WRITING A PLAN OF CORRECTION

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PLAN FOR TODAY

• What is a PoC?
• Why are they necessary?
• What do you need to do to complete one?
• How do you do it?
• What happens after it’s completed?
• Where can you get help?
What is a PoC?

• It’s your facility’s response to the survey findings
• It’s your opportunity to demonstrate how substantial compliance will be attained after the survey team reviews your response
• It’s an opportunity for you to investigate and focus on noncompliance, the remedy and how it can be prevented in the future!

Why are PoC’s necessary?

• It’s required by CMS for federal compliance
• It’s required by the State for licensing compliance
When Do you Need to Complete a PoC?

- After completion of the survey and when you receive the “2567” – report of your deficiencies
- A letter will accompany the 2567 and address the requirements, and timelines you need to comply with

HOW DO I COMPLETE IT?

- Follow the instructions in the letter
- The letter tells you:
  What to do, what items need to be included, when you have to have the plan returned to the SHD
- Remember, it’s a TEAM effort & everyone needs to understand what the concerns are and what needs to be done in order to remain in compliance.
Where do we begin?

• The Exit Conference!
  – It’s your first look at what the surveyors found are concerns
  – It’s the first time most will hear of what the concern is, and how many patients/residents it affects
  – It’s the first time you will be given the Federal/State Tag number in order to review the regulation and get ready to address the concern

THE EXIT CONFERENCE

• TAKE NOTES
  - I use this opportunity to do an actual “Exit Conference” report to target specifics
  - Have facility staff sign in
  - We have our first initial “planning meeting” after the conference has concluded and the surveyors are on their way!
Exit Conference & Initial Poc Meeting

• Purpose:
  Identify the specific deficiency
  What was the concern
  What patients/residents did it involve
  What evidence /people/documentation supports their concern

*Note, when the surveyors request a copy of something during the survey, we make a second copy – it will help you see the exact documentation they are referring to and save you time looking for it!
Sample forms included as Attachment A & B

It’s HERE!

• 2567 arrives via certified mail
• Make copies - # as applicable BUT keep one clean copy to type your PoC in.
• Read through the deficiencies
• Set up your meeting(s) to determine what you are going to do to correct this concern
How are we going to do that?

• Go through each deficiency and note the “Failure Statement”
• It’s your first clue to determine exactly what you have to correct
• Identify which patients/residents are involved
• Identify what your actions are going to be
• Keep in mind – you have 10 calendar days to complete the plan and have it into the State Health Dept.; Day 1 is the day you sign for it. The CLOCK is TICKING……….

Things to remember:

• ALL deficiencies cited in the CMS-2567 must be individually addressed in your Plan of Correction
• Your PoC is a public document and must not include patient/resident/staff names, allude to another supplier, or malign any individual. Use only the identifiers provided by the surveyors – you will receive a list for those, as applicable
More things to remember:

- The content of your PoC for each deficiency depends on whether the deficiency is:
  - **patient/resident centered**
    - The facility failed to protect the dignity of patient # 4 (as evidenced by….)
  - **facility centered**
    - The facility failed to conduct fire drills…

What needs to be included for each deficiency:

- Should provide a step by step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the INTENT of the regulation – as indicated/evidenced by the examples provided in the 2567 – is met.
DESCRIPTIVE CONTENT

• Stating that a deficiency is “corrected” is NOT acceptable – need to be specific &
tell:
  – How the corrective action will be accomplished for those patients/residents
    found to be affected by this deficient practice.
  – How you will identify other patients/residents having the potential to be affected by the
    same deficient practice

DESCRIPTIVE CONTENT
continued

• Tell what measures will be put into place or what systemic changes will be made to ensure that
  the deficient practice will not reoccur
• How you plan to monitor your performance to make sure the solutions you have put into place
  are sustained
• Who (title, not name) is responsible for these areas
• Date(s) accomplished and date you are in compliance
EXAMPLES:

• Patient/resident:
  - Failure statement: The facility failed to provide pain medications and determine their effectiveness when administered for 2 of 3 hospitalized patients

*Remember – these things will be KNOWN to you before the survey team leaves – take care of the issues that you can immediately address

What are you going to do?

• 1. How will you address this for the current patients affected?
  - Address their pain- document – and determine effectiveness
  - Start to determine why this wasn’t done?
    - Staff education? Policy/procedure?
    - Medication unavailable?
    - Communication? Miss an order??
Your PoC could state:

• 1. How corrective action will be accomplished for those patients/residents found to have been affected by the deficient practice?
  • After being informed of the concern, facility staff assessed and completed a Pain assessment for Patient # 2 (pain level 6/10) and Patient #6 (Pain level 8/10). The physician was contacted and orders received, observed and pain medication was provided for Patient # 2 and Patient #6 within 10 minutes. A follow-up assessment and evaluation of the effectiveness of the pain medication was done by the RN 30 minutes later and both patients indicated current pain levels had significantly decreased (2/10) and did not want any additional interventions at this time. Effectiveness was documented on each patient’s PRN MAR and in the nurses notes. The DON and nursing staff were responsible for this completion. (Date)

Continuing on…..

• 2. How will the facility identify other residents having the potential to be affected by this same deficient practice?
  • All patients/residents in the hospital have the potential to be affected by this identified concern. (Date)
  • Keep in mind – the deficiency may be one that is facility wide (above); is gender specific (all males) – failed to clean urinals; addresses a specific diagnosis/condition: pressure ulcer or specific intervention: patients with a low salt diet
Continuing on……

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

- Look at why this occurred? Read the deficiency statement and see what they reviewed – was it a policy/procedure that didn’t include something? Was it an interview with a patient? Was it an observation? Did they do a staff interview and the answer they gave didn’t comply with your facilities policy/procedure. Get everyone to “brainstorm”!

Ex: An in-service was held to review the deficiencies and inform/educate staff on the new Pain assessment tool, Medication policy and procedure, pain scale, prn medications. The orientation checklist was reviewed and all items were added to their orientation skills checklist. The DON met with the pharmacist re: the hospital formulary and 3 additional pain medications were added to address breakthrough pain. The DON and/or designee was and will continue to be responsible for these nursing areas. All changes were reviewed with and approved by the Medical Staff and Board of Directors. The QA coordinator is responsible for ensuring reports are completed and available for the Medical Staff and BOD meetings. The Hospital Administrator is responsible to ensure the designated staff complete their assigned reporting measures. (Date)

Almost done…….

4. Indicate how you plan to monitor your performance to make sure the solutions are sustained, correction is achieved, evaluated for effectiveness, and integrated into the quality assurance program.

- The PoC will be reviewed quarterly at nurses meetings to ensure continued understanding and compliance. Monitors for Medication administration, pain assessments and Pain documentation were developed and will completed on every staff nurse X 3 observations for each area to assure compliance, additional monitoring times will be done until 100% compliance is obtained and maintained by nursing staff; pain assessments, prn documentation and evaluation of effectiveness were added to the medical record audits and will be completed on all charts. Facility policies and procedures will be reviewed annually or as often as needed to ensure compliance and accuracy. Pharmacist will review the formulary and utilization of medications every quarter or as often as needed to assure adequate medications are on hand to address pain control; Department managers will report findings at monthly departmental meetings, and medical staff meetings; QA reports will be reviewed by the QA committee quarterly at a minimum or as often as needed to assure compliance. Nursing Staff evaluation forms will include standards of practice related to their licensure and be evaluated annually; Any concerns identified will be addressed immediately and monitored until 100% compliance is achieved. All departments QA have been added to the Facility QA plan and calendar and will be reported to the QA committee, Medical Staff, and BOD’s as often as necessary, but at least quarterly. The DON and/or designee is responsible for all nursing actions indicated above and will inform the Medical staff and Administration of any noncompliance by facility staff and pharmacy. The Administrator is responsible for reporting to the BOD’s and continued compliance is maintained. (Date)
LAST ONE to ADDRESS!!

- Include the dates when corrective action will be achieved.
- Address as soon as possible, but make sure you give yourself the time needed to correct the areas of concern. If you feel you are going to need additional time – contact your team leader/SHD and explain it in your plan of correction with the reasons why.
- Remember, the survey team will probably need to return and ensure compliance. Make sure you have done all that you indicated and be ready to show documentation/evidence of compliance as of the PoC date of correction, and for the entire period of time until they return and are assured you not only have achieved compliance, but that you CONTINUE to be in compliance. Make sure your survey team has enough days to do the survey too!
- Include your newly developed and any completed monitor forms and meeting agenda’s, minutes and attendance forms (plus whatever else you have accomplished) when you initially mail in your PoC for their review. Continue to complete monitors and meetings as indicated in your PoC, and make sure you have the documentation to show same when they return on site or request information to be mailed in.

REMEMBER

- The surveyors are on “your” side
- They want the same thing you do – quality care!
- The 2567 is NOT punitive – though when you are in the process of addressing the concerns, it sure feels like it!
- If you have a question – call them
- Celebrate your successes – keep your staff informed, and educate, educate, educate.
WHAT HAPPENS NEXT?

• Do a QA monitor on your PoC:
  – Have you provided a plan of correction for EACH deficiency listed?
  – Does each PoC show a completion date in the right hand column?
  – Is each plan descriptive as to how the correction will be accomplished?
  – Have you indicated what staff position will monitor the correction of each deficiency?

Aaahhh QA – don’t you love it?
Just about done…..

• Has the administrator or another authorized official signed and dated the first page of the Statement of Deficiencies?
• If you included attachments, have they been identified with the corresponding deficiency number or with a page number or something to indicate what area(s) of concern they apply to?
• Pictures are great, if appropriate!
• Keep a copy of everything you have sent in
• Send it to the right address and within the timelines indicated.
The PoC is done, Now what?

- Continue monitoring
- Your PoC will be reviewed in their office and don’t worry, you will be notified if they have any additional questions, or if they would like additional information
- An onsite revisit will be done, as applicable.
- You will be notified of your compliance or additional work that needs to be done.
- The Surveyors will work with you to get into compliance.

Where can you get help?

- Call the State Health Dept – contact your surveyors/team leader
- If you don’t want to reinvent the wheel and need some ideas re: policies/procedures/what other facilities are doing, contact the ND CAH Quality Network – they have a listserv
- If education/mentoring is needed, Contact the Center for Rural Health
- Don’t forget your neighboring CAH’s
- Check with your tertiary
Contact Information

• ND Dept. of Health; Division of Health Facilities: 701-328-2352
• ND CAH Quality Network: Jody Ward – 701-858-6729
• Center for Rural Health, CAH Quality Network Coordinator: Call Shawnda Schroeder : 701-777-0787

CONGRATULATIONS!

• QA→QI→PI…Today, Tomorrow, Future

• You not only have survived a survey …. But the work you and your coworkers have done and will continue to do, has or will have a MAJOR impact on EVERY patient who comes into your facility ….WOW!!
Any Questions?

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Thank you!