

FALL/WINTER 2021



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BY PROVIDERS.



Quality Review Edition

THE SURVEYOR



AMBULATORY SURGERY CENTER

THE SURVEYOR

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MISSION STATEMENT

Accreditation Commission for Health Care (ACHC) is dedicated to delivering the best possible experience and to partnering with organizations and healthcare professionals that seek accreditation and related services.



CORNER VIEW

In the fall of 2020, ACHC merged with the parent company of the first U.S. healthcare accreditation program, HFAP. The merger added CMS-deemed accreditation for facility-based care including acute care hospitals, ambulatory surgery centers, clinical laboratories, critical access hospitals; non-deemed accreditation for office-based surgery; and certification for stroke care, wound care, joint replacement, and lithotripsy to ACHC's existing portfolio of community-based accreditation and education programs.

Part of the assimilation process has been to audit our distinct resources in order to bring the very best from each separate entity to our new, unified company. You are reading one result of

While healthcare is constantly evolving, we are currently emerging from a time of unusually rapid change.

that exercise. **The Surveyor** is an ACHC legacy publication, but the Fall/Winter edition now parallels what was previously HFAP's annual **Quality Review**. That publication examined the most frequently cited deficiencies for each accreditation program to give organizations a tool for benchmarking and improving their performance.

In years past, ACHC identified frequent deficiencies by program and made them available annually as a "top ten" list. Now, using **The Surveyor** to share the data gives us a vehicle to add value by deepening the analysis. This is presented in separate editions for closely

affiliated programs. You can access any of them on our website (achc.org) under Resources and Education/Publications.

As you review the edition or editions most relevant to your setting, you will read examples of actual survey findings. These serve to clarify the specific aspects of the standard that were found to be non-compliant. Following the sample citations, you'll find tips for compliance.

While healthcare is constantly evolving, we are currently emerging from a time of unusually rapid change. Some of the deficiencies cited in the following pages can be traced directly to the impact of COVID-19. Many organizations made significant adjustments to continue to meet the needs of their patient/client populations: adopting new technology for remote visits and patient monitoring; sourcing against PPE shortages; reassigning staff to manage furloughs and quarantines. These are all examples of unanticipated change that required quick action that may have shifted focus away from some areas of required compliance.

Organizations that previously received the HFAP **Quality Review** used it in conjunction with their Deficiency Report (ACHC's Summary of Findings) to compare their performance against peer organizations and to proactively address issues frequently seen in other organizations. Used this way, the data becomes part of the process of continuous quality improvement and on-going survey readiness. We want to help you avoid a series of ramp up activities as your survey approaches by making ACHC Standards part of your overall quality strategy.

As always, ACHC is here as a partner in meeting your accreditation and education needs. Your feedback on this publication and on any aspect of our programs is welcomed and invited.



José Domingos
President & CEO

The ACHC Ambulatory Surgery Center Accreditation Program offers “deemed status” for Medicare-certified centers, or “accreditation only” for those that are private-pay or reviewed for CMS by the state agency.

FROM THE PROGRAM DIRECTOR

ASCs have long been known for providing safe, high-quality surgical services in a setting that is convenient and efficient for both patients and surgeons. During the ongoing COVID-19 public health emergency — and especially when most ASCs closed temporarily — the importance of ASC settings became even more apparent as patients couldn’t get procedures that screen for cancers or alleviate pain. Although “elective,” such a procedure can be vital to a patient’s continued health and well-being.

Beyond the impact on patient care, temporary closures had significant negative economic repercussions on ASC operations. Staffing has become an issue for many as the attraction of a no-weekends-or-overnights schedule has had to compete with significant sign-on bonuses offered by hospitals. For many organizations, these factors continue to create challenges as scheduling to meet pent-up demand confronts diminished resources in staffing or expansion dollars.

Despite this, ACHC’s ASC Accreditation Program continues to grow. Many small organizations hire consultants to help with management of the business. As these consultants work with us and discover our excellence in customer service and the fit of our programs with the needs of their clients, they recommend ACHC to others.

Our focus is always on the individual organization and how it meets the standards in a practical, sustainable way. This personal approach is appreciated by ASCs of all sizes and organizational structures, and we are proud of our exceptional customer retention rate.

Frequently-Cited Deficiencies

Organizations look to ACHC for leadership in establishing and evaluating quality. Identifying frequently-cited deficiencies provides a data-driven review of survey results across a defined period of time. It gives ACHC-accredited ambulatory surgery centers a roadmap for improvement and it helps guide our efforts to provide relevant, actionable education.

The data in this report reflect deficiencies cited on surveys performed between June 1, 2020, and May 31, 2021. Over this period, I have been reminded

that ASC staff are generally focused on providing patient care and often they wear many hats in the performance of their duties. While patients should always be at the center of an ASC’s policies and procedures, the administrative effort to manage these can be secondary, resulting in missed details.

The most frequent deficiency for this period was Standard 06.00.03 which includes a lengthy list of items that are to be included in a distinct file maintained for each of the ASC’s licensed providers. Much of the documentation requires renewal and movement through a process of periodic review culminating in governing body approval, at least triennially. Compliance is at risk if any element is missing or if expired documentation remains in individual files.

The next most frequently-cited Standard is 02.02.02 which relates to signage indicating hours of operation and communication directed to patients instructing them how to respond in the case of an “after-hours” emergency. This is a task that, once performed, needs only to be revisited when there is a change in hours of operation.

More and more, ASCs see improved survey results as they go through the accreditation process multiple times. Each cycle allows for a deeper dive for the ACHC Surveyor and a recalibration opportunity for the organization. Generally speaking, we find that providers who embrace the concept of accreditation as a framework for continuous quality improvement do improve over time.

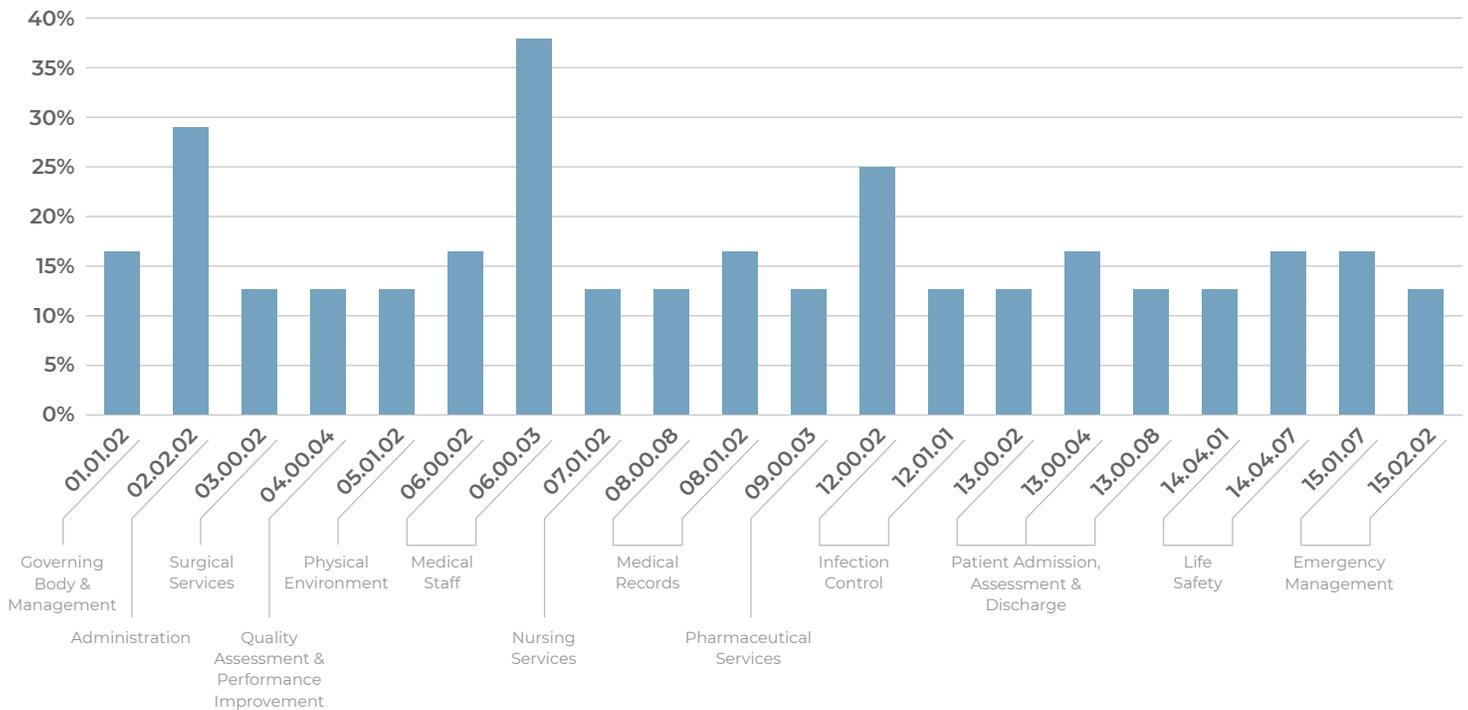
The ACHC ASC team continues to look for ways to use customer feedback to improve our process, specifically with training and consistency among surveyors and standards interpretation. In the coming year, we plan to build on the momentum that the program has created by improving internal performance and building increased value in the programs that we offer. I speak for the entire team when I say that your response to this publication is welcomed and valued.



Marci Ramahi, CAE
Program Director



AMBULATORY SURGERY CENTER DEFICIENCIES



GOVERNING BODY AND MANAGEMENT QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT

01.01.02 Contract Services

04.00.04 Quality Program Data

Overview of the requirement

These related standards represent elements of a robust quality program that provides comprehensive, data-driven evaluation of all services provided.

- The governing body holds responsibility for all services provided by the ASC, even those provided by contractors and ancillary to patient care. To ensure quality, contracted services must be included in the organization's QAPI program.
- The ASC collects data related to identified indicators at the frequency defined by the QAPI program.

Comment on deficiencies

Deficiencies cited lack of comprehensive documentation of contracted services or failure to identify measurable quality metrics related to contracted services. Surveyors noted that data collection did not cover all patient care services and all contracted services, or data was not collected at the interval stated in the QAPI program.

Frequency of citation: 01.01.02: 17% | 04.00.04: 13%

Examples of Surveyor findings

01.01.02

- The ASC did not maintain a list of all contracted services to facilitate governing body review.
- The ASC's QAPI program did not include performance indicators related to contracted services.

04.00.04

- Services provided under contract were not included in the data collection.

Tips for compliance

- Document all contracted services and perform regular audits to maintain accuracy and completeness.
- Establish and communicate expectations for performance through identification of metrics and regular reporting.
- Include quality metrics in service contracts to support accountability.
- When metrics are not met, define corrective actions and time frame for reimbursement.
- Establish a schedule for patient care and contracted services to be reviewed and for data to be collected.
- Educate the staff on the QAPI plan and data collection interval indicated.

ADMINISTRATION

02.02.02 Patients Informed of Dates and Times of ASC Services

Overview of the requirement

The organization must communicate the hours of available services and what to do in the event of an emergency.

Comment on deficiencies

Deficiencies resulted from missing signage.

Frequency of citation: 29%

Examples of Surveyor findings

- Building entrances lacked signage to address the standard.

Tips for compliance

- This is a simple “just do it” standard. Signage and telephone messages should indicate hours of operation and provide instructions for patients in the event of an emergency such as “call 911” or “go to the nearest emergency room.”

SURGICAL SERVICES MEDICAL STAFF

03.00.02 Surgical Procedures: Performed by Qualified Physicians

06.00.02 Medical Staff Granted Privileges

06.00.03 Medical Staff: Credential Files

Overview of the requirement

These related standards require a credentialing and privileging process that supports ongoing review of medical staff credentials and licensure and a proactive process of granting and reevaluating privileges to perform specific procedures within the ASC’s scope of services.

- Policies and procedures define the criteria and process used by the governing body when determining the scope of privileges granted including documentation thereof.
- Criteria for surgical privileges include, at minimum, legal qualification, demonstrated competence, written recommendation(s), and reporting when privileges are reduced or denied.
- A credentials file is maintained for each member of the medical staff that is complete and current.

Comment on deficiencies

Deficiency citations are not indicative that procedures are being performed by unqualified individuals but that the credentialing and privileging process is not adequate or did not reflect governing body review of qualifications and approval of initial and renewal privileges granted.

Frequency of citation: 03.00.02: 13% | 06.00.02: 17% | 06.00.03: 38%

Examples of Surveyor findings

- Files lacked evidence that the governing body had reviewed medical staff privileges.
- No evidence that practitioner credentials were verified prior to granting surgical privileges.
- Credentialing and privileging files contained expired information.

Tips for compliance

- Review policies and procedure to ensure that the governing body follows an established process for credentialing and granting surgical privileges.
- Assign oversight of the credentialing and privileging process to an individual.
- Conduct regular audits to ensure current, accurate and complete credentialing and privileging files.

PHYSICAL ENVIRONMENT

05.01.02 Temperature, Humidity, and Air-Flow Requirements

Overview of the requirement

Temperature, humidity, and relative air-pressure must be maintained within acceptable ranges to reduce risk of infection, inhibit microbial growth, and promote patient comfort.

Comment on deficiencies

Deficiencies resulted from environmental levels not being monitored and documented.

Frequency of citation: 13%

Examples of Surveyor findings

- The ASC did not monitor the OR room temperature and humidity when the OR was being used.
- Temperature logs revealed operating rooms with lower than acceptable temperatures and no documented corrective actions.
- Airflow in one area was neutral; no airflow from clean to dirty areas.

Tips for compliance

- Re-educate staff on the procedure to monitor and maintain temperature, humidity, air-pressure levels.
- Assign the responsibility to the facilities manager to review logs frequently and perform corrective actions when necessary.

NURSING SERVICES

07.01.02 Patient Assessment throughout the ASC Experience

Overview of the requirement

ASCs must conduct pre-operative, intraoperative, and post-operative nursing assessments of the patient.

Comment on deficiencies

Deficiencies resulted from lack of comprehensive policies or incomplete documentation.

Frequency of citation: 13%

Examples of Surveyor findings

- Patient records lacked documentation of vital signs taken during the recovery period.
- Patient assessment policy did not address the frequency and required elements of the nursing assessments.

Tips for compliance

- Review facility policies related to nursing assessments to ensure that all required elements are included.
- Review the assessments and best practices for documentation with the nursing staff.

MEDICAL RECORDS

08.00.03 Form and Content of the Medical Record

Overview of the requirement

The ASC must maintain an accurate and complete medical record for each patient.

Comment on deficiencies

Deficiencies were cited when one or more required element of the medical record was missing.

Frequency of citation: 13%

Examples of Surveyor findings

- Review of the medical records showed incomplete history and physical documentation.
- Informed Consent Forms were incomplete or not signed by the appropriate medical staff.

Tips for compliance

- Review the medical record policy and forms to confirm that all requirements of the standard are included.
- Have a process to ensure that all signatures on informed consents are verified prior to the procedure.

08.01.02 Record Storage

Overview of the requirement

Medical records must be secured to prevent unauthorized access and protected from physical destruction.

Comment on deficiencies

When physical records are maintained, fire protection requirements must be met for their storage

Frequency of citation: 17%

Tips for compliance

- If the record storage area does not meet the required fire rating, records can be stored in fire resistant containers.
- Consider any other potential environmental threats.
- Develop and implement a plan addressing security of digital files.

PHARMACEUTICAL SERVICES

09.00.03 Administration of Drugs: Labeling, Storage, and Disposing of Expired Medications

Overview of the requirement

ASC policies provide instructions for drug storage and disposal that aligns with manufacturer's guidelines.

Comment on deficiencies

Deficiencies were noted when drugs were not adequately secured from unauthorized access, when expired inventory remained accessible for use, and when syringes with drugs drawn up for use during procedures were unlabeled.

Frequency of citation: 13%

Examples of Surveyor findings

- Drugs were observed to be stored in unsecured cabinets.
- Expired medications were kept in storage.
- Medications for use during surgical procedures were not labeled.

Tips for compliance

- Ensure staff education on medication storage, labeling and disposal.
- Perform regular inventory audits and segregate expired drugs from active stock prior to disposal.

INFECTION CONTROL

12.00.02 Sanitary Environment

Overview of the requirement

All areas must be maintained to avoid sources and transmission of infection. Environmental cleanliness policies are based on nationally-recognized infection control guidelines.

Comment on deficiencies

Deficiencies cited lapses in routine maintenance and housekeeping.

Frequency of citation: 25%

Examples of Surveyor findings

- Policy included no routine maintenance procedure assigned to the housekeeping department and no designated area for storage of dirty linen/trash (which led to overflowing trash cans, linen hampers).
- Cardboard shipping containers and patient care supplies were stored together.

Tips for compliance

- Develop policies and procedures regarding cleaning.
- Educate staff on these policies.
- Conduct regular environmental surveillance rounds that include participation of the facilities manager and the infection control officer.

12.01.01 Decontamination and Sterilization: Policies

Overview of the requirement

ASCs have policies and procedures for decontamination and cleaning of surgical instruments that are consistent with manufacturer's instructions and national guidelines, reviewed and approved at least every three years, and provided to staff responsible for these processes.

Comment on deficiencies

Most deficiencies cited reflected inconsistent compliance with existing policies. This indicates that staff responsible for implementing policy may be unfamiliar with it or inadequately trained on it. The standard is closely related to 12.01.02 which addresses both compliance with ASC policies and the appropriateness of processes used for decontamination and cleaning of surgical instruments.

Frequency of citation: 13%

Examples of Surveyor findings

- Based on review of sterilization policies and logs, the policy for biological testing weekly or prior to intermittent use of the sterilizer was not followed.
- Review of the sterilizer logs indicated that bacteriologic spore testing is being done monthly rather than weekly as required by policy.

Tips for compliance

- Align timelines for policy review with national guidelines and manufacturer's updates.
- Ensure staff is familiar with policy and receives training updates with each policy review cycle.

PATIENT ADMISSION, ASSESSMENT, AND DISCHARGE

13.00.02 Patient Pre-surgical History and Physical

Overview of the requirement

The standard in 2020 stated that ASCs must have a policy identifying which patients require a medical history and physical prior to surgery and define the time frame for this examination. The manual also had the requirement that an H&P be performed for all patients no more than 30 days prior surgery.

In 2021, the standard was revised to allow the ASC to determine, based on recognized standards of practice, which patients would be required to have a complete history and physical prior to surgery.

Comment on deficiencies

Deficiencies were cited for incomplete history and physical documentation in patient medical records.

Frequency of citation: 13%

Examples of Surveyor findings

- H&Ps lacked the date of exam.
- H&Ps lacked a comprehensive inventory of the body systems; the physical examinations lacked a cardiac examination, including auscultation of chest and heart sounds.

Tips for compliance

- The purpose of a comprehensive medical history and physical assessment is to determine whether there is anything in the patient's overall condition that would affect the planned surgery or indicate that an ASC might not be the appropriate setting for the surgery. Consider patient population, allergies, comorbidities, etc. when developing your policy.

13.00.04 Patient Pre-surgical Assessment

Overview of the requirement

The patient must have a pre-surgical assessment completed by a qualified practitioner to evaluate the patient's risk for the procedure and anesthesia *immediately prior to surgery*.

Comment on deficiencies

Deficiencies were cited for incomplete assessments.

Frequency of citation: 17%

Examples of Surveyor findings

- Document review revealed a failure to complete all portions of the pre-surgical assessment.
- A physician completed the assessment after the surgical procedure.
- No anesthesiology status classification documentation was made prior to the administration of sedative agents.

Tips for compliance

- Regardless of whether an H&P was completed within the 30 days preceding surgery, assessments must be performed by qualified practitioners prior to surgery to evaluate the patient's risks for the procedure and the anesthesia.

13.00.08 Discharge Order

Overview of the requirement

Each patient must have a discharge order signed by the physician who performed the procedure.

Comment on deficiencies

The intent of the standard is that each patient is assessed to ensure that they have recovered sufficiently to be safely discharged from the facility.

Frequency of citation: 13%

Examples of Surveyor findings

- During review of three closed medical records, none included a physician order for discharge of the patient.

- During review of open and closed medical records, it was noted that the physicians were writing discharge instructions and/or ordering medications prior to the time of entry into the ASC and before the day of surgery. The date of the discharge orders preceded the date of admission in two of two (2/2) closed medical records and six of six (6/6) open medical records.

Tips for compliance

- Although using standard order sets is permissible, the physician who performed the procedure must review, sign, time, and date the discharge order following the procedure.
- Assign responsibility for management of discharge paperwork.
- Create dashboards that show compliance with documentation requirements at the team or individual level to boost accountability.

🛡️ 14.04.01 Fire-Rated Barriers

Overview of the requirement

ASCs must maintain one-hour fire-rated barriers and ensure that the barriers are not damaged.

Comment on deficiencies

Deficiencies resulted from fire barriers not meeting the required rating due to damages.

Frequency of citation: 13%

Examples of Surveyor findings

- Fire-rated walls were observed to have penetrations and holes that were not fire caulked to provide the rated protection required.

Tips for compliance

- Review the physical state of fire-rated barriers. Rated doors are high-use items and their state of compliance may not be consistent from one annual inspection to the next.

🛡️ 14.04.07 Fire-Rated Door Assemblies

Overview of the requirement

Fire-rated door assemblies must meet requirements of NFPA 80 Standard for Fire Doors and Fire Windows, 2010 edition.

Comment on deficiencies

Deficiencies were cited when fire doors lacked labels, automatic closure devices, or when documentation was missing regarding annual inspection.

Frequency of citation: 17%

Examples of Surveyor findings

- The door to the electrical room, which was in a one-hour fire-rated wall, had a rating sticker on the door frame but the door itself lacked a fire rating and a self-closing device.
- It was observed that the following locations for five doors in the one-hour fire-rated wall did not have fire-rated labels on the doors. All door frames were labeled as fire-rated. Locations were:
 - » The pre-op area from the corridor.
 - » The pre-op area from the waiting area.

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- » From the PACU to the lobby.
- » The lounge to the women's locker entrance door.
- » The lounge to the men's locker entrance door.
- Two doors were observed with 20-minute fire-rating labels instead of 45-minute rating labels.
- The ASC did not have documentation of an inventory of fire doors or yearly rated-door inspections.

Tips for compliance

- Inventory fire doors and conduct an annual audit to ensure that doors and frames are appropriately labeled.

15.01.07 Invoking the 1135 Waiver

Overview of the requirement

A waiver under section 1135 may be issued during a public health emergency to modify certain Medicare, Medicaid, or Children's Health Insurance Program requirements to ensure adequate health care supplies and services in an emergency.

Comment on deficiencies

Deficiencies resulted when ASCs did not include reference to use of an 1135 waiver in the Emergency Operations Plan.

Frequency of citation: 17%

Examples of Surveyor findings

- Review of policies and procedures did not identify a plan for invoking an 1135 waiver or for coordinating care at alternate sites.

Tips for compliance

- When a blanket waiver is announced by CMS, review your EOP to determine how the waiver conditions are applicable to your organization.
- Compliance with blanket waiver conditions must be documented. Focus on each element required for a complete EOP.
- Be sure that components required by the standards are delineated in the EOP or EOP-referenced policies.

15.02.02 Contact Information

Overview of the requirement

An emergency communication plan includes complete contact information for specified individuals and organizations.

Comment on deficiencies

Deficiencies resulted when the emergency communications plan was incomplete.

Frequency of citation: 13%

Examples of Surveyor findings

- The Emergency Operations Plan lacked documentation of contact information for entities involved with the emergency operations.

Tips for compliance

- Periodically review the contact list to ensure that contact information is complete and accurate/current.



We're here to help.

To learn more, visit our website at [achc.org](https://www.achc.org), call us at (855) 937-2242, or email customerservice@achc.org.

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