Successfully Preparing for Your Next AAAHC Accreditation Survey

2012 Annual Conference
Guest Speaker

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Presentation Outline

- Staying Current with AAAHC Standards and CMS Conditions for Coverage
- What Do Surveyors Look for to Determine Compliance
- Preparing for Accreditation or Re-Accreditation
- 2012 Update
- Q & A
Successfully Preparing for Your Next AAAHC Survey
Successfully Preparing for a AAAHC Survey

- Complete the *Application for Survey* 6 months prior to expiration date
- Complete the most recent Edition of the *Physical Environment Checklist (PEC)* and perform spot check on “hot list”
- Read the 2012 *Handbook* thoroughly
- Audit your records with the credentials, personnel and medical records worksheets
Successfully Preparing for a AAAHC Survey

- Consider attending an Achieving Accreditation Workshop (“Boot Camp”)
- Work with your West Region application coordinator (Brandy Dye) and scheduling coordinator (Liza Torres)
- For those who choose a Deemed-Status survey, CMS mandates unannounced surveys within a window of 90 calendar days.

The first day of the window begins after:
- The application is complete,
- Any black-out dates are confirmed,
- Surgery days are confirmed,
- BE READY & PREPARED!
Successfully Preparing for a AAAHC Survey

- Post the Notice of Accreditation at least 30 days prior to the 90 day window

- Consider providing a power point presentation on your organization during the initial survey orientation meeting. Information from your annual shareholders meeting and annual medical staff meeting is a great place to start. *Put you best foot forward!*
1. 2012 AAAHC Handbook, CMS Conditions for Coverage now listed below the corresponding standard.

2. Additional Medicare Requirements are listed in *Blue Italics* at the end of those chapters that include additional CMS-only standards.
3. 2012 AAAHC Physical Environment Checklist (PEC) is cross-referenced with the NFPA Life Safety Code. *This must be updated for each survey.*

4. Credentialing Records Worksheet, Personnel Records Worksheet, Clinical Records Worksheet. *Pull 10 records from each and complete the worksheets to show your surveyors where and how to find the data.*
The citing of a Condition Level Deficiency will require a written Plan of Correction (POC) be submitted to AAAHC prior to determination of the accreditation decision, and will also result in a return, un-announced visit, usually by one surveyor for one day to “inspect” the progress of the POC. The cost is billed to the organization.

Let's try to avoid a Condition Level Deficiency.
There are 14 *Condition* level requirements.

1. 416.25 see AAAHC 10. sub-l. MS
2. 416.40 see AAAHC 2. sub-l.A- MS
3. 416.41 see AAAHC 2. sub-l.B- MS-1
4. 416.42 see AAAHC 10. sub-l.C- MS
5. 416.43 see AAAHC 5
6. 416.44 see AAAHC 8
7. 416.45 see AAAHC 2. sub-ll. A
8. 416.46 see AAAHC 10. sub-l.H- MS
9. 416.47 see AAAHC 6
10. 416.48 see AAAHC 11. A.
11. 416.50 see AAAHC 1.F- MS(1)
12. 416.51 see AAAHC 7. sub-l
13. 416.52 see AAAHC 10. sub-l. D- MS
14. 416.49 see AAAHC 12 (Lab) and 13 (Radiology Services)
For more information on specific actions you can take to avoid a Condition Level deficiency, please refer to the slides from my 2012 presentation located at the end of this presentation.
"Hot List" of Most Frequently Cited Life Safety Code Deficiencies

- 1.7 Emergency call system is provided to alert staff of urgent need for health care assistance. **Finding: No Code** Blue component to emergency call sys.

- 3.17.7 Directional indicators on exit signs. **Finding: Exit** signs missing, obstructed view to 40 ft., incorrect lettering block size and shape.

- 7.3n & 7.6.2n New Systems (built after 3/11/2003) individual medical gas cylinders are properly chained or supported. **Finding: Cylinders chained together.**

- 12.1 The facility is separated from adjacent occupancies by walls of 1-hour resistive construction. **Finding: Non fire-rated glass, glass wall panels with gaps.**
10.1.2 A manual pull station is located inside the ASC near each required exit (within 5 feet of the exit opening). Finding: Missing pull stations from each egress exit inside the ASC. Reliance on pull stations in Common Areas.

8.31.22 Generators serving as the alternate source comply with....(22) the alternate source location is provided with self-contained battery-powered emergency lighting. Finding: No battery-powered lighting for outdoor generator.

8.28 Storage batteries used in connection with EESs are inspected (including electrolyte levels) at intervals of not more than 7 days. Finding: Battery not being inspected q 7 days and non-sealed battery not tested for electrolyte levels.
“Hot List” of Most Frequently Cited AAAHC Standards Deficiencies

- 2-I Governance, B-21. Establishing processes for the identification, reporting, analysis, and prevention of adverse incidents. **Finding:** Missing key elements include definition, review of frequency and severity, through analysis, process of reporting, and action plan.

- 2-II Privileging, D. Privileges to carry out specific procedures are granted. **Finding:** Surgeons missing administration of anesthesia, supervision of others administering anesthesia, and interpretation of diagnostic images.

- 3 Administration, B-7. Specify privileges and responsibilities of employment, including compliance with an adverse incident reporting system. **Finding:** Not in job description or orientation checklist.
“Hot List” of Most Frequently Cited AAAHC Standards Deficiencies

- 5-II Quality Improvement Program, B. Quality studies. Finding: Studies “stuck” in Quality Assurance and not advancing to Quality Improvement (plan of correction, re-measurement).

- 6 Medical Records, K. The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistent location and verified at each visit. Finding: Missing the “at each visit” verification.

- 7-I Infection Prevention & Control, C. An active surveillance program. Finding: Lack of an active surveillance program.
New in 2012

- **Existing Standard - 9.W**

  **9.W:** In settings where anesthesia may be provided by other than a physician anesthesiologist, oral and maxillofacial surgeon, certified registered nurse anesthetist, or an Anesthesiologist Assistant within his/her scope of practice, the organization has a written protocol that explains how the organization will respond in the event that a deeper-than-intended level of sedation occurs.

- **Rationale for Change:** To clarify when standard is applicable.

- **Review Guideline:** When anesthesia services are provided by other than a physician anesthesiologist, oral and maxillofacial surgeon, certified registered nurse anesthetist, or an Anesthesiologist Assistant within his/her scope of practice, the organization will have a written protocol that explains how it will respond in the event that a deeper-than-intended level of sedation occurs.
**Chapter 10 preamble:** In this chapter and throughout this Handbook, the terms “surgery”, “procedure”, and “operation” are used interchangeably. The use of any of these terms is to reference any such skill, method, or technique that involves cutting, abrading, suturing, laser, or otherwise physically entering or changing body tissues and organs, including invasive pain procedures.

**Rationale for Change:** To clarify that Chapter 10 standards are applicable in settings where invasive pain procedures are performed. This is an edit to the preamble of Chapter 10; no standards have been altered.

**Review Guideline:** The standards in this chapter also apply to organizations that provide invasive pain management procedures.
New in 2012

- **New Standard Element - 7.I.E-**
  - **6 7.I.E.** A sharps injury prevention program must be present in the organization. Such a program will include: 6. Use of a safe or neutral zone or “hands free” technique for passing of sharps between team members.

- **Rationale for Change:** Organizations to include process for safe sharps handling.

- **Review Guideline:** A safer method of passing sharp instrument, called the “hands free” technique. One team member places the sharps item into a suitable container (the “safe or neutral zone”) and the second team member removes the item. There is no hand-to-hand transfer of sharps.
New in 2012

- **New Standard - Placement to be determined:** Organizations that receive/store/issue blood and blood products for transfusion or human cells or tissues for transplantation must have written protocols for handling, maintenance and storage, consistent with those of a nationally-recognized authority, such as the American Association of Tissue Banks (AATB) and the U.S. Food and Drug Administration (FDA).

- **Rationale for Change:** Proposed standard to address the handling of human cells and tissues.

- **Review Guideline:** Organizations that use human cells and tissues or provide blood or blood products must adopt written policies consistent with those of the AATB, FDA or other nationally recognized authority.
In April, the AAAHC Board of Directors approved a change to a 3 year term of accreditation for all accredited organizations, replacing the 3 year, 1 year, 6 month. Based on the results of the accreditation survey, some organizations may be required to have an intra-cycle survey during their 3 year term. Early Option Surveys will automatically have an intra-cycle survey after 6 months or 1 year.
Proposed for 2013

- Monitoring for the presence of exhaled CO2 will be required (currently it is recommended) during the administration of moderate (conscious) sedation.
Other questions you would like to discuss?
What do Surveyors Look for to Determine Compliance with the 14 CMS-Medicare Condition Level Requirements (from Slide #8).
What do Surveyors Look for to Determine Compliance

1. **416.25 - AAAHC 10. sub-l.MS** *Meet the basic requirements and CMS definition of an ASC.*

2. **416.40 – AAAHC 2. sub-l. A-MS** *Comply with State license requirements.*

3. **416.41 – AAAHC 2. sub-l. B-MS(1)** *The ASC must have a governing body that takes full legal responsibility, has oversight and accountability. Has approved the QI Plan, Infection Control Plan, Disaster Plan in meeting minutes.*
Standards

What do Surveyors Look for to Determine Compliance

4. 416.42 – AAAHC 10. sub-l. C-MS  

*Surgical procedures performed safely and by individuals credentialed and privileged by the governing body. Review and self-audit 10 credential files including any Allied Healthcare practitioners.*

5. 416.43 – AAAHC 5.  

*All of Chapter 5 applies; peer review, quality improvement, and risk management. Peer review should include all practitioners. QI studies should show performance improvement and include some benchmarking. Risk management includes annual staff training, and policies on visitors, incapacitated provider, impaired provider, correct site and time-out. Add incapacitated provider to your Disaster Plan and perform a drill on this.*
What do Surveyors Look for to Determine Compliance

6. 416.44 – AAAHC 8. *A functionally safe and sanitary environment for patients, staff and visitors. Documented emergency drills quarterly, at least one CPR. PM logs on all equipment, temperature monitoring: drugs, soaking solutions.*

7. 416.45 – AAAHC 2. sub-II. A. *The medical staff must be accountable to the governing body. Check the preamble to your Bylaws. Mechanism for credentialing and privileging.*
What do Surveyors Look for to Determine Compliance

8. 416.46 – AAAHC 10. sub-I. H-MS(1). The nursing services must be directed and staffed to assure the nursing needs of all patients are met. Looking for RN’s with appropriate education/training in sufficient numbers and supervised.

9. 416.47 – AAAHC 6. All of Chapter 6 applies. A letter standard scored NC will make the entire chapter PC. Patients with multiple visits need a summary sheet.
What do Surveyors Look for to Determine Compliance

10. 416.48 – AAAHC 11. A. *Pharmaceutical services are provided in a safe and effective manner. Pharmacist consultant not required by highly recommended. Look for outdates, policy on look-alike-sound-alike drugs, pro-active monitoring of recalls, safe injection practices.*

11. 416.50 – AAAHC 1. F-MS. *Patient rights – include all elements of the standards and additional CMS requirements. Patient prior notification with advanced directives, financial ownership disclosure, patients rights and responsibilities may be done on the day of admission.*

What do Surveyors Look for to Determine Compliance

14. 416.49 – AAAHC 12 (Lab) and 13 (Radiology), as appropriate. **CLIA waiver.** Pathology log book with chain of custody and date report received. A Radiologist must be credentialed to your medical staff if ionizing radiation sources are in use (pp. 116 of 166 of CMS Interpretive Guidelines; § 482.26(c)(1)).
What do Surveyors Look for to Determine Compliance, PEC

On the Medicare surveys, there are several items from the Physical Environment Checklist (PEC) that the centers should pay particular attention to. These are;

- **PEC item 2.1 Construction type/fire protection**

1. The overall building shell has only one story that is less than ½ buried, or
2. Every space of every story of the overall building shell is protected by a supervised automatic fire sprinkler system, or
3. Every structural membrane in the overall membrane shell is enclosed with fire resistive material.
PEC Item 3.17 Number of Exits from the ASC
PEC item 3.16 Egress lighting tests

Emergency Lighting & Exit Sign Maintenance Checklist

(Insert Facility Name)

Note: All emergency lighting and emergency egress (EXIT) signs for this facility shall be inspected by the (insert day) day of each month. All locations for such equipment are identified below, and the person evaluating the equipment shall note status and date for all items and shall initial each line. Details regarding the facility maintenance process for this location are maintained by (insert name) in the (insert location where procedures are kept). This record shall be retained on file for 3 years.

<table>
<thead>
<tr>
<th>Equipment location</th>
<th>Location identifier</th>
<th>Type, e.g., Exit Sign, Emergency Light, Emergency Ballast</th>
<th>Date Inspected</th>
<th>Status, e.g., Fully Functional, Needs Repair, Non-Functional</th>
<th>Comments</th>
<th>Date Acceptable</th>
<th>Initials</th>
</tr>
</thead>
</table>

...
PEC Item 3.17 Exit Signs
PEC Item 6.1 Hazardous Area Protection
PEC Item 7.1 Medical Gas Cylinder Locations
PEC Item 8.26
Restricted Access to Alternate Source Circuit Breakers
PEC Item 8.3

Essential Electrical System (EES) Maintenance Records On-Site
PEC Item 10.1

Manual Pull Fire Alarm

At Each Exit From the ASC Occupancy

Not Greater than 5 Feet from the Door handle
PEC Item 12.1
One-Hour Occupancy Separation
PEC Item 12.3  Fire Wall Penetrations

Probably the #1 item cited on LSC Inspections
PEC item 12.4 & 12.5 Smoke barriers required and detail
PED Item 13.1 Portable Fire Extinguishers with at least 2 units of A (look on the label)
PEC Item 16.2  Staff Response to Fire
PEC item 8.4
Essential Electrical System (EES) Requirement for Dual Sources