

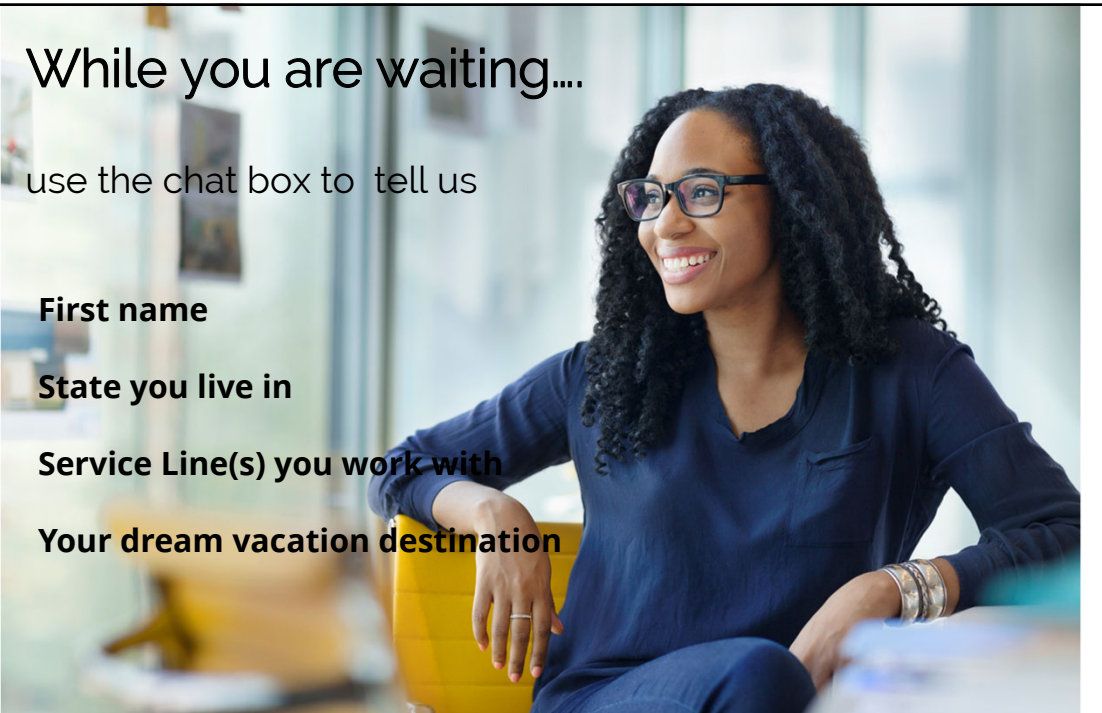
Hospice Day 2 Home Health Day 1 Accreditation Intensive

An Interactive Training

Bobbie Warner RN, BSN
Director of Education
June 29, 2022

CHAP Community Health Accreditation Partner

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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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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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Welcome Back Hospice
and Welcome Home
Health

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Resource Tool Example – Home Health Infection Control

CHAP CHAP Home Health Standards of Excellence
Summary of Infection Prevention and Control June 2021

Standard	Summary of Content
IPC.1.D	Policies and Procedures reflect the scope and complexity of services
IPC.1.D.M1	IPC Program required Policies and Procedure
IPC.1.I	Policies implemented to minimize risk of infections and communicable disease
IPC.1.I.M1	Organization follows standards of practice including standard precautions
IPC.1.I.M2	Agency wide surveillance, identification, prevention, control, and investigation of infections
IPC.1.I.M4	Flu and pneumonia vaccines may be administered per organization policy and physician orders
IPC.3.I	Personnel use hand hygiene products, PPE and other supplies as per policy
IPC.3.1.M1	Instances the use of hand hygiene is implemented
IPC.4.I	Storage, Transport, and use of supplies and equipment follow policy and procedure

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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

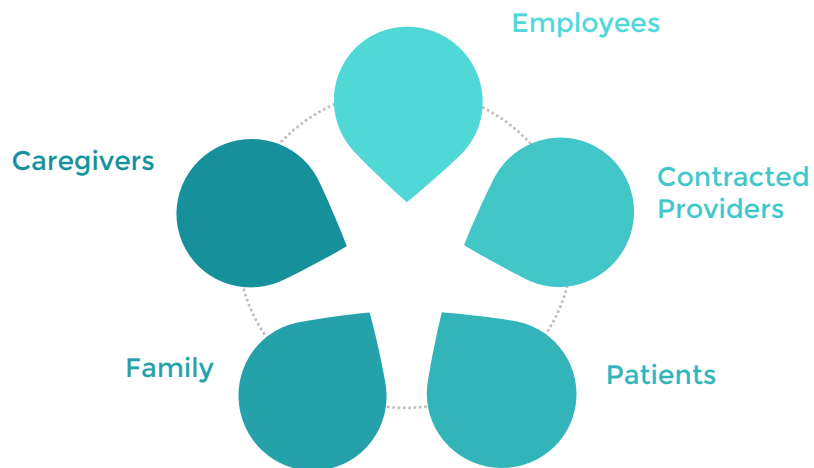
Includes:

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

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Education



10

Review the Handouts



Handwashing



Bag Technique

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Discussion

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This slide features a decorative header on the left with a teal vertical bar, a yellow bar with diagonal lines, and a solid yellow bar. The main content area contains six overlapping speech bubbles in green, yellow, orange, blue, yellow, and purple. The word "Discussion" is centered below the bubbles. A grey footer bar at the bottom contains the text "CHAP" in bold black letters.

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Focused Infection Control Survey

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This slide features a decorative header on the left with a teal vertical bar, a yellow bar with diagonal lines, and a solid yellow bar. The main content area contains a microscopic image of numerous blue, rod-shaped bacteria. The text "Focused Infection Control Survey" is overlaid in the center. A grey footer bar at the bottom contains the text "CHAP" in bold black letters.

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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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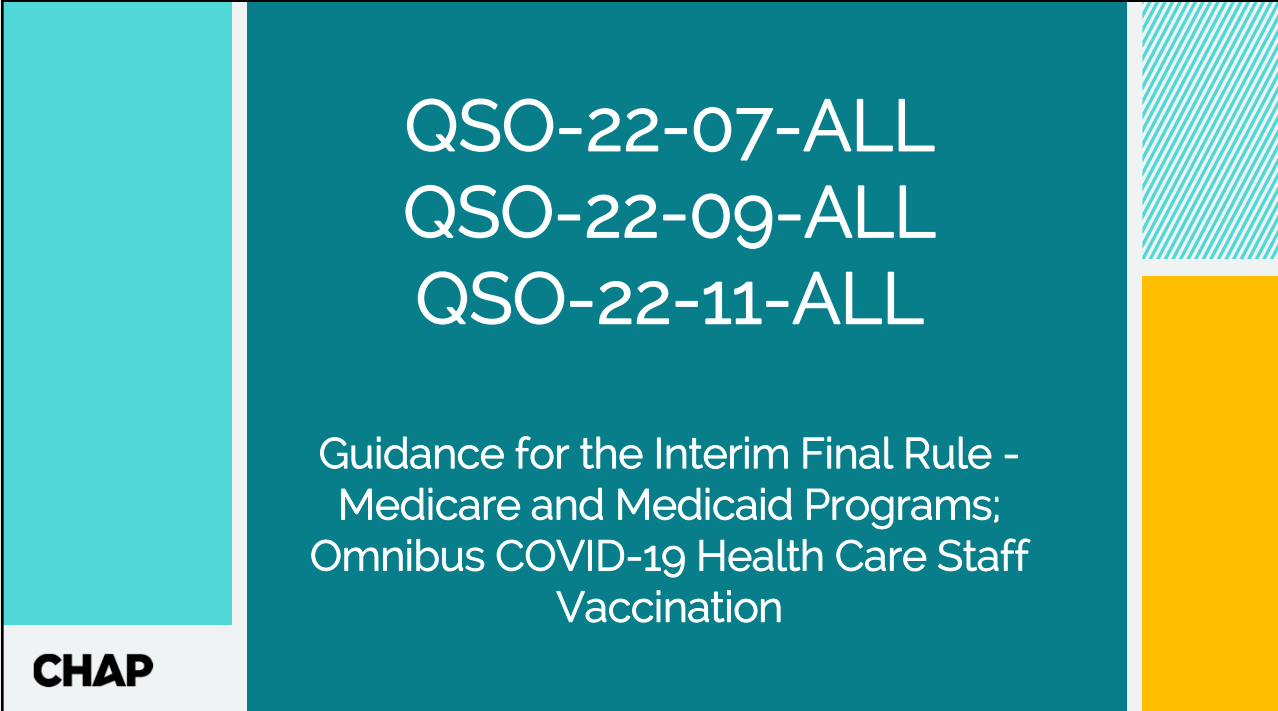
A healthcare worker in blue scrubs is leaning over and showing a tablet to an elderly woman. The woman is looking at the tablet with a focused expression. The background is a plain, light-colored wall.

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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

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

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 diseases.*

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

HSRM16.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

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 10.I; No Tag- *Personnel performance is evaluated as defined by organizational policy*

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

G768- Home Health Aide competency

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Tips for Success



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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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Specific

Measurable

Attainable

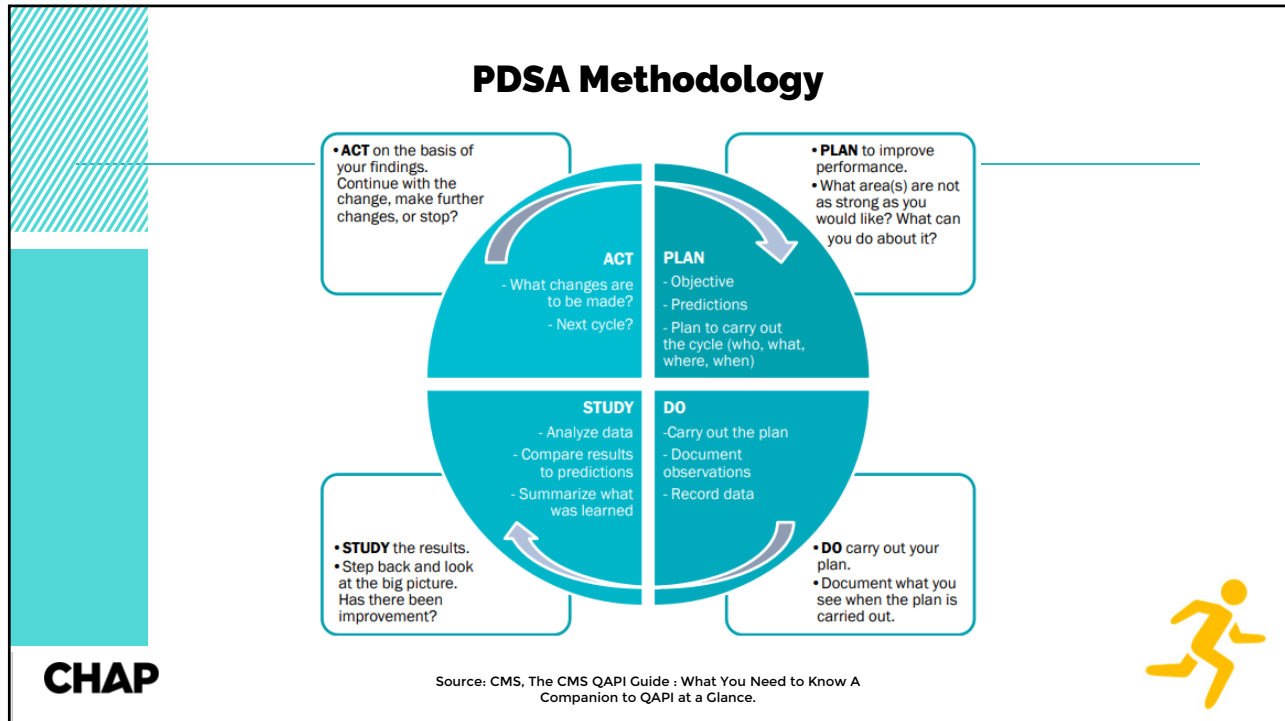
Relevant/Realistic

Time-based

**G
o
a
l
s**

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Goal:

Amy will learn to roll over upon verbal command within one month from the first lesson

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PLAN:

Treats

Practice every day for 10 minutes

Reward Success

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DO:

Practice
every
day for
10
minutes
for one
month

Reward
Success
with
treats

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ACT

Success...next trick please



Back to the drawing board....

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Quality Activity

Breakout Rooms – 4 (1 person to report out)

Scenario – PIP for handwashing and bag technique

- Group 1a – Governing body: measurable predictive outcome develop smart goal
- Group 1b – Administrative staff developing a plan to address the deficiency – determine a multifaceted plan
- Group 1c – clinical staff implementing corrective steps – what action steps are being implemented
- Group 1d – performance improvement monitoring for improvement- What will they monitor

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Quality Activity

Breakout Rooms - 4 (1 person to report out)

Scenario – PIP for wound care

- Group 1a – Governing body: measurable predictive outcome develop smart goal
- Group 1b – Administrative staff developing a plan to address the deficiency – determine a multifaceted plan
- Group 1c – clinical staff implementing corrective steps – what action steps are being implemented
- Group 1d – performance improvement monitoring for improvement- What will they monitor

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Quality Activity

Breakout Rooms - 1 (1 person to report out)

Scenario – Freestanding Organization recently had a first renewal site visit conducted. Active patient census is 75.

Agency Support

- Administrator – nonclinical
- Clinical Manager with the following oversight responsibilities
 - Quality Improvement
 - Education
 - Orientation
 - Supervision

Improvement Needed – In the renewal site visit, 11 of 11 records reviewed revealed deficiencies such as medication profiles not kept current or not present, medication reconciliation not conducted with changes in medication, and no over-the-counter medications identified.

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Quality Activity

Breakout Rooms - 1 (1 person to report out)

Scenario – Corporate entity with 20 locations.

Regional Support

- Education department
- Quality Improvement department
- Regional director

Branch Support

- Administrator and Clinical Manager at each branch
- Clinical Manager provides oversight for education and quality

Improvement Needed –In the past quarter, 10 locations had site visits conducted and each site visit revealed deficiencies such as medication profiles not kept current or present, medication reconciliation not conducted with changes in medication, and no over-the-counter medications identified.

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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

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

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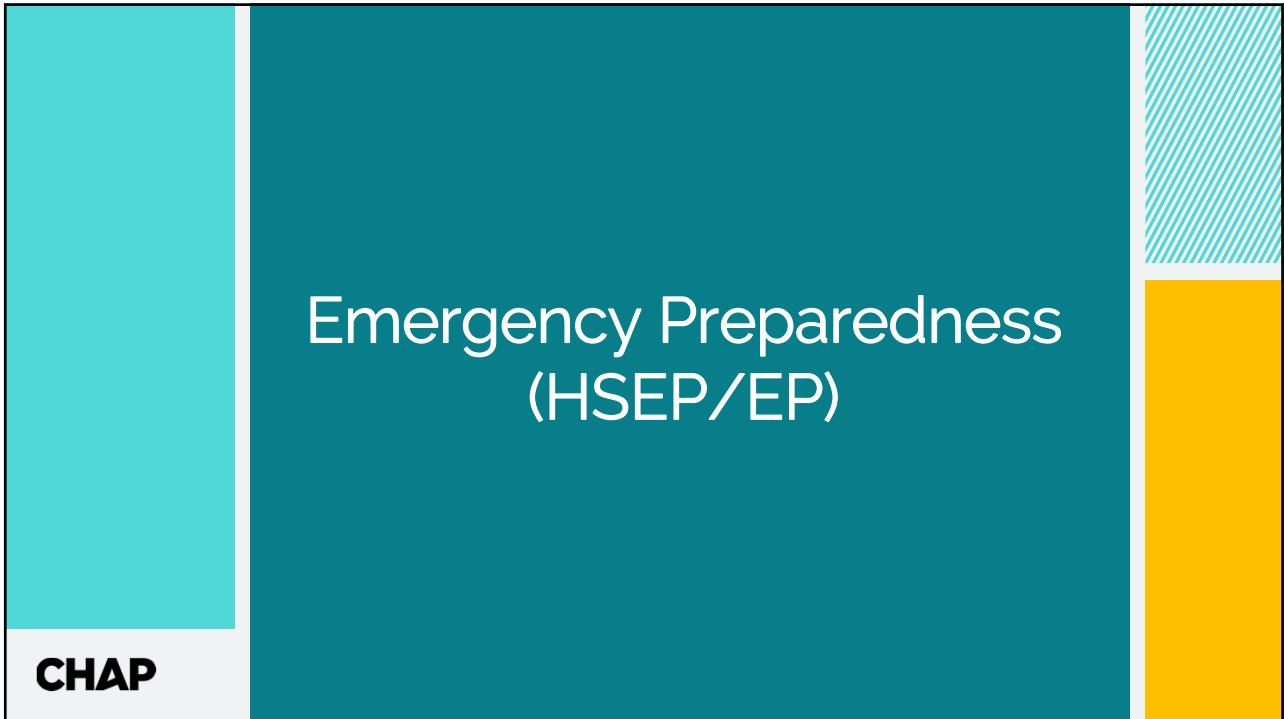
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- Place quality meetings on the calendar
- Plan for involvement from staff
- Document actions taken ongoing
- Develop a template for monitoring a performance project
- Ensure your plan is agency-wide
- Follow up on analysis of data, not only collection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

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Emergency Preparedness Plan

- 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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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

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

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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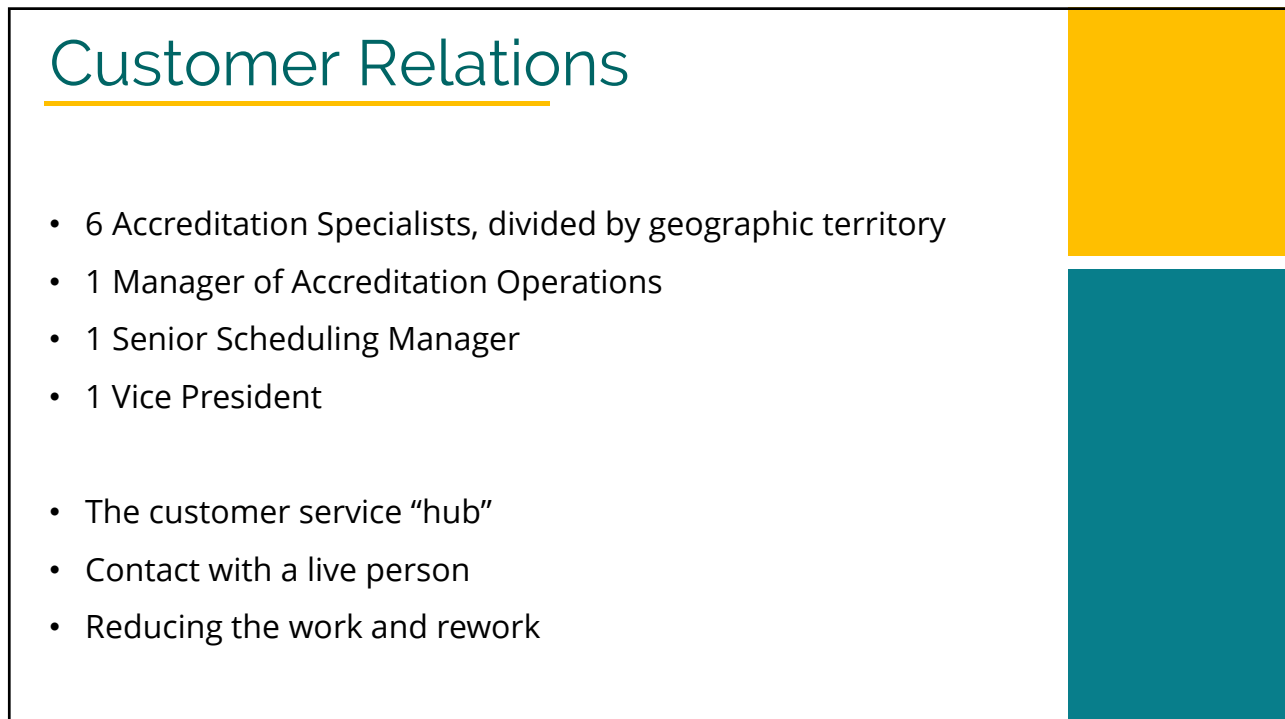


CHAP Application
CHAP LinQ
Customer Relations

CHAP

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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

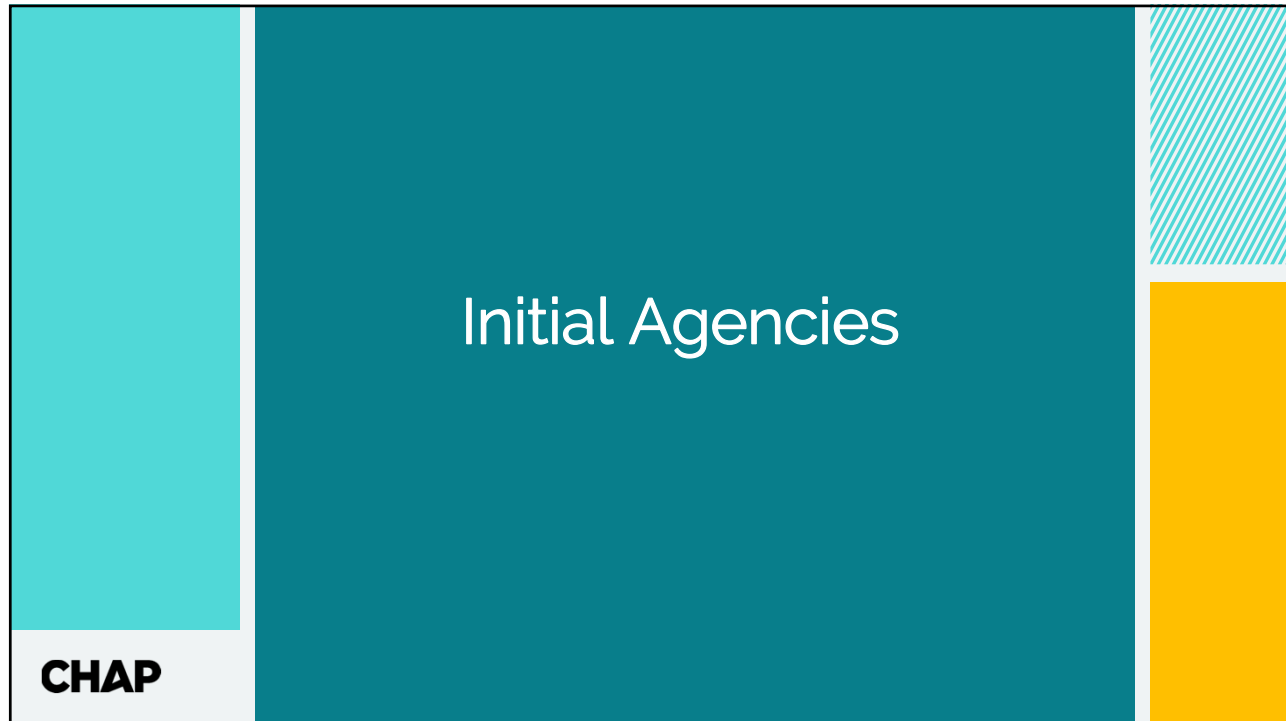
- 4 Directors of Accreditation divided by geographic territory
 - 3 Senior Accreditation Managers
 - 1 Vice President of Accreditation
 - 1 Vice President of Corporate Accounts and Governmental Affairs
-
- Clinical expertise with years of experience in the industry
 - Contact with a live person

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Steps to Accreditation



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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.

[www.chaplingq.org](#)
[www.chapinc.org](#) and click on "Your CHAP LinQ Account"
❖ **Create An Account**

Create an Account

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CHAP LinQ

APPLICATION

Organization Profile

Sunshine Hearts, Inc

Add New Services

Location Name: Sunshine Hearts, Inc

Address:

Select all accreditations this location provides:

Home Care Home Health

Home Medical Equipment Hospice

Infusion Therapy Nursing Pharmacy

Public Health

Select all certifications this location provides:

Palliative Care

Cancel Submit

Important Information:

- Home Office:** The main setting of an organization's governance. It is usually defined by a federal tax identification number (EIN).
- Service Location:** A place at which care/services are scheduled, employee and patient/client records are housed or centrally managed, and oversight of care/service occurs.
- Dependent Location:** A location affiliated with a service location that may (e.g. home health branch, hospice ADS) or may not (e.g. HME warehouse) be the location where care/services are scheduled, managed, etc.

Version: 1.51.0.21961

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 in 1-30 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

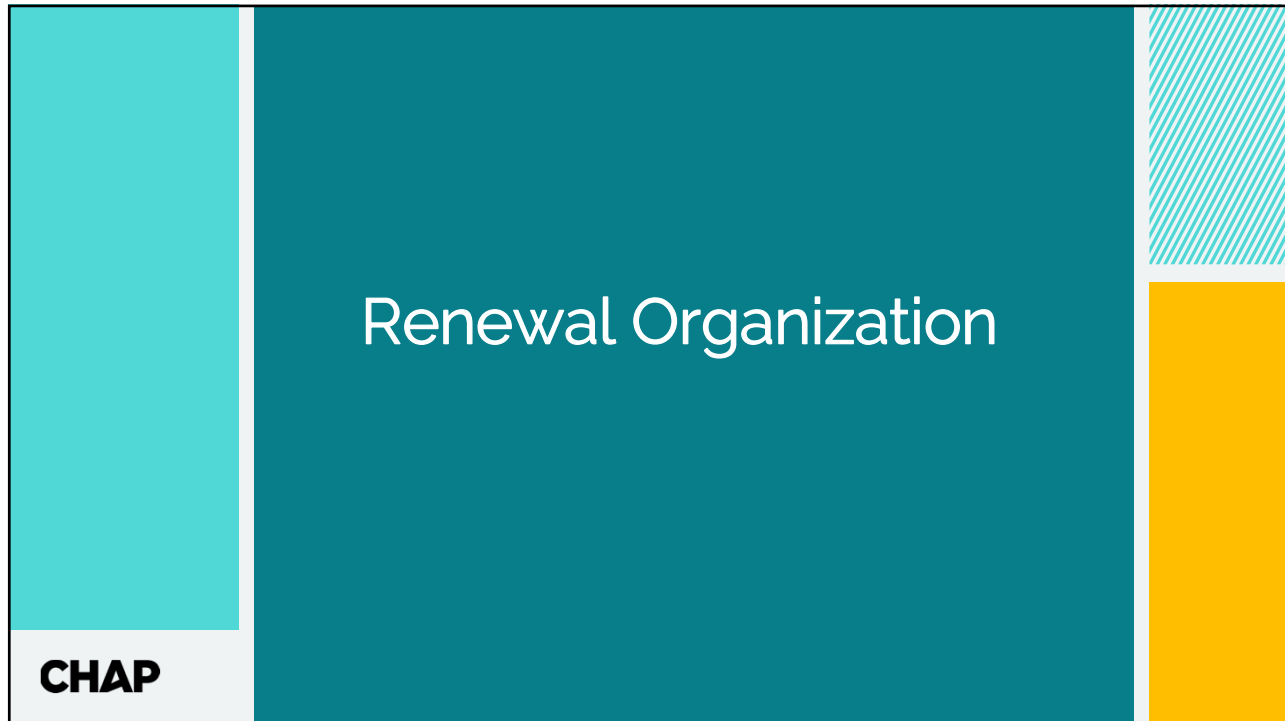
Initial agency – First site visit

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

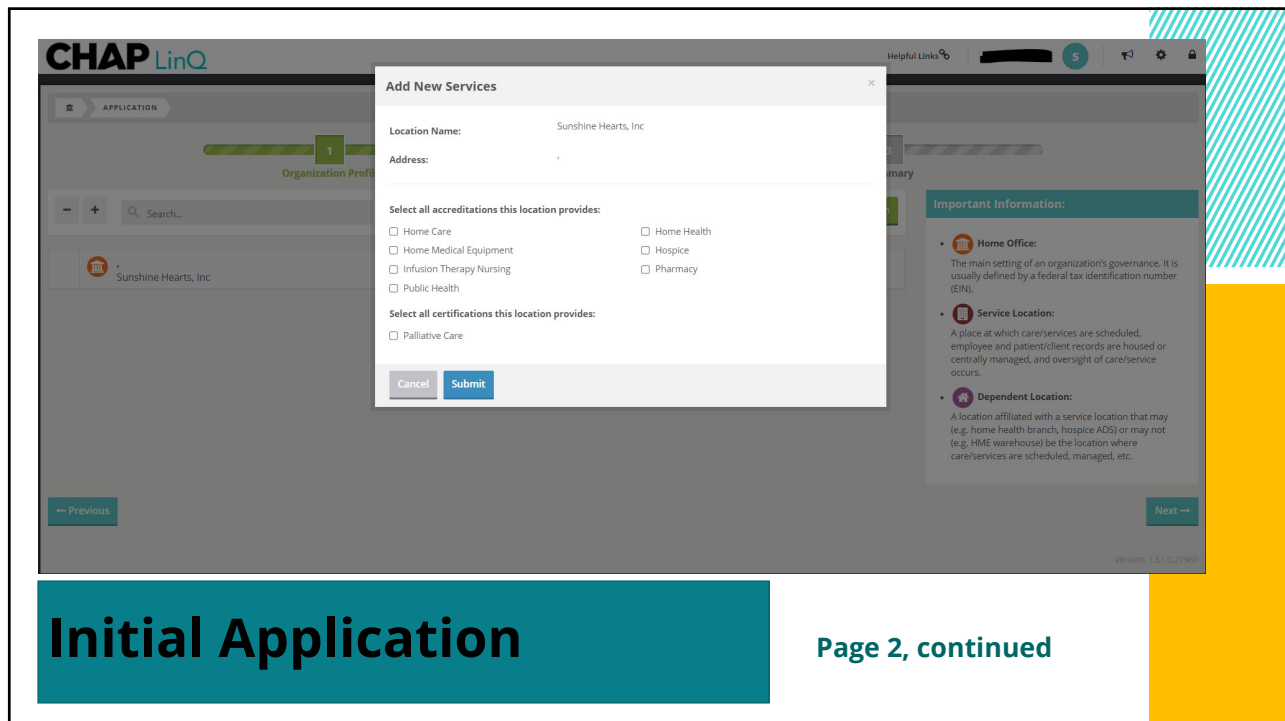
Multiple Findings

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Grid for record reviews and home visit numbers

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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



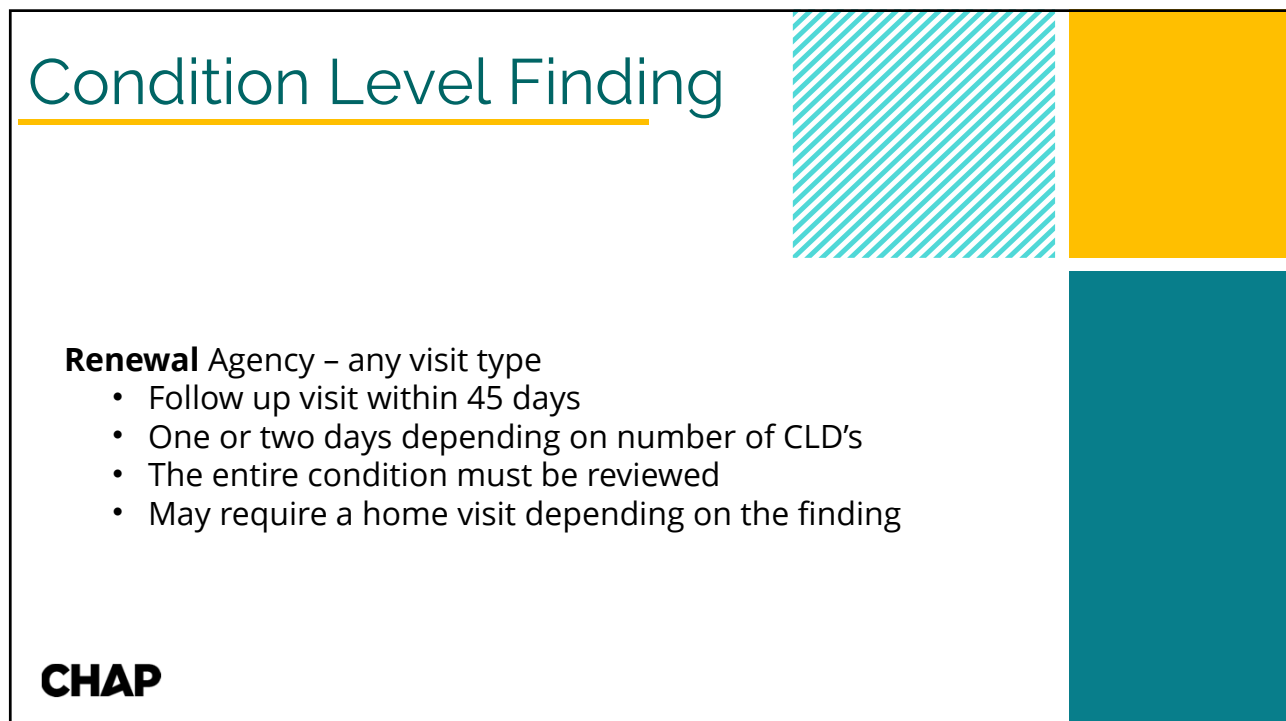
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Condition Level Finding

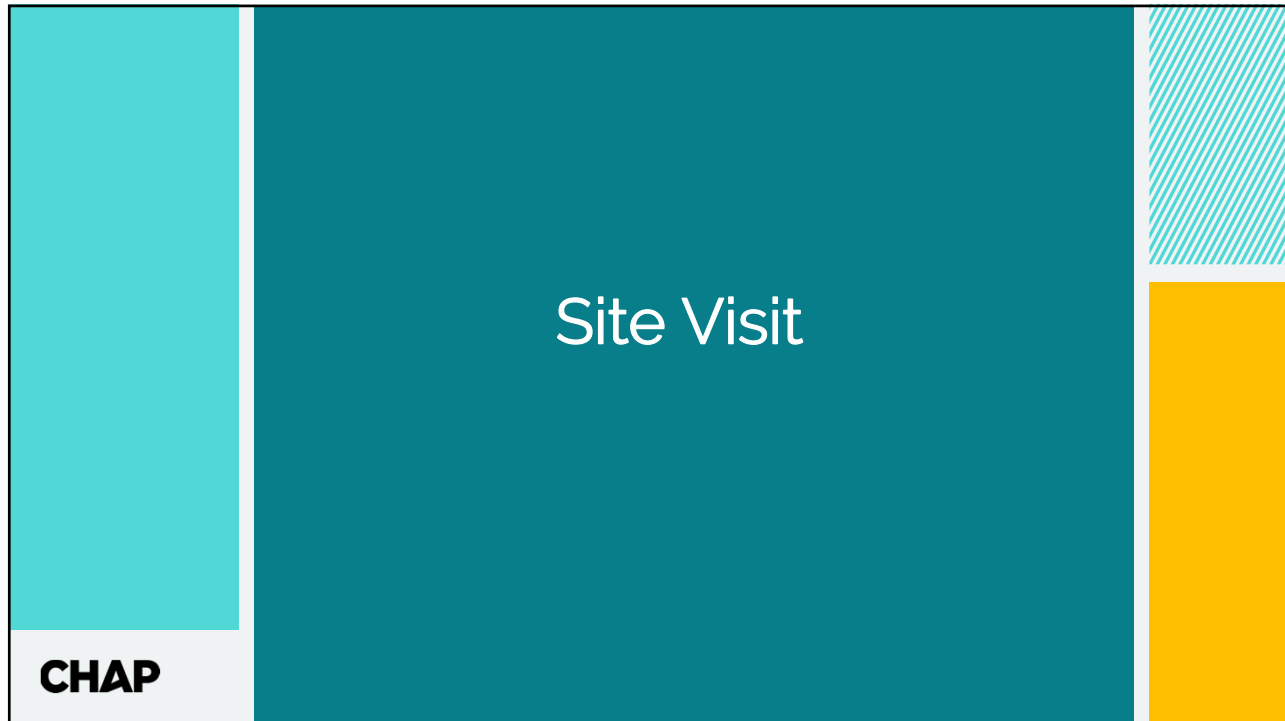
Renewal Agency – any visit type

- 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 Preparation

CHAP Preparation Resources

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

Mock record review

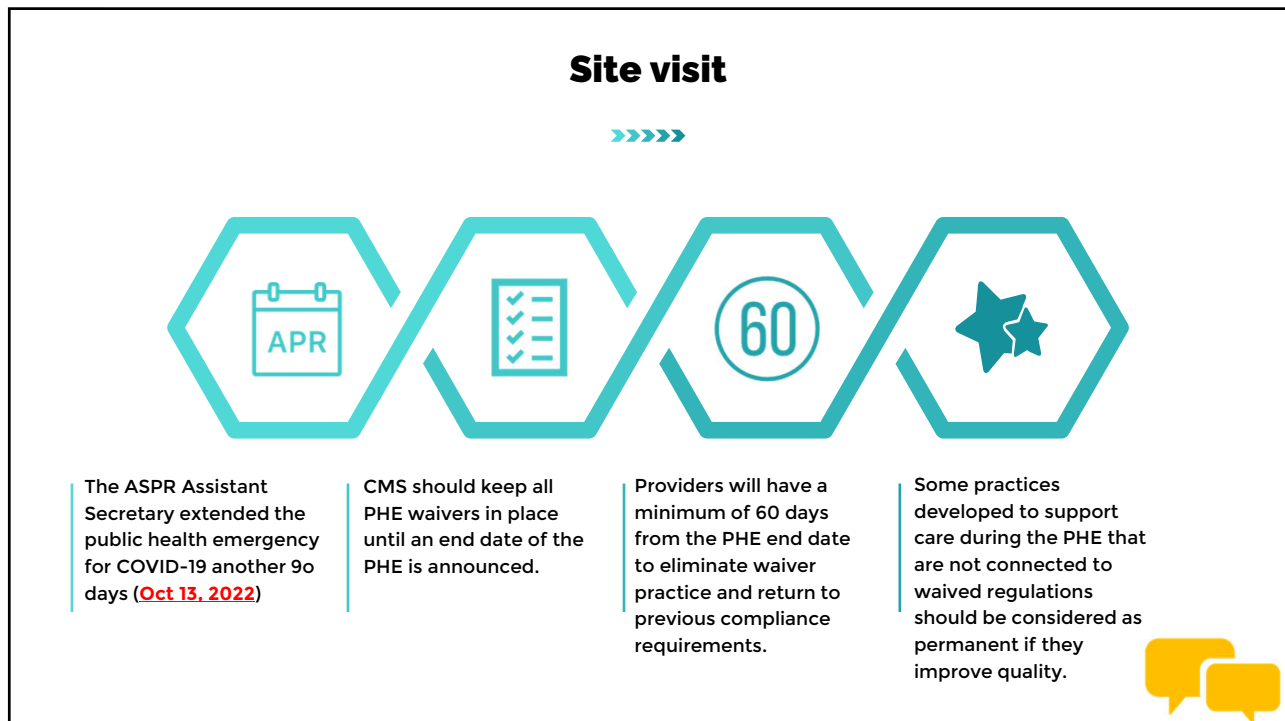
- Multi-discipline
- High acuity interventions
- Using quality results
- Consider additions of new services

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Site Visit Activities

- Clinical Record Review
- Personnel Record Review
- **Home Visit Observations**
- QAPI Review
- Emergency Preparedness Review
- **Policy Review**
- **Communication**

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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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Scenario #1 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

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