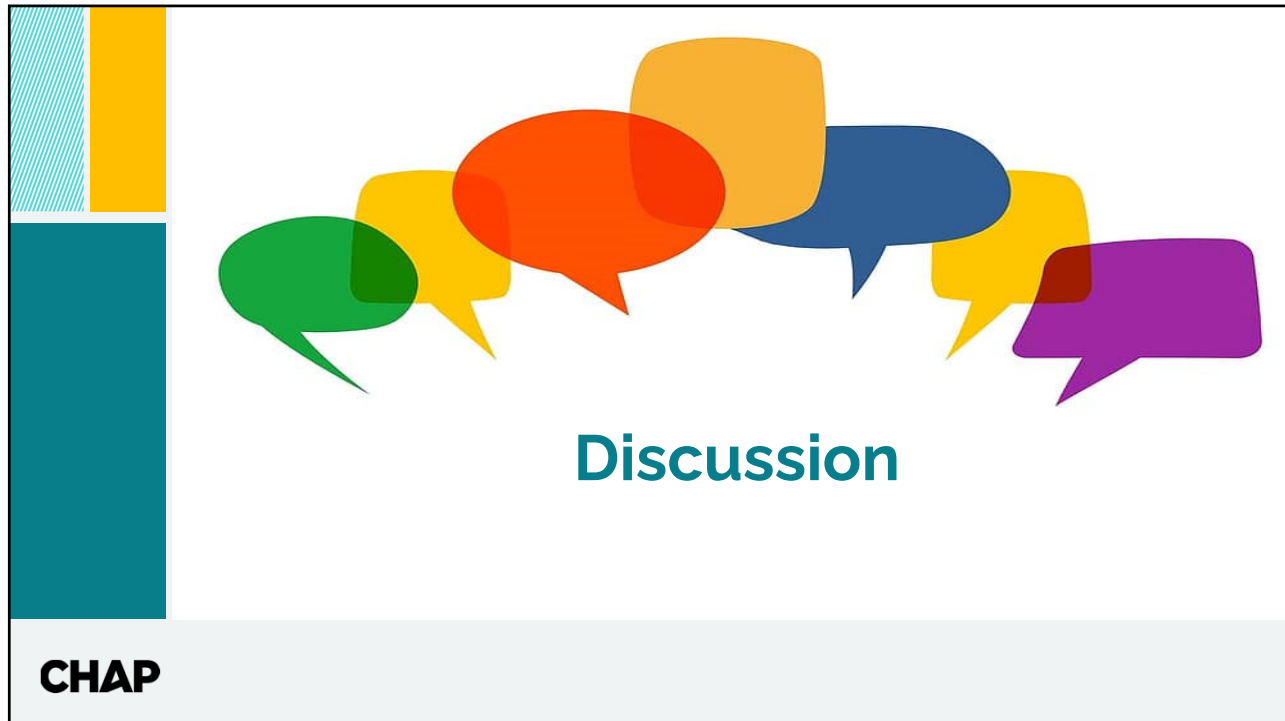
Scenario B - Infection Control- Groups 1-4

An agency performs home visits with clinical staff at
the time of their annual competency
evaluations. The Performance Improvement
committee performed an end of year evaluation of
the results and discovered infection control
violations on 35% of their clinical staff; Nursing and
Rehab. The rehab staff were contracted.
The Nursing violations were bag technique; the
Rehab staff were deficient in hand washing. The
Rehab staff were observed using hand gel after
obtaining equipment out of their car and before
entering the home. The Rehab staff did not utilize
hand gel or wash their hands, after entering the
home.
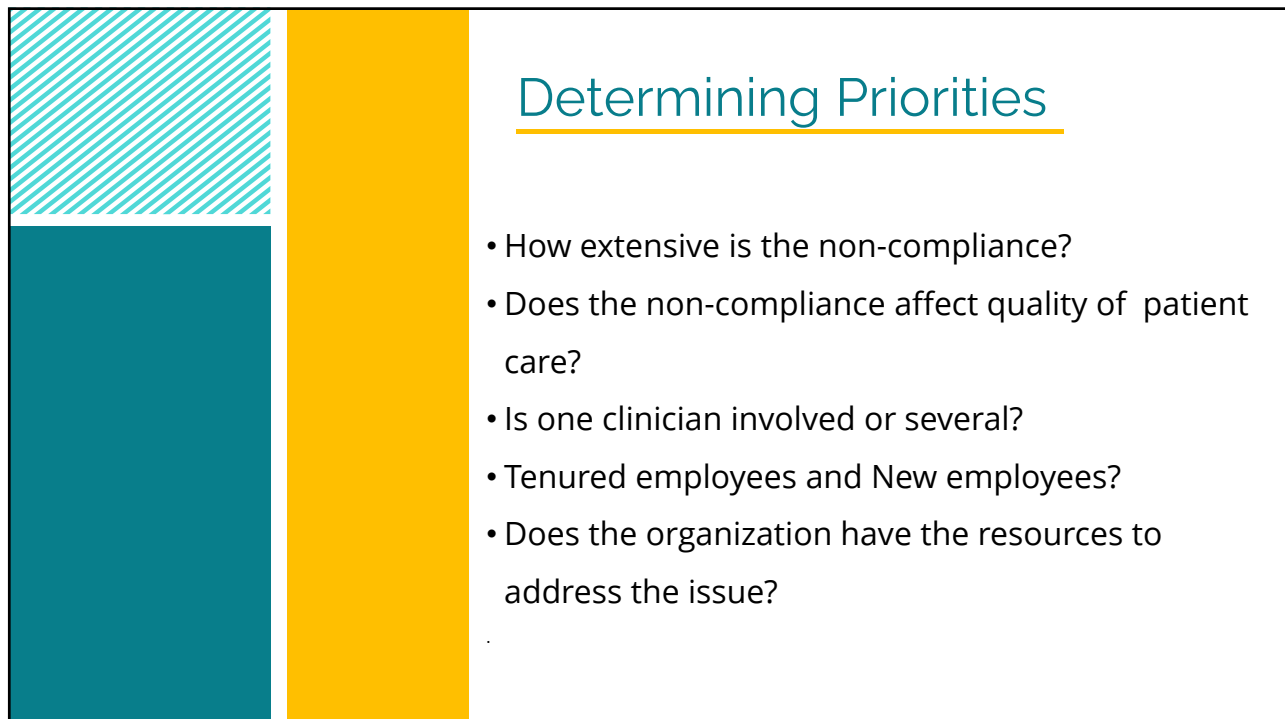
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Discussion

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Determining Priorities

- How extensive is the non-compliance?
- Does the non-compliance affect quality of patient care?
- Is one clinician involved or several?
- Tenured employees and New employees?
- Does the organization have the resources to address the issue?
  .

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Top Findings in CQI and HQPI

Standard	Summary of Content	CMS Tag	% Cited
CQI.1.I.M2	Skilled professionals participate in CQI	G 720	27%
CCQI.2.M1	Quality indicators include measures from OASIS	G 644	16%
CQI.3.I.M2	Activities include high-risk, high-volume and problem prone areas	G642	14%
Standard	Summary of Content	CMS Tag	% Cited
HQPI 8.I	Action is taken, success measured, and positive results sustained	L 570	33%
HQPI 1.D	Agency-wide program is in place to improve care and safety	L 560	17%
HQPI 2.I	Appointed individual is responsible for QAPI program	L 576	17%

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Top Findings in CQI- Home Health

CQI.1.I.M2; Participation in the HHA's QAPI program

G720 *-All skilled professional staff must provide input into and participate in the implementation of the HHA's QAPI program*

G44 *-The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data*

G642 *– Activities include the measurement, analysis, tracking of* quality indicators

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Top findings HCPI-Hospice

HQPI 8.I; Performance Improvement Activities

L570- *Define actions, implement, measure , track performance and ensure sustainability*

L560 - *The governing body must ensure that the components of a QAPI program involve all hospice services*

L576- *The governing body must also appoint individuals who will operate the QAPI program for the hospice.*

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- Place quality meetings on the calendar
- Plan for involvement from staff
- Document actions taken ongoing
- Develop a template for monitoring a performance project
- Ensure your plan is agency-wide
- Follow up on analysis of data, not only collection of data
- Focus audits are your friend

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Emergency Preparedness (HSEP/EP)

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Emergency Preparedness Plan

- Utilize **all-hazard** approach
- Documented facility and community-based **risk assessment**
- Include **strategies** to address emergency events identified
- **Review**ed and updated every two years
- Address **patient** population
- Include process for cooperation and **collaboration**

with local/tribal/regional/state/federal emergency **officials** for

an integrated response

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Policies and procedures are based on emergency plan, risk assessment, and communication plan updated at least every 2 years.

Policies and Procedures address:

- Patient emergency plan
- In comprehensive assessment
- Inform officials of evacuation needs
- Determine staff and patient needs
- Medical documentation
- Staffing strategies

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Communication Plan

- Reviewed every 2 years

- Name and Contact information

- Primary and alternate means of communication

- Sharing information

  - Condition and location of patients

  - Facility's occupancy needs

  - [Facility's] ability to provide assistance

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Training

- Utilize all-hazard approach
- Documented facility and community-based risk assessment
- Include strategies to address emergency events identified
- Reviewed and updated every two years
- Address patient population
- Include process for cooperation and collaboration
- With local/tribal/regional/state/federal emergency officials for

an integrated response

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Testing

- **Annual testing is to be conducted**
    - **Full-scale, community-based exercise every 2 years OR**
        - **Facility-based functional every two years** if full-scale not available
        If an actual event occurs requiring activation of the plan, the agency is exempt from the next required community-based facility based functional exercise.
    - **Additional exercise every 2 years, opposite the full-scale or functional**
        - A second full scale OR
        - Mock-disaster drill OR
        - Tabletop exercise or workshop
    - **Analysis of response and documentation required**

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Integrated Healthcare Systems

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Top Findings in EP

Standard	Content	CMS Tag	% Cited
HSEP 3.D	Required policies and procedures of the emergency plan	L16, L13	78%
HSEP 5.D	Elements and updating of the EP training program	L37	14%
Standard	Content	CMS Tag	
EP.3.D.M1	Training program based on EP plan/risk assessment/policies	E37	23%
EP.1.D.M3	Communication Plan required elements	E31	23%
EP.2.D.M1	Policy and Procedure development	E17	18%

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Top Findings EP-Home Health

EP.3.D.M1; Agency Emergency Training program components and timing

E37-*Reviewed and updated at least every two (2) years initial training (during orientation or shortly thereafter) all new and existing personnel, services under arrangement, and volunteers, EP training is provided at least every two (2) years.*

E31-*EP communication plan that complies with local, state and federal requirements. Contains 6 elements*

E17- Policy and Procedures –17 elements 6 potential tags

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Top Findings in HSEP-Hospice

HSEP 3.D; L16,13: *Emergency preparedness (EP) policies and procedures, based on the emergency plan, the risk assessment, and the communication plan.*

HSEP5.D; L37- *Maintains an emergency preparedness training program of all hospice employees and individuals providing services under arrangement at least every two (2) years; program is reviewed every 2 yrs .*

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- Identify the individual responsible for oversight of the Emergency Preparedness program

- Schedule annual tasks at the beginning of the year so they aren't missed

- Keep staff and patient lists updated with current information

- Validate the current contact information for your emergency officials

- Build community relationships before a disaster occurs.

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CHAP Application
CHAP LinQ
Customer Relations

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Customer Relations

- 6 Accreditation Specialists, divided by geographic territory
- 1 Manager of Accreditation Operations
- 1 Senior Scheduling Manager
- 1 Vice President

- The customer service "hub"
- Contact with a live person
- Reducing the work and rework

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Accreditation Clinical Support

- 4 Directors of Accreditation divided by geographic territory
- 3 Senior Accreditation Managers
- 1 Vice President of Accreditation
- 1 Vice President of Corporate Accounts and Governmental Affairs

- Clinical expertise with years of experience in the industry
- Contact with a live person

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Steps to Accreditation

| Accreditation Agreement | Site Visit Preparation | On-Site Visit and Review | Accreditation Determination |

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Initial Agencies

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Initial CHAP LinQ Account
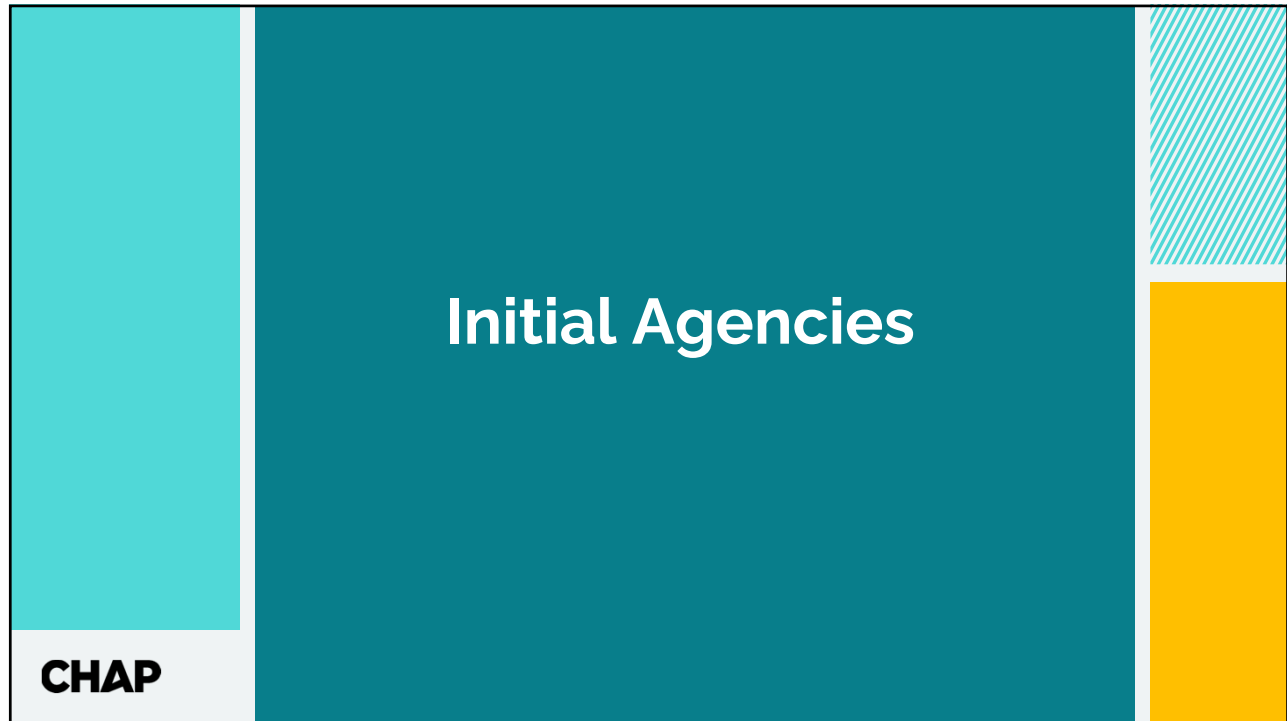
CHAP LinQ

Apply for Accreditation and/or Certification

Simple
To begin your CHAP application, simply sign in to your CHAP LinQ account. If this is the first time you are applying, select the Create an Account button.

Account
Your CHAP LinQ account will guide you through every step of the accreditation process and provide access to all your accreditation information.

Questions
For any questions regarding your CHAP LinQ account, call (202) 862-3413 or email customerservice@chapinc.org.

Create an Account

www.chaplinq.org
www.chapinc.org and click on "Your CHAP LinQ Account"
❖ **Create An Account**

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Initial Application

Page 2, continued

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Following Contract Execution

- Email with the contract

- Phone call or e-mail from the Accreditation Specialist

- The "What Next" Call

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Timing to Prepare

Work on preparation continuously

Initial organizations
- Visit in1-30 days of readiness submission
- Deemed – not announced
- Non-deemed – announced
- Only hit **submit** button when ready!!

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Site Visit Readiness Numbers

Service Line	Required Documents	Required Census	Deemed Status Requirements
Home Health	• Copy of state license(s), if required by state	• 10 served • 7 active at time of survey	Copy of approved 855A letter
Hospice	• Copy of state license(s), if required by state	• 5 served • 3 active at time of survey	Copy of approved 855A letter
Home Medical Equipment (HME/DMEPOS)	• Copy of state license(s), if required by state	• 5 served (sale or rental) • No active patients required at time of survey	
Home Care	• Copy of state license(s), if required by state	• 5 served • 3 active at time of survey	
Pharmacy	• Copy of state license(s), if required by state	• 5 served (sale or rental) • No active patients required at time of survey	
Infusion Therapy Nursing (ITN)	• Copy of state license(s), if required by state	• 5 served (sale or rental) • 3 active at time of survey	
Palliative Care	• Copy of state license(s), if required by state	• 5 served (sale or rental) • 3 active at time of survey	

* How do I submit readiness?
* Black out dates?

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LinQ Site Visit Posting

Type: Initial

1 Application
2 Contract
3 Self-Study / Readiness
4 Site Visits
5 Action Plans
6 Board Review
7 Accreditation

CHAP is currently:

CHAP is performing the following Site Visit:
Initial Site Visit started on 1/19/2022 - Lead Site Visitor: Deborah Lasater

Completed Items In Accreditation Cycle

✓ Your Application was accepted!
✓ Contract executed (5/6/2021 8:41:37 AM).

Other Actions

View Notification Settings
View Application Summary
View Contract Document
Fill out Blackout Dates
View Self-Studies
View Site Visit Readiness
View Site Visits
View Findings
View Complaints
View All Locations
View Documents
View Journals
Pay Outstanding Invoices

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Condition Level Finding

Initial agency – First site visit
- Deferral of accreditation
- 2nd comprehensive visit within 90 days
- If continues – 3rd and last visit within 90 days

Multiple Findings

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Renewal Organization

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Initial Application

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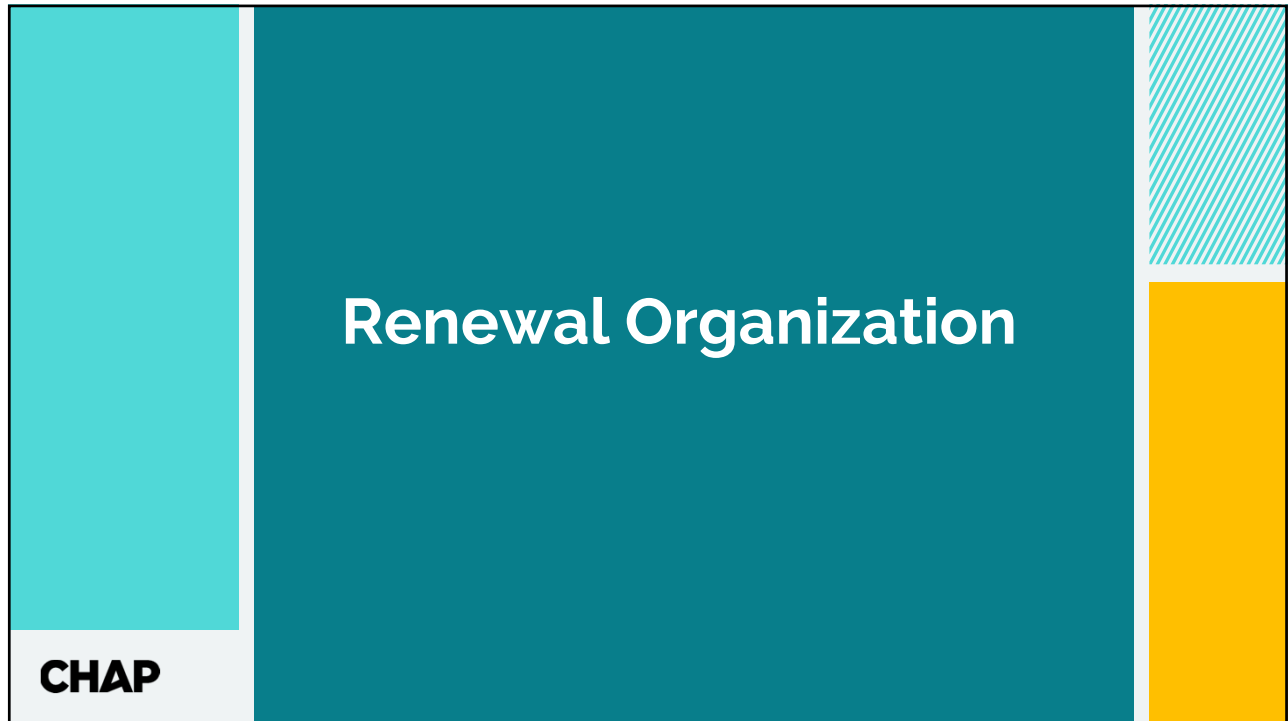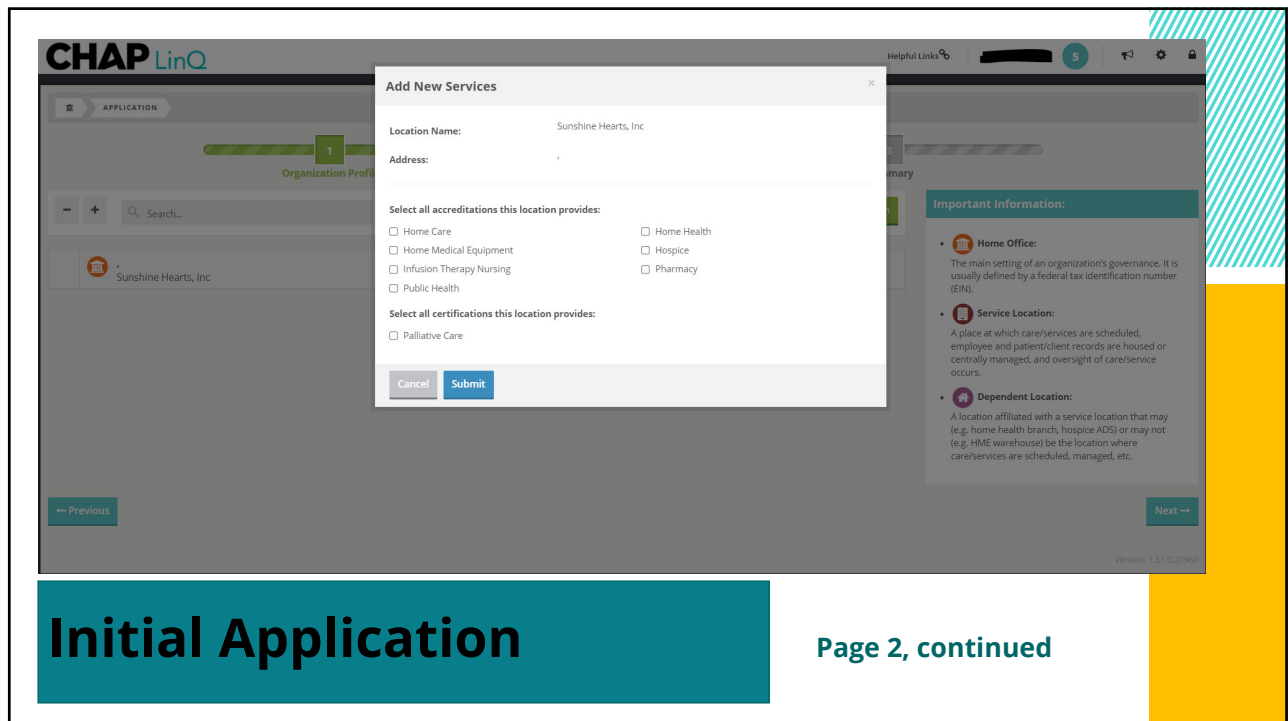
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The Work per CMS – Home Health

Table 6A: Home Health Home Visits and Clinical Record Reviews

Unduplicated skilled admits recent 12-month period	Minimum # active patient record reviews without home visit	Minimum # of active patient record reviews with home visit	Minimum number of discharged patients (closed) record review	Total record reviews
Less than 300	2	3	2	7
301-500	3	4	3	10
501-700	4	5	4	13
701 or more	5	7	5	17

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The Work per CMS - Hospice

Table 6B: Hospice Home Visits and Clinical Record Reviews

Unduplicated admits 12-month period	Minimum # of record reviews without home visit	Minimum # of record reviews with home visit	Total record reviews
5	2	3	5
6–149	8	3	11
150–750	10	3	13
751–1,250	12	4	16
1,251 or more	15	5	20

(Source: SOM Appendix M, Task III)

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Renewal Application:
And then?

❑ *Preparedness Call*
❑ *Submitting Blackout Dates*
❑ *Scheduling Site Visit*
❑ *Site Visit posted in LinQ on the morning of the survey*

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Timing to Prepare

Work on preparation continuously

Renewal organizations
- Visit in 32-36 months of prior comprehensive visit
- Review of entire Accreditation cycle

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Condition Level Finding

Renewal Agency – any visit type
- Follow up visit within 45 days
- One or two days depending on number of CLD's
- The entire condition must be reviewed
- May require a home visit depending on the finding

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Site Visit

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Site Visit Preparation

CHAP Preparation Resources

- Document Request List
- Policy List
- Top Ten Findings per the service line
- Optional self study

Mock record review

- Multi-discipline
- High acuity interventions
- Using quality results
- Consider additions of new services

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Visit Components

»»»»

Entrance Conference
- *Communication*

Site Visit Activities
- *Communication*
- *Home Visits*
- *Record Reviews*
- *Document Review*
- *Interviews*

Daily Wrap Ups
- *Communication*
- *Review of work*
- *Potential Findings*
- *Pending Work*

Exit Conference
- *Communication*
- *Formal*
- *Report of findings*
- *Next steps*
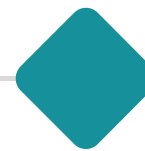
Action Plan
- *Communication*
- *Determine plan*
- *Implement*
- *Monitor*

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Waiver Implications

The ASPR Assistant Secretary extended the public health emergency for COVID-19 another 9o days (**Oct 13, 2022**)

CMS should keep all PHE waivers in place until an end date of the PHE is announced.

Providers will have a minimum of 60 days from the PHE end date to eliminate waiver practice and return to previous compliance requirements.

Some practices developed to support care during the PHE that are not connected to waived regulations should be considered as permanent if they improve quality.

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Action Plan

Action plan to provider within 10 *business* days

- Submission of report by site visitor
- Full review by the Director of Accreditation or Senior Accreditation Manager

Provider has 10 *calendar* days to submit their plan of correction.

- **PLUS** the 10 business days of the DA

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Action Plan

A successful Plan of Correction:

- Defines a process for achieving compliance

- Designates responsibility

- Establishes a threshold of compliance to achieve within a designated timeframe

- Provides steps for implementation

- Establishes a timeline for implementation and monitoring

- Outlines activities to assure continued compliance

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Prior to Determining the Actions

Identify the underlying cause for the deficiency
- Who is involved in the deficient practice –a specific discipline, contract staff
- What is the actual deficiency – a practice deficiency or documentation deficiency
- When does this deficiency occur – only on admissions, during care observation
- Where does it occur – in the organization, the field, in a specific department
- Why is the deficiency occurring – lack of education, lack of resources, lack of oversight

Who is responsible for implementation
- Development of the plan (ex PDCA)
- Day to day
- Role of agency Board of Directors

Timeline for completion

On-going Monitoring to sustain compliance

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Action Plan Tips

REMEMBER

- Don't approach you action steps with generic statements
- This is a blind review. Do not include any identifying information: agency or patient
- The reason for the deficiency will affect your timeline for implementation
- Document
- If at once you don't succeed, try again **
- You have **10 calendar** days to respond from the day the Director of Accreditation notified you of the final decision on the deficiencies. NOT from the day you receive the emailed written report of deficiencies
- You will enter your Action Plan directly into CHAPLinQ.

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Coordination of Care

- It is required that the clinical record retain documentation of coordination of care between disciplines, patients/caregivers.

- The standard was not met by clinical record review and interview. 2 of 5 (40%) of the clinical records did not provide evidence of coordination of care.

- Clinical record #1 Patient Plan of Care revealed a diagnosis of a pressure ulcer with orders for Nursing to provide wound care. The clinical record revealed clinical notes from a Registered Nurse and a Licensed Practical Nurse. The RN (agency employee) documented a visit on 3/1/21. The patient had an oral temperature of 101.4 and the pressure ulcer had increased drainage and odor. The physician was contacted, and an antibiotic was ordered. The EMR identified an LPN (contract employee), was also provided the next visit for this patient. The RN did not document contact with the Clinical Manager or the LPN regarding the patients change in condition and change in orders.

- Clinical record #2- The Physical Therapy Assistant (PTA), an agency employee, documented on 3/5/21 the patient went to the Emergency room on 3/4/21 for disorientation and agitation. The Plan of Care revealed the patient was a diabetic with orders for Physical Therapy only. The clinical record did not reveal communication by the PTA to the Physical Therapist(a contract employee) and/or the Clinical Manager regarding the ER visit.

- Site visitor reviewed the clinical record documentation and agency policy on coordination of care with the Clinical Manager on 9/27/21. The Clinical Manager identified in the policies that use of the EMR tab labeled "communications" and the agency internal email system is allowed for coordination of care activities. The Clinical Manager reviewed the clinical record for additional documentation, but none was identified. She called the RN who had called the physician and obtained the verbal orders who indicated she had texted the change to the LPN.

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Relieving Anxiety

Constant Preparation
- Mock surveys and staff observations
- Education
- Document readiness

Prepare for the site visit
- Documents ready for review – contracts and policies

Updated lists
- Active patients
- Employee listing
- Discharge listing
- Unduplicated admission *number*

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Relieving Anxiety

Site Visit Plan
- Appoint a **point-person**
  - Designate an alternate
- Methods for **sharing information**
  - Records/Documents
  - Onsite/Offsite
- **COVID practices** sustained
- **Workspace** determined
- **Prepare staff** through practice drill

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Relieving Anxiety

Communication

- Share difficulty in obtaining information

- Share your anxiety with the site visitor

- Ask questions!

- Take notes at each daily wrap up

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Pandemic Effect on Visit

- Site Visitors

- Home Visits

- Record Reviews

- Communication

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Handling Conflict

Should occur **during** the site visit

Steps to successful resolution
- Share concern with site visitor
- Each side should explain their point of view

If conflict continues, add the Director of Accreditation

Final opportunity is to appeal the finding

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Earning CE Contact Hours

To take the post evaluation

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thank you!

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