

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

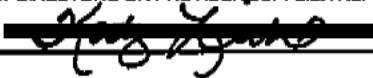
PRINTED: 03/23/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34C0001017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/09/2018
NAME OF PROVIDER OR SUPPLIER HEALTHSOUTH BLUE RIDGE SURGERY			STREET ADDRESS, CITY, STATE, ZIP CODE 2308 WESVILL COURT RALEIGH, NC 27607	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{Q 000}	INITIAL COMMENTS A complaint investigation and follow-up survey to the investigation conducted January 30, 2018 through February 2, 2018, was conducted March 7, 2018 through March 9, 2018. The Immediate Jeopardy was abated. Based on findings during the survey, the ambulatory surgery center remains out of compliance with the following Conditions for Coverage: 416.41 Governing Body 416.42 Surgical Services 416.43 Quality Assessment and Performance Improvement	{Q 00}	The governing body has full legal responsibility for determining, implementing and monitoring policies that oversee the center's total operations. Surgical services are inclusive of procedures in operating and procedure rooms. The governing body limits only those procedures that are approved. Quality Assessment is the responsibility of a team of professionals that included a physician on the medical staff, the medical director and key members of the surgery center team, named the Quality Council (QC).	3/14/2018
{Q 040}	GOVERNING BODY AND MANAGEMENT CFR(s): 416.41 The ASC must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan. This CONDITION is not met as evidenced by: Based on policy and procedure reviews, observation, and staff and physician interviews the Governing Body failed to provide oversight and accountability to ensure safe surgical services processes and effective quality assessment and performance improvement (QAPI) programs and prioritization.	{Q 04}	Policies are approved by the governing body whether created new or a revision of a current policy. Related new policies are included in this action plan which will be presented to the governing body in April 2018. Policies will be reviewed, revised where necessary, and approved by the governing body at that time. Policies that will be forwarded for review and reconsideration by the governing body include: Auditing for Documentation Safety N95 Respirator	3/14/2018 5/14/2018

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



CEO

3/30/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{Q 040}	Continued From page 1 The findings include: 1. Based on medical record review, observation and staff interviews the ASC failed to ensure safe surgical services by failing to prevent documenting in advance of performance, including documenting a time-out process to be performed in the OR prior to leaving the pre-procedure area, antibiotic prophylaxis (preventive measure) and normothermia (normal body temperature) measures before performing them, and History and Physical review prior to it being placed on the medical record, which could result in omitted processes and/or patient care errors. ~Cross refer to 416.42, Condition for Coverage: Surgical Services 2. Based on review of the facility plan of correction (POC), review of data, observation, and staff interviews the ASC audited processes according to the plan of correction but there had not been adequate time to ensure ongoing compliance and failed to observe documentation processes in real time to prevent and/or correct precharting of pre-procedure verification processes resulting in the risk of errors. ~Cross refer to 416.43, Condition for Coverage: Quality Assessment and Performance Improvement	{Q 040}	Policy named Auditing for Documentation Safety was created in addition to an audit form, Admission Audit for Documentation Compliance Working Document.	3/24/2018	
		{Q 060}	Review with designated personnel for auditing procedure training was performed. Policy Auditing for Documentation Safety was provided to designated personnel. A phone conference was made mandatory with key members of this audit team and corporate representatives to discuss the roll-out of the policy and audit process.	3/28/2018	
			1. 100% of teammates and anesthesia providers will be audited in pre-op when greeting patients. Audits will include observations of staff that include: Pre-op nurses, Circulating nurses, and Anesthesia providers	4/2/2018	
			2. Real time observations of healthcare workers (HCW) will be performed according to the Auditing for Documentation Safety policy. The audit working document (attached) is the tool for these observations. These audits will be performed on 100% of patients for at least the first 30 days beginning on this date.	4/2/2018	
{Q 060}	SURGICAL SERVICES CFR(s): 416.42 Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body		3. Training of the designated personnel, responsible for audits begins.	3/30/2018	

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{Q 060}	Continued From page 2 of the ASC in accordance with approved policies and procedures of the ASC This CONDITION is not met as evidenced by: Based on medical record review, observation and staff interviews the ASC failed to ensure safe surgical services by failing to prevent documenting in advance of performance, including documenting a time-out process to be performed in the OR prior to leaving the pre-procedure area, antibiotic prophylaxis (preventive measure) and normothermia (normal body temperature) measures before performing them, and History and Physical review prior to it being placed on the medical record, which could result in omitted processes and/or patient care errors. The finding include: Based on medical record review, observation and staff interviews, facility staff failed to ensure all members of the procedural team charted pre-procedure verification activities at the time of or after they were completed for 3 of 4 pre-procedure observations of charting (#3, 4, 8).	{Q 060}	Audit of working documents addresses a review of three HCW observations related to documentation of safe surgical checklists. The three HCW include: The pre-op nurse; The circulating nurse; and The anesthesia provider Surgery has a Safe Surgical Checklist (attached), revised current Safe Surgical Checklist by separating the circulating nurse responsibilities and initiated.	4/2/2018	
{Q 064}	~Cross refer to 416.42, Standard Level Tag for Condition for Coverage Surgical Services, Q-0064 STANDARD LEVEL TAG FOR SURGICAL SERVICES CFR(s): 416.42 Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body	{Q 064}	Anesthesia has an Anesthesia Safety Checklist (attached), revised current Safe Surgical Checklist by separating anesthesia responsibilities from the Safe Surgical Checklist and initiated. The form Admission Audit for Documentation Compliance Working Document is a tool that tracks compliance with appropriate documentation timing and identifies outliers and action plan steps in real time (attached). Audits will continue at 100% for at least 30 days if compliance is maintained at 95%. If target not reached, 100% continues for an additional 30 days, 50% follows for 30 days and 25% for the next 30.	3/19/2016 3/19/2018 3/30/2016 4/2018 5/2018 6/2018	

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{Q 064}	Continued From page 3 of the ASC in accordance with approved policies and procedures of the ASC. This STANDARD is not met as evidenced by: Based on medical record review, observation and staff interviews, facility staff failed to ensure all members of the procedural team charted pre-procedure verification activities at the time of or after they were completed for 3 of 4 pre-procedure observations of charting (#3, 4, 8). The findings include: 1. Medical record review, on 03/08/2018, revealed Patient #3 arrived to the ASC on [REDACTED] 2018 for a [REDACTED] (surgical procedure to visualize, diagnose and treat knee problems). Review of the "Safe Surgical Checklist" revealed it was initialed and a check mark was placed in all required boxes. Review revealed the surgery started at 1208 and ended at 1243. Observation revealed at 1135, RN #2, an Operating Room RN entered the pre-operative area and started the pre-procedure verification process. Observation revealed RN #2 had the "Safe Surgical Checklist" and put check marks in the "Time Out (Immediately Before Incision)" area of the form, making marks in the following spaces: "...Confirm patient identity, Surgeon confirms procedure, site, side, Confirm consent, Confirm site marking is visible ..." Observation revealed RN #2 charted the time out while Patient #3 was still in the pre-procedure area. Observation at 1130 revealed CRNA #2 entered the Preoperative area and begin the pre-procedure verification process. CRNA #2 was observed to check off items on the checklist that	{Q 064}	The working document audit initiative provides observation and interactions with patients which allows verification of events as they occur. Beginning on this date, audits by the trained designated personnel are completed on 100% of patients admitted for care. The pre-op nurse, circulating nurse and anesthesia provider are observed in the pre-op environment validating the following: • Identification of the patient or authorized caregiver • History & Physical (H&P)/Orders • Consent • Schedule • Booking sheet from physician's office • Verification of the procedure Following completion of the above, the Safe Surgical Checklist and/or Anesthesia Safety Checklists are completed. Areas where compliance is not 100% will be addressed real time. Once the patient is taken to the operating or procedure room, the auditor performing the time-out in the room will review the Safe Surgical Checklist and the Anesthesia Safety Checklist to ensure no documentation was completed prematurely. Audits will continue at 100% for at least 30 days if compliance is maintained at 95%. If target not reached, 100% continues for an additional 30 days, 50% follows for 30 days and 25% for the next 30.	3/30/2018	
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{Q 064}	Continued From page 4 had not yet been completed, including items related to antibiotic and normothermia (to maintain temperature) measures. Interview, on 03/08/2018 around 1140, revealed CRNA #2 charted those measures in the pre-operative area because the items checked would be done as soon as the patient got to the OR. Interview, on 03/08/2018 about 1150, revealed RN #2 checked off the timeout before the case. Interview revealed RN #2 may not have time to document during the case. Once in the OR, RN #2 stated, the timeout would be done and any necessary changes would be made on the form. Interview on 03/09/2018 at 0955 with Nurse Manager (NM) #1 revealed pre charting should not happen. Interview revealed it was not acceptable for staff to pre-chart the Operating Room (OR) time out in the pre-operative area. Interview on 03/09/2018 at 1010 with Administrative Staff (AS) #1 revealed the focus had been on the standardization of the processes, not on the forms. Interview revealed it was not safe practice to pre-chart. AS #1 stated there was not a policy or procedure on use of the "Safe Surgical Checklist" and there had not been any recent staff education on the form. Follow-up interview at 1400 revealed AS #1 had spoken with staff members and heard from two people that they charted as they did because it saved a little time. 2. Medical record review revealed Patient #8 arrived on [REDACTED]/2018 for partial [REDACTED] surgery.	{Q 064}	The working document audit initiative provides observation and interactions with patients which allows verification of events as they occur. Beginning on this date, audits by the trained designated personnel are completed on 100% of patients admitted for care. The pre-op nurse, circulating nurse and anesthesia provider are observed in the pre-op environment validating the following: • Identification of the patient or authorized caregiver • History & Physical (H&P)/Orders • Consent • Schedule • Booking sheet from physician's office • Verification of the procedure Following completion of the above, the Safe Surgical Checklist and/or Anesthesia Safety Checklists are completed. Areas where compliance is not 100% will be addressed real time. Once the patient is taken to the operating or procedure room, the auditor performing the time-out in the room will review the Safe Surgical Checklist and the Anesthesia Safety Checklist to ensure no documentation was completed prematurely. Audits will continue at 100% for first 30 days. Target 95% compliance. If target not reached, 100% continues for 30 days. Once at 95%, subsequent months will be 50% then 25%, increasing compliance goal by 5% each time.	4/2/2018	4/2/2018

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{Q 064}	Continued From page 5 Observation beginning 03/08/2018 at approximately 1320 revealed a Pre-operative RN (RN #5) opened the "Safe Surgical Checklist" and stated it could not be completed until all paperwork was received. Observation revealed there was not a History and Physical on the chart. Further observation of the pre-operative area revealed Certified Registered Nurse Anesthetist (CRNA) #3 entered the area on 03/19/2018 around 1405, pulled out the Medical Record Completion Checklist form and proceeded to check items off the form. Observation revealed CRNA #3 checked off the H&P as received/ reviewed prior to it being on the record. Interview with RN #5 on 03/08/2018 revealed this surgeon did not generally send the H&P in advance, instead the surgeon would bring the H&P to the Pre-operative area when seeing the patient prior to surgery. Interview with CRNA #3 on 03/08/2018 around 1405 revealed the H&P would be on the record before Patient #8 left the pre-operative area and went to surgery. Interview on 03/09/2018 at 1010 with Administrative Staff (AS) #1 revealed it was not safe practice to pre-chart. Interview revealed the focus had been on the standardization of the processes, not on the forms. Follow-up Interview at 1400 revealed AS #1 had spoken with staff members and had heard from two people that they charted as they did because it saved a little time. 3. Medical record review on 03/09/2018 of Patient #4 revealed a [REDACTED] male who arrived to the	{Q 064}	The working document audit initiative provides observation and interactions with patients which allows verification of events as they occur. Beginning on this date, audits by the trained designated personnel are completed on 100% of patients admitted for care. The pre-op nurse, circulating nurse and anesthesia provider are observed in the pre-op environment validating the following: • Identification of the patient or authorized caregiver • History & Physical (H&P)/Orders • Consent • Schedule • Booking sheet from physician's office • Verification of the procedure Following completion of the above, the Safe Surgical Checklist and/or Anesthesia Safety Checklists are completed. Areas where compliance is not 100% will be addressed real time. Once the patient is taken to the operating or procedure room, the auditor performing the time-out in the room will review the Safe Surgical Checklist and the Anesthesia Safety Checklist to ensure no documentation was completed prematurely. Audits will continue at 100% for at least 30 days if compliance is maintained at 95%. If target not reached, 100% continues for an additional 30 days, 50% follows for 30 days and 25% for the next 30.	4/2/2018	

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{Q 064}	Continued From page 6 ASC (Ambulatory Surgery Center) on [REDACTED] 2018 for [REDACTED] (removal of tissue that connects the upper lip to the upper gum). Review of the "Safe Surgical Checklist" revealed it was initialed and a check mark was placed in all required areas of the form by RN (Registered Nurse) #1 or CRNA (Certified Registered Nurse Anesthetist) #1. Observation on 03/09/2018 at 0915 in the pre-operative area revealed on the "Safe Surgical Checklist" under "Before Incision" RN #1, the operating room nurse, put a check mark indicating he had verified the following: "Time Out (Immediately Before Incision)" "All Other Activity is Suspended Confirm patient identity, Surgeon confirms procedure, site, side Confirm consent, Confirm site mark is visible Before Draping After Draping ..." Interview on 03/09/2018 at 0915 revealed RN #1 checked the "Before Incision ...Time Out" boxes because he already checked those things and would check them again in the operating room. Interview on 03/09/2018 at 0955 with Nurse Manager (NM) #1 revealed pre charting should not happen. Interview revealed it not acceptable for staff to pre-chart the Operating Room (OR) time out in the pre-operative area. Interview on 03/09/2018 at 1010 with Administrative Staff (AS) #1 revealed the focus had been on the standardization of the processes, not on the forms. Interview revealed it was not safe practice to pre-chart. AS #1 stated there was not a policy or procedure on use of the "Safe Surgical Checklist" and there had not been any recent staff education on the form. Follow-up	{Q 064}	The working document audit initiative provides observation and interactions with patients which allows verification of events as they occur. Beginning on this date, audits by the trained designated personnel are completed on 100% of patients admitted for care. The pre-op nurse, circulating nurse and anesthesia provider are observed in the pre-op environment validating the following: • Identification of the patient or authorized caregiver • History & Physical (H&P)/Orders • Consent • Schedule • Booking sheet from physician's office. • Verification of the procedure Following completion of the above, the Safe Surgical Checklist and/or Anesthesia Safety Checklists are completed. Areas where compliance is not 100% will be addressed real time. Once the patient is taken to the operating or procedure room, the auditor performing the time-out in the room will review the Safe Surgical Checklist and the Anesthesia Safety Checklist to ensure no documentation was completed prematurely. Audits will continue at 100% for at least 30 days if compliance is maintained at 95%. If target not reached, 100% continues for an additional 30 days, 50% follows for 30 days and 25% for the next 30.	4/2/2018	
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{Q 064}	Continued From page 7 Interview at 1400 revealed AS #1 had spoken with staff members and heard from two people that they charted as they did because it saved a little time.	{Q 064}	(continued from page 7)	4/2/2018	
{Q 080}	Interview on 03/09/2018 at 1130 with NM #2 revealed pre-charting on the "Safe Surgical Checklist" was incorrect. QUALITY ASSESSMENT AND PERFORMANCE CFR(s): 416.43 The ASC must develop, implement and maintain an on-going, data-driven quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by: Based on review of the facility plan of correction (POC), review of data, observation, and staff interviews the ASC audited processes according to the plan of correction but there had not been adequate time to ensure ongoing compliance and the ASC failed to observe documentation processes in real time to prevent and/or correct precharting of pre-procedure verification processes resulting in the risk of errors. The finding include: 1. Based on plan of correction (POC), Quality Assurance and Performance Improvement (QAPI) data from process monitoring, observation and staff interviews, the ASC observed and audited pre-procedure verification processes in the Operating Room but there had not been adequate time to ensure ongoing compliance and the ASC had not observed/audited the preoperative area documentation processes and precharting occurred.	{Q 080}	The working document audit initiative provides observation and interactions with patients which allows verification of events as they occur. Beginning on this date, audits by the trained designated personnel are completed on 100% of patients admitted for care. The pre-op nurse, circulating nurse and anesthesia provider are observed in the pre-op environment validating the following: • Identification of the patient or authorized caregiver • History & Physical (H&P)/Orders • Consent • Schedule • Booking sheet from physician's office • Verification of the procedure Following completion of the above, the Safe Surgical Checklist and/or Anesthesia Safety Checklists are completed. Areas where compliance is not 100% will be addressed real time. Once the patient is taken to the operating or procedure room, the auditor performing the time-out in the room will review the Safe Surgical Checklist and the Anesthesia Safety Checklist to ensure no documentation was completed prematurely.		

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{Q 080}	Continued From page 8	{Q 080}					
{Q 082}	-Cross refer to 416.43(b) 416.43(c)(2) 416.43(c)(2) & (3) Quality Assurance Standard: Tag Q-0082 PROGRAM DATA: PROGRAM ACTIVITIES CFR(s): 416.43(b), 416.43(c)(2), 416.43(c)(3) (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care. (c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time. (c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies. This STANDARD is not met as evidenced by: Based on plan of correction (POC), Quality Assurance and Performance Improvement (QAPI) data from process monitoring, observation and staff interviews, the ASC observed and audited pre-procedure verification processes in the Operating Room but there had not been adequate time to ensure ongoing compliance and the ASC had not observed/audited the preoperative area documentation processes and	{Q 082}	The working document audit initiative provides observation and interactions with patients which allows verification of events as they occur. Beginning on this date, audits by the trained designated personnel are completed on 100% of patients admitted for care. Areas where compliance are not 100% will be addressed real time. Once the patient is taken to the operating or procedure room, the auditor performing the time-out in the room will review the Safe Surgical Checklist and the Anesthesia Safety Checklist to ensure no documentation was completed prematurely. Audits will continue at 100% for at least 30 days if compliance is maintained at 95%. The risk management program includes a requirement for tracking and trending of outcomes. Each documented event of non-compliance will generate an incident report that will be submitted on the day of occurrence. What happens next is the management team and corporate representatives are notified of the event of non-compliance as soon as the event is submitted. Non-compliance data will be aggregated and trended by the Quality Coordinator.	4/2/2018			
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NAME OF PROVIDER OR SUPPLIER HEALTHSOUTH BLUE RIDGE SURGERY			STREET ADDRESS, CITY, STATE, ZIP CODE 2308 WESVILL COURT RALEIGH, NC 27607		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{Q 082}	Continued From page 9 precharting occurred. The findings include: Review of monitoring data presented by the ASC, on 03/08/2018, revealed the facility audited operative time-outs according to the plan of correction beginning 02/05/2018 with 100% of cases audited starting 03/02/2018. From 02/06/2018-03/01/2018 audits were completed daily on 32 (one day 03/01/2018) to 66 percent of cases and compliance ranged from 60% (one day 02/22/2018) up to 100%. Review of data revealed 100% of cases were audited with 100% compliance on 03/02/2018 and 03/03/2018. On 03/08/2018, data review revealed 93% of cases were audited with 80% compliance. Review of data revealed inadequate time to ensure monitoring of 100% of cases continued until all processes demonstrated sustained compliance. Observation of the preoperative areas on 03/08-03/09/2018 revealed staff documented some pre-procedure verification processes prior to performance rather than at the time of or after completion. Monitoring review did not reveal data from monitoring the preoperative area/ real time documentation. Interview on 03/09/2018 at 1010 with Administrative Staff (AS) #1 revealed the focus had been on the standardization of the processes, not on the forms. Interview revealed it was not safe practice to pre-chart. AS #1 stated there was not a policy or procedure on use of the "Safe Surgical Checklist" and there had not been any real time audits related to documentation of pre-procedure verification processes.	{Q 082}	Audits on the time-out process will continue with the target of 90% compliance. Daily audits reach 100%, with the exception of 2 days. Overall compliance with the time-out process in operating and procedure rooms reached at least 90%. These audits will continue simultaneously to the audits described below. The working document audit initiative provides observation and interactions with patients which allows verification of events as they occur. Beginning on this date, audits by the trained designated personnel are completed on 100% of patients admitted for care. Areas where compliance is not 100% will be addressed real time. Once the patient is taken to the operating or procedure room, the auditor performing the time-out in the room will review the Safe Surgical Checklist and the Anesthesia Safety Checklist to ensure no documentation was completed prematurely. Audits will continue at 100% for at least 30 days if compliance is maintained at 95%. If target not reached, 100% continues for an additional 30 days, 50% follows for 30 days and 25% for the next 30.	Ongoing	4/2/2018
				4/2/2018	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER HEALTHSOUTH BLUE RIDGE SURGERY				STREET ADDRESS, CITY, STATE, ZIP CODE 2308 WESVILL COURT RALEIGH, NC 27607			
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Q 242 Q 242	Continued From page 10 INFECTION CONTROL PROGRAM CFR(s): 416.51(b) 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. This STANDARD is not met as evidenced by: Based on manufacturer's guidelines and staff interview, facility staff failed to mitigate the risk of infection for employees by failing to perform fit-testing on a respirator requiring fit-testing. The findings include: Review of manufacturer's instructions for N95 respirators stocked at the facility revealed "NOTE: Before issuing any respirator to be worn, a face fit test must be performed. See OSHA regulations 1910.134." Interview with NM #1 on 03/09/2018 at 1027 revealed in condyloma (genital warts) cases, nurses, techs, and the CRNA (Certified Registered Nurse Anesthetist) all wear N95 masks as a precaution. Interview revealed masks are readily available for staff to wear. Interview revealed the facility had not done fit testing. NM #1 stated she had used an N95 respirator but had not been fit tested at the facility. Interview with AS #1 on 03/08/2018 at 1435 revealed no fit testing had been performed at the		Q 242	The Interim DON researched locations for N95 respirator fitting finding options in Morrisville NC or an 800# to call and find a location closest to the center. The preferred method of fit testing being one that would come on site. (Morrisville location and 800# attached) A policy on the N95 Respirator was created by the Interim DON, in preparation for the N95 mask fitting and respirator use by HWCs. This policy will be reviewed by the QC and will be recommended to the Medical Executive Committee (MEC) for adoption. The MEC will present to the governing body at the next meeting in April 2018. The new N95 Respirator policy is attached. Mask fitting has been scheduled with Occupational Health Partners in April. Prior to procedures that require protection with the N95 respirator, staff will be appropriately fitted by the contracted vendor for masks and trained on their use, donning and disposal. Masks of appropriate size will be provided for all HCW's involved in procedures where exposure is eminent. Management is responsible to ensure masks are always available for HCWs. Cases where the N95 may be required will not be scheduled until training complete.		3/8/2018 3/24/2018 MEC 5/9/2018 GB 5/14/2018 4/4/2018 & 4/11/2018 4/12/2018	

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Q 242	Continued From page 11 facility. Interview revealed there was no policy related to the procedure or the use of the N95 respirator. AS #1 stated it did not appear they needed to be fit tested, the N95s looked like they would be secure enough. Follow-up interview on 03/09/2018 around 1400 revealed AS #1 did not realize fit testing was required and that fit testing would be done. Interview with Employee #5 on 03/09/2018 at 1730 revealed the facility had boxes of N95 respirators. Employee #5 stated people are instructed to wear the respirators snugly. Interview revealed Employee #5 enters the OR to move patients on stretchers and Employee #5 dons an N95 prior to entering a room with a condyloma case. Further interview revealed Employee #5 had not been fit tested at the ASC.	Q 242	(continued from page 11) Education of HWC's will be completed by the new DON that started in his position on March 12, 2018. Education will be done in conjunction with the scheduling of fit testing for the N95 respirator. The testing will be done by a contracted vendor, Occupational Health Partners and training is scheduled on April 4 th and April 11 th , from 0930-1400. The fitting takes approximately 5 minutes. Trained designated personnel mentioned in this document include those members of the team and anesthesia providers that have been exposed to the policy on Auditing for Documentation Safety, and appropriate training attended. Also included in the training for these auditors is familiarization with the tool used for audits named Admission Audit for Documentation Compliance Working Document. These audits will be forwarded to the Quality Coordinator for aggregation of data and percent compliance with these efforts.	4/4- 4/11/2018 Note Only	

Surgical Care Affiliates Name of Facility: Blue Ridge Surgery Center		Policy No.
Prepared by: PR	Approved by: MEC/GB	Title-Provision of Care PC- Auditing for Documentation Safety
Origin Date: 3/2018		
Date reviewed or revised:	Page 1 of 2	

Policy:

Documentation of Information in the medical record must be legible, accurate and timed appropriately. At no time will Blue Ridge Surgery Center allow and healthcare practitioner to document in the record prior to activities being performed. Audits will be performed by designated personnel that have been appropriately trained to perform these audits.

Procedure:**Admission Audit for Documentation Compliance - Auditor Instruction**

Auditors: 100% is mandatory. Validation by one item below is **NEVER** an appropriate means of procedure identification! Initial audits will be a review of 100% of scheduled procedures in the first 30 days of audits.

Nine rights of procedural identification will be reviewed and are included in the information gathered by each auditor, each patient. These are as follows:

- Patient
- Physician
- H & P/Orders
- Consent
- Procedure(s)
- Side
- Site
- Physician Mark
- Antibiotics

Pre-op nurse validates procedure to be performed before the consent is completed.

Watch for the following:

- Patient/Authorized Caregiver
- H & P/Office Notes/Physician's Order
- Schedule
- Booking Sheet
- Verified: Patient, Physician, H & P/Orders, Procedure(s), Side, Site, Marking, Antibiotics

Circulating nurse validates the procedure to be performed before documenting on the safe surgical checklist and taking the patient to the operating/procedure room.

Watch for the following:

- Patient/Authorized Caregiver
- H & P/Office Notes/Physician's Order
- Consent

Surgical Care Affiliates Name of Facility: Blue Ridge Surgery Center		Policy No.
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Schedule

Booking Sheet

Verified: Patient, Physician, H & P/Orders, Procedure(s), Side, Site, Marking, Antibiotics

Safe surgical checklist completed following confirmation of above

Anesthesia Provider validates the procedure to be performed before documenting on the safe surgical checklist and taking the patient to the operating/procedure room.

Watch for the following:

Patient/Authorized Caregiver

H & P/Office Notes/Physician's Order

Consent

Schedule

Booking Sheet

Verified: Patient, Physician, H & P/Orders, Procedure(s), Side, Site, Marking, Antibiotics

Anesthesia checklist completed following confirmation of above

In Room Audit Procedure:

During the time-out audit, the person performing the time-out audit will:

Review the circulating nurse's Surgical Safety Checklist for compliance with appropriate charting, to confirm no pre-charting is done.

Review the CRNA's Anesthesia Safety Checklist for compliance with appropriate charting, to confirm no pre-charting is done.

Next Steps:

1. Actions for Missed Steps/Pre-Charting Opportunities, list where indicated on audit form. If no issues were noted, indicate by checking N/A for no issues.
2. If teammate, list who involved in missed steps/pre-charting on audit form
3. If anesthesia, list who involved in missed steps/pre-charting on audit form
4. If physician, list who involved in missed steps/pre-charting on audit form

Policy Updates: 3/24/2018 Policy adopted following results of a CMS survey where healthcare practitioners were found to be pre-charting in clinical areas.

Admission Audit for Documentation Compliance Working Document**Pre-op Nurse:**

- ☐ Patient/Authorized Caregiver
- ☐ H & P/Office Notes/Physician's Order
- ☐ Schedule
- ☐ Booking Sheet
- ☐ Verified: Patient, Physician, H & P/Orders, Procedure(s), Side, Site, Marking, Antibiotics

Circulating Nurse in Pre-op:

- ☐ Patient/Authorized Caregiver
- ☐ H & P/Office Notes/Physician's Order
- ☐ Consent
- ☐ Schedule
- ☐ Booking Sheet
- ☐ Verified: Patient, Physician, H & P/Orders, Procedure(s), Side, Site, Marking, Antibiotics
- ☐ Safe surgical checklist completed following confirmation of above

Anesthesia Provider in Pre-op:

- ☐ Patient/Authorized Caregiver
- ☐ H & P/Office Notes/Physician's Order
- ☐ Consent
- ☐ Schedule
- ☐ Booking Sheet
- ☐ Verified: Patient, Physician, H & P/Orders, Procedure(s), Side, Site, Marking, Antibiotics
- ☐ Anesthesia checklist completed following confirmation of above

*** Note: Missed steps/pre-charting, document below.**

If teammate, list who involved in missed steps/pre-charting:

☐ N/A = No issues

If anesthesia, list who involved in missed steps/pre-charting:

☐ N/A = No issues

If physician, list who involved in missed steps/pre-charting:

☐ N/A = No issues

Actions for Missed Steps and Opportunities for Improvement

☐ N/A = No issues

Patient Sticker

Surgical Care Affiliates: Name of Facility – Blue Ridge Surgery Center		Policy No.
Prepared by: PR	Approved by: MEC/GB	Title-N95 Respirator Mask IC – N95 Respirator
Origin Date: 3/2018		
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Policy:

This policy applies to Blue Ridge Surgery Center teammates - Healthcare Workers (HCW), contracted individuals, vendors, visitors, and students who may be exposed to harmful dusts, fumes, mists, gases, smokes, sprays, vapors, or airborne pathogens during routine operations, where respiratory protection is required. This is determined to be the responsibility of the Infection Control Program.

Scope and Purpose:

This policy establishes the Blue Ridge respiratory protection. The design is to minimize HCW exposure to hazardous air contaminants in the workplace. Procedures for respiratory protection selection, medical evaluation, fit testing, use and maintenance, training, and policy evaluation, are outlined in this policy. Fitting may include N95 Respirators.

This policy meets respiratory protection requirements mandated by the U.S. Department of Labor Occupational Safety and Health Administration (OSHA) and (29 CFR 1910.134 and 29 CFR 1901.139).

Process:

Participation in the Program is at no charge to HCWs. Expenses associated with respirator fitting and provision of respirators will be covered by the surgery center.

Requirements

Departments shall provide respirators, including N95 disposable respirators, at no cost to HCW, when respiratory protection is required.

Administration shall establish the nature of the work operation or process that requires the use of the N95 respirator and the physical characteristics, functional capabilities, and limitations of the N95 respirator.

Voluntary Use of Respirators

When respiratory protection is not required, yet an HCW voluntarily desires it, Blue Ridge Surgery Center is not obligated to provide equipment.

The HCW's manager must be informed if the HCW has any medical condition which would place the HCWs' health at increased risk of impairment from respirator use and any limitations upon the use of respirators for each HCW required to wear a respirator, as appropriate.

Surgical Care Affiliates: Name of Facility – Blue Ridge Surgery Center		Policy No.
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The following information is important in evaluating an teammate's situation:

The type of respiratory protection to be used; description of the work effort required; duration and frequency of usage; and additional requirements for protective clothing and equipment.

The HCW reports to their manager, any concerns related to using a respirator, such as difficulty breathing or significant physical or health changes.

Fit Testing

Fit testing must occur prior to initial use of the respirator and annually thereafter. Fit test procedures will be outsourced to a vendor chosen by Blue Ridge Surgery Center. The HCW shall be refitted when visual observations are noted regarding a HCWs' condition which could affect respirator fit. Conditions to look for include facial deformities or scarring, facial hair, cosmetic surgery, or an obvious change in body weight. HCWs are responsible to report any such conditions and to request repeat fit testing. HCWs shall be given the opportunity to repeat fit testing at any time to ensure their comfort and protection.

N95 respirators: These will be fit tested qualitatively. Fit testing will be coordinated by administration with an outsourced vendor.

Use

Respirators are to be worn by HCWs when required for a given task or by the work area.

Respirators that depend on a tight facepiece-to-face seal for effective performance, including disposable N95 respirators, are not to be worn by HCWs with conditions that prevent acceptable fits. Examples of these conditions include facial hair that interferes with the facepiece seal, absence of normally worn dentures, significant facial deformities or scars, temple pieces of glasses or headgear that projects under the facepiece seal.

If an HCW must wear corrective glasses or goggles while wearing respiratory protection, the department manager shall ensure that they are worn in such a manner that they do not interfere with the seal of the facepiece to the face of the wearer.

The department manager shall determine the types and numbers of HCW positions that are required to use respirators and ensure adequate compliance to accomplish work.

The department manager shall permit HCWs to leave the respirator use area to wash their faces and respirator facepieces as necessary to prevent skin irritation associated with respirator use.

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The department manager shall ensure that respirators are immediately discarded when they are used.

NOTE: Disposable N95 respirators may usually be used for the duration of a shift and are discarded instead of cleaned or when they become soiled, wet or damaged. In the case of SARS or pandemic flu, the outside of the respirator would be considered contaminated from droplets and the N95 should be discarded after each use.

Storage

The supervising department shall store respirators as follows:

All respirators shall be stored in a manner that protects them from damage, dust, sunlight, extreme temperatures, excessive moisture, or damaging chemicals. Disposable N95 respirators, once used, are to be stored for no more than the single shift during which they are used.

Training

Training shall be provided prior to requiring the HCW to wear a respirator in the workplace, and annually thereafter. The employer must provide general training and must inform the HCW of specific hazards.

Training in the use of N95s used for airborne isolation is the responsibility of the department manager.

Before any HCW wears a respirator for the first time, and annually as long as respirator use is required, they must receive and understand training that covers the following: Nature, extent, and effects of respiratory hazards to which the HCW may be exposed; Explanation of the operation, limitations, and capabilities of the respirator; Instruction in procedures for inspection, donning and removal, and in the wearing of the respirator, including sufficient practice to enable the HCW to become thoroughly familiar and confident with the use of the respirator; and The contents of the OSHA Standard (29 CFR 1910.134).

Responsibilities

The successful prevention of respiratory injury is dependent on the understanding and follow through responsibilities.

Infectious Disease Provisions

Provisions specific to surgery center personnel and situations are provided under the control of the Infection Control Program.

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Recordkeeping

Administration shall establish and maintain an accurate record for each HCW subject to N95 respirator use and fit testing.

This record may include: The name and job title of the HCW; Fit test results including date.

Training records will be maintained. Training will be fully documented, certifying that the HCW understands the concepts presented and has demonstrated how to use and wear the respirator.

Resources:

U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) (29 CFR 1910.134 and 29 CFR 1910.139)

Related policies: Blue Ridge Infection Control Plan.