AAHHS | HFAP

HFAP QUALITY REPORT 2017

A review of standard deficiencies based on HFAP surveys of:

- Acute Care Hospitals and Critical Access Hospitals (CAHs)
  - Including Emergency Management, Physical Environment, and Life Safety Code issues
- Laboratories
- Ambulatory Surgical Centers (ASCs)

FROM THE BOARD CHAIRS

This HFAP Quality Report is the first of a planned annual compilation and review of data from surveys conducted the prior year. Surveys from each HFAP accreditation program are reviewed for non-compliant ratings by surveyors for each standard. This report focuses on the most frequent findings of deficiency within each program, on the prevalent reason(s) for the findings, and on tips for correcting and avoiding non-compliance. The top issues in emergency management, life safety, and physical environment for hospitals are identified separately.

Hospitals, CAHs, Laboratories, and ASCs can use this report to:

1. Prepare for an initial accreditation survey

For a healthcare facility new to HFAP (or for an individual in a currently accredited facility who is new to the HFAP standards and survey process), this report suggests areas in which to begin focused efforts when preparing for a survey. Look at the standards noted as the most common challenges for your peer institutions. Study the examples of comments made by surveyors to help guide you in preparation for a successful initial survey. Reach out to HFAP standards interpretation staff for help.

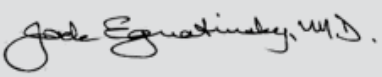
2. Prepare for reaccreditation

For a facility that is readying itself for a biennial (lab) or triennial (hospital, CAH, or ASC) survey, this document should be used in conjunction with your most recent deficiency report. Read together, the two will show how your performance compares with that of similar facilities. You may find that you have already identified and addressed the problems that are commonly cited by surveyors for your type of setting, or you may find it helpful to explore some of the additional educational resources we offer to pre-emptively correct ongoing issues and improve your performance on your upcoming survey.

3. Conduct a mid-cycle self-assessment

The myth that accreditation is a cycle of "heavy lifting" that occurs in the months just prior to a survey can be dispelled by shifting your point of view. Look to accreditation as an on-going cycle of continuous improvement. With that mindset, this report can be a tool for frequent self-assessment. Rather than waiting to prepare for reaccreditation when the next survey is in sight, use this report with the current standards manual as a framework for regular review of how your facility delivers important aspects of care and maintains the physical environment.

We at HFAP are committed to providing a quality accreditation experience focused on your success. We hope that this new resource is useful and we welcome your feedback.



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Setting the context

The information in this report comes from HFAP surveyors' ratings of compliance with the 2016 Standards and their comments describing the nature of any deficiencies found. The data were collected during onsite surveys and are segmented by type: acute care hospitals, critical access hospitals (CAH), laboratories, and ambulatory surgery centers (ASC). Because the physical environment is constantly changing and the relevant standards include on-going monitoring and maintenance that often is performed or overseen by an engineering department, the high-deficiency standards for emergency management, life safety and physical environment are identified in their own section of this report.

This report includes data collected from initial and reaccreditation surveys only. It does not include focused surveys—those that did not include all applicable Standards—or those that were the result of a formal complaint.

The top areas of deficiency—with specific standards identified, representative comments on the findings, and suggestions for improvement—are presented for each facility type as follows:

The concluding section (page 25) lists additional resources to support compliance.

Note: *the terms "governing board" and "governing body" are used interchangeably throughout this document.*

Accreditation Survey Findings by Facility Type

Acute Care Hospitals: Top Areas of Deficiency

The table below begins with the chapter title from the HFAP manual, *Accreditation Standards for Acute Care Hospitals*, to indicate the broad area encompassed by the frequently cited deficiency. The specific standard(s) within that chapter are listed with a high level overview of their essence or intent. Please note that this is not intended to be a comprehensive review of standards; review the language of the standards and the accompanying explanations provided in the manual for additional detail.

Specific examples of surveyor comments when scoring non-compliance are included under "Examples of Surveyor Findings" and below that are "Tips for Improvement" that identify areas often missed by acute care facilities that have been rated not compliant with the requirement.

Note: The most frequent deficiency cited for hospitals is **11.00.01 Condition of Participation: Physical Environment**. See page 12 for the standards that most often contributed to this deficiency.

Administration	**Standard 01.01.23 – Contractor Quality Monitoring**	
	ESSENCE OF THE REQUIREMENT	EXAMPLES OF SURVEYOR FINDINGS
	The governing body has responsibility to ensure that services provided under contract are safe and effective. In order to fulfill this responsibility, the hospital must communicate the list and scope of services the contractors provide. This is done through the QAPI program.	▪ A complete list of contracted services is not maintained. ▪ List does not include scope and nature of service. ▪ No evidence of an evaluation process for contracted services. ▪ Contractor's quality data is reviewed by the QAPI committee, but not communicated to the governing board. ▪ Cannot have a "one size fits all" evaluation form for all contracted services. ▪ QAPI plan approved by the governing board does not include a mechanism to evaluate the quality of each contracted service. ▪ The process (including frequency) for evaluating contracted services included in the QAPI plan was not approved by the governing board.

Administration

Standard 01.01.23 – Contractor Quality Monitoring *cont.*

TIPS FOR IMPROVEMENT

- Maintain a comprehensive list of contracted services including scope and nature of service.
- Ensure that the QAPI plan includes how and when the quality of each contracted service will be evaluated and that the overall plan is approved by the governing board annually.
- When developing a contract for services, detail how the service will be evaluated, the frequency of data collection, and the means of submission.
- After contractor data is submitted to the QAPI committee, be sure that it is included in the report to the governing board.
- When the governing board reviews contracted services evaluations, the discussion and approval must be memorialized in the minutes.

Medical Staff

Standards 03.01.01 – Medical Staff Bylaws; 03.04.03 – UR Review Requirements; 03.15.01 – Ongoing Professional Practice Evaluation (OPPE)

ESSENCE OF THE REQUIREMENT

The hospital has an organized medical staff that operates under bylaws approved by the governing body. The medical staff is responsible to the board of trustees for the quality of medical care provided to patients in the hospital under the structure of medical staff governance.

The Utilization Review Plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of:

(i) Admissions to the institution;

(ii) The duration of stays;

(iii) Professional services furnished including, drugs and biologicals.

The Medical Staff bylaws define the process of OPPE.

EXAMPLES OF SURVEYOR FINDINGS

- The UR Plan does not list all requirements in standard 03.04.03.
- Medical Staff bylaws did not include quality measures or FPPE/OPPE process to justify granting privileges.
- OPPE process not implemented.

Medical Staff

Standards 03.01.01 – Medical Staff Bylaws; 03.04.03 – UR Review Requirements; 03.15.01 – Ongoing Professional Practice Evaluation (OPPE) ***cont.***

TIPS FOR IMPROVEMENT

- Medical Staff bylaws must include quality measures (for physicians and non-physician practitioners granted privileges), the OPPE plan, and process.
- Use at least two administrative quality measures and two clinical measures.
- The UR Plan includes every item listed in the standard and the UR meeting minutes reflect review of these items.
- OPPE data is collected at least 3 times during the 2 year appointment period.
- The medical staff has a process to evaluate low volume practitioners.
- The credentialing files reflect that OPPE data was reviewed and considered at the time of reappointment.

Infection Control

Standard 07.01.01 - Infection Control Officer, 07.01.02- Infection Prevention

ESSENCE OF THE REQUIREMENT

An individual is designated as ICO and in this role holds responsibility for developing, implementing and evaluating measures governing the identification, investigation, reporting, prevention and control of infections and communicable diseases.

The ICO develops a system for identifying, investigating, reporting and preventing the spread of infections among patients and personnel.

EXAMPLES OF SURVEYOR FINDINGS

- Summaries of “walking rounds” are not documented in the Infection Control committee minutes.
- The operating rooms had penetrations, rust on exit doors, door frames and cabinets, chipped paint, insects in the lenses of light fixtures and divots in the operating room doors.
- Hand washing observations revealed lapse in hand hygiene before entering a patient room, prior to gloving, and upon exiting a patient room following patient contact.
- Clinics and outpatient/off-site areas are not included in infection control plans.
- Air flow exchanges in decontamination rooms are not documented and/or do not meet standard rates and/or are not submitted to the IC committee.
- Decontamination rooms have inadequate separation of clean and dirty scopes.

Infection Control

Standard 07.01.01 - Infection Control Officer, 07.01.02 - Infection Prevention *cont.*

TIPS FOR IMPROVEMENT

- Include all areas of the facility in "walking rounds": ORs, decontamination rooms, clinics, outpatient areas and off-site facilities. Write summaries for review in the minutes of IC committee meetings.
- Review hand hygiene guidelines and schedule education for staff/physicians. Posting scorecards by department can be an effective means of improving compliance. "Secret Shoppers" can be used for surveillance of compliance with hospital policy.
- Observe and evaluate the process for cleaning scopes to ensure adequate space and separation of clean and dirty areas.
- Collect air exchange data for submission to the IC committee.
- Ensure that more than one staff member is trained in sterilization and disinfection processes.

Quality

Standard 12.00.01 – Data Collection & Analysis: Program Scope; 12.00.03 – Patient Safety, Medical Errors & Adverse Events; 12.00.05 – Executive Responsibilities

ESSENCE OF THE REQUIREMENT

The QAPI program must be comprehensive, hospital wide and data driven.

EXAMPLES OF SURVEYOR FINDINGS

- No evidence of review of patient safety events.
- No evaluation of contracted services.
- The pharmacy's Medication Use Evaluation was not submitted to the quality committee.

TIPS FOR IMPROVEMENT

- Implement a database for tracking events such as medication errors (including missed medications), wrong site surgery, etc.
- Review data with those directly involved.
- Monitor effectiveness of corrective action.
- Include expectations for safety in the QAPI plan.
- Maintain current list of contracted services and ensure that each service monitors quality indicators.

Patient Rights

Standard 15.01.03 - Patient grievances; 15.01.04 – Governing Body Responsibility for the Grievance Process; 15.01.05 – Timely Referrals; 15.02.00 - Restraint or Seclusion; 15.02.10 – Orders for Restraint or Seclusion

ESSENCE OF THE REQUIREMENT

Patients' basic rights are identified including a process for communicating and resolving grievances, ensuring patient safety, and eliminating the inappropriate use of restraint or seclusion.

EXAMPLES OF SURVEYOR FINDINGS

- Grievance policy was not approved by the Governing Board.
- Grievance policy omits how patients are informed of the grievance process, definition of complaint vs. grievance, time frame for resolution.
- Response letter to grievance was sent beyond 7 days expectation of the standard.
- Grievance response letter lacks steps taken to investigate, decisions made, completion date and/or contact person.
- Grievance files lacked evidence of investigation.
- Hospital was unable to demonstrate how complaints are resolved.
- Medical record lacked documentation of "least restrictive" intervention used.
- Physician restraint orders used the term "per protocol" without supporting detail (how, when, intervals, etc.) describing protocol.
- Policy permitted "trial release." PRN orders for use of restraints are prohibited.
- Gaps in monitoring based on policy requirements.
- No evidence of physician training.

TIPS FOR IMPROVEMENT

- Make sure the grievance policy addresses all required items in the standard as well as how the grievance process must be implemented.
- Follow the HFAP accreditation requirements in the "explanation" column of the manual that identifies components of the policy, the medical record documentation required, responsibilities of each staff member.
- Ensure the restraints policy includes all required components of the standard.
- Schedule and conduct periodic audits of patients in restraints or of closed medical records to confirm that all policy requirements are followed and appropriately documented.

Nursing Services

16.01.01 – Preparation and Administration of Drugs

ESSENCE OF THE REQUIREMENT	EXAMPLES OF SURVEYOR FINDINGS
There must be a safe and effective method for administration of medications with policies and procedures approved by the medical staff. Staff must be educated and competent in implementing protocols.	▪ No evidence of ICU RN staff training and competency assessment for the administration of IV Propofol.

TIPS FOR IMPROVEMENT

- Identify high risk medications.
- Provide education and competency assessment for high-risk medication protocols.

Surgical Services

Standard 30.00.10 – History & Physical; 30.01.00 – Condition: Medical Leadership for Anesthesia Services; 30.01.05 – Pre-anesthesia Evaluation; 30.01.07 – Post-anesthesia Evaluation

ESSENCE OF THE REQUIREMENT	EXAMPLES OF SURVEYOR FINDINGS
A complete H&P is completed no more than 30 days before or 24 hours after admission, except in emergencies. *A physician who has privileges and qualifications is appointed to direct anesthesia services in all areas of the hospital providing anesthesia.* *Evaluations are performed for patients undergoing general, regional or monitored anesthesia prior to and within 48 hours after receiving anesthesia.*	▪ Medical record includes H&P older than 30 days without an update. ▪ No documentation of appointed director of anesthesia services. ▪ No evidence of the evaluation of quality of anesthesia service in the hospital QAPI program.

TIPS FOR IMPROVEMENT

- A physician is appointed Medical Director of Anesthesia and the appointment includes written documentation.
- Include the appointment in organizational chart for anesthesia.
- Written qualifications and eligibility of the Medical Director of Anesthesia are approved by the medical staff and governing body.
- Include the responsibility for monitoring the quality and appropriateness of anesthesia services in the Medical Director's job description.

Critical Access Hospitals (CAH): Top Areas of Deficiency

The table below begins with the chapter title from the HFAP manual, *Accreditation Standards for Critical Access Hospitals*, to indicate the broad area encompassed by the frequently cited deficiency. The specific standard(s) within that chapter are listed with a high level overview of their essence or intent. Please note that this is not intended to be a comprehensive review of standards; review the language of the standards and the accompanying explanation provided in the manual for additional detail.

Specific examples of surveyor comments when scoring non-compliance are included under "Examples of Surveyor Findings" and below that are "Tips for Improvement" that identify areas often missed by CAHs that have been rated not compliant with the requirement.

Note: The most frequent deficiency cited for CAHs is **03.00.01 Condition of Participation: Physical Environment**. See page 12 for the standards that contributed most often to this deficiency.

Staffing and Staff Responsibilities

Standard 05.00.09 – Responsibilities of the MD or DO: Reviews and Signs Medical Records.

ESSENCE OF THE REQUIREMENT	EXAMPLES OF SURVEYOR FINDINGS
All inpatient records are reviewed and signed by a CAH MD/DO even when care was managed by a non-physician practitioner.	▪ Medical records signed by allied health staff are not signed off by the medical staff.

TIPS FOR IMPROVEMENT

- Develop a process for medical records review and co-signing.

Provision of Services

Standard 06.00.03 – Policy Scope; 06.01.00 – Medication Storage and Administration

ESSENCE OF THE REQUIREMENT	EXAMPLES OF SURVEYOR FINDINGS
The CAH's written policies describe the range of services provided on-site and off-site, and furnished by CAH staff or by contractors. *Policies include rules for storage, handling, dispensing, and administration of drugs and biologicals.*	▪ The scope of services document does not address all departments or services. ▪ Medications are found unsecured in outpatient settings.

Provision of Services

Standard 06.00.03 – Policy Scope; 06.01.00 – Medication Storage and Administration *cont.*

TIPS FOR IMPROVEMENT

- Ensure the scope of service document lists every department and service, including the laboratory and any services furnished by a contractor.
- The pharmacy is responsible for all medications at all inpatient and outpatient locations. Medications must be secure in all areas.

Provision of Services

Standard 07.00.04 – Record Content Requirements

ESSENCE OF THE REQUIREMENT

The medical record includes evidence of informed consent for procedures, medical history, progress notes and documentation that justifies admission, supports the diagnosis, describes the patient's response to treatment and provides a discharge summary.

EXAMPLES OF SURVEYOR FINDINGS

- Medical record lacks tests results.
- Medical record lacks discharge summary.

TIPS FOR IMPROVEMENT

- Audit medical records periodically to ensure all patient data is noted.
- Review the standard for the list of items that should be included in the record, among them: diagnosis, orders, evaluations, treatments, test results, care plans, consents, interventions, discharge summary.
- Include clinical evaluation information obtained from post-discharge follow-up telephone calls: care provided and the patient's response to treatments and interventions.

Emergency Management Standards: Top Deficiencies

The deficiency findings below are applicable to both acute care hospitals and CAHs. The first identifier comes from *Accreditation Standards for Acute Care Hospitals* and the second from *Accreditation Standards for Critical Access Hospitals*. The standards are listed in descending order of frequency as deficiencies for acute care hospitals with 09.01.12 appearing as a deficiency in 32% of surveys and 09.01.08 appearing as deficiency in 7% of surveys.

All of the deficiencies reflect missing elements of an Emergency Operations Plan (EOP). **Tip:** Make your EOP as comprehensive as possible.

Standard number and topic	Deficiency	Tip for improvement
09.01.12/17.01.12 **Business Continuity**	▪ No written business continuity plan.	▪ Develop strategies for how the organization will recover from an emergency event.
09.01.02/17.01.02 **Emergency Supplies**	▪ The emergency supply plan was incomplete. ▪ There was no inventory of emergency supplies that would be used at the start of an emergency event. ▪ An inventory of the emergency supplies was not conducted semi-annually. ▪ Supply of emergency water was not kept on site.	▪ Define the list of emergency supplies. Review at least semi-annually that the supplies on hand inventory is complete and segregated from items for on-going use.
09.01.01/17.01.01 **Emergency Safety & Security**	▪ The safety and security plan was incomplete. ▪ The Emergency Operations Plan (EOP) does not provide for the security of supplies.	▪ Include the security of emergency supplies in the EOP.
09.01.05.17.01.05 **Emergency Personnel Protective Equipment**	▪ The EOP does not address PPE.	▪ Account for PPE in the EOP.

Standard number and topic	Deficiency	Tip for improvement
09.01.04/17.01.04 **Emergency Decontamination**	▪ The EOP does not provide for chemical, biological, and radioactive decontamination. ▪ There was no training provided for the decontamination equipment. ▪ The emergency decontamination room was used for storage.	▪ Develop a training program for use of the decontamination equipment that also identifies who (by role) should be trained. ▪ Ensure the decontamination facilities are ready for immediate use.
09.01.09/17.01.09 **Emergency Triage**	▪ The EOP does not include triaging of victims.	▪ Even if you use the same triaging procedures for an emergency as you would for normal business, it should be spelled out in the EOP.
09.01.03/17.01.03 **Emergency Utilities**	▪ The EOP does not provide for emergency utilities.	▪ Develop written agreements with vendors to provide specific utilities and supplies during an emergency event.
09.01.06 **Emergency Nutritional Services**	▪ The EOP does not provide for nutritional needs.	▪ Review the nutritional services portion of the EOP, and document all of the alternate methods of feeding patients and staff during an emergency.
09.01.11/17.01.11 **Volunteer Management**	▪ The EOP does not address volunteers.	▪ Use the same process for credentialing volunteers during an emergency event as you would to credential new professional staff during normal business. ▪ Consider your ability to implement a credentialing process during an emergency and consider writing a policy that states that the organization will refuse all professional volunteer help.
09.01.08/17.01.08 **Incident Command Center**	▪ The EOP does not include drawings for the incident command center. ▪ The EOP does not identify the location of the incident command center.	▪ Inventory all equipment that will be used in the Incident Command Center. ▪ Document where that equipment is stored before an emergency event. ▪ Create drawings identifying where that equipment needs to be set-up when the Incident Command Center is launched.

Physical Environment Standards: Areas of Deficiency

The deficiency findings below are applicable to both acute care hospitals and CAHs. The first identifier comes from *Accreditation Standards for Acute Care Hospitals* and the second from *Accreditation Standards for Critical Access Hospitals*. The standards are listed in descending order of frequency as deficiencies for acute care hospitals with 11.01.10 appearing as a deficiency in 33% of surveys and 11.01.01 appearing as deficiency in 6% of surveys.

Standard number and topic	Deficiency	Tip for improvement
11.01.10/03.01.02 **Eyewash Stations**	▪ Eyewash stations are not tested on a weekly basis. ▪ Eyewash stations installed do not meet ANSI Z358.1-2014 requirements. ▪ Eyewash stations are not located within 55 feet of hazardous materials.	▪ Purchase a copy of the ANSI Z358.1-2014 standard on eyewash stations and comply with the installation and testing requirements.
11.01.02/03.01.02 **Building Safety**	▪ Ligature risks in behavioral health unit without a risk assessment. ▪ Rooftop exhaust fans for isolation areas not marked with bio-hazard symbols. ▪ Dirty ceiling tiles, dirty vents and cracked walls in exam room. ▪ Trash compactor has key left in controller.	▪ Conduct frequent inspections of behavioral health units looking for potential ligature risks.
11.04.02/03.04.02 **Fire Drills – Quarterly**	▪ Off-site locations did not conduct drills. ▪ Fire drills were not conducted on all shifts every quarter	▪ Schedule fire drills once *per shift* per quarter. ▪ Stagger the start times for fire drills on the same shift each quarter, by 2-hours.

Standard number and topic	Deficiency	Tip for improvement
11.05.01/03.05.01 **Medical Equipment & Systems – Maintenance**	▪ Blanket warmers are not included in the medical equipment preventative maintenance program. ▪ No preventative maintenance records on medical equipment for previous year. ▪ No risk assessment for medical equipment in Alternate Equipment Management (AEM) program. ▪ No annual evaluation of AEM program. ▪ Past due inspections on medical equipment.	▪ It is no longer acceptable that only 95% of the medical equipment be tested. CMS now requires that 100% of the medical equipment be properly tested.
11.07.03/03.07.03 **Ventilation, Light & Temperature Controls**	▪ Multiple rooms had been identified as not having proper air pressure relationships but no evidence of corrective action. ▪ No consistent ventilation in clean utility rooms. ▪ Positive air pressure relationship not maintained in Central Sterile.	▪ Develop a program whereby you inspect every air-pressure relationship room weekly, checking for proper air-pressure relationships (positive or negative) and making corrections as needed.
11.00.02/03.00.02 **Required Plans and Performance Standards**	▪ The facility did not present one or more required management plans.	▪ Management plans are low-hanging fruit: Either you have them or you don't. Ensure you have a management plan for every discipline required.
11.02.04/ **Security Sensitive Areas**	▪ The facility did not identify security sensitive areas. ▪ Security sensitive areas identified but no plan for how the organization will secure them.	▪ Identifying security sensitive areas is as easy as sitting down and discussing it with a group of stakeholders.
11.03.06/03.03.06 **Hazardous Areas – Routine Monitoring**	▪ The facility does not have any evidence of monitoring waste anesthesia gas. ▪ The facility does not have any evidence of monitoring ethylene-oxide gas.	▪ Develop a program of monitoring hazardous areas.

Standard number and topic	Deficiency	Tip for improvement
11.06.09/03.06.04 **Plant Equipment & Systems – Maintenance**	▪ Not all plant equipment was included in the preventative maintenance program. ▪ Plant equipment identified as being on the AEM program did not have a risk assessment conducted. ▪ AEM program for plant equipment did not have an annual evaluation.	▪ An AEM program is not for everyone… it's not to be used without serious and careful considerations of all of the required actions.
11.01.01/03.01.01 **Periodic Monitoring for Safety Issues**	▪ Not all patient-care areas were monitored twice per year. ▪ Offsite locations that are patient care areas were not monitored. ▪ Deficiencies identified during the routine monitoring were not resolved.	▪ Develop a program of monitoring all offsite locations.

Life Safety Areas of Deficiency

The deficiency findings below are applicable to acute care hospitals, critical access hospitals, and frequently, to ambulatory surgical centers. The first identifier comes from *Accreditation Standards for Acute Care Hospitals* and the second from *Accreditation Standards for Critical Access Hospitals*. When a third standard is listed, it is from *Accreditation Standards for Ambulatory Surgical Centers*. The absence of a standard specific to ASC settings does not mean that the standard is not relevant; it may be a regulation included in NFPA 99 or 101, which serve as additional references for life safety requirements in ASCs. The standards are listed in descending order of the frequency of citation for acute care hospitals. Fire alarm system installation is cited in 78% of surveys; ceilings in 49%.

Standard number and topic	Deficiency	Tip for improvement
13.02.01/14.02.01/ 05.03.07 **Fire Alarm Systems – Installation**	▪ Smoke detectors are mounted too close to air diffusers. ▪ Smoke detectors are mounted more than 12 inches below a deck.	▪ Read and understand the NFPA 72-2010 fire alarm installation requirements. ▪ Discuss fire alarm system installation issues with your fire alarm contractor – learn from them. ▪ Conduct frequent inspections of the facility.
13.01.05/14.01.05/ 05.03.03, 04 **Means of Egress – Signage**	▪ "Exit" signs are not installed where the path of egress is not readily apparent. ▪ "No Exit" signs are not installed where a door may be confused as an exit.	▪ Do your own self-inspection of each path of egress… Is the egress path marked with 'Exit' signs?
13.02.02/14.02.02/ 05.03.07 **Fire Alarm Systems – Testing**	▪ Not all of the devices connected to the fire alarm system are actually tested. ▪ No device inventory identifying a 'Pass' or 'Fail' decision. ▪ Report not signed by the technician performing the service. ▪ Report does not reference the correct NFPA standard or edition.	▪ Copy Table 14.4.5 from NFPA 72-2010 and make sure your testing contractor tests every component listed that you have in your system. ▪ Use HFAP standard 13.00.07 as a template to ensure the report has all of the required information.

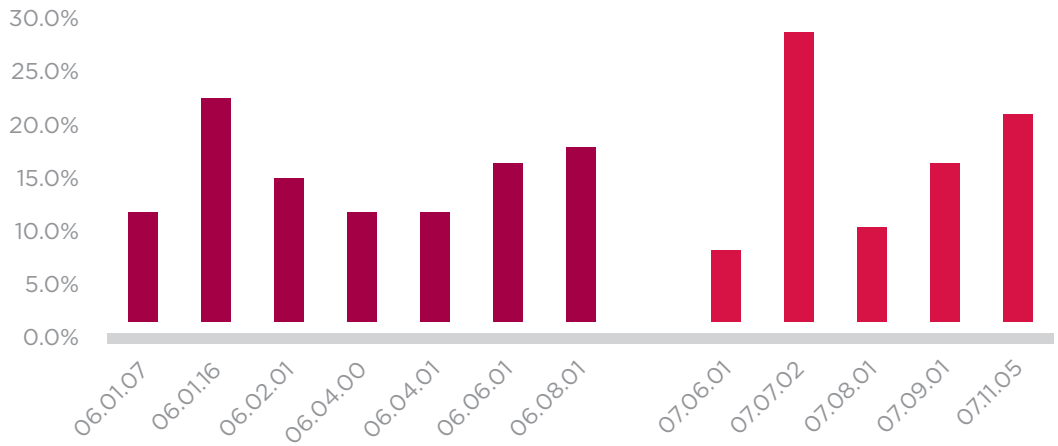
Standard number and topic	Deficiency	Tip for improvement
13.05.09/14.05.09 **Utility Systems**	▪ Junction boxes above the ceiling do not have covers. ▪ Access to electrical panels and controls is obstructed.	▪ Do your own frequent inspections above the ceiling, and in electrical rooms, looking for items of non-compliance.
13.00.05/14.00.05 **Facility Demographic Report (FDR)**	▪ The FDR is not completed properly – questions left unanswered. ▪ Construction type is not listed in NFPA vernacular. ▪ Occupancy classification is not listed in NFPA vernacular.	▪ Ensure the person who completes the FDR is qualified to provide the answers. S/he must have a working knowledge of the hospital facility, and of the NFPA codes and standards.
13.01.02/14.01.02/ 05.03.06 **Door Locks**	▪ Doors in the path of egress are locked and do not comply with the Life Safety Code. ▪ Access-control locks do not have the motion sensor installed on the egress side. ▪ Delayed egress locks are installed in buildings that are not fully protected with sprinklers. ▪ Inappropriate use of 'Clinical Needs' locks. ▪ Mistaken belief that security over-rides the need for safety.	▪ Read and understand section 19.2.2.2.4 of the 2012 Life Safety Code regarding the exceptions that permit certain doors to be locked in the path of egress in a hospital. ▪ Life Safety compliance overrides security. Do not allow security people to install locks on doors that do not comply with the LSC.
13.04.01/14.04.01 **Fire Rated Barriers**	▪ Unsealed penetrations in fire rated barriers. ▪ Top of fire walls do not always extend to the deck above. ▪ Patches installed on fire-rated barriers that do not comply with the UL listing.	▪ Establish an 'Above Ceiling Permit' program whereby every contractor who works above the ceiling must receive a permit from Engineering. Engineering then tracks all work and holds that contractor responsible for filling all unsealed penetrations in rated barriers. ▪ Conduct frequent inspections above ceiling on rated walls, looking for unsealed penetrations and improperly applied patches over holes.

Standard number and topic	Deficiency	Tip for improvement
13.06.04/14.06.04 **Life Safety Drawings**	▪ Drawings do not include all of the required information. ▪ Drawings do not accurately reflect as-built conditions.	▪ Contract with an architect who has experience with healthcare and the Life Safety Code to create working drawings of your rated wall system.
13.04.07/14.04.07 **Fire Rated Door Assemblies**	▪ Label identifying the fire-rating is missing or painted over. ▪ Door and frame are not fire-rated.	▪ Conduct annual (or more frequent if necessary) inspections of all fire-rated door assemblies.
13.04.09/14.04.09 **Ceilings**	▪ Holes and gaps in ceiling are larger than ⅛ inch. ▪ Missing ceiling tiles.	▪ Replace all missing or damaged ceiling tiles as soon as they are discovered. Do not let a day pass without all the ceiling tiles in place. ▪ Conduct frequent inspections, and add ceilings to the list of things to inspect.

Laboratories

The findings in this section come from HFAP biennial laboratory surveys that lead to accreditation with deemed status for CLIA regulations. These standards are distinct from the review of laboratory services that takes place as a component of a survey for an acute care hospital or critical access hospital which are based on Medicare Conditions of Participation.

Laboratory High-Deficiency Findings



The Laboratory deficiencies seen in 2016 surveys clustered primarily into two groups. The first group is from chapter 6: Analytic Systems. These regulations require laboratories to follow test system manufacturer's instruction for performing the testing. This means the laboratory must follow and perform the manufacturer's package insert instructions as approved or cleared by the FDA.

For standard **06.01.07**, most surveyor comments referenced a discrepancy between manufacturer's instructions and actual laboratory practice primarily related to lapses in quality control for specific tests.

Tips for improvement

- Each test procedure should include quality control and frequency of use. At least annually, quality control procedures should be audited to be sure they reflect actual practice.
- The procedures must be tailored to reflect individual lab processes while adhering to manufacturer's instructions.

Deficiencies cited for standard **06.01.16** relate to missing documentation; specifically, manuals that included updates and revisions that had not been approved in writing by the Laboratory Director.

Tips for improvement

- Conduct a periodic review of all manuals to ensure that procedures reflect current practice. Updated procedures should be dated and signed by the Director. Outdated procedures should be removed from the manual, dated with the reason for removal noted, and retained in an outdated procedure file.
- In the event of a change in Laboratory Director, a timeline for review and sign-off on all procedures should be established with completion scheduled for no longer than three to six months from the date the new Director assumed responsibility for the lab.

Standard **06.02.01** requires the laboratory to define criteria for water quality, temperature, humidity and electrical fluctuations/interruptions. Surveyors cited missing policies and failure to log documentation that policies were followed.

Tips for improvement

- The procedure that defines water types used must also specify what water checks are done and in what time frame.
- Review instrument manuals and package inserts for minimum/maximum temperature and humidity. A daily log may be helpful but if the area is not monitored over a weekend/holiday period, a hi-low thermometer may be used. In the event that the temperature/humidity is outside of the manufacturer's range, documentation of corrective action is required.
- Be aware that certified thermometers/hygrometers have expiration dates and must be re-certified or replaced.

Standard **06.04.00** and **06.04.01** require that maintenance and function checks respectively, as defined by the manufacturer and at a specified frequency, are required for equipment, instruments, and test systems. Most deficiencies result from a discrepancy between the maintenance frequency identified in the lab policy and the actual maintenance performed.

Tips for improvement

- At minimum, the lab must perform what is recommended by the manufacturer. Review package inserts and instrument manuals.
- Set up a schedule for maintenance and function checks with log sheets.
- Empower staff to share in responsibility for completion of maintenance.
- Don't forget to include the daily maintenance of microscopes and peripheral equipment in the plan and documentation.
- Document review of log sheets (at least monthly) by lead staff or supervisor to ensure that all function tests have been performed.

Standard **06.06.01** is focused on quality control that meets or exceeds CLIA regulatory requirements.

Tips for improvement

- Laboratories must perform two levels of external controls on each test system for each day of testing and follow all specialty/subspecialty requirements for nonwaived tests OR develop an Individualized Quality Control Plan (IQCP) to customize the quality control procedures for a test system.
- CMS and CDC have developed a step by step manual "Developing an IQCP," that is available for download at www.cdc.gov/clia/Documents/IQCP%20Loyout.pdf.
- Additionally CMS has three brochures to assist laboratories with IQCP.
  Brochure #11 - CLIA Individualized Quality Control Plan Introduction (IQCP)
  Brochure #12 - CLIA IQCP, Considerations When Deciding to Develop an IQCP
  Brochure #13 - CLIA IQCP, What is an IQCP?

  The free brochures are available at:
  www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/CLIA_Brochures.html.

06.08.01 concerns instrument correlation studies to ensure that tests using different methodologies, instruments, or performed at different sites are evaluated to define the relationship across results. Deficiencies here are the result of failure to conduct the comparisons.

Tips for improvement

- Use a calendar reminder system to schedule comparisons that must be made every six months.
- Indicate the acceptable range of difference when defining the procedure.
- Periodically audit what tests are performed on what instruments. Determine if there is a manual back-up method. Compare the back-up result to the primary instrument if it is to be used in case of an instrument failure.
- Eliminate instrumentation that is no longer used in either primary or back-up status.
- Test procedures should indicate the back-up steps in the event of an instrument failure.

The second cluster of high deficiency citations comes from chapter 7: Proficiency Testing. For proficiency testing (PT), failure to attain a score of at least 80% of acceptable responses for each analyte in each testing event is considered unsatisfactory analyte performance for the testing event. Surveyors noted scores ranging from 0% to 60% for a range of analytes used in testing for general immunology (**07.06.01**), routine chemistry (**07.07.02**), endocrinology (**07.08.01**), toxicology (**07.09.01**), and hematology (**07.11.05**).

Tips for improvement

- Clerical errors play a big role in PT deficiencies. Have a system in place that requires a thorough review of all PT results before they are submitted to the PT vendor.
- Use on-line submission if available rather than faxing. Look for transposed numbers.
- Check that the test reporting units are the same as those of the PT vendor.
- Make sure that the codes entered for test instrumentation are correct.
- Investigate all 80% results to rule out potential technical problems that could lead to future PT failures.

Ambulatory Surgery Centers

Governing Body Management

Standard 01.00.02 – Governing Body and Management

ESSENCE OF THE REQUIREMENT

The ASC has a designated governing body with direct oversight of

- the Quality Assessment Performance Improvement (QAPI) program.
- the quality of the services provided.
- the safety of the environment.
- The development and maintenance of a disaster preparedness plan.

EXAMPLES OF SURVEYOR FINDINGS

- The policy defining the operation of the ASC did not reflect actual services provided.
- No performance measures were identified to monitor contracted services.
- The Emergency Operations Plan was outdated.
- No current transfer agreement with a hospital.
- No policy for the scope and timeframe for completing an H&P.
- No initial credentialing for physicians.
- No credentialing and privileging structure in place.
- No quality information available for review for physicians prior to appointment.
- No defined job responsibilities for department managers.

TIPS FOR IMPROVEMENT

- Develop a written ASC scope of services document which includes the population served with action plans defined if a patient falls outside that scope.
- Follow the ASA Physical Status Classification System for ASC risk.
- Create checklists to ensure that the governing body reviews all areas of service at least annually.
- Make sure that meeting minutes reflect review and approval of each area of responsibility.

Surgical Services

03.00.02 – Surgical Services Performed Safely

ESSENCE OF THE REQUIREMENT

Only those procedures defined within the organization's scope of services are performed by qualified physicians who have been credentialed and privileged.

All phases of the procedure meet acceptable standards of practice.

EXAMPLES OF SURVEYOR FINDINGS

- Procedures performed by a physician without privileges.
- CRNA had expired credentials and performed anesthesia services.
- No RN supervision of LVN function.

TIPS FOR IMPROVEMENT

- The ASC has written policies and procedures which reference nationally-accepted guidelines.
- The governing body grants privileges based on written qualifications for specific services offered within the ASC.

Quality Assessment Performance Improvement

Standard 04.00.02 – Program Scope; 04.00.10 – Performance Improvement Projects; 04.00.11 - 04.00.12 – Governing Body Responsibilities

ESSENCE OF THE REQUIREMENT

The ASC demonstrates a focus on continuous quality improvement through an organized, ongoing program of quality assessment and improvement. The program is enacted through a number of distinct projects that reflect the scope and complexity of the ASC's services. The ASC maintains records of its projects that include documentation of the purpose, the data collection, and the results. The governing body is ultimately responsible for the QAPI program.

EXAMPLES OF SURVEYOR FINDINGS

- No annual quality report.
- No education on QAPI facility-wide.
- No quality indicators for contracted services.
- No annual QAPI plan approval by the QAPI committee or the governing body.
- Peer review activity and/or patient survey data not reviewed by the QAPI committee as required.
- No rationale for selected QAPI projects.
- Quality Manager had no quality training.

TIPS FOR IMPROVEMENT

- Ensure that the designated quality manager has resources for training.
- The governing body allows sufficient time and staff to perform quality activities.
- Discussion of quality issues is reflected in governing body meeting minutes.

Medical Staff

06.00.01 - Medical Staff Membership and Clinical Privileges; 06.00.03 - Reappraisals

ESSENCE OF THE REQUIREMENT

The organization of the medical staff and the granting of privileges is the responsibility of the governing body.

EXAMPLES OF SURVEYOR FINDINGS

- Procedures performed by physician were not on the list of privileges granted by the governing body.
- CRNA had expired privileges.
- CRNA had expired ACLS and BLS certification

TIPS FOR IMPROVEMENT

- Review and amend the Scope of Procedures/Delineation of Privileges at least every two years and prior to physician reappointment.
- Create a schedule for reappraisal of medical staff and non-physician practitioners that require privileging at least every 2 years.

Infection Control

12.00.01 – Infection Control

ESSENCE OF THE REQUIREMENT

The ASC's infection control program provides a sanitary environment for surgical services based on nationally-recognized infection control guidelines.

EXAMPLES OF SURVEYOR FINDINGS

- The ASC lacks an infection control program/plan.
- The infection control plan is not based on a risk assessment of the geographic area or patient population served.
- The ASC uses a hospital-based IC plan not specific to the facility.
- No trained and qualified person designated to oversee the IC program.

TIPS FOR IMPROVEMENT

- Designate a qualified person to develop and oversee the infection control program. Training can be via on-line modules or conferences.
- Make resource references available; use part-time staff or a consultant to assist in the IC program.
- Provide in-services and orientation training to all ASC staff.
- Review and implement nationally-recognized infection control guidelines such as CDC, APIC, AORN, HICPAC, etc., and include with policy and procedures.
- ASCs can contact a hospital ICP to provide direction or support.
- Contact the local DPH or CDC to identify IC risks to your areas.

Patient Admission, Assessment, and Discharge

13.00.02 – Admission and Presurgical Assessment; 13.00.03 – Admitting History & Physical Update

ESSENCE OF THE REQUIREMENT

A comprehensive H&P is intended to determine if there is anything in the patient's overall condition that would affect the planned surgery. It must be performed and documented no more than 30 days before the scheduled surgery.

Upon admission to the ASC, a presurgical assessment must be performed by a physician to evaluate the risk of the anesthesia and the procedure.

EXAMPLES OF SURVEYOR FINDINGS

- Medical record lacks a H&P completed within 30 days.
- Medical record lacks a presurgical assessment completed by a physician to evaluate the risk prior to procedure and anesthesia.

TIPS FOR IMPROVEMENT

- Schedule regular review of medical records to determine compliance.

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