The Surgical Services Inspection Preparation Guide

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Introduction:

The purpose of this Surgical Services Inspection Preparation guide is to provide education to Surgical Services leaders about general health and safety expectations commonly surveyed during inspections, and to serve as a foundation for establishing both a monitoring program to ensure inspection preparedness and a training program where employees can be educated about these expectations. While healthcare entities are tightly controlled by expectations enforced by state and federal deregulatory entities, these expectations are not explained or even outlined in healthcare training programs. Regulatory expectations can seem mysterious and intimidating to managers who have little or no exposure to the inspection process. The goal of this guide is to provide the S surgical Services leader with a foundation on which the leader can feel confidently prepared for upcoming inspections, and proudly lead their department through an inspection.

Important consideration: this guide cannot anticipate every local, state and federal expectation, and thus should be used as a preliminary preparation guide*. Department leaders should always collaborate with organizational compliance experts on finer details to ensure best level of inspection preparation.*

Why are hospitals / ambulatory surgery centers inspected?

Simply put, the mission of state-controlled entities like a State Department of Public Health and federal entities such as Centers for Medicare / Medicaid (CMS) is to ensure public safety. Understanding that healthcare is a complicated service industry, these entities have established basic health and safety expectations of should be supported by healthcare entities advertising their services to the public. The role of the inspector is to methodically review personnel training, patient care processes, and state of the facility to ensure the public can receive safe treatment.

What happens if a hospital fails an inspection?

Ultimately, the healthcare entity operations are at-risk if the entity fails the inspection. Though extremely rare, State health departments can suspend the entities operations license, brining all patient care actions to a stop. CMS can suspend payment for all patients covered by Medicare / Medicaid

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insurance. As this population comprises over 50% of patients treated in most hospitals, this action effectively suspends operations as well. These severe actions are very rare; more often, the inspector will assign expectations that the infraction is rectified and demonstrated to be in working order either during the survey or within 30 days from date of the survey. Example: a fire safety door closes upon activation of a fire alarm but fails to latch closed. This can risk spread of a fire, should one develop. The facility would affect repairs and demonstrate to the Inspector that the fire door indeed closes per expectations.

Who is doing the inspecting?

Inspectors have a variety of backgrounds, and typically inspect areas in which they have professional training. An inspector can be a physician, a nurse, and administrator, a finance officer, or a facilities engineer.

Nurse Surveyor	Follows competency, nursing assessment & patient care practice issues
Physician surveyor	Focuses on practitioner credentialling, documentation, and practice issues
Facilities surveyor:	Focuses on the safety & maintenance of facilities infrastructure operations
Administrative surveyor	Focuses on organizational governance issues

The Surgical Services leader can expect visits from the Nurse, Physician, and Facilities surveyors. This Inspection Preparation guide will cover issues identified for review by all three types of surveyors.

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CMS allows a number of entities to perform inspections. A reference list follows below:

Accrediting Institution	# accredited organizations	Description
The Joint Commission	22,000	Founded in 1951, The Joint Commission accredits and certifies more than 22,000 health care organizations and programs in the United States, including hospitals and health care organizations that provide ambulatory and office-based surgery, behavioral health, home health care, laboratory and nursing care center services.
Healthcare Facilities Accreditation Program (HFAP)	400	Founded in 1943 by the American Osteopathic Association, this organization provides accreditation for hospitals, clinical laboratories, ambulatory surgical centers, office based surgery, and critical access hospitals
Center for Improvement in Healthcare Quality (CIHQ)	500	Started in 1999 CIHQ is a membership-based organization focusing on acute care & critical access hospital accreditation
Community Healthcare Accreditation Program (CHAP)	9,000	Created in 1965, focused on home health and community-based healthcare organization accreditation
DNV GL Healthcare (DNV)	650	This accreditation division of the global company DNV was launched in 2008; applies the international standards process ISO 9001 to accreditation acute care hospitals.
Institute for Medical Quality (IMV)	n/a	An organization focused on providing quality of care across the continuum.
Accreditation Association for Ambulatory Health Care (AAAHC)	6,600	Formed in 1980, this organization was founded by the American College Health Association, the American Medical Group Association), the Ambulatory Surgery Foundation, the American Association of Health Plans, the Medical Group Management Association, and the National Association of Community Health Centers to focus on accreditation for ambulatory entities.

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What happens during the inspection?

Though exact survey dates are typically unannounced, the window of time in which the survey can be expected is known, so when the surveyors appear, the organization leadership is ready. The surveyors are greeted and escorted to the workspace from which they will direct survey activities of the duration of their visit. Depending on entities, surveys can range from one day to several weeks. The Joint Commission surveys typically last five days.

The survey's will introduce themselves to the organization leadership, and then delineate the survey schedule for their expected length of stay. During a typical Joint Commission survey, a department leader can expect several visits throughout the week by various inspectors. Surgical Services will be visited by a nurse surveyor, a facilities surveyor, and a physician surveyor.

What to do when a surveyor identifies a citation?

The natural reaction for any healthcare leader is to be upset when an inspector uncovers a finding that is likely to result in a citation. Many leaders often enter into the Kubler Ross grieving process, where in communication with the inspector, the leader may begin denying the citation, become frustrated with the inspectors response, begin bargaining, enter more frustration and sadness, and may never acceptance over the citation, especially if the leader disagrees with the inspector's observations. The healthcare leader should avoid this exhausting and frutiless phenomenon as the act is both ineffective and energy-consuming. when facing a citation, the healthcare leader should:

1. Do NOT enter into mid-inspection bargaining with the inspector over solutions to implement.
    a. Any innovated solution will not negate the citation, which will require a written action plan regardless of any quick-fix innovated during the inspection.
    b. Often, the instant solutions prove to be problematic for other sections of the organ Zaiton facing the same issue, so the effort is essentially wasting time and energy.
    c. The inspector may be mis-understanding the situation, which under further deliberation during the inspection would result in no citation.
2. Await the end-of-day summary or end-of-inspection summary to understand the full extent of the citation to be addressed.

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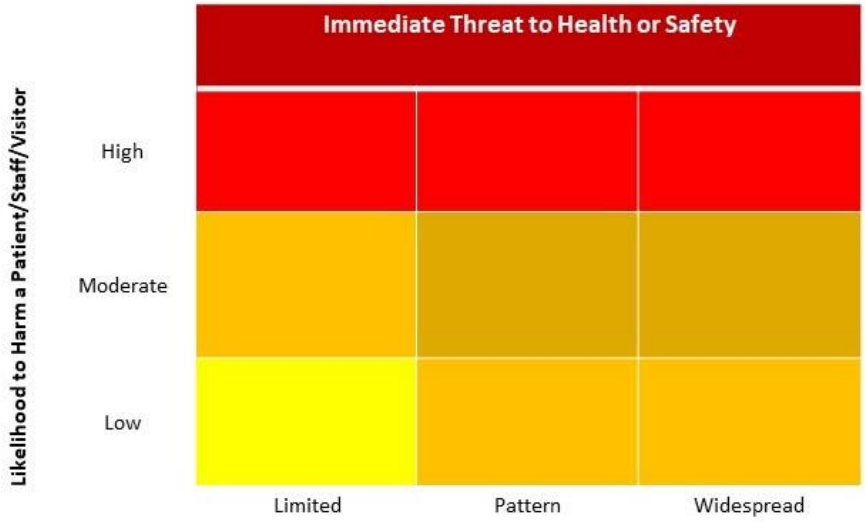
3. Carefully organize representatives from all departments affected by the citation to craft a solution for the identified problem, so the solution can be communicated to the inspection entity.

What is the SAFER Matrix?

The SAFER Matrix template is the scoring grid where TJC inspectors place the identified standards (elements of performance, or EP) that they have observed to be in violation. The EP is placed on the grid according to the harm it could cause (low, moderate, or high) and the prevalence in which the violation was found to occur. Prevalence can be limited (found only in one area / department), a pattern (error found across several departments) or widespread (found throughout the organization). Expectations for corrective action follow the severity index of the grid. The graphs below are taken directly from The Joint Commission website, https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-safer-matrix-scoring-process/ .

The SAFER Matrix



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The SAFER Matrix grading scale resolution expectations:

SAFER Matrix Placement	Required Follow-up Activity
High/Limited, High/Pattern, High/Widespread	• 60-day Evidence of Standards Compliance (demonstration of compliance) • Compliance evidence must include evidence of leadership involvement and preventative analysis • Finding will be highlighted to be included in follow-up surveys
Moderate/Pattern, Moderate/Widespread	
Moderate/Limited, Low/Pattern, Low/Widespread	• 60-day Evidence of Standards Compliance (demonstration of compliance)
Low/Limited	

Limited Pattern Widespread

Reference:

- All Accreditation Programs Survey Activity Guide, January 2022, The Joint Commission, 2022.
- www.jointcommision.org

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Use of the manual

This manual is meant to be used as a hands-on guide for perioperative leaders to partner with department staff in ensuring perpetual inspection readiness. The contents should be shared with staff; the leader should engage staff in performing short individual inspections of the different sections of the department which will create both short-term and long-term positive results for the leader, including:

- Short term:
    - Leader confidence in inspection readiness
    - Elimination of last-minute exhaustive efforts in meeting inspection readiness just prior to inspector arrival
    - Reduction / elimination of managerial and staff time spent on after-inspection improvement projects (as a result from inspection citations)
    - Sufficient lead time for Facilities or Administrative personnel to address structural or policy deficiencies identified in routine readiness surveys
- Long-term:
    - Increased education about regulatory requirements, and the reasoning behind said requirements for
        - Department staff
        - Organization support staff
        - Physician / medical providers working in the department
    - Leader confidence in staff ability to adeptly answer inspector questions during the formal survey.

IMPORTANT POINT:

Regulatory inspectors will often request department leaders to provide employees for questioning who have less than two years' experience in the department. The reasoning behind this request is that lesser-experienced employees theoretically pose a risk to patients due to unfamiliarity with safe practice operations; thus, if the newer employee can adequately answer survey questions, then the surveyor can be assured that all other employees are properly trained. This experience can obviously be incredibly stressful for the newer employee, for fear that they might accidentally answer a question incorrectly and bring undue hardship to the company. The leader would greatly serve newer employees by reviewing with them their respective department chapter.

Additionally, the leader may discover that long-tenured employees may have developed mis-understandings or practice habits contrary to accepted policies, hence the importance of reviewing this material with the entire department.

SUGGESTON: Consider **adding** the appropriate **department chapter** from this guide to the final section of **New Employee Orientation**. The operations included in this survey are included in the employee's orientation, they just may not be aware of the wording or reasoning behind some of the actions, so reviewing these details with the new employee helps the employee, the department, and the organization.

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Manual outline:

The manual begins with a generic employee education guide. This question / answer guide is meant to be used as a preparatory tool during education sessions, where leaders can review finer aspects of operations that may not leap directly to an employee's mind when answering a question.

Remember: all items included in this manual are reviewed with employees during their orientation; however, employees often rarely ever asked to verbalize the functions they use on a regular basis, so preparation with scripting is very helpful in decreasing inspection anxiety and increasing confidence in the strength of department patient safety operations.

The manual then progresses through each department, following the patient through their procedural experience. Each chapter is meant to:

- Stand alone, being fully self-sufficient in preparing that department for inspection readiness
- Be used as a checklist, where leaders can assign sections of the chapter to various team members so that the workload of readiness can be shared across multiple individuals.

Chapter outline

The leader should review the chapter contents with employees and give education as needed on the different aspects of the survey section as well as listed contents to be inspected. The guide is purposefully made to be separated into sections so the leader can assign small parts of the department to different staff members to both decrease individual inspection preparation workload and increase universals education about regulatory expectations.

Each chapter will follow the below-listed format:

- Department section title
- Human Resource Department file expectations
- List of all logs kept in the department that need to be reviewed
- Physical room inspections included
- Patient care / department process tracer question / answer guide

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