Survey Analysis for Evaluating Risk™ (SAFER™) Matrix

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Survey Analysis for Evaluating Risk (SAFER)

- A transformative approach for identifying and communicating risk levels associated with deficiencies cited during surveys
- Helps organizations prioritize and focus corrective actions
- Provides one, comprehensive visual representation of survey findings
- Replaces current scoring methodology

**Implementation: January 2017**

- Was implemented June 6th, 2016 for deemed Psychiatric Hospitals only
Current State

- Multiple different “taggings”
- Attempt to pre-determine risk through:
  - “Direct” versus “Indirect”,
  - “A” category vs. “C” category,
  - Measure of Success (MOS) sometimes required
  - Risk Icon sometimes applied
Problem

- Require extensive upkeep
- Can be confusing to customers
- At times are contradictory
- Creates a “one size fits all” approach
Solution

Develop one single, comprehensive method of categorizing the risk associated with standards.
IC.02.02.01 - The hospital implements infection prevention and control activities when doing the following:

IC.02.02.01, EP 4 - Storing medical equipment, devices, and supplies.

<table>
<thead>
<tr>
<th>Likelihood to Harm a Patient/Visitor/Staff</th>
<th>HIGH</th>
<th>MODERATE</th>
<th>LOW</th>
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<tbody>
<tr>
<td><strong>Proof of Concept</strong></td>
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<td><strong>Limbited</strong></td>
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<td><strong>Pattern</strong></td>
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<td><strong>Widespread</strong></td>
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<tr>
<td><strong>Scope</strong></td>
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</table>
| "A colonoscope used for the operating room was stored in an operating room cabinet with the tip of the colonoscope touching supplies stored in the bottom of the cabinet."
| "During an upper endoscopy procedure, a GI technician entered the endoscopy suite from the adjoining endoscope reprocessing room in order to place a processed endoscope into storage. This practice posed an unacceptable risk of cross-contamination. During an endoscopy procedure, the GI technician opened the endoscope storage closet to retrieve a CLOtest kit. This action had the potential to expose the stored endoscopes to aerosolized particles in the endoscopy suite."
| "During a building tour of the Imaging/Radiology Center and the Emergency Department, it was observed that, in all of the respiratory carts inspected, the oral airways were stored in bulk and not individually wrapped, thereby creating the possibility for cross-contamination."
| "In the supply room was one opened and partially used bottle of 0.9% normal saline used for dental irrigation. The bottle was not labeled with the open date, and the instructions on the bottle stated ‘discard unused portion’."
| "During the building tour in the pediatric area, the intake room and two examination rooms were observed. Located under the sinks in all three areas were multiple boxes of gloves at risk of damage from water."
| "During the building tour it was noted that in the radiology area there were several cardboard boxes on the floor that appeared to be water logged. In addition, throughout this entire facility there were other cardboard boxes stored directly on the floor at risk for water damage."
How is Risk Determined?

- Operational definitions and “anchors”
- Surveyor experience and expertise will provide the support to determine the “scope” and “likelihood to harm” for the finding
- Based on the context of the finding
- Discussion amongst the survey team
Operational Definitions

- Applied at the organization level
- Looks at the scope of patients impacted (or potentially impacted) by an issue of noncompliance
  - Shift from historical approach of “counting” observations
  - Now we want to assess the patient impact, or potential impact, of an issue(s)
Likelihood to Harm

**High:** Could directly lead to harm without need for other significant circumstances or failures.
- Likely

**Moderate:** Could cause harm directly, but more likely to cause harm as a contributing factor in the presence of special circumstances or additional failures.
- Possible

**Low:** Undermines safety/quality or contributes to an unsafe environment, but very unlikely to directly contribute to harm.
- Rare
## Scope

### Widespread: issue is “pervasive at the organization”
- Process failure/systemic failure
- Majority of patients are/could be impacted

### Pattern: issue has potential to “impact more than a limited number of patients”
- Process variation

### Limited: issue is a “unique occurrence”
- Outlier
- Not representative of routine/regular practice
Example #1 (Home Care Program)

In 3 of 8 records reviewed, the organization did not obtain orders for medical equipment provided to patients. For two patients receiving crutches and one patient receiving a walker, the patient record did not contain an order for the item provided. In discussion with Leadership, it was noted that there is a process to obtain an order prior to providing medical equipment to a patient, but it appears that in these cases the process was not followed.
Example #2 (Hospital Program)

In one record reviewed, the immediate post-procedure/operative note was written on a paper form without a date or time. The patient had a GI procedure and had been transferred back to the inpatient unit. The note was authenticated, however the lack of a date and time did not indicate when the activity occurred. The dictated full procedure note was not yet transcribed.
Example #3 (Behavioral Health Care Program)

During an observation in the organization's co-occurring disorders program, a male adult patient identified himself as being chronically depressed, with a history of multiple psychiatric hospitalizations for suicidal ideations and alcohol intoxication. The patient had lost friends, become socially isolated and verbalized suicidal intent. His record did not contain an assessment of his suicidal risk. No suicide precautions were in place to ensure the patient's safety. This was confirmed by administration.
In review of pain medication management for 3 out of 8 orthopedic hip patients, the documentation reveals that nurses are administering severe pain medication for moderate level pain scale ratings.

- In one record review, morphine IVP was ordered for severe pain but was administered for a pain scale rating of 6 (moderate pain).
- In the second record review, morphine was administered as choice #1 on EMAR when the EMAR physician orders noted Tylenol as first choice for moderate pain, Norco as second choice for moderate pain, Percocet as for severe pain, and Morphine as the last choice for severe pain.
- In the third record review the physician ordered 1-2 tablets of Norco for moderate pain, the nurse administered 2 tablets for mild pain.

Leadership acknowledged the need for nurses to administer pain medication as prescribed. Leadership also acknowledged that physicians should not order dose ranges of medication.
Example #5 (Laboratory Program)

One patient tracer revealed critically high Troponin and CKMB levels. There was no documentation in the medical record that these critical values were called in to the provider within one hour of the confirmation the results as required in the laboratory’s own policies and procedures for critical result reporting. The lab director confirmed that the results were not called in within the required timeframe for a critical value. The organization did have written procedures for the definition of critical results of tests and diagnostic procedures, timeframe for notifying providers and by whom and to whom critical results of tests and diagnostic procedures should be reported. The technician failed to report critical results in a timely manner as required by the organization’s policies and procedures.
A Picture is Worth 1000 Words…
Benefits of the SAFER matrix

- Focus on patient safety/risk to patients
- Risk analysis
  - Takes each finding to the next level – the “so-what?” as to why the finding is important
Benefits of the SAFER matrix (cont.)

- Visual representation of survey
  - Indicates severity of findings to organizations for prioritization
  - More clearly identifies the highest risks

- Aggregate data for standards refinement, improving consistency, etc.
NOTE: This is a sample report and the findings and placement of standards and elements of performance within the SAFER™ matrix do not represent findings or placement within the SAFER™ matrix for any future onsite events.
Where will SAFER be in the Report?

- Report Contents page
- SAFER Matrix Description page
- Survey Analysis for Evaluating Risk (SAFER) Matrix
- Likelihood to Harm and Scope designations for each EP
Executive Summary

Survey Analysis for Evaluating Risk (SAFER™)

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right.

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. *(Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.)* The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.
SAFER Matrix Description Page

SAFER$^{TM}$ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow-up. As the risk level of a RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

All Evidence of Standards Compliance (ESC) forms, which outline corrective actions, will be due in 60 days. For those findings of a higher risk, two additional fields will be required within the ESC for the organization to provide a more detailed description of leadership involvement and preventive analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

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<tr>
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<th>Required Follow-Up Activity</th>
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<td>- ESC will include Who, What, When, and How sections</td>
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SAFER Matrix
Element of Performance Likelihood to Harm and Scope Designations

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.03.05

Standard Text: The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment of features exists within the building, then the follow maintenance, testing, and inspection requirements apply.

Element(s) of Performance:

19. Every 12 months, the hospital tests automatic smoke-detection shutdown devices for air-handling equipment. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems, 1999 edition (Section 4-4.1).

Likelihood to Cause Harm: High
Scope: Widespread

Observation(s):

EP 19
Observed in Building Tour at ABC Medical Center (123 Anywhere Street, Somewhere, IL) site. At the time of the survey there was no record of the hospital’s automatic smoke-detection shutdown devices for air-handling equipment being tested.
Post Survey Follow-up
Follow-up Actions

- Follow-up **customized** and **prioritized** according to placement within SAFER Matrix
## Prioritized Follow-up Action

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  Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey |
| **MODERATE / LIMITED, LOW / PATTERN, LOW / WIDESPREAD** | • 60 day Evidence of Standards Compliance (ESC)  
  - ESC will include Who, What, When, and How sections |
| **LOW/LIMITED** | • 60 day Evidence of Standards Compliance (ESC)  
  - ESC will include Who, What, When, and How sections |
ESC Changes

- All Requirements for Improvement (RFIs) due in a 60 day ESC
  - 45 day ESC no longer applicable
- All findings will require an ESC
  - OFI section of the report no longer applicable
- Findings of higher risk will require 2 additional ESC fields
Current ESC Fields

- WHO
- WHAT
- WHEN
- HOW

*These are required for all RFIs cited during the survey
New ESC Fields

- Only for findings cited within the higher risk areas (dark orange and red areas of SAFER matrix)

- Includes 2 new fields:
  1. Leadership Involvement
  2. Preventive Analysis
Leadership Involvement

- The measure of the success of change is in its sustainability within organizations.
- Success and sustainability are highly influenced by support from the top level of leadership.
Leadership Involvement - ESC

In order to achieve the goal of reducing risk, which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

- President
- Chief Executive Officer
- Vice President
- Chief Quality Officer
- Chief Medical Officer
- Chief Nursing Officer
- Chief Operating Officer
- Medical Director
- Director of Nursing
- Facilities Director
- Director of Clinical Services
- Other

Please describe how the above leadership involvement is helping to sustain compliance with this Element of Performance in the future.

For example: “Our Chief Quality Officer directly participated in meetings where Infection Control Policy #123 was revised and approved. The Chief Quality Officer is serving as the champion for implementing the revised policy, including communicating the changes to leadership across the organization and establishing a monitoring system to ensure all staff are educated on the policy. Additionally, as part of the Chief Quality Officer’s monthly leadership meeting, a standing agenda item will be added related to compliance with the revised policy.”
Preventive Analysis

- Ensures the corrective action does not simply fix the issue at hand
- Focuses on identifying and addressing underlying reasons that caused the issue
- Efforts also focused on preventing future occurrences of the high risk issue
Preventive Analysis - ESC

What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution) but also any underlying reasons for the failure were addressed as well?

Example: "A group of staff including members from the quality improvement team, infection control and nursing met to discuss and understand why the hand hygiene compliance program was not effectively being implemented. It was determined that there had been numerous staff changes over the past year, leading to inconsistent responsibility for the program. Moving forward, there will be two co-owners for the program – one from nursing and one from infection control. This will help ensure consistency and continuation of the program in the event of future staff turnover."
What does this mean?
Beginning January 2017

- SAFER implemented for all accreditation and certification programs
- No more Direct and Indirect EP designations
  - Consolidated ESC into one 60-day timeframe
- No more A or C categories
  - No more Opportunities for Improvement (OFIs)
  - No more Measures of Success (MOS)
Beginning January 2017

For all surveys:

- The SAFER matrix will be implemented for the organization as a whole (including tailored programs)
- The SAFER matrix will be generated and embedded within the survey process and the final report
- Matrix data will be shared with the customer
- Matrix data will drive the updated post-survey process
What is NOT Changing?

1. Adverse decision process
2. Immediate Threat to Life process
3. Determination of Condition Level Deficiency (CLD) process (applies to those using TJC for deeming purposes)
4. Onsite survey activities utilized during survey (i.e. Tracer Methodology, Record Review, etc.)
How do I prepare?

Preparing for a SAFER survey is the same as preparing for a survey today:

1. Ensure full understanding of requirements
2. Continue conducting self-assessments of compliance
3. “Practice” placing findings (perhaps findings from previous surveys) on the SAFER matrix
What have we learned so far?

- Implemented June 6th, 2016 for deemed psychiatric hospitals:
  - Surveyor feedback
  - Organization feedback
Resources
## Resources Available

### Extranet Site:

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<th>Pre-Survey</th>
<th>Post-Survey</th>
<th>Customer Feedback</th>
<th>Contracts and Billing</th>
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<tr>
<td>- Survey Planning Tools</td>
<td>- Evidence of Standards Compliance</td>
<td>- Evaluations</td>
<td>- Contracts</td>
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<tr>
<td>- Survey Activity Guide</td>
<td>- Measure of Success</td>
<td>- Customer Value Assessment</td>
<td>- Fee, Billing and Invoice Information</td>
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<td>- Accreditation Report and Letter</td>
<td>- Customer Value Assessment</td>
<td>- Pricing Schedule</td>
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<td>- General Application</td>
<td>- Intracyle Monitoring (ICM)</td>
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<td>- What’s New in Quality Report</td>
<td>- Lab Application</td>
<td>- Statement of Conditions</td>
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<td>- Organization Commentary</td>
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<td>- Lab Central Connect®</td>
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<td>- Individualized Quality Control Plan</td>
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<td>- Corporate Portal</td>
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Extranet Site Documents

- Leave Behind Document
- May *Perspectives* article
- October *Perspectives* article
- FAQs
- Blank SAFER matrix in PowerPoint document
- SAFER elevator speech
- Sample Report
- Webinar replay
- October 18th Webinar
- ESC Instructions and FAQ
Questions?

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