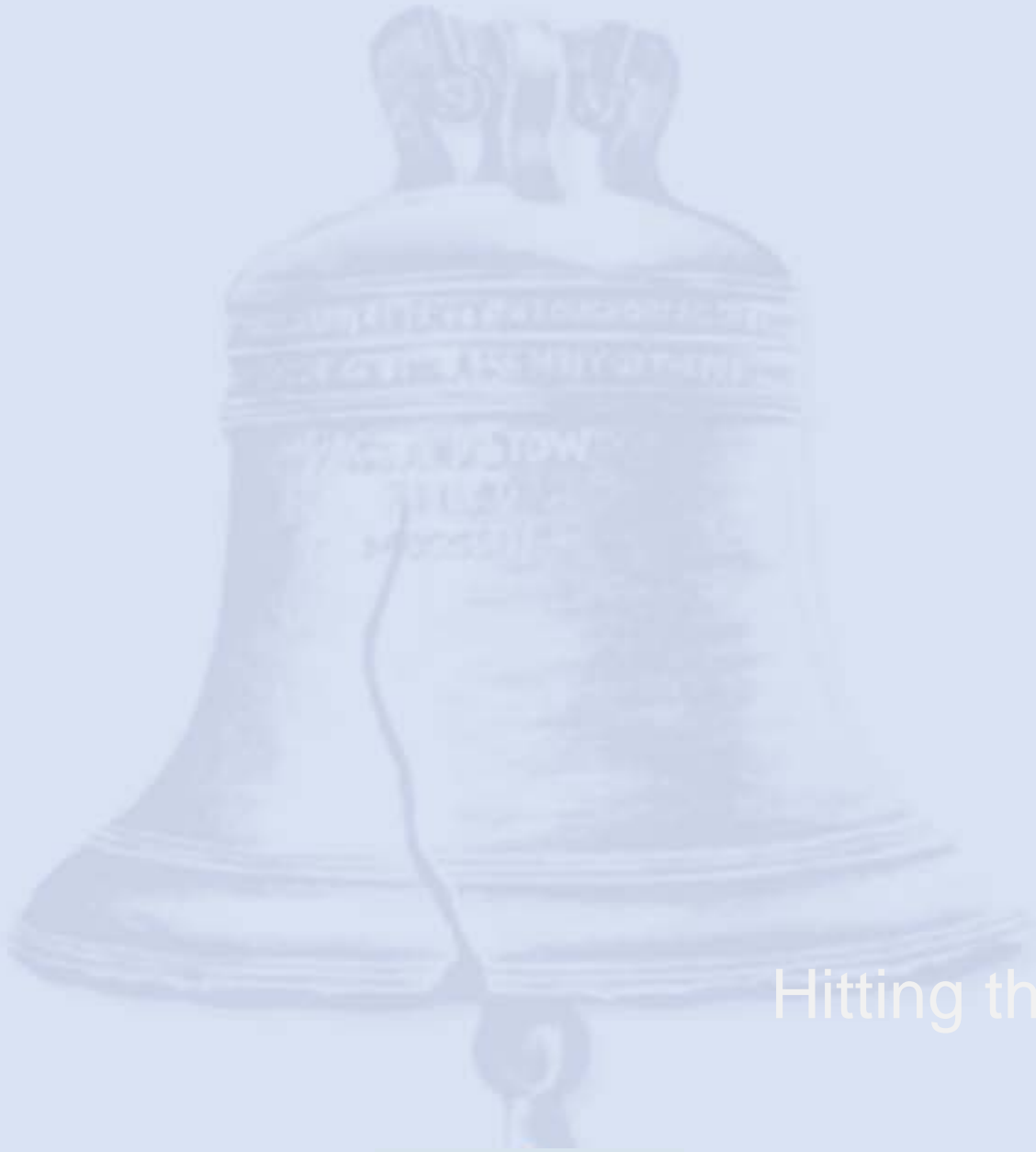




***NEW***

# The ^ESRD Core Survey

The Role of the Hemodialysis Technician in assuring your clinic is survey ready and your patient is treated in a clinics with a Culture of Safety!!



# Hitting the Target

# Hitting the Target...

- Understanding the Condition for Coverage (CfC)
- How to be 'survey ready'
- 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

CMMS, CFC, State Surveyors

Doctors, Nurses, SWs, RDs, Bio Meds

Direct Care Staff (YOU!)

Patient

# Condition For Coverage (CfC)

- Original CfC published in 1976
- Proposed rule for current CfC- 2005
- Final rule for CfC- 2008
- ...and so it continues

## CMS Notice for Conditions of Coverage

*NRAA Members are Encouraged to Make Suggestions via e-mail by April 1, 2015*

The Clinical Standards Group (CSG) in the CMS Center for Clinical Standards and Quality (CCSQ) is responsible for developing, updating and overseeing the CMS regulations on the Conditions for Coverage (CfCs) for ESRD facilities. These particular regulations were last revised in 2008; therefore, CSG is asking the ESRD community to review the current CfCs and provide suggestions for additions/changes/obsoletions that may be useful in a future update to the current regulations.

Please email [ESRD CSG@cms.hhs.gov](mailto:ESRD CSG@cms.hhs.gov) by April 1, 2015 with your suggestions for future updates to the CMS regulations on CfCs for ESRD facilities.

# Why Focus on the CfC?

- Clinic must meet CfC to receive \$\$ from Medicare/Medicaid programs
- It establishes *Health and Safety Standards* for Improving *Quality of Care* and protecting the *Health and Safety* of Beneficiaries
- It establishes the 'Conditions' on which the Core Survey Process is based

# Conditions

## PART 494 CONDITIONS FOR COVERAGE FOR END-STAGE RENAL DISEASE FACILITIES Interpretive Guidance

### **Subpart A—General Provisions**.....

§ 494.1 Basis and scope.....

§ 494.10 Definitions .....

§ 494.20 Condition: Compliance with Federal, State, and local laws and regulations (V100).....

### **Subpart B—Patient Safety**

§ 494.30 Condition: Infection control (V110-148) .....

§ 494.40 Condition: Water and dialysate quality (V175-278) .....

§ 494.50 Condition: Reuse of hemodialyzers and bloodlines (V300-383) .....

§ 494.60 Condition: Physical environment (V400-420) .....

### **Subpart C—Patient Care**

§ 494.70 Condition: Patients' rights (V450-470) .....

§ 494.80 Condition: Patient assessment (V500-520) .....

§ 494.90 Condition: Patient plan of care (V540-562) .....

§ 494.100 Condition: Care at home (V 580-599).....

§ 494.110 Condition: Quality assessment and performance improvement (V625-640) .....

§ 494.120 Condition: Special purpose renal dialysis facilities (V660-667).....

§ 494.130 Condition: Laboratory services (V675-676) .....

### **Subpart D—Administration**

§ 494.140 Condition: Personnel qualifications (V680-696).....

§ 494.150 Condition: Responsibilities of the medical director (V710-716) .....

§ 494.160 [Reserved]

§ 494.170 Condition: Medical records (V725-733) .....

§ 494.180 Condition: Governance (V750-772)



# Standards and Vtags

## Interpretative Guidelines (299 pgs!)

V516	<p><i>(b) Standard: Frequency of assessment for patients admitted to the dialysis facility.</i></p> <p>(1) An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis</p>	<p>Each patient new to dialysis must have a comprehensive assessment completed within 30 days or 13 treatments of admission. This requirement applies to all new dialysis patients, without regard to the modality of treatment. Patients returning to dialysis from a failed transplant or changing modalities are also considered “new” patients.</p>
V542	<p><i>(a) Standard: Development of patient plan of care.</i> The interdisciplinary team must develop a plan of care for each patient.</p>	<p>There must be an interdisciplinary plan of care developed for each patient. Facilities must have a system for developing patients’ plans of care. The IDT members are expected to interact and share information from the comprehensive assessment to facilitate the development of the plan of care.</p>
V628	<p>(2) The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. The program must include, but not be limited to, the following:</p>	<p>The facility’s QAPI program monitors the assessment and improvement of care in the facility.</p> <p>CMS-generated data reports, including the Dialysis Facility Reports (DFR) and other Consolidated Renal Operations in a Web-enabled Network Web (CROWNWeb) provided data reports, are and will be distributed to facilities to help them focus their QAPI improvement programs. Each facility should be comparing their performance with community-based standards and with other facilities in their State, their Network and the U.S. and working to improve their outcomes where needed. This comparative data is readily available to all facilities, whether they are corporate-owned or independent.</p>

# Core Survey Process from the *Surveyors* Perspective

- Intended to increase efficiency and effectiveness of the survey process (they have fewer resources)
- Shift to a more collaborative approach
- Partner with and listen to PATIENTS
- Focus on patient safety and quality outcomes
- Utilize data to prioritize where they will focus
- More about *performance improvement* and less about 'policing' the clinic

# 5 “T’s” of the Core Survey

- *Theme*
  - Use of data, Infection Control, QAPI
- *Threads*
  - Technical Safety, Culture of Safety, Patient Voices
- *Tasks*
  - 4 page document that outlines survey process
- *Tools*
  - Used to promote survey consistency
- *Triggers*
  - Each task has a ‘trigger’; if identified, then surveyor ‘digs deeper’

# Core Survey Experience

# Pre Survey Preparation

- Surveyor will review the clinic's most current Dialysis Facility Report (DFR)
  - If clinic not meeting state/national goals, it will be an area of more intense focus

TABLE 6 (cont.): Facility Modality, Hemoglobin, and Dialysis Adequacy for Medicare Dialysis Patients<sup>\*1</sup>, 2010-2013

Measure Name	This Facility				Regional Averages <sup>*2</sup> , 2013		
	2010	2011	2012	2013	State	Network	U.S.
Urea Reduction Ratio (URR; among HD patients with ESRD for 183+ days and 4+ URR claims at this facility) <sup>*7</sup>							
6r Eligible patients (n)	11	24	40	50	33.0	39.2	43.3
6s URR 65+ (% of 6r; meets a KDOQI guideline)	100	100	97.5	100	99.7	98.6	98.7

- Contact the ERSD Network
- Review complaint and survey history
- Collect Survey entrance data

# Flash Tour *(triggers)*

- Purpose: to look for observable indicators of patient safety concerns
  - Culture of Safety
    - *Question the staff (including YOU!)*
  - Observe clinical floor
    - *Staffing, blood spills, covered accesses, disrespectful communication, strong reuse odors, dysfunctional emergency equipment*
  - Water Treatment/Dialysate Preparation Area
  - Reuse Room
  - Home Dialysis Training Area

# Staff Questions

- What can a HD Tech do to prevent or reduce treatment errors?
- What errors or near misses are you expected to report?
- Do you feel comfortable reporting errors or making suggestions to improve safety?
- How comfortable are you to report an error, if you made it?
- What is your role in follow up?
- Are you involved in your clinic's QAPI program?

# Full Survey

- Will focus on areas based on the pre-survey review, flash tour and patient interviews (concerns they express)
- Medical Record review
- Personnel Interviews
- Personnel Record Reviews
- QAPI Review



# Quality Assessment Performance Improvement (QAPI)

- Expects a vigorous, comprehensive and proactive QAPI program to protect patients 24/7/365
- 3 Key areas of focus (DATA, DATA, DATA)
  - Monitoring Care and facility operations
  - Review 3 critical priorities
    - Mortality review
    - Infection prevention and control
    - Medical error/adverse event reporting
  - Culture of Safety!
    - Risk identification
    - Staff and Patient 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

**ESRD CORE SURVEY INTERVIEW WORKSHEET:  
IN-CENTER HEMODIALYSIS PATIENT**

Patient Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Facility: \_\_\_\_\_ CCN: \_\_\_\_\_

Surveyor: \_\_\_\_\_ #: \_\_\_\_\_

From your sample, choose “interviewable” (i.e., alert, oriented, not mentally impaired) in-center HD patients to interview. Explain the purpose of the interview. Ask if the patient would prefer to be interviewed at the facility or by phone. Ask the **core questions**. If an issue is identified in one or more data-driven focus areas, ask appropriate additional questions.

**Core Questions**

	Deficient Practice?	
How do the staff at this facility encourage you to give input? If you had a complaint, how would you file it here or elsewhere?	<input type="checkbox"/> V465 <input type="checkbox"/> V466 <input type="checkbox"/> V627	<input type="checkbox"/> No
Do dialysis staff members treat you with respect and dignity and protect your privacy during dialysis?	<input type="checkbox"/> V452 <input type="checkbox"/> V454	<input type="checkbox"/> No
How do staff encourage you to participate in care planning and consider your needs, wishes and goals? How do staff help you address barriers to meeting goals (targets)? Do staff discuss changes in your prescription before making them?	<input type="checkbox"/> V456 <input type="checkbox"/> V541	<input type="checkbox"/> No
What were you told about other treatment options? How did you choose in-center hemodialysis? Are you satisfied with in-center hemodialysis?	<input type="checkbox"/> V458	<input type="checkbox"/> No
What have you been told about your condition, risks and benefits of dialysis and access types, infection prevention, personal care, home dialysis, self-care, quality of life, rehabilitation, transplant, your rights and responsibilities, and what to do in an emergency here or at home, including if you're not able to get to dialysis?	<input type="checkbox"/> V451 <input type="checkbox"/> V562 <input type="checkbox"/> V464	<input type="checkbox"/> No
How safe, clean, and comfortable is this facility?	<input type="checkbox"/> V401 <input type="checkbox"/> V402	<input type="checkbox"/> No
Do you see staff cleaning hands and changing gloves when moving from one patient or station to another?	<input type="checkbox"/> V113	<input type="checkbox"/> No
Have you ever had any problems or symptoms during dialysis and if so, how and how quickly were they addressed?	<input type="checkbox"/> V681 <input type="checkbox"/> V713	<input type="checkbox"/> No
Are there enough staff, i.e., nurses, technicians, dietitians and social workers at this facility to meet your needs?	<input type="checkbox"/> V757	<input type="checkbox"/> No
Have you been offered a survey that asks how your health and symptoms affect your energy, activity level, and lifestyle? If problems were identified, how were they addressed?	<input type="checkbox"/> V552 <input type="checkbox"/> V628	<input type="checkbox"/> No
Is there anything else you would like to tell me about this facility?	<input type="checkbox"/> V467	<input type="checkbox"/> No

How to ‘engage’ the patients and make them survey ready?  
*YOU* ask them these questions routinely!

There are HD, PD and Home HD questionnaires

If a surveyor interviews 3-4 patients and none of them can answer the majority of these questions, the surveyor would 'assume' the culture of the clinic is NOT patient centric!

**ESRD CORE SURVEY INTERVIEW WORKSHEET:  
IN-CENTER HEMODIALYSIS PATIENT**

**Additional Questions**

<b>Patients' Rights and Responsibilities</b>	<b>Deficient Practice?</b>	
What do staff do to make sure you can understand information they give you? How comfortable do you feel asking questions? How well do you feel staff answer your questions?	<input type="checkbox"/> V453	<input type="checkbox"/> No
Has anyone talked with you about your right to have an advance directive (living will, durable power of attorney for healthcare decisions, do not resuscitate order)?	<input type="checkbox"/> V457	<input type="checkbox"/> No
<b>Treatment Issues</b>	<b>Deficient Practice?</b>	
How do you feel after dialysis? Do you get to your target weight? Have you ever had physical problems at home after dialysis?	<input type="checkbox"/> V543	<input type="checkbox"/> No
<b>Infection Control</b>	<b>Deficient Practice?</b>	
What have you been taught about washing hands and cleaning your access site (fistula or graft) before dialysis and washing your hands before leaving the clinic?	<input type="checkbox"/> V562	<input type="checkbox"/> No
<b>Emergency Preparedness</b>	<b>Deficient Practice?</b>	
If your dialysis facility was closed in case of a disaster, what would you do?	<input type="checkbox"/> V412	<input type="checkbox"/> No
<b>Patient Assessment &amp; Plan of Care</b>	<b>Deficient Practice?</b>	
What would you do if you had bleeding from your dialysis access after dialysis or signs and symptoms of access infection or clotting?	<input type="checkbox"/> V550 <input type="checkbox"/> V551	<input type="checkbox"/> No
What has the dietitian told you about food options, meal preparation, and adjusting your diet to meet nutritional goals? What other things has the dietitian helped you with?	<input type="checkbox"/> V545	<input type="checkbox"/> No
What have you been told about how to manage your fluid intake and blood pressure?	<input type="checkbox"/> V543	<input type="checkbox"/> No
What has the social worker told you about living with kidney disease? What other things has the social worker helped you with?	<input type="checkbox"/> V514 <input type="checkbox"/> V552	<input type="checkbox"/> No
How often do you see a physician/nurse practitioner/clinical nurse specialist/physician assistant? Is this enough? Do you know how to contact him/her if needed?	<input type="checkbox"/> V560	<input type="checkbox"/> No
How often do staff review your medications with you?	<input type="checkbox"/> V506	<input type="checkbox"/> No
(If reuse) What were you told about dialyzer reuse? How do you know you get your dialyzer each treatment?	<input type="checkbox"/> V312 <input type="checkbox"/> V348	<input type="checkbox"/> No

# **“CULTURE OF SAFETY”**

**IT STARTS WITH YOU!  
WHAT CAN YOU/ WOULD YOU  
DO?**

# Why the Focus on Safety?

- 1996 IOM published “*Crossing the Quality-Chasm*”
  - *Shifted Healthcare industry focus to patient centeredness and safety!*
- 1999, 2001 IOM reported +/- 10,000 patients die each year due to hospital preventable medical errors!
  - Today, hospitals do not receive \$\$ for hospital acquired infections!

# Does Your facility have a *Culture of Safety?*

- Facility-wide program
- Robust and proactive system for reporting and addressing errors/risk
- ‘Blame-free’ communications
- Engaged patients and staff

# Why the traditional 'Blame/Shame' Culture does NOT Protect Patients

- *Error* occurs, staff is sought out, blamed and punished
- *Fear* of punishment causes staff to 'clamp down'
- Errors, events, 'near misses' are *under-reported*
- *Result:* prevents meaningful investigation and change in process to improve outcomes!



**ESRD CORE SURVEY INTERVIEW WORKSHEET:  
PATIENT CARE TECHNICIAN**

Facility: \_\_\_\_\_ CCN: \_\_\_\_\_ Date/Time: \_\_\_\_\_

PCT: \_\_\_\_\_ ID#: \_\_\_\_\_

Surveyor: \_\_\_\_\_ ID#: \_\_\_\_\_

Ask the core questions. If an issue has been identified in one or more data-driven focus areas, ask appropriate additional questions.

**Core Questions**

	Deficient Practice?	
	<input type="checkbox"/>	<input type="checkbox"/>
How has the facility leadership defined your role in patient safety?	<input type="checkbox"/> V627	<input type="checkbox"/> No
What do you do to prevent or reduce treatment errors or near misses at this facility? How would you expect an error or near miss involving you or someone else to be addressed?	<input type="checkbox"/> V627 <input type="checkbox"/> V634 <input type="checkbox"/> V715 <input type="checkbox"/> V756	<input type="checkbox"/> No
What types of patient concerns were you taught to document and address? How are patients encouraged to voice suggestions and complaints without fear of reprisal?	<input type="checkbox"/> V465 <input type="checkbox"/> V466 <input type="checkbox"/> V636	<input type="checkbox"/> No
Are there sufficient qualified and trained staff in this facility to meet patients' medical, nutritional, and psychosocial needs?	<input type="checkbox"/> V757	<input type="checkbox"/> No
How and how often do you monitor in-center patients before, during and after dialysis?	<input type="checkbox"/> V503 <input type="checkbox"/> V504 <input type="checkbox"/> V681	<input type="checkbox"/> No
When would you notify a nurse if a patient has a problem?	<input type="checkbox"/> V681	<input type="checkbox"/> No
What training do you and in-center patients have in infection prevention?	<input type="checkbox"/> V132 <input type="checkbox"/> V562	<input type="checkbox"/> No
How do you encourage patients to meet outcome targets?	<input type="checkbox"/> V559	<input type="checkbox"/> No
How would you work with patients who have mental illness, cognitive impairment, cultural or language differences that may contribute to challenging behaviors as a way to prevent involuntary transfers and involuntary discharges?	<input type="checkbox"/> V452	<input type="checkbox"/> No
How do you participate in and/or learn about QAPI activities?	<input type="checkbox"/> V626 <input type="checkbox"/> V756	<input type="checkbox"/> No
What are you and the in-center patients taught about emergency preparedness?	<input type="checkbox"/> V409 <input type="checkbox"/> V412	<input type="checkbox"/> No
Is there anything else you would like to tell me about this facility?	<input type="checkbox"/> V467	<input type="checkbox"/> No

HD Survey  
Interview  
Worksheet

**ESRD CORE SURVEY INTERVIEW WORKSHEET:  
PATIENT CARE TECHNICIAN**

**Additional Questions**

<b>Patient Assessment &amp; Plan of Care</b>	<b>Deficient Practice?</b>	
How and who would you report patients' interest in other treatment modalities (home dialysis and transplant) to?	<input type="checkbox"/> V553 <input type="checkbox"/> V554	<input type="checkbox"/> No
Who is available to provide resources and assistance to respond to questions/concerns from in-center HD patients/families/partners?	<input type="checkbox"/> V514 <input type="checkbox"/> V552	<input type="checkbox"/> No
What types of patient issues would you refer to the dietitian or social worker?	<input type="checkbox"/> V509 <input type="checkbox"/> V510	<input type="checkbox"/> No
<b>Infection Control</b>	<b>Deficient Practice?</b>	
Were you offered the Hepatitis B vaccine?	<input type="checkbox"/> V126	<input type="checkbox"/> No
How do you care for patients who are HBV susceptible?	<input type="checkbox"/> V124	<input type="checkbox"/> No
<b>QAPI</b>	<b>Deficient Practice?</b>	
What practice audits of patient care are done at this facility and which ones have you performed?	<input type="checkbox"/> V637	<input type="checkbox"/> No

# 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 2<sup>nd</sup> 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 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**

# 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**

# “CULTURE OF SAFETY”

**IT STARTS WITH YOU!**  
WHAT WOULD YOU DO?

# 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!**



# How to Stay Informed CMS 'Open Door Forum'

http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForu Centers for Medicare & Medic... End-Stage Renal Disease an...

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**End-Stage Renal Disease and  
Clinical Laboratories Open Door  
Forum**

## End-Stage Renal Disease and Clinical Laboratories Open Door Forum

### Overview:

The End Stage Renal Disease (ESRD) and Clinical Laboratories Open Door Forum (ODF) addresses the concerns of the renal care and lab service communities in relation to the Medicare & Medicaid programs. Payment, billing and coverage issues are all handled in the discussions, as well as specifics within CLIA, the Fistula First Initiative and ESRD-related provisions of the Physician Fee Schedule (PFS) and the Medicare Modernization Act (MMA). Timely announcements and clarifications regarding important rulemaking, agency program initiatives and other related areas are also included in the forums.

To receive notice when the next End Stage Renal Disease (ESRD) & Clinical Laboratories Open Door Forum is scheduled, please refer to the "Related Links" section below to sign up on the Mailing List.



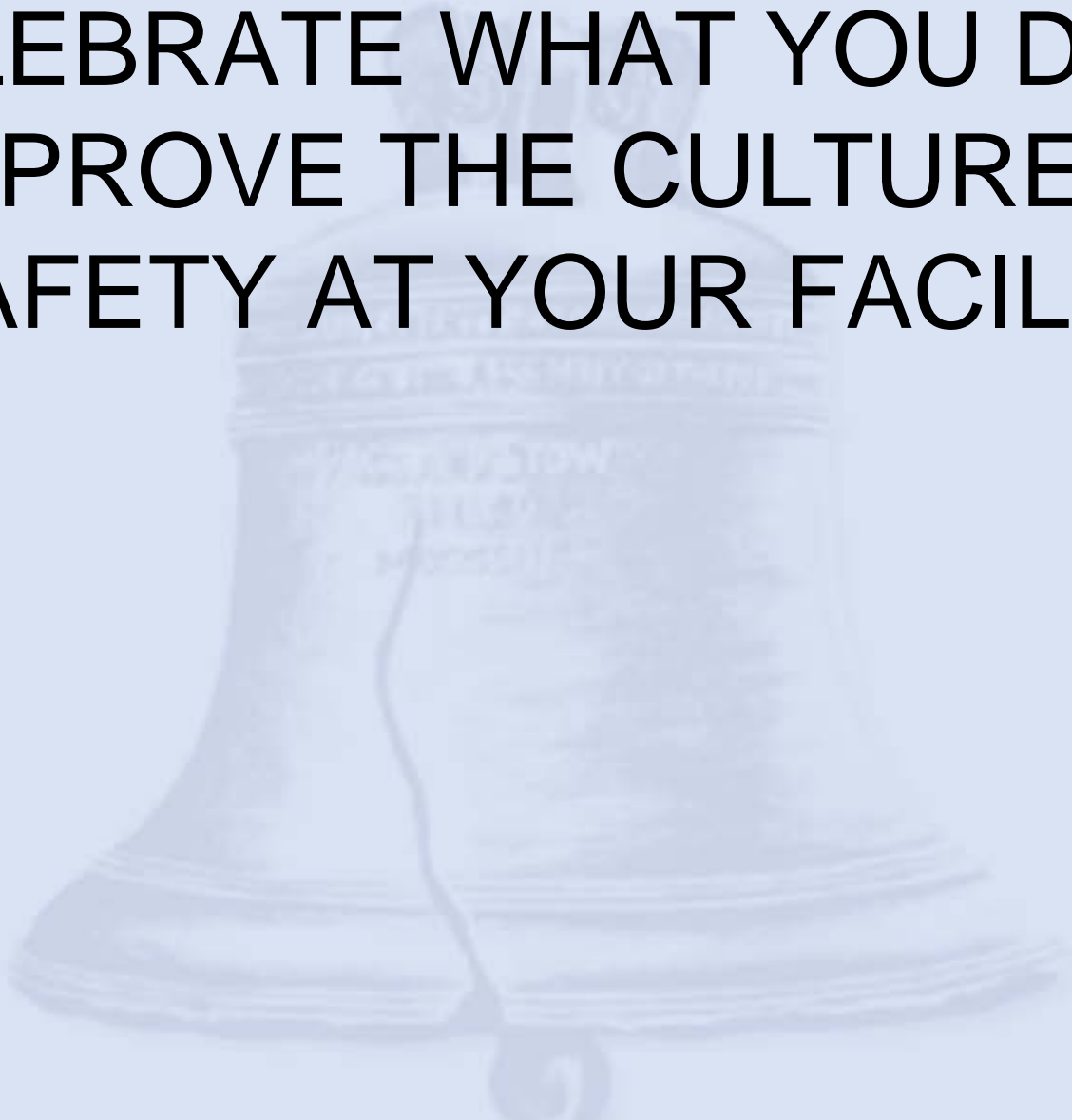
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**CELEBRATE WHAT YOU DO TO  
IMPROVE THE CULTURE OF  
SAFETY AT YOUR FACILITY!**



**THANK YOU!**