



## Patton Healthcare Consulting Newsletter February 2015

### NEWS FROM TJC

This month's edition of Perspectives starts off with an update on the revised standards for diagnostic imaging which take effect July 1, 2015. These are currently available for downloading from the prepublication standards portion of the Joint Commission website. We would encourage our readers to download this version before it is taken down as it provides "one stop shopping." These standards are scattered throughout the EC, HR, PC and PI chapters and this is likely to be the last time you see them compiled all together in one place. You will note a significant similarity to the draft that was not implemented in July 2014. Nevertheless, these should again be shared with the radiology department leadership and they should be asked to provide feedback on any perceived vulnerabilities. Here are some issues we would encourage your radiology leadership to verify in their self-assessment:



**EC.02.01.01, EP 16** requires restricting access to the magnet room (Zone IV) and the area immediately adjacent to the magnet room (Zone III) to only those individuals who have been clinically screened. We would assume that this immediately adjacent space often includes the control room and we suggest verifying that both policies and practices prohibit strangers including surveyors from entering the control room (i.e., Zones III) prior to being screened. Often on mock surveys we find the departmental

host or escort being too accommodating and welcoming of the reviewer to the control room area to talk with staff without having been screened.

**EC.02.04.03, EP 19** identifies 11 specific measures the Joint Commission surveyor is going to want to see from the radiation



physicist for evaluation of the CT scanner. EP 20 identifies 10 measures for MRI. EP 21 another 6 measures for nuclear medicine scanners, and EP 22 another 4 measures for PET scanners. Then EP 23 identifies one more test to evaluate the image monitors used in all these settings. Last year we had looked at some of these reports and the terminology in radiation physicist reports seemed similar, but slightly different, which could lead to confusion. One organization we visited had asked their radiation physicist to create a translation table, between the terms they had used in their reports and the terms TJC uses in these EPs. This was extremely helpful and we would encourage all organizations to verify that either the exact same terms are used, or create a similar translation table. Since the radiation physicist may not be on duty or available during the survey, these documents need to speak for themselves. In addition make sure the department manager or administrator and their back up has access to these reports.

**HR.01.05.03, EP 14** requires the verification that the CT technicians have obtained annual

continuing education using Image Gently and Image Wisely, two online educational programs. This may require some refinement in record keeping as it is not sufficient for the technician to merely know individually they have taken this CE or be able personally go to the online program and verify they have taken it. The HR file or



education file available in the hospital has to have this verification because the technician may not be on duty the day it is requested.

**PC.01.02.15, EP 10** requires staff to verify correct patient, correct patient positioning, correct imaging site and, for CT, correct imaging protocol and correct scanner parameters. Department staff will likely say, “yes, we do all this.” However, where will the surveyor see, hear, or read in the medical record that verifies that all this was done?



**PC.01.03.01, EP 25 and 26** requires imaging protocols and a hospital-defined timeframe for updating those imaging protocols. Defining a timeframe is always tricky. You could say when the literature changes, but how do you or the surveyor know something important was not missed. You could say annually, but then you might go through unnecessary paperwork for many of the protocols. We would suggest a compromise, perhaps saying we revise them when ever the professional literature changes or at least reaffirm the protocols once every three years.

**PI.01.01.01 and PI.02.01.01** simply call for reporting of incidents through your incident reporting process. This should be easy, but may require some reminders to staff to use the incident reporting process. On mock surveys we have been able to get staff to recall similar incidents, but unable to find incident reports reflecting the personal recollection of the event.

The February issue of Perspectives also describes a new set of standards for Acute Stroke-Ready Certification. This is an interesting expansion of the continuum, which currently consists of Primary Stroke Centers and Comprehensive Stroke Centers. This is intended for organizations that may be more rural or not quite able to achieve certification as a primary stroke center. This may turn out to be another way to tip toe into stroke certification by starting on the road to standardization of stroke care practices.

## EC NEWS:

Last month we “jumped the gun” describing the EC spreadsheets which were actually described in the February edition of EC News, but unfortunately we attributed them to the January edition of EC News. This also means we failed to discuss any of the content from the January edition of EC News. In January there was a useful article from TJC on the CMS Waiver for relocatable power taps, or RPT’s. This does not contain new content, but is useful to help further explain the CMS memo and validate how TJC will examine the same issue. The January EC News also provides warning to organizations surveyed as ambulatory surgical centers that the survey team is going to add a life safety code specialist. When this first started in the hospital program it had a profound effect upon scoring and totally changed the 10 most frequently scored standards. Given the thoroughness of these LSC specialists, it is likely to have a similar impact on the ASC survey process.



## CMS UPDATE:

On January 30th, CMS issued SC letter 15-22 for hospitals, ambulatory surgical centers, rural



health clinics and federally qualified health centers entitled: Revised guidance on new and revised regulations. CMS included revised language for the various appendices to the State Operations Manual including appendix A for , appendix T for swing beds in hospitals, appendix L for ambulatory surgical centers and appendix G for the RHC and FHQC's. Key changes for the hospital industry include:

482.28 permitting dieticians to order therapeutic diets, if authorized by the medical staff of the hospital to do so. Here if you plan to authorize this activity you will want to be able to trace back to where and when it was authorized by the medical staff and ensure that this authorization translates into rules and regulations, policies and practices for the dieticians.



482.30 utilization review looks quite simple. The hospital either has a UR plan or a contract with the QIO to evaluate UR. This is already part of the day one document review conducted by TJC.

482.53 eliminating the requirement to have a physician or pharmacist provide direct visual oversight of the of radioactive isotopes. CMS suggests using the processes outlined in a document entitled the "Scope of Practice and Performance Standards for Nuclear Medicine Technologists" developed by the Society of Nuclear Medicine and Molecular Imaging as an alternative to direct visual oversight by a physician or pharmacist. While CMS does not mandate the use of this document they warn hospitals that they better be able to explain the basis for the policies and supervision process that they have developed. It would seem simpler to use the suggested document as a resource. This document may be



found at: <http://www.snmni.org/files/docs/NMT%20SOP%20Clinical%20Performance%20Standards%20June%202013.pdf>

482.54 permitting physicians who do not have privileges at the hospital to order outpatient services, providing this is permitted by the medical staff. This issue poses several issues on survey. First, it has to be permitted by the medical staff and governing body if you are going to allow it. This means you must have the to trace back to some meeting minutes where this might have been approved. Second, the physicians ordering the tests or treatments must be doing so under the appropriate scope of their professional licensure. This means you need a method to determine if the individual ordering the exam or treatment is appropriately licensed and you need to verify they are acting within their scope of practice. We see surveyors commonly ask for this verification process in hospital operated sleep centers, pulmonary function test labs, clinical laboratory, radiology, and physical therapy. When the surveyor asks "how you know the individual ordering the test or treatment is licensed to do so," you need a better answer than "it came written on a prescription." Either the clinical department, or the scheduling department or central registration department has to have a mechanism to verify licensure and scope or practice . This may involve a look up on the state board of medicine website and/or insurance panel participation.



482.58 describes movement of the swing bed requirements from subpart D to subpart E under optional outpatient services and a plan to ask accrediting bodies to develop standards for and evaluate these services in the future.

416.42 Conditions for coverage for ASC's. This portion of the memo describes some

environmental requirements CMS will be looking for in the ASC, which made us consider once again the new assignment by TJC of life safety code reviewers to the ASC survey teams. Here CMS describes positive pressure air handling, temperature and humidity requirements, which have plagued hospitals since TJC started to focus on these issues. Be forewarned, if you have one of these ASC's, the depth of the environmental assessment may be much more intense on your next survey.

## **NEW YEAR REMINDER:**

If your hospital operates on a calendar year cycle you should now be reviewing your revised EC

and IC plans along with last years annual evaluation. If your evaluation concludes that last year's plan worked perfectly then you aren't looking hard enough, and you don't have targeted and appropriate performance measures to qualitatively evaluate the plan. Take a look at what is proposed for 2015 to make sure that each EC plan has actual performance measures, not generalities. In addition as you develop your 2015 infection control risk assessment there is likely to be two additions that were never considered at the start of 2014, Ebola and measles.

Best Regards,

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