

2022

## Evaluation of Action Plan Management Strategy to Improve Survey Readiness and Decrease Negative Accreditation Findings

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# Walden University

College of Nursing

This is to certify that the doctoral study by

Carla Smiley Pierson

has been found to be complete and satisfactory in all respects,  
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Walden University  
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Abstract

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Decrease Negative Accreditation Findings

by

Carla Pierson

MBA, Western Governor's University, 2017

MSN, Austin Peay State University, 2015

BSN, Shorter University, 2012

Project Submitted in Fulfillment  
of the Requirements for the Degree of  
Doctor of Nursing Practice

Walden University

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## Abstract

This project was an evaluation of a quality improvement (QI) initiative conducted in a large medical enterprise to address the problem of poor performance of their hospitals in accreditation surveys. The desired outcome was to evaluate whether an innovative plan of correction process was impactful in reducing the negative outcomes of regulatory and accreditation surveys. The practice-focused question guiding this project addressed the effect of the pre-accreditation evaluation and a plan of correction process in this QI initiative on reducing requirements for improvements (RFI) and condition-level deficiencies (CLD) cited in a recent The Joint Commission survey review. This project was grounded in Kotter's model for change. Comparative analyses of sets of RFI and CLD data obtained from the reports produced after the surveys measured differences in accreditation outcomes prior to and after the implementation of the plan of correction process. Of the hospitals that participated in the QI initiative through the 30-day plan of correction call, two (13%) received at least one CLD, compared to all six (100%) of the hospitals that did not participate. The number of RFIs for the facilities who completed at least through the 30-day call were significantly lower ( $p = .017$ ) than the number of RFIs in facilities that did not. This project will help guide hospital leadership to make informed preparations for improved regulatory and accreditation outcomes. Improved accreditation outcomes will indicate enhanced patient safety, positive patient outcomes, and a higher quality of patient care.

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## Section 1: Nature of the Project

### **Introduction and Problem Statement**

Preparation for regulatory and accreditation survey activity is a challenge. There are internal processes in some health systems to help facilities prepare for these types of surveys. A gap in knowledge remains regarding how to maintain survey readiness between the time of the internal survey or preparedness strategies and the actual regulatory or accreditation visit. The Centers for Medicare and Medicaid Services (CMS) is a federal regulatory agency that provides oversight for quality of care for all US hospitals who receive Medicare and Medicaid funding. This means hospitals who accept patients who carry Medicare or Medicaid as their insurance, which is approximately 61.4 million Medicare (Parts A and B) users and 75.8 million Medicaid users, must meet the conditions of participation mandated by CMS (2020) to receive reimbursement for the care provided.

The CMS requires a hospital carry an accreditation from one of ten organizations, such as The Joint Commission (TJC; Center for Clinical Standards and Quality/Quality, Safety, & Oversight Group, 2018). Clinical care is heavily evaluated throughout the accreditation survey process. Nursing is one of the focal points of any accreditation survey, as nursing is responsible for providing direct patient care. Nurses are expected to participate in the survey process and nurse leaders are responsible for action plans resulting from any findings in their specific areas.

An accreditation visit, or survey, can happen at any time of day, or any day of the week, and it is the hospital leadership's responsibility to be continually prepared for a

survey, whether announced or unannounced, to occur. Nurses, especially new graduates, report feeling unprepared related to accreditation surveys (Campbell & Leger, 2020). Often, the nursing staff receive little warning of a survey commencing, as they are unannounced in most cases (TJC, n.d.). The stress of suddenly having to recall information and data that may not be used daily can be stressful for nurses and, because surveys happen on the actual units in the hospitals, nurses are in the midst of patient care and managing a patient load when being surveyed. Surveyors prefer to speak to the nurse who is caring for a patient they are tracking or speak to frontline staff about what they know of policies and procedures (TJC, 2020). As a result, implementing a quality improvement (QI) project to improve survey and visit readiness is warranted.

A large healthcare corporation with many hospitals, the setting for this project, uses TJC as the accrediting body for all its hospitals located in the United States. A process has been in place for decades for an internal corporate team to perform an initial survey before an impending TJC survey or visit to ensure compliance with basic accreditation standards and recommendations. This internal team is highly trained in CMS conditions of participations, TJC standard, state laws and statues, and local rules and regulations. Until recently, each hospital was responsible for developing an action plan or follow-up after this initial internal review to help correct accreditation deficiencies before the TJC visit or survey. The problem that led to a QI initiative for this group of hospitals was related to the number of deficiencies in regulatory requirements found despite the establishment of action plans implemented before the TJC visit. As a result, a new plan of correction process QI initiative was implemented to improve

preparedness for TJC accreditation survey with anticipation of a reduction in the number of requirements for improvements (RFIs) and condition-level deficiencies (CLDs) as cited by TJC during triennial surveys at facilities. The gap in knowledge was the lack of an evaluation of this QI initiative. The QI project is patient safety focused, as it is related to TJC; therefore, nursing plays a large role in the plan of correction, but the initiative is not limited to nursing and encompasses all areas of a hospital.

### **Purpose Statement**

The purpose of this DNP project was to evaluate the corporate QI initiative by comparing the results of accreditation surveys for facilities who went through the plan of correction process to those that did not. The reason for comparing the two is to evaluate if the new plan of correction process had an impact on outcomes from the TJC triennial survey. The TJC reports released for each facility were used to aggregate the overall data associated with the total facilities.

### **Practice-Focused Question**

The practice-focused question guiding this project was:

PFQ: What is the effect of a preaccreditation evaluation and plan of correction process QI initiative on reducing RFIs and CLDs cited in a TJC survey review?

### **Nature of the Doctoral Project**

There are 186 hospitals owned and operated by the hospital corporation where this QI initiative has been implemented. There are 22 hospitals that have completed the entire plan of correction process and subsequently completed their triennial TJC survey as of this writing. The QI process itself is still ongoing and this project will be an

evaluation of the 22 current facilities that have completed an internal survey and then completed their triennial TJC survey. The data were used to compare the number of TJC RFIs and CLDs from the triennial TJC surveys of the hospitals who have completed the plan of correction process with those who have not participated in the plan of correction process. There also was a comparison of cycle over cycle for the hospitals who have completed the QI initiative during this triennial cycle. The internal triennial survey team's metrics for success are directly related to the number of RFIs and CLDs cited by TJC for each facility.

When the internal triennial survey team arrives 6 to 9 months prior to the due date of the TJC triennial survey, a report of deficiencies of evaluated items are left for the facility to address. These findings are summarized in the internal report under the headings of major, important, and general findings. Depending on the number of findings, the burden on each facility is to correct these findings before the impending TJC visit and ensure consistent, sustainable solutions are put into place for what could be dozens of citations is the connection to the project. The major findings align directly with known CLDs reported by TJC during triennial surveys. These findings are considered the highest risk to patient, visitor, and staff safety.

If TJC arrives and the same findings from the internal survey are cited on the TJC survey or a CLD is cited, a resurvey must ensue and the entire process of the action plan, including what the facility did to correct the original findings from the internal survey, is explored by the highest levels of the corporation. Often times, due to the overwhelming nature of the internal survey and findings, not all findings are addressed in a timely

manner. Implementation of the plan of correction process not only helps ensure all findings are addressed, but it reduces the burden of the facility in managing the overall process.

When TJC arrives for an onsite facility visit, it is only then some of the barriers to correcting the internal survey findings have been discovered. For example, if a fix to an internal air handler is needed to correct pressure issues in the operating room suites, that fix could cost upwards of \$50,000 and trigger a capital expenditure. Without oversight and support from leadership, these requests often are missed or overlooked in terms of importance at a higher level due to the number of requests that come from many facilities. The new initiative corrects this situation by prioritizing expenditures needed for resolving accreditation issues and removing barriers to correction. This is just one example of a barrier overcome by implementing the QI initiative.

### **The Preaccreditation Evaluation and Plan of Correction Process**

After each internal preparation survey conducted by a trained team from the corporate office, a report is given to the facility. These surveys are completed by the same internal team every time, with little variation from hospital to hospital. Due to the pandemic, recent surveys have been performed virtually, and several hours are now dedicated to COVID-19 prevention practices in the hospital and the degree to which the facility has aligned with the overall corporate and Centers for Disease Control and Prevention guidelines. The virtual aspect has not changed the format or survey function. Instead of being onsite, someone simply is required to use a virtual viewing application

and escort the surveyor virtually around to the designated locations. All aspects of the survey have been vetted and approved for safety and protection of sensitive information.

A defined plan of correction timeframe (14-, 30-, 60-, and 90-day marks) and expectations were set with the facility as part of the final report from the internal preparation survey. By the 14-day mark postsurvey closing, the facility has completed a plan of correction for the most important, or major, findings from the survey. The set time periods are marked by a plan of correction call. During each plan of correction call, barriers to resolution of the findings are discussed and ideas for improvements and best practices from other sister facilities are shared. In addition, data from implemented audits are evaluated and analyzed as part of the plan of correction to ensure internal reliability of improvements. Action plans and audits are uploaded into a shared team room for any necessary analysis and for accountability purposes. Further validation of the audits and data also occurs as part of the plan of correction process through virtual or onsite “check-in” surveys reviewing specific elements of the action plan. The entire plan of correction process is supported by the enterprise team, and assistance with leading practices, capital requests, and other issues is given. For example, a capital request might take months on a noncritical issue, but through this process, if identified as a high-risk to the accreditation process, capital requests are expedited through higher-level leadership.

### **Sources of Evidence**

Some of the key sources of evidence used for evaluation of the project included TJC reports from the facilities from their last two surveys. These reports included the findings and the standards to which the findings are associated from each facility. For

example, if a requirement was for a fire extinguisher to be within a certain distance from an operating room, the finding in the report would cite this standard, and then describe exactly where the extinguisher was in relation to an operating room.

### **Approach or Analyzing Data**

The approach to completion of this project was to analyze the number of RFIs and CLDs cited by TJC during triennial surveys at facilities who have been surveyed by the internal triennial survey team and underwent the 90-day plan of correction process described above and compare those findings to those that did not go through or complete the process. This included comparing the same group of hospitals from one cycle to the next against their own outcomes, as well as comparing two groups of hospitals within the current triennial cycle. The percentage of facilities who received one or more CLDs and did not complete the plan of correction process was compared to the percentage of facilities who did not receive a CLD and who did complete the plan of correction process. Comparisons were made between facilities in the same triennial cycle year as well as cycle to cycle against their own outcomes. Comparisons between the two sets of data using the Excel program to calculate *t* tests, was the method for comparing the number of RFIs from the facilities that did not participate in the plan of correction process to those that underwent the same internal survey but did not go through a plan of correction process in prior years. RFIs are any findings of any severity or pattern of occurrence from a TJC accreditation survey. TJC typically follows a “see-it-cite-it” pattern of surveying; therefore, RFI counts can be high. CLDs can be one single finding or a combination of RFIs that pose a high risk and/or pattern of occurrence to patient, visitor, or staff safety.

RFI and CLD data were obtained from the TJC reports that were released to the company once a survey was finalized. I performed all data analyses.

### **Significance**

By positively influencing regulatory and accreditation outcomes, patient safety is improved. This is beneficial to patients, healthcare workers, executive leaders and board members, and the overall health of the community. For nursing practice, gaps in the process or practice associated with a lack of regulatory or accreditation compliance puts the profession at risk for patient harm. Identifying these issues and gaps helps to guide nursing practice to better evidenced-based practice processes and overall better quality of care. The stakeholders involved in this project are inclusive of every member of the healthcare organization and the patients they serve. The gap is the lack of evaluation of effectiveness of the QI project.

### **Social Change**

The root of the mission of TJC (2020) is to improve healthcare through quality of care evaluation. Ultimately, any project that improves outcomes at a healthcare organization from a clinical, regulatory, accreditation, or experience perspective is promoting positive social change. By maintaining standards based on evidence and research and monitored by accreditation agencies, high quality healthcare is provided to the communities served. The process of accreditation contributes to healthier populations, which promotes positive social change due to better and stronger workforces, healthier and happier populations, and less burden on the healthcare system overall.



## Summary

Regulatory and accrediting bodies serve to protect the public. Their mission is to help guide hospitals in providing the safest patient care possible. Participation in the accreditation process is an integral part of nursing and leadership. Regulations, standards, and rules change frequently as new information or concerns arise, and it is important to stay abreast and prepared for these changes and the arrival of an external surveying team. The implementation of a plan of correction process after an internal survey to improve accreditation preparedness and outcomes was the QI initiative being evaluated for this project. The next section will describe the background, model, and relevance of this project to nursing practice.

## Section 2: Background and Context

### **Introduction**

Regulatory and accrediting bodies exist to make certain that safe, effective, and quality patient care is provided by all healthcare providers. Providing readiness for the surveys performed by these bodies helps to ensure patient safety is integrated and engrained into all care and processes in a hospital. The purpose of this DNP project was to evaluate the corporate QI initiative by comparing the results of accreditation surveys for facilities that went through the plan of correction process to those that did not. The desired outcome of the initiative was improvement in the number of RFIs and CDLs cited by accreditors after a scheduled visit. This section focuses on the background and context of the project, the relevance to nursing and the role of the doctoral student in this project. The practice-focused question guiding this project was:

PFQ: What is the effect of preaccreditation evaluation and plan of correction process QI initiative on reducing the number of RFIs and CLDs cited in a TJC survey review?

### **Concepts, Models, and Theories**

The overwhelming key to change is not as much the implementation of the change, but the sustainability of that change over time (Kotter, 2012). Literature has shown engagement in the change is critical and required for sustainability (Mohiuddin & Mohteshamuddin, 2020). For this doctoral project, the model that grounded the QI initiative and this evaluation project was Kotter's model for change (Kotter, 2012). This model has been used successfully in relation to gaining accreditation in a healthcare

setting previously (Kuo & Chen, 2019). The model consists of eight steps to guide change, and it can be applied in many settings (Kotter, 2012). The steps include (a) creating a sense of urgency, (b) building a guiding coalition, (c) forming a strategic vision and initiatives, (d) enlisting a volunteer army, (e) enabling action by removing barriers, (f) generating short-term wins, (g) sustaining acceleration, and (h) instituting change (Kotter, 2007). It is around this model the QI initiative and subsequent evaluation was based.

For this project, the first step, which is noted as key by Kotter (2007), was the most critical to the overall plan of correction process. Instilling in the various organizations at the highest level a sense of urgency and importance related to continual survey readiness was a key factor in the overall project's success. While the other steps are important, evoking authority as the steps continue throughout the process helps ensure change and compliance with the overall process, thus driving results. The first step in the process model of change was successfully implemented at the senior leader level for the QI initiative, allowing the remaining steps to proceed.

The second step in the process, creating a strong guiding coalition, was reflected in the support process of the plan of correction, that is, from the leader of the plan of correction process in guiding change. This step ensured the process was on track and the leader embodied a project manager sort of role to push the overall process forward and accelerate change (Kotter, 2007). This role also ensured any changes implemented fell within acceptable regulations and policies. In addition, this step highlighted the support and engagement from all levels of leadership throughout the process to continue to push

forward the overall plan of correction process through the 90-day period. As Kotter (2012) noted, failure in this step often occurs when leaders do not recognize teamwork as a major step in organizational change.

The 3rd, 4th, and 5th steps in Kotter's (2007) model for change describe creating, communicating, and acting on a vision. The purpose of this project was to evaluate the plan of correction process, which was important to developing a vision of the future and being able to articulate this vision to the frontlines. Engaging the frontlines with a clear vision is key, as Kotter (2012) notes, to the successful implementation of a new quality initiative. If stakeholders cannot picture where the end goal is or where something is headed, the project often will fail (Kotter, 2007).

The 6th, 7th, and 8th steps in the model, in relation to this project and the overall plan of correction process, describe future actions to continue the evaluation and improvement of the plan of correction process (Kotter, 2007). Adapting and adjusting the process through continuous evaluation was important to the overall change. Connecting the successes with the process was an important part of engraining the behaviors and truly promoting permanent change (Kotter, 2007). This model was used to guide the evaluation project to ensure each step of the model was represented in the QI initiative and the evaluation process and will help guide ongoing evaluations in the future, identifying both strengths and weaknesses in the QI initiative.

### **Terminology**

Throughout this project, several terms are used in acronym form. The table below defines commonly used terms throughout the project paper.

**Table 1***Common Acronyms*

Term/acronym	Definition
TJC	The Joint Commission: The accrediting agency who performs the triennial accreditation surveys
QI	Quality improvement
RFI	Requirement for improvement: A type of finding from The Joint Commission that is any violation of a standard of care found on a survey
CLD	Condition-level deficiency: A type of finding from The Joint Commission that can be a single or multiple, bundled RFIs that pose a higher risk to patient, staff, or visitor safety.

**Relevance to Nursing Practice**

An accreditation visit, or survey, can happen at any time of day or any day of the week, and it is the hospital leadership's responsibility to be continually prepared for an unannounced survey visit to occur. Nurses, especially new graduates, report feeling unprepared related to accreditation surveys (Campbell, & Leger, 2020). This all relates to the project at hand and the QI initiative as the internal survey process and plan of correction process were all intended to help prepare nurses and staff for the official accreditation visit. Often, the nursing staff receives little warning of a survey commencing, as surveys are unannounced in most cases (TJC, n.d.). The stress of suddenly having to speak to specific details of policies and procedures is intense for nurses, and because surveys happen on the actual units in the hospitals, nurses are in the midst of patient care and managing a patient load when being surveyed. Surveyors prefer to speak to the nurse who is caring for a patient they are tracking or speak to frontline staff about what they know of policies and procedures (TJC, 2020). Clinical care is

heavily evaluated throughout the survey process. Nursing is one of the main focal points of any survey, as nurses provide the most direct patient care. Nurses are expected to participate in the survey process and nurse leaders are responsible for action plans resulting from any findings in their specific areas. Ultimately, a successful accreditation visit means patients are being cared for at a high level of quality and safety; therefore, this is the bedrock of relevance for the overall project. As a result, the corporation implemented a QI project to improve survey and visit readiness.

Previously, there were no official or standardized strategies, policies, or procedures in place to address the problem described in any of the dozens of hospitals represented by this corporation. As mentioned previously, after the internal survey process was completed, there was no follow-up or resources given to help the facility correct the issues with best practices from around the enterprise, nor was there any structure of accountability to ensure the issues were corrected. This lack of follow-up led to repeat findings from the internal survey on the regulatory and accreditation surveys, which ultimately meant patient safety and quality of care remained at a risk.

### **Local Background and Context**

The CMS is a federal regulatory agency that provides oversight for quality of care for all US hospitals that receive Medicare and Medicaid funding. This means to receive reimbursement for care provided, the hospital must meet the conditions of participation mandated by CMS (CMS, 2020). CMS requires a hospital to participate in or conduct an accreditation from one of 10 organizations, such as TJC (Center for Clinical Standards and Quality/Quality, Safety, & Oversight Group, 2018).

Until recently, each hospital was responsible for developing an action plan or follow-up after this internal review to help correct deficiencies. Highlighting gaps in appropriate processes as they relate to survey readiness and preparation has been successful for the project site for many years; however, follow-up and implementation of the resulting action plans has been inadequate. The gap addressed by this project was the lack of evaluation of the effectiveness of this QI intervention. For example, when deficiencies have been identified, the issue has not been addressed because of a breakdown in communication with staff, failing to include them in planning for needed change. This was evidenced by the same findings from the internal survey appearing on the TJC survey report and a lack of awareness of staff regarding the action plan. As a result, the corporation implemented a QI project to improve survey and visit readiness at each hospital at the local level.

### **Role of the Doctor of Nursing Practice Student**

As a member of the regulatory and accreditation team for the corporation, I was invested in this project overall. I was a consultant nurse surveyor who travels to facilities to survey TJC standards and CMS conditions of participation. In the past, the team has spent a full week in a facility examining every issue and leaving the facility with a comprehensive, detailed report that was considered a guide to a successful accreditation survey visit and report. The failure was the follow-through with this information and the follow-through with any action planning associated with it. The internal triennial survey team schedules a survey for each facility within 6 to 8 months of their triennial TJC due date. Between the time of the internal survey and the arrival of TJC, correcting and

maintaining the discovered deficiencies was difficult. The new QI initiative was expected to improve follow-through with action planning with each facility responsible for implementing the action plans until issues are resolved.

My role in the doctoral project was to gather the data associated with the outcomes of TJC accreditation surveys for those facilities who have completed the entire plan of correction. I work for the corporation for which the project is being evaluated, and I was a member of the department and team who designed and implemented the plan of correction process across the enterprise, giving me a thorough understanding of the expectations of the initiative. I was given access to the outcomes data for each facility, which I analyzed. Much of the outcome data was quantitative in nature, making it easy to determine the progress toward the project goals.

### **Summary**

With little time to prepare for an accreditation survey, a plan has to be in place to be continually survey ready. The struggle for hospitals lies in the constant changes in regulatory and accreditation standards and staying up-to-date on these important patient safety standards. An internal survey process helps nursing and leadership prepare for the upcoming accreditation survey with a trial run. A follow-up plan of correction process helps guide leadership and nursing in the changes that need to be made in order to provide the safest care possible as defined by regulatory and accreditation standards. Ensuring a facility, including nursing, has the tools and resources needed to provide the safest possible care is critical to the success of this QI initiative. In the next section, I



describe the sources of evidence and data and the methods for analysis and synthesis of this data.

## Section 3: Collection and Analysis of Evidence

### **Introduction**

This DNP project was designed to address the problem of lack of readiness of the facility for accreditation. Ensuring readiness for the surveys performed by regulatory and accrediting bodies only helps to ensure patient safety is integrated and engrained into all care and processes in a hospital. Section 2 focused on the background and context of the project, the relevance to nursing, and my role as the doctoral student in this project. The model used to inform this project was Kotter's (2012) model for change. In this section I describe the overall scope of the project, the practice-focused question, and sources of evidence analyzed.

### **Practice-Focused Question**

The practice-focused question guiding this project was:

PFQ: What is the effect of preaccreditation evaluation and plan of correction process QI initiative on reducing RFIs and CLDs cited in a TJC survey review?

The purpose of this DNP project was to evaluate the corporate QI initiative by comparing the results of accreditation surveys for facilities that went through the plan of correction process to those that did not. In this project I sought to analyze the difference in the number RFIs and of CLDs from the TJC accreditation visit for those hospitals that have undergone the complete plan of correction process as defined earlier. By analyzing the differences in the number of RFIs and CLDs, the effectiveness of the overall QI project was evaluated.

The operational practice-focused question pertinent to the project was as follows:

PFQ: Were the numbers of RFIs and CLDs identified by accreditation visits lower in facilities that have participated in the QI initiative?

This was the primary question the final evaluation attempted to answer in relation to the QI project.

### **Sources of Evidence**

The approach to completion of this project was to analyze the RFIs and CLDs cited by TJC during triennial surveys at facilities that had been surveyed by the internal triennial survey team and that had undergone the 90-day plan of correction process described. The number of CLDs that were collected from these reports were captured on a spreadsheet to facilitate comparisons of key measurements, including counting the number of RFIs and CLDs identified before and after implementation of the correction plan. Anecdotally, actions taken were explored when and if plans of correction were not successful. Identifying both patterns within and across facilities where the QI project was successful and noting factors that could improve the process in the future in facilities where it was not successful also contributed to the data. The data was organized by facility identified by code, the number of RFIs, then CLDs in a table format.

### **Archival and Operational Data**

The previous number of CLDs from TJC accreditation surveys also was used as part of the evidence for the doctoral project. I used this evidence to compare the number of RFIs and CLDs in current TJC survey reports to prior year TJC surveys when a plan of correction process was not in place. These reports, which are a part of the normal operational data for the company, were analyzed as part of this project. The data was

from the years 2017-2021. The data originally was collected as part of a report from TJC's triennial survey process, which is validated by the CMS. This operational data is available to all employees and facilities as part of a transparent culture of patient safety. Access has been approved by the vice president of regulatory and accreditation services and through the appropriate enterprise channels. No specific facility or details of the RFIs or CLDs were included in the analysis of the project or in the project report or summary.

Regarding ethical concerns, there were no human subjects as a part of this project. The data from facilities, although sensitive to individual facilities, was deidentified. This study required Institutional Review Board approval from Walden University (approval number 10-06-21-0995354). The reports from TJC are confidential, but the only data used for each facility were the total number of RFIs and CLDs cited for a given year. No facility was identified and codes were used in place of names. The release of information was approved through the external data release process for the enterprise, which is a robust process of approval by which the enterprise vets through its own internal review board for the release of any data and its purposes.

### **Analysis and Synthesis**

I compared two sets of data to measure any impact of the QI initiative on the numbers of RFIs and CLDs cited by TJC. First, the two sets of data compared were the number of RFIs and the presence of a CLD cited by TJC during the most recent TJC survey for those facilities who completed the QI imitative plan of correction to those who did not. I calculated differences for the total number of facilities in each of the two groups. I used a one-tail analysis to measure the significance in the reduction of RFIs and

between the two groups. For CLDs, a comparison of the percentage of facilities who received a CLD was compared to the number who did not in each of the groups.

A second analysis compared the number of RFIs and CLDs cited by TJC during the most recent TJC visit to those facilities that completed the QI initiative plan of correction and the most recent visit previous to implementation of the QI initiative. I used a one-tail analysis to measure the significance in reduction of RFIs between the two groups. The tool that I used to analyze the data was the Excel application. Various *t* tests were the methods used to compare the data sets. For CLDs, a comparison of the percentage of facilities who received a CLD was compared to the number who did not in each of the groups.

I obtained RFI and CLD data from the TJC reports that were released to the company once a survey was finalized. Anecdotal data regarding success factors or improvement factors was discussed as well through the plan of correction process during each call. The calls were designed to improve communication between different levels of the facility and at the local, division, and enterprise level. By keeping communication channels open, information regarding barriers such as financial needs, accountability and performance opportunities, and other operational barriers were discussed and best practices from other calls and facilities shared.

### **Summary**

Availability of historical and recent data allowed completion of the evaluation of the QI project. By gathering the number of RFIs and CLDs from facilities that have gone through the QI project or plan of correction process associated with the internal survey, I

made comparisons to determine statistically significant differences. These differences were the evidence supporting the success or failure of the plan of correction process implemented by the corporation to improve accreditation outcomes. Identification of factors leading to success and opportunities for further improvement also provided evidence of the success of the overall project. In the next section, I present the findings and recommendations from the completed evaluation of the QI project.

## Section 4: Findings and Recommendations

### **Introduction**

This DNP project was designed to address the problem of lack of readiness of the facility for accreditation. Ensuring readiness for the surveys performed by regulatory and accrediting bodies only helps to ensure patient safety is integrated and engrained into all care and processes in a hospital. The purpose of this project was to evaluate a QI project to measure the effectiveness of a plan of correction process implemented across a healthcare system. The metrics used to determine effectiveness were the numbers of RFIs and CLDs cited by TJC after scheduled survey visits. The practice-focused question guiding this project was as follows:

PFQ: What is the effect of preaccreditation evaluation and plan of correction process QI initiative on reducing requirement for improvements (RFI) and condition level deficiencies (CLD) cited in a TJC survey review?

### **Sources of Evidence**

RFI and CLD data were obtained from the TJC reports that were released to the company once a survey has been finalized. Descriptive statistics were used to measure the difference in the number of RFIs between facilities. Comparisons of percentages were used to analyze the difference in CLDs. RFIs are the standard findings from TJC and include any finding during the triennial survey. CLDs are findings that pose a higher risk to patient safety and can be one RFI deemed high-risk or multiple RFIs bundled together. Anecdotal data regarding success factors or improvement factors were gathered through discussion throughout the plan of correction calls. The sets of data that were analyzed

utilizing a *t* test in the SPSS system were the number of RFIs from facilities from the current TJC survey cycle versus the number of RFIs from facilities in the previous TJC survey cycle for those facilities who have completed the described 90-day plan of correction process. For CLDs, the percentage of facilities who received a CLD who went through the plan of correction process was compared to the percentage of facilities who received a CLD and who did not go through the plan of correction process. Also, the same data was compared in facilities that did not go through the QI initiative and those that did in the current TJC cycle.

### **Findings**

Since the implementation of the plan of correction process through the data collection period, a total of 22 hospitals have completed their 2020/2021 triennial survey by TJC. Of those 22, 12 completed the full plan of correction process. Eleven hospitals of the 12 were included in the comparison data presented in Table 2, which includes the number of RFIs and number of CLDs for each hospital for each cycle. One hospital was omitted when comparing same group cycle over cycle outcomes due to the fact it was not TJC accredited last cycle. That facility was included in the current cycle, two group outcome data comparisons.



**Table 2**

*Comparison of Hospital Outcomes From 2017/2018 Cycle to 2020/2021 Cycle*

2017/2018 Cycle			2020/2021 Cycle		
Hospital	RFIs	CLDs	Hospital	RFIs	CLDs
A	39	2	A	28	0
B	34	0	B	36	2
C	37	1	C	38	0
D	31	0	D	33	0
E	19	0	E	51	0
F	44	1	F	15	0
G	24	0	G	24	0
H	35	1	H	32	0
I	43	0	I	5	0
J	27	1	J	48	0
K	33	0	K	40	0

I performed paired samples  $t$  test on the 11 facilities that completed the plan of correction process. One test compared the number of RFIs from the prior TJC accreditation visit (2017 and 2018 cycle) to the number of RFIs from the most recent cycle (2020 and 2021). The results of this test are listed in Table 3.

The results of the paired sample  $t$  test comparing the RFIs cycle over cycle shown in Table 3 was not significant ( $p = .40$ ). The average number of RFIs from the 2017/2018 cycle was 33.2 compared to 31.8 for the 2020/2021 cycle. Of note, many of the hospitals saw an increase in the number of RFIs from cycle to cycle.

**Table 3**

*Paired Samples t Test Comparing Requirements for Improvements from 2017/2018 Cycle to 2020/2021 Cycle*

*t* test: two-sample assuming equal variances

	<i>2017/2018 RFI</i>	<i>2020/2021 RFI</i>
Mean	33.27272727	31.81818182
Variance	59.41818182	183.1636364
Observations	11	11
Pearson Correlation	-0.713606633	
Hypothesized Mean Difference	0	
Df	10	
t Stat	0.243821997	
P(T<=t) one-tail	0.40614898	
t Critical one-tail	1.812461123	
P(T<=t) two-tail	0.81229796	
t Critical two-tail	2.228138852	

The results of the comparison in Table 4 showed a substantial drop in the percentage of hospitals who received one or more CLDs when comparing them to their own outcomes cycle over cycle. In the previous 2017/2018 cycle, before the implementation of the plan of correction process, 45% of hospitals received at least one CLD. For the 2020/2021 cycle, after the implementation of the plan of correction process, of those same hospitals, only one, or 9%, received one or more CLDs.

**Table 4**

*Percent of Facilities with Condition-Level Deficiencies from 2017/2018 Cycle to 2020/2021 Cycle*

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	2017/2018 Cycle (No plan of correction process)	2020/2021 Cycle (Completed plan of correction process)
Percentage of Hospitals with CLD	45% (5/11)	9% (1/11)

The second comparison made was between the 22 hospitals that had completed a triennial TJC survey in the 2020/2021 cycle. As mentioned previously, 12 of those hospitals completed the full plan of correction process. The RFI and number of hospitals that received a CLD results data for all 22 hospitals are presented in Table 5 below.

**Table 5**

*Hospital Requirements for Improvement and Condition-Level Deficiencies from  
2020/2021 Cycle Only*

Hospital	RFIs	CLDs
A	28	0
B	36	2
C	38	0
D	33	0
E	51	0
F	15	0
G	24	0
H	32	0
I	5	0
J	48	0
K	40	0
L	8	0
M	11	0
N	30	0
O	48	1
P	15	0
Q	36	0
R	75	2
S	39	0
T	72	3
U	34	1
V	33	1

I performed a two-sample  $t$  test assuming equal variances to compare the number of RFIs between the two groups of hospitals. The number of RFIs between the two groups, those that went through the process (Hospitals A-L), was not significantly different ( $p = 0.11$ ) as shown below in Table 6.

**Table 6**

*Comparison of Requirements for Improvement Between Hospitals in 2020/2021 Group (Plan of Correction vs. No Plan of Correction)*

$t$  test: two-sample assuming equal variances

	<i>Variable 1</i>	<i>Variable 2</i>
Mean	29.83333333	39.3
Variance	213.7878788	441.7888889
Observations	12	10
Pooled Variance	316.3883333	
Hypothesized Mean Difference	0	
df	20	
t Stat	-1.242985715	
P(T<=t) one-tail	0.114124232	
t Critical one-tail	1.724718243	
P(T<=t) two-tail	0.228248464	
t Critical two-tail	2.085963447	

For the 10 hospitals that did not go through a plan of correction process, 50% ( $n = 5$ ) received at least one CLD. Of the 12 that went through an entire plan of correction process, only 8% ( $n = 1$ ) received at least one CLD. The comparison of the two percentages is shown below in Table 7.

**Table 7**

*Percent of Facilities with Condition-Level Deficiencies versus without Condition-Level Deficiencies Between Hospitals in 2020/2021 Group (Plan of Correction vs. No Plan of Correction)*

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	2020/2021 Cycle (Did not complete plan of correction process)	2020/2021 Cycle (Completed plan of correction process)
Percentage of Hospitals with CLD	50% (5/10)	8% (1/12)

Incidentally, while reviewing the data for the 22 hospitals from the 2020/2021 cycle, I discovered other significant findings. Of the 22 hospitals from this group, 16 of the hospitals completed at least through the 30-day plan of correction call and only two (13%) received at least one CLD. Of the remaining 6 hospitals that did not complete at least the 30-day plan of correction call and that had no plan of correction calls, every hospital received at least one CLD. These results are displayed in Table 8.

**Table 8**

*Percent of Facilities with Condition-Level Deficiencies versus without Condition-Level Deficiencies for Hospitals Who Completed at least through the 30-Day Plan of Correction Call to Those Who Completed Zero Plan of Correction Calls*

	2020/2021 Cycle (Did not complete any of the plan of correction process)	2020/2021 Cycle (Completed at least 30-day Plan of Correction Call)
Percentage of Hospitals with CLD	100% (6/6)	13% (2/16)

Finally, a two-sample *t* test assuming equal variances was completed comparing the number of RFIs for the facilities who completed at least through the 30-day call to those who did not. The results are shown in Table 9 below and show a significant difference ( $p = .017$ ) in the RFIs between the two groups.

**Table 9**

*Comparison of Requirements for Improvements for Hospitals Who Completed at Least Through the 30-Day Plan of Correction Call to Those Who Completed Zero Plan of Correction Calls*

*t* test: two-sample assuming equal variances

	<i>Variable 1</i>	<i>Variable 2</i>
Mean	29.25	47.16667
Variance	183.2667	533.3667
Observations	16	6
Pooled Variance	270.7917	
Hypothesized Mean Difference	0	
df	20	
t Stat	-2.27438	
P(T<=t) one-tail	0.017054	
t Critical one-tail	1.724718	
P(T<=t) two-tail	0.034107	
t Critical two-tail	2.085963	

An unanticipated limitation of the QI evaluation was the worldwide pandemic resulting from the COVID-19 virus. Due to the altered functions allowed by waivers from CMS, accreditation surveys were halted in order to preserve personal protective equipment, reduce burden on hospitals, and protect the health and safety of surveyors. For this reason, the projected number of facilities who would have completed the plan of correction process and subsequently an accreditation survey were diminished. While the number of the facilities who did complete the process and underwent their TJC survey were adequate for the evaluation of the process, the overall number would have been higher if not for the impact of the pandemic.



## **Implications**

When considering the implications of the findings, it is important to note the difference in the two types of findings being compared. RFIs are considered lower level findings than CLDs. TJC uses RFIs and a Survey Analysis for Evaluating Risk (SAFER) matrix for associating findings to scope and patient harm risk within a facility. RFIs are placed into one of nine boxes on this matrix and can range from a low limited finding to a high pattern finding. There also is a box specifically for immediate threats to health and safety, which include findings that are endangering patients at the time they are found. The more likely the RFI is to cause patient harm and the more widespread the finding is within a facility affects where placement on the matrix will be. RFIs come with a 60-day corrective action period within which the facility has to create and implement an action plan for each finding and submit to TJC. CLDs can be a bundle of RFIs or one, single RFI with enough patient risk and scope to warrant a CLD. These findings come with a 10-day corrective action period. A follow-up survey from TJC also will occur within 45 days of the initial accreditation survey for hospitals who receive a CLD. This is costly and also means there is more potential danger to patients, visitors, or staff.

The results of the comparisons of CLDs from one cycle before the implementation of the plan of correction process to the cycle after it was implemented were noteworthy. The facilities in the group who were compared to their performance in the last triennial cycle had a far less occurrence of a survey resulting in a CLD than they did in the previous cycle. The focus of the plan of correction process on the findings that would correlate with a CLD was impactful. Creating a culture of accountability across

multiple disciplines helped change occur quickly and efficiently. Through the process, removing barriers such as approval barriers, financial barriers, and other types of issues was possible by bringing all levels of leadership to the table to focus specifically on what was holding up implementing the change. At times, simply the presence of high-level leadership was enough to propel change. This was echoed in the feedback received from participant throughout the QI project evaluation. Participation was high in every instance of the plan of correction and this was a key factor in the overall improvements seen.

When comparing within the 2020/2021 cycle group, the facilities who went through the plan of correction process to those who did not, the results of the CLD comparison were also substantial. While COVID-19 and its impact in each market across the country was different during different times, these impacts did not seem to play a role in the participation or accountability aspects of the overall success. There were a couple instances where plans of correction calls were rescheduled or modified due to priorities associated with the pandemic, but these were kept to a bare minimum. The adherence to a strict schedule of meetings and expectations was a component of success as well. Setting a tone of high expectations for participation and completion of audits and action items was a factor.

Another finding related to CLDs that was discovered incidentally as the data was analyzed was the fact that if a facility made it through at least the 30-day plan of corrections call, their chances of receiving a CLD in the triennial TJC survey further reduced. The difference between the facilities who at least went through a 30-day plan of correction call and those who had no calls was also substantial. Again, the reasoning

could result in the fact the first couple calls were so heavily focused on the major findings, which are aligned with the CLD type findings from TJC. They also carry a higher risk to patients, visitors, and/or staff so correcting these issues is of highest priority.

The results of the comparison of RFIs from one cycle before the implementation of the plan of correction process to the cycle after it was implemented were not significant. In fact, there was an increase of RFIs for several facilities. This could be explained by the fact the plan of correction process, while intended to target all the findings from the internal survey, primarily focused on the major findings. These major findings are in alignment with the CLD level findings for TJC. As TJC changes their focus cycle to cycle, the major findings and foci for the internal survey team adapt to ensure alignment. During the plan of correction process, the first calls (14 and 30 day) are solely dedicated to these major findings, as they typically pose not only the greatest risk of a CLD, but also a high risk of danger to patient or staff safety. Due to the focus on those major findings, focus on some of the other RFIs could have been diminished, therefore resulting in a higher number of these types of findings during the TJC accreditation visit.

### **Implications for Positive Social Change**

Providing a roadmap for facilities to use via the internal survey and subsequent plan of correction call allows for individual leader to correct issues in their own areas, but also enable the system as a whole to address systemic issues. TJC standards encompass the entire facility, addressing everything from leadership and culture issues to the

integrity of the building and life safety codes. One of the major issues found during internal surveys is a lack of knowledge from all types of disciplines as to what the standards are, how to interpret them, why the standards are what they are, and how to enact them. This process allows for an education and collaboration opportunity with the facility to provide the insight and resources needed to ensure the most compliant state is attained. By doing this, patient safety and quality, staff safety, and overall community health is improved.

### **Recommendations**

Due to a focus on CLD-level related findings in the plan of correction process, there could have been a diminished focus on perceived ‘smaller’ findings that could result in RFIs. A recommendation would be made to form another team or subset of the plan of correction and regulatory readiness team that would focus on these lesser findings to ensure they are not forgotten in the shadows of the larger findings.

Survey readiness and preparation is often overlooked in the times between the triennial surveys. In order to maintain a constant state of survey readiness, which also includes preparations for a centralized room for running the survey, opening presentations, etc., and ultimately maintaining the highest level of patient safety, a recommendation for a consistent survey readiness team is made. It is very difficult to wait every three years to look and see what new standards, rules, and regulations may have come out. It also is important to note at any time, a surveying agency may show up at a facility. A recommendation would be made to form another team or subset of the

plan of correction and regulatory readiness team that would focus on these lesser findings to ensure they are not forgotten in the shadows of the larger findings.

A recommendation also would be made to consider the fact that one person was the leader of the plan of correction process for this project. It is important to note some of the success of the process could be person dependent and the personality, knowledge, and leadership ability of the person running the plan of corrections calls should be highly considered. For this project, there was almost no instances where the same person did not lead the calls from start to finish.

Next, a recommendation to only consider comparisons of CLDs in future studies and comparisons is made. The reason is RFI comparison could be considered inaccurate due to the focus and structure of the plan of correction process and the emphasis on the major findings, which align with CLDs from TJC. As previously mentioned, this could inadvertently drive the RFI findings up as more focus is placed on correcting the higher risk findings first.

Finally, a recommendation for all facilities to implement a team or group of people to conduct internal surveys is made. This team should be acutely aware of local, state, TJC, and CMS standards, rules, and regulations in order to adequately assess the level of survey readiness each facility was maintaining. It also would serve as the basis for the plan of correction process to be implemented in order to prepare for the pending accreditation survey. Without an internal survey team of some kind, there would not be a platform for the plan of correction process to exist.

### **Strengths and Limitations**

The major strength of this project was the reduction of CLDs in the facilities. This equates to safer environments and better patient care and outcomes. Another strength of this project was the large number of hospitals who were able to participate in the plan of correction process before this evaluation. A final strength is the level of impact this project has on the individual, community, facility, and system-wide patients and people it involved. Compliance with TJC standards sets the stage for the best quality outcomes for patients to occur in the safest environments possible.

A limitation of this project included the worldwide pandemic COVID-19. Although the number of facilities who participated thus far in the plan of correction process was robust, there were some facilities impacted by the pandemic, and the majority of facilities who were unable to complete the plan of correction process were due to some impact from COVID-19. Another potential limitation of the project is the fact that one person was the leader of the plan of correction process. It is important to note that some of the success of the process could be person dependent and the personality, knowledge, and leadership ability of the person running the plan of corrections calls should be considered.

## Section 5: Dissemination Plan

The dissemination of the project and results has begun at the enterprise level. The significance and impact of the results, as well as the impact on patient care has been shared throughout the company. The results are going to be synthesized and presented to the highest levels of leadership and to the rest of the organization. Because the project required all facilities to participate in the plan of correction process, all impacted facilities will receive the project information and implementation. Other plans for collaboration with TJC are underway as well to share this information and project to other health systems accredited by TJC. Further dissemination for application across other accrediting and regulatory bodies through external journals is currently underway. Finally, due to the nature of the project, a conference would be the most useful setting for presentation. This is due to the fact there are expected to be many process-specific questions and discussions that could benefit those trying to implement a similar process.

### **Analysis of Self**

From a personal growth perspective, this project was more beneficial to me professionally than I could have imagined. Managing a project of this size helped me develop project manager skills that I was not aware I possessed. I was able to learn the in-depth considerations for operational and financial concerns and barriers related to making some of the large and impactful changes that this project brought on. A highlight was having results that were significant, and with that, the importance of disseminating them widely to encourage others to implement a similar practice will propel my experience in publishing information. This project also will help in my long-term goals of educating the

nursing and healthcare community on how DNP scholars need to evaluate improvement projects more to enhance our practice.

Overall, the completion of this project, although large in its scope, was supported by the corporation. While the process is robust, the natural progression from internal survey to plan of correction made this an easy and acceptable process by the frontline staff. Also, providing the extra resources to the facilities to help them overcome barriers was a welcome perk of the project. Personally, after a few months of the project being underway, and the first facilities going through TJC and coming out with no CLDs, it was very exciting to continue to push through and watch the process mold and grow. More than anything, the impact and changes made in the facilities to improve patient safety and outcomes was the most impactful and energizing aspect of this project.

### **Summary**

This evaluation of an action plan management strategy, the plan of correction process related to decreasing negative accreditation outcomes, was a major success. By reducing the number of CLDs received during the triennial TJC survey, better patient outcomes and safety can be assumed. Implementing a presurvey and subsequent action plan strategy to address those concerns before an accreditation survey was shown to be impactful in reducing negative outcomes.



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