ASC Compliance in 2021

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QAPI

Rule/Statute

• (a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.

• (a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control, and other aspects of performance that includes care and services furnished in the ASC.
(c)(1) The ASC must set priorities for its performance improvement activities that:

- Focus on high risk, high volume, and problem-prone areas.
- Consider incidence, prevalence, and severity of problems in those areas.
- Affect health outcomes, patient safety, and quality of care.
Findings:
The ASC failed to document and implement an ongoing Quality Management (QM) program. Failure to establish a QM program poses the potential risk of a lack of critical oversight related to patient safety, patient outcomes, and the quality of patient care being provided.

Detailed Findings:
Copies of meeting minutes from the past QM meetings were requested and a policy for the QM program was requested. None were provided.
Rule/Statute

The governing body must ensure that the QAPI program:

1) Is defined, implemented, and maintained by the ASC.

2) Addresses the ASC’s priorities that all improvements are evaluated for effectiveness.
Governing Body Responsibilities

3) Specifies data collection methods, frequency, and details.
4) Clearly establishes its expectations for safety.
5) Adequately allocates sufficient staff, time, information systems, and training to implement the QAPI program.
Findings:

The ASC failed to ensure that QAPI meetings were held and minutes documented, posing the risk that the quality of patient care may not be appropriately monitored.
Detailed Findings:

Review of facility document "QAPI Meeting Minutes" revealed last documentation of QAPI meeting minutes was first quarter of 2020.

Review of facility document "Board of Directors Meeting Minutes" revealed last documentation of Board of Directors meeting minutes was third quarter of 2020.
Emergency Equipment

Rule/Statute

The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC's operating room. The equipment must meet the following requirements:

- Be immediately available for use during emergency situations.
- Be appropriate for the facility's patient population.
- Be maintained by appropriate personnel.
Emergency Equipment

Findings:
The ASC failed to maintain the code cart with:
1. A current emergency medication list,
2. Appropriate emergency medication,
3. Non-expired adult resuscitation pads and endotracheal (ET) tube.
Emergency Equipment

Detailed Findings:

• Employee #8 verified in an interview on 02/23/2021, that no list indicating what drugs should be present on the code cart was available.

• An examination of the contents of the emergency code cart on 02/22/2021 revealed it did not contain Epinephrine.
An inspection of the emergency code cart on 02/23/2021 identified the following:

a) Two Adult Stat Padz Adult Electrodes with an expiration date of 9/05/2020.

b) One Mallinckrodt 7.0 ET tube with an expiration date of 10/20/2020.
Rule/Statute

Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.
Reappraisals

Findings:

The facility failed to ensure medical staff privileges were periodically reappraised by the facility and failed to ensure the scope of procedures performed in the facility were periodically reviewed and amended as appropriate.
Reappraisals

Detailed Findings:

• Review of Provider #3’s personnel file revealed the last documentation of credentialing was in 2018.

• Review of Provider #2’s personnel file revealed no documentation of credentialing existed.
Reappraisals

• The administrator confirmed during an interview conducted on 03/10/2021, that provider #3’s last credentialing documentation was in 2018 and that provider #2 had no documentation of credentialing.
Form and Content of Record

Rule/Statute

The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:

- Patient identification.
- Significant medical history and results of physical examination.
- Pre-operative diagnostic studies (entered before surgery), if performed.
- Findings and techniques of the operation including a pathologist’s report on all tissues removed during surgery, except those exempted by the governing body.
- Any allergies and abnormal drug reactions.
- Entries related to anesthesia administration.
- Documentation of properly executed informed patient consent.
- Discharge diagnosis.
Findings:

- The facility failed to ensure physicians orders were dated and timed as to when they were signed by the physician.
- The facility failed to ensure an entry in a patient's medical record is legible.
Form and Content of Record

Detailed Findings:

• There were no dose or instructions for taking the medication listed on the discharge instructions.

• Review failed to verify orders were signed before medications were administered to patients.

• Review of handwritten anesthesia record failed to document times the anesthetic medications were administered.
During medical record review for anesthesia providers #2 and #10, the surveyors identified 10 of 10 records with illegible entries.
Form and Content of Record

• No documentation of a “time-out” procedure was noted.
Administration of Drugs

Rule/Statute

Drugs must be prepared and administered according to established policies and acceptable standards of practice.
Findings:

• The ASC failed to ensure prescription medications were stored in a locked area that was not accessible to non-licensed and unauthorized staff.
Administration of Drugs

The administrator failed to ensure staff discard:

1. Expired supplies and medications
2. Opened syringes
Administration of Drugs

- Review of 6 sampled patients' medical records revealed prescription eye medications were administered by a non-licensed staff member and not under the supervision of a nurse or physician.
• The ASC failed to ensure the medication refrigerator in the surgical suite was locked/secured. Observation during a tour of the facility revealed the presence of an unlocked small black refrigerator that contained multiple medications. Employee #2 verified that the refrigerator contained medications used for ophthalmology surgical procedures.
The ASC failed to require that Pharmaceutical Services were provided in a safe and effective manner, in accordance with acceptable standards of practice, regarding the storage of Pre Drawn Lidocaine medications in the Pre Op area unlocked and unattended.
Privacy

Rule/Statute
The patient has the right to personal privacy.

Findings:
The ASC failed to ensure patient privacy was maintained.

Detailed Findings:
Staff was noted reviewing discharge instructions with patients in the waiting room with other patients and visitors present.
Sanitary Environment

Rule/Statute

The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.
Sanitary Environment

**Findings:** The (ASC) failed to ensure that staff:

1. Perform hand hygiene before and after patient contact
2. Perform hand hygiene prior to donning gloves
3. Separate clean and dirty supplies in the operating room
Findings: The facility failed to require staff to properly clean all equipment and surfaces in the procedure rooms;

1. In between patient procedures, and;
2. For the terminal cleaning process at the conclusion of daily cases.
Sanitary Environment

Detailed Findings:

• Employee #2 confirmed in an interview on 02/23/2021, that the shelves and endoscopy associated equipment on the purple carts in rooms 1 through 4 had an egregious amount of dust and debris on them and were not cleaned to desired facility standards, and further acknowledged that it was the "techs" responsibility to clean all surfaces and equipment in the procedure rooms in between cases.
Sanitary Environment

Findings: The facility failed to:

1. Maintain a clean, dust free and pest free surgical floor/area
2. Ensure staff wear appropriate surgical attire to include proper PPE
Detailed Findings: During a tour of the surgical suite and interview conducted, Employees #1 and #2, confirmed that the OR floor had several greyish-brown colored stains throughout and the perimeter of the floor metal stripping where it met the wall contained dust. Additionally, in a corner adjacent to a small black medication refrigerator, a small dead dark bug was observed.
Findings: The ASC failed to:

1. Ensure that staff perform hand hygiene before and after direct patient contact, before and after donning and doffing gloves, and wear gloves when performing patient related tasks, or tasks where there is a potential for cross contamination; and
2. Ensure that medical staff disinfect the rubber septum of medication vials and the intravenous injection (IV) port with alcohol prior to entering the vial with a needle, and the IV injection port with a syringe. This poses the potential risk of patients being exposed to infection from contamination, and the introduction of microorganisms.
Findings: The ASC failed to ensure that the patient care environment was cleaned appropriately, which increases the potential risk of patients' exposure to pathogenic and/or airborne substances resulting from contaminants, dirt, dust and debris present in patient areas.
Sanitary Environment

**Detailed Findings:** During the tour, identified patient gurneys located in the pre-op bay #3, and in the PACU area in bay #1, #2. All gurneys had several magazines stored on the base of the gurneys, and the gurney in bay #2 had an incontinence bed pad stored there in addition to the magazines.
Further examination of the gurneys revealed a layer of dust on the bottom base of all three gurneys. A dried liquid stain, approximately 5 inches in length of a brown color was noted on the base of the gurney in pre-op bay #3, and a light brown droplet stain, approximately 1/4 inch in diameter was noted on the gurney in PACU bay #1.
Physical Environment

**Rule/Statute:** The ASC must provide a functional and sanitary environment for the provision of surgical services.

Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area.
Physical Environment

**Findings:** The ASC failed to require staff properly clean all equipment, surfaces, counters, and floor within the OR after completion of surgery.
Physical Environment

Detailed Findings:

Following the termination of the OR case of patient #20, the surveyor remained in the OR suite to observe the terminal cleaning process. Employee #2 was observed wiping the top portion of the OR bed, but did not wipe the base of the bed, nor did he/she remove the removable pads from the OR bed to clean the surfaces underneath them.
Infection Control Program

Rule/Statute

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.
Infection Control Program

Findings:

The ASC failed to establish policies and procedures in alignment to with current recommendations and guidelines to prevent the transmittal of Coronavirus Disease 2019 (COVID-19) infection. This poses the increased risk to visitors, staff, and patients being exposed to, and/or a source for the transmission of COVID-19 infection if no facility policies are available for instruction and guidance.
Infection Control Program

CDC guidelines titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" revealed "...Facilities should develop policies and procedures to ensure recommendations are appropriately applied in their setting..."
Findings: A facility policy on COVID-19 was requested on 03/11/2021. None was provided. Employees #5 and #7 confirmed in interviews on 03/11/2021 that no policies and procedures relating to COVID-19 were available for review.
Emergency Plan

Rule/Statute

[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]
Emergency Plan

Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**
Findings: The ASC failed to ensure within their Emergency Preparedness plan that they incorporated documentation to include the needs of the patient population they serve or a delegation of authority as part of the continuity of operations.
Findings: The ASC failed to include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials.
Emergency Preparedness Plan

Findings: The facility failed to develop a facility based emergency planning, training, and testing program.
Thank You

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Form and Content of Record

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- Any allergies and abnormal drug reactions.
- Entries related to anesthesia administration.
- Documentation of properly executed informed patient consent.
- Discharge diagnosis.
The Shareable way

It’s goes beyond technology. We are forming connections in healthcare across the globe.
Digitize your paper chart

Your paper chart + A secure iPad = Shareable Solution
Shareable in action
CHALLENGES

• Paper Charting

• No Integration with existing electronic ecosystem

• Boxed In workflows associated with certain technology solutions

SHAREABLE SOLUTION

• Forms-based mobile platform

• Seamless integration with EHR systems

• Practice-driven forms and workflows
Shareable: A simple solution with powerful results

**Simple.**
Almost nothing has to change. We take things that you already love and make them work better for your practice.

**Powerful.**
Paper forms that ask smart questions, prevent mistakes, and intelligently pass information throughout the perioperative process.

**Reportable.**
Our comprehensive data and analytic tools will give your practice a new level of efficiency and accuracy to make smarter decisions and provide greater patient care.

**Connectable.**
Shareable Forms connects seamlessly into your patient workflow with powerful and simple integrations that bridge the gap in your healthcare infrastructure.
Integrations

- Billing
- Practice Management
- Scheduling
- Electronic Health Records

75+ Systems

Logos: Azalea, HCA, nextec, App Orchard, greenway, BOLDER, Meditech, Cerner
If you are in the market for a compliant platform, we’d love to talk further!

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