NEW

THE^ESRD CORE SURVEY

Recognizing the Importance of Direct Care Staff in Assuring Patient Safety and Quality Care

What will be discussed…

- Background, development and focuses of the ESRD Core Survey
- What constitutes a Culture of Safety
- How a facility-wide culture of safety will protect patients
- The key role direct care staff play in the culture of your dialysis facility

2008 Brought New ESRD Conditions for Coverage (CfC) and ESRD Survey Process

- Comprehensive ESRD CfC published, including:
  - CDC comprehensive infection control elements
  - AAMI comprehensive elements on water/dialysate/reuse/home dialysis
  - Specific clinical standards for patient assessment, patient plan of care & QAPI (MAT)
- Detailed Interpretive Guidance for the CfC
- Detailed ESRD Survey Process with 16 separate survey tasks-AKA “Yellow Brick Road”
- Measures Assessment Tool (MAT)

Lessons Learned Since 2008

- The Traditional ESRD Survey process is not time efficient
- Average ESRD survey time ⬆38% since 2008
- Interval time between surveys increased since 2008
- Meanwhile, the total number of ESRD facilities has ⬆

CMS Efficiency & Effectiveness Initiatives-FY 2012 & Beyond

- Survey resources are limited, and may not improve
- Need to focus survey activities to achieve the most **efficient** use of survey resources to conduct an **effective** survey that:
  - Focuses on patient safety and quality
  - Utilizes **facility data** to focus
  - Supports a robust facility-based **QAPI program**

The ESRD Core Survey

- The **first** in CMS Efficiency & Effectiveness Initiatives
- Pilot testing conducted in portions of 11 States in July, August, September, 2012
- National roll-out in FY 2013
- Transparency for all Core Survey manual materials/tools-will be posted at CMS ESRD Survey & Certification web site:

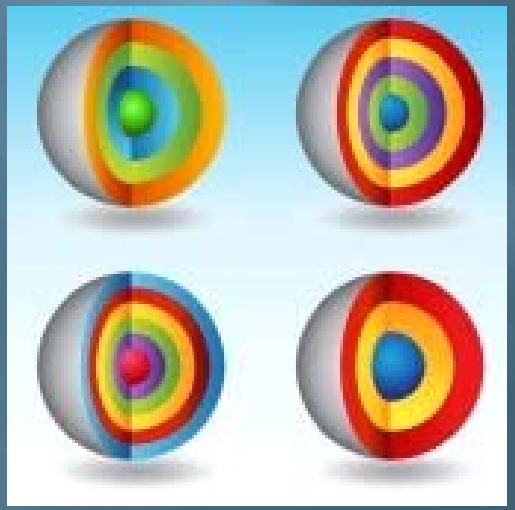
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Dialysis.html

Evolution of the ESRD Core Survey Process

The Development Process

- **Evaluated the data**: citation frequency, patterns, research on outcomes
- **Solicited input** on which Vtags have the most impact on patient safety and quality care
  - **These correlated!**
- **Looked to** the patient & facility outcomes
  - **Desired**: clinical areas (e.g. adequacy, nutrition)
  - **Adverse**: infection control and technical areas (e.g. sepsis, chloramines breakthrough)
- Evaluated what facility structure and processes of care must be in place to facilitate the desired & prevent the adverse outcomes
- Determined what core survey actions could most efficiently validate the presence of those facility structures and processes

The ESRD Core Survey for 2013



The ESRD Core Survey

- **Streamlined, more concise reviews of what REALLY impacts patients**
- Starts with “the basics” , and expands to more detailed review **if there is reason to**
  - **“Triggers” listed for each survey review indicate a problem or the need to look into something further**
- Recognizes the major role direct care staff play in keeping patients safe and providing quality care

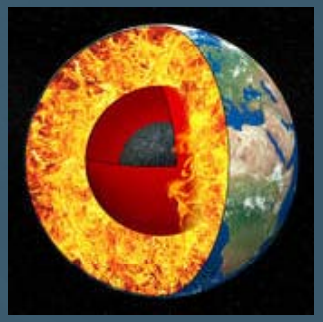
The ESRD Core Survey Focuses on Contemporary Issues in Dialysis

- Data use
- Quality Assessment & Performance Improvement (QAPI)
- Listening to the Patients' Voices
- A facility-wide "Culture of Safety" implemented
  - All of these will be referred to throughout this workshop

- Infection prevention and control
- Hemodialysis technical safety
  - Both of these will be covered with separate talks in this workshop

Data Use

- Facility and patient-specific data is used to focus review **where improvement is needed**
- Starts with off-site preparation by **review of the Dialysis Facility Reports**
- At onset of survey, will ask for **the current outcome data**
  - **Selects those areas that need improvement as**
    - Basis for sampling patients for review
    - Focus area(s) for QAPI review



QAPI

- Expects a vigorous, comprehensive and pro-active QAPI program to protect patients 24/7/365
- Core Survey QAPI Review has 3 segments:
  - Monitoring ALL facility areas
    - Clinical & operational indicators
    - Oversight of technical areas
  - Performance Improvement activities
    - Mortality review/evaluation
    - Infection prevention & control program
    - Error/adverse event investigation system
    - Focus areas specific to your facility
  - Culture of Safety-facility-wide
    - Risk identification, reporting
    - Patient engagement
    - Staff engagement

Listening to Patients' Voices in the Core Survey

- As the frequent recipients of care at the facility, patients have the "best view" of safety & quality
- Patient interviews are **enhanced** & open-ended
- **Patients will be asked:**
  - **How are they encouraged to report concerns & suggestions?**
  - **Do they feel free to speak up?**
  - **How does the direct care & administrative staff respond?**
- Patient **education** and **engagement** are emphasized
- QAPI review includes a segment dedicated to the patients' voice/engagement

"Culture of Safety"

It starts with YOU!

What would YOU do?

Scenario 1

- You are getting ready to put John Smith on dialysis. You cannulate his fistula, hook up his lines, and before you start the blood pump you notice that the reprocessed dialyzer is labeled for Joseph Smith, a patient on the next shift.

What would you do?

Scenario 2

- The patient schedule was revised last week, and your 4 station patient assignment now has 2 patients going on dialysis at the same time on the first and third shifts, and 2 patients coming off at the same time on the 2nd shift. You are having a very hard time keeping up with it, and are worried about not being able to safely monitor your patients.

What would you do?

Scenario 3

- Your patient, Mr. Doe always watches the staff working during the turnovers. When you come over to his station to take him off dialysis, he asks you if you sanitized/washed your hands before coming over.

What would you do?

What is Facility "Culture"?

The values and behaviors that contribute to the unique social, psychological environment of an organization…It is based on shared attitudes, beliefs, customs, and written and unwritten rules that have been developed over time and are considered valid.

It is shown in:

- The ways it conducts it's business and treats it employees and customers
- The extent to which freedom is allowed in decision-making, developing new ideas, and personal expression
- how power and information flow through it's hierarchy
- How committed employees are towards collective objectives

It affects the organization's performance, productivity…product quality and safety…is unique for every organization and one of the hardest things to change.

http://www.businessdictionary.com/definition/organizational-culture.html#ixzz2KnbZ5nC3

What is the culture of your facility?

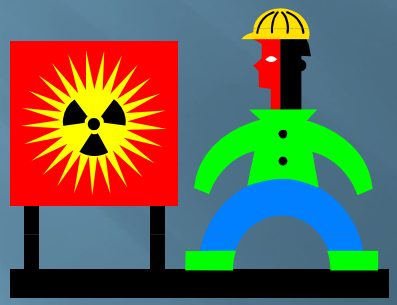
Facility culture is the MOST important thing for PATIENT SAFETY!

The Patient Safety Movement

- Institute of Medicine (IOM) reports-1999, 2001
  - ≈100,000 patients die each year d/t preventable hospital medical errors!
- More recent suggestions of many more times this in outpatient settings
- Healthcare Associated Conditions (HAC)
  - Healthcare Associated Infections (HAI)
- HUGE efforts and resources spent to study **WHY**

Looked to Other High Reliability Industries

- Where an error will likely have disastrous results
  - Aviation
  - Nuclear energy



- Clear lessons were learned…

Patient Safety Lessons Learned

Lesson #1: No one intends to harm patients

- Flaws in systems facilitate errors
- "Human factor": Nobody's perfect
- Comfort with a system will cause people to deviate from what they were taught to do with the belief they are acting safely

Patient Safety Lessons Learned

Lesson #2: The "blame/shame" culture of healthcare does not protect patients

- When an error occurs, the person(s) responsible is sought out, blamed and punished
- Fear of punishment causes staff to "clamp down"
- Errors and "Near Misses" are under reported
- Prevents meaningful investigation into WHY something happened or almost happened!

A Culture of Safety in Dialysis-the CORE of Patient Safety

Lesson #3: A facility-wide "Culture of Safety" will protect patients

Everyone at the facility is committed to identifying and eliminating any risks to patients

- **Open, non-judgmental communication b/t all levels of personnel and patients-ALL share patient safety goal (no blame/shame)**
- **Clear direction for staff of what is expected**
  - **Less reliance on memory**
- **Robust system for reporting & investigating causal factors of ALL abnormal events, and near misses/close calls: NOT WHO, but WHAT and WHY did it happen?**

CMS Expects All Dialysis Facilities to Implement a True Culture of Safety!

not just in words or on paper

How the Core Survey Will Identify a Culture of Safety-You are the key!

Surveyors will ask YOU about:

- **The facility system of communication**
  - **What is the facility system of communication like here?**
  - **How does the administration ask for your input?**
  - **Are you comfortable bringing issues and concerns to administration's attention? Do they listen to you?**
  - **How are you involved in the QAPI Program? How are QAPI plans for improvement communicated to you?**

How the Core Survey Will Identify a Culture of Safety-You are the key!

Surveyors will ask you about:

- **Your involvement in investigating & problem-solving at the facility**
  - What can someone in your position here do to prevent or reduce treatment errors?
  - **What errors or near misses are you expected to report?**
  - Do you feel comfortable reporting errors?
  - **How and to whom would you report an error or near miss you observed or were involved in?**
  - How would you expect the error or near miss to be addressed? What is your role in follow up?

Your Role in Promoting a Culture of Safety

- **Know what is expected** in all of the care you give-be clear on HOW to best do things to protect patients and **do it that way all the time**
- **Speak up** about your work environment, issues, and concerns that may lead to problems with patient safety
- **Report ALL abnormal events and close calls-** openly give your POV of what and why
- **Encourage patient engagement-**don't take offense if they speak up-YOU are the professional
- **Be open & honest with surveyors about your facility's "culture"! They can help improve things!**

CELEBRATE WHAT YOU DO TO IMPROVE THE CULTURE OF SAFETY AT YOUR FACILITY!

THANK YOU!