NEWS FROM TJC AND CMS

Patton Healthcare Consulting Newsletter
October 2015

NEWS FROM PHC

Our Continuous Accreditation Support (CAS) clients may have noticed a change of address for PHC in their 4th quarter invoices. The new address for the business will be 5 S. Washington St. #11, Naperville, IL 60566-0011. In addition as of January 2016 PHC will have a new CEO, Jennifer Cowel. Kurt, John and Mary will still be consulting, but Kurt's aim is to be consulting less often. With the help of Jennifer, John Mary and most importantly our consulting clients what started out as a part time business has grown 10 fold since the business was founded in 2006. In addition to our leadership team we have a dozen equally skilled and dedicated per diem consultants that help to meet our clients needs. This transition should be invisible to our consulting clients and, as you have in the past, feel free to contact your consultant directly to arrange assignments or purchase new services.

NEWS FROM TJC

The October issue of Perspectives cover story is about the Accreditation and Decision rules for 2016. This is probably the least read section of the accreditation manual, but it is critically important if you encounter a problem on survey with the proposed decision. This chapter provides the road map or the rules from TJC on what the decision will be, what the follow up will be, what the improvement category will be, or what the next step down the ladder would be if you are not successful. Organizations in contingent accreditation or accreditation with follow up will now have two opportunities to dig out of the hole before the decision is worsened. A decision rule now has been created for condition level findings that don't clear on the first survey, allowing for a second survey. Something similar has been done for the ESC and MOS, allowing for a second submission prior to downgrading the accreditation status. While not an exciting read, it is a very worthwhile chapter to become more familiar with.

There is another in a series of articles entitled Clarifications and Expectations, continuing to help explain all the requirements of EC.02.03.05, a very challenging standard. This months article focuses on EP 14, 15 and 16 dealing with gaseous automatic fire extinguishment systems and monthly checks on portable fire extinguishers and annual certification on these extinguishers. The gaseous system (e.g., Halon) is one you might have in an area like MRI or IT and testing the system does not involve an actual discharge of the gas, but does involve evacuating the area prior to the test in case some unintended discharge does occur. The article advises what to look for on the monthly inspection process and what must be done during the annual recertification.

In addition we would like to point out that EP 15 is often a missed opportunity to clarify. While the surveyors might find 2 fire extinguishers that have missed an inspection or fallen off the inventory, this is a C element of performance and if you conduct an audit on compliance it is most likely going to be successful. Another reminder to highlight deals with leased space where you have clinics or other services. The landlord is usually responsible for placement and inspection of portable fire extinguishers, however don't forget to ensure the landlord complies with EP 15 and 16. If it is in your clinic, you own it during a survey.

TJC also released Sentinel Event Alert #55 in late September discussing fall prevention. As with all Sentinel Event Alerts there are recommendations that you want to consider and suggested resources or references for further information. This issue has 6 specific suggested actions, each of which should be evaluated and considered if not already done at your organization. Most hospitals we consult with are already doing these suggested actions and, while falls have been reduced, regrettably no one has found a way to eliminate them entirely. Nevertheless don't forget to document your analysis of this Sentinel Event Alert.

EC NEWS:

The lead story is on safe management of patients in police custody or forensic patients. Seeing patients in custody in the emergency room or on the units has been a regular feature in healthcare for many years. The article mentions a 2011 analysis documenting that 99 individuals tried to escape or did escape from hospitals while in custody. The standards do have clarity on two important issues. The police handle security including weapons and handcuffs, and clinicians handle patient care and assessment. The article suggests hospitals conduct risk assessments and revise their emergency operations plan accordingly to keep patients and staff safe, in the event of an escape or attempted escape.

There is also an article on protecting patients and staff from infections. While it does not appear there are any undiscovered pearls in this article there is a great boxed synopsis of the Hierarchy of Decontamination. This is a very useful reminder on low level, intermediate level, high level disinfection and sterilization and how they differ. This same box summary reminds us of the Spaulding classification system and what is semi-critical requiring at a minimum high level disinfection and what is critical equipment.

CMS UPDATE:

There are again no new survey and certification memos to discuss from CMS. I would like to say we are not getting our monies worth from our federal government, but having heard from many hospitals who have had CMS surveys we know they are out and about with seemingly increasing frequency and finding lots of deficiencies. There is a database of CMS survey report findings that CMS places on their website that we would encourage readers to access and study for at least their state. This information can be found at:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

This is a huge Excel spreadsheet, over 16,000 lines long. The last column is the finding and you will want to "word wrap" the column to be able to read the findings. Each row identifies a state ID and the A tag for sorting and analysis. Since CMS uses state surveyors to conduct their surveys, there is a value to analyzing and understanding what is being scored in your state so that you can prepare and prevent the same issues from arising in your hospital. You may find it interesting to sort by state, just to see how many different findings are occurring in your state. Our assumption was that California would have the most findings as it is the largest population and a "well-regulated state." However, it appears that Texas is the national winner with over 1800 lines of the spreadsheet.

You can also sort the spreadsheet by CMS A tag and as you might expect patient rights and rights around the use of restraint are huge in this database. Tags 0154-0214 that range from the right to be free from restraint to requiring death reporting logs for restraint related deaths comprises over 1300 lines of this spreadsheet! If you are going to invest time and energy in getting ready for CMS, perfecting your restraint use process clearly is a good way to spend your time.

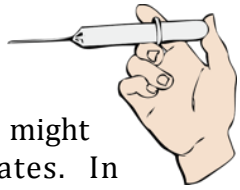
One of the issues we frequently find on mock surveys is that the hospital has someone analyzing restraint episodes for quality and completeness. Usually the self-assessment demonstrates 100% compliance with internal policy requirements. Quite often when we conduct a re-review of these same restraint episodes we don't find the same 100% compliance. This is really an area that requires a rigorous self-assessment, looking for perfection without any assumptions about what staff are doing or thinking. There are 3 common problems we see with significant regularity.

1. The order is for non-violent, non-self-destructive behavior and the order has to be renewed every 24 hours. This is somewhat of a set-up for staff to fail in that adherence to a 24 hour requirement is not required by CMS or TJC and it makes the process of getting practitioners to re-order the restraint on time more complex. Some staff in an effort to be compliant make things worse by dating and timing the forms for the physician to sign, whenever they arrive on the unit. These unsigned forms - reflecting a timeframe inside 24 hours when in fact are already outside 24 hours - when found by surveyors after the specified time has already passed may be construed as falsification of the medical record.

2. The order is for either non-violent or violent and self-destructive behavior and CMS and TJC expect the care plan to be updated to reflect the application of restraint and to document the care activities that will help to keep the patient safe. This extra step is often missed, particularly when the patient may only be in the restraint for an hour or two before they are released. One of the simple solutions we have seen is to redefine what constitutes the care plan. Some organizations have defined their care plan to include the restraint monitoring form, which should address both the physical and psychological wellbeing of the patient and is used to document assessments every 15 minutes in the case of violent restraint or every 2 hours in the case of non-violent restraint. All you have to do is document the care expectation on the restraint monitoring form, then evaluate if staff have fulfilled that expectation by documenting their monitoring. In this case, "initiating a care plan" is unnecessary so long as caregivers remember to initiate and maintain the restraint monitoring form.

3. A third situation we have seen recently is staff getting confused about definition of the restraint behavior when an unusual restraint device is used. For example when the physician orders

restraint for violent and self-destructive behavior, but then orders soft wrist and soft ankle restraint devices. Use of a soft restraint device does not change the rationale for the restraint and the requirement to monitor every 15 minutes because it was for violent and self-destructive behavior.



Then there is also something new appearing in the CMS survey database regarding chemical restraint. It is being scored with greater frequency than we might have expected in some states. In searching that database for the term chemical we see this popping up in Texas, Vermont, Utah, Oklahoma, Tennessee, Washington and Wisconsin. The policy we see most often in hospitals is in one in which they declare they do not use chemical restraint, but rather do use FDA approved medications in dosages and routes that are usually used to treat the symptoms of mental illness. But then this policy definition falls apart when someone inarticulately documents a progress note indicating there was intent to "restrain", or intent to "sedate" this patient rapidly.

CMS has a great definition of chemical restraint under Tag A-0160 where it states: "a drug or medication when it is used as a restriction to manage the patient's behavior, or restrict the patients freedom of movement and is not a standard treatment or dosage for the patients condition." This tag is then followed by some examples of what would or would not be a chemical restraint. If the drug is used to "enable" the patient to participate in their care and treatment, the drug is not a restraint. On the other hand, if the drug "disables" the patient, it is a restraint. In addition to the progress note staff write to document the rationale, hospitals should be careful to note the dosage and route of administration, and even the approved indications for that medication. If the progress note discusses "sedating" as a goal and the medication is an antipsychotic or benzodiazepine and the route is IV, you are leading the surveyor in the direction of considering this a chemical restraint. Bump up the dose of the medication, include it as part of a multidrug cocktail, and administer it to an elderly patient with dementia and you are further building the foundation for the surveyor to consider this a chemical restraint.

The use of STAT medications to control behaviors can also pose a problem, even if used in FDA labeled doses, routes and frequencies, if you have to physically hold the patient to inject the medications. The definitions of the types of physical holds which do or do not constitute a form of restraint are detailed in CMS tag A-0160. A physical hold to forcibly administer psychotropic medications against a patient's will would be a form of restraint.

Given the complexity of defining chemical restraints some hospitals are taking the approach of just agreeing with the regulators much like the nursing home industry does and defining this therapeutic treatment as a chemical restraint. But unfortunately when you do that you open yourself up to additional requirements including the need to have documented less restrictive alternatives tried, monitoring the patient every 15 minutes for the duration of the medications action and adding the chemical restraint to the care plan.

So we don't have a fail safe plan for you to prevent difficulty with chemical restraint perceptions, but do take a look at progress notes for rationale, indications for the medication, ages appropriate for the medication, doses and routes used to determine if you have risk in this area. If you do perceive risk you will want to further define your policies, procedures and training to help reduce that risk.

Best Regards,

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