



Patton Healthcare Consulting Newsletter September 2015

NEWS FROM TJC

Perspectives:

We hope everyone had a pleasant summer and had a chance to break away from the routine grind at some time while the weather was nice. But, welcome back and now its time to gear up for another year of “being ready.” The August and September editions of Perspectives have several important articles dealing with different aspects of the environment of care. As our readers know this portion of the survey process continues to grow in importance and remains as some of the most challenging parts of the survey. The July edition discusses a new portal that TJC has launched in cooperation with the American Society for Healthcare Engineering (ASHE). It looks like it is going to have some useful information and, as with all technological solutions, finding it, using it appropriately, understanding it, and benefiting from it are unique challenges. As consultants we see many organizations, department heads and chapter leaders who do not have the latest version of the standards and who do not know anything about accessing the E-Edition standards manual. This new portal-based information source risks being underutilized also unless we plan for success. We want to suggest a “tour” of the portal involving your quality staff, facilities staff and IT staff at



your hospital. As a group you should go on and explore this new portal, connect a printer and download and print the tools and resources available. More importantly, use this tour time as the time to ensure everyone has access to and the basic navigation skills to move around the portal site. Then develop a very basic plan identifying who is going to go and search out new content each month and who is going to bring that content forward to the appropriate section heads or subject matter experts. Lastly each time you download a new tool or document from the portal, you will want to assign someone to conduct the self assessment, identify gaps or identify existing processes that are equivalent to the portal suggestions.

Why this is important brings us to the September edition of Perspectives. In this issue TJC identifies the top 10 most frequently scored standards for the first half of 2015. Our last look at these frequently scored standards was in April and it summarized the surveys from 2014 only. Now we have data from 2015. Eight (8) of the most frequently scored standards come from the EC and LS chapters and it does NOT look like the percentage noncompliance is dropping. As Captain Renault said in the old movie Casablanca, “round up the usual suspects.” In this case the usual suspects are:

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- EC.02.06.01 - 59% failure rate, a large percentage are temperature and humidity problems

- EC.02.05.01 - 53% failure rate, a large percentage is “airborne contaminants” (i.e., areas that are to be positive pressure to adjacent areas are reliably positive, and areas that are to be negative pressure to adjacent areas are reliably negative) EP 15
- LS.02.01.20 - 50% failure rate, a large percentage is failure to maintain the means of egress
- LS.02.01.30 - 46% failure rate, and while there are many EP’s a large percentage is improper closing of smoke or fire doors. While these are C elements of performance most hospitals have no numerator/denominator data from their inspection process.
- LS.02.01.10 - 45% failure rate. Again there are many EP’s but improper self latching on fire doors and fire wall penetrations are the usual suspects.
- EC.02.03.05 - 39% failure rate. This is the documentation intensive standard where you need to be able to rapidly bring forward all your testing and inspection documentation for fire suppression and announcement tests. Organization of these essential documents is critical, as is making sure that EP 25 is properly documented with the NFPA references for each of these tests.
- EC.02.02.01 - 38% failure rate. This is a potpourri of hazardous waste or materials issues including eyewash stations and radiation safety.

So now lets look back at the new portal. The initial tool focus on EC.02.05.01 which we said had a 53% failure rate. Through this portal TJC supplies the breakdown by EP of the percentages of total noncompliance for this standard so you can focus energy on the problematic EP’s. The portal includes examples of how to achieve

compliance with each EP and a primer for leadership on this standard so the VP over facilities can have the necessary background knowledge to understand the requirements. Lastly there is a clinical impact page so everyone can understand how patient care may be affected by noncompliance. For additional explanation, go back to the August edition of Perspectives to see the column titled Clarifications and Expectations. This article focuses on EC.02.05.01, EP’s 8-13 and EP 16. Additionally, EC News from September 2014 focused on the EP’s 2-7 from this standard.



Sticking with the EC/LS focus, the next Survey Activity Guide has a new document list to help hospitals gather all their essential EC/LS documents in order to allow the surveyor to systematically evaluate these documents. This document list is important because these should all become part of your day-one documents or “first impression documents.” You can’t wait and be gathering them the day that Joint Commission shows up. They should all be neatly organized in tabbed binders or folders and none of these required documents should involve a search to locate them. The new tool tells you which documents to have, how often there should be a new test or inspection document, and provides space for the surveyor to score compliance or you to score compliance before they ever show up.



So we have a persistent breakdown point in the survey process and it appears TJC is trying to point hospitals to tools and resources that can help improve compliance. But you have to know where to access them and actually use them. Our suggestion is to start the “tour” we discussed earlier, to download, study, complete and use these new tools to your benefit. The portal is going to continue to have new content

added to it, but people have to know where to look and be able to take the time to maximize the value of these new tools. It's like buying a treadmill, but not using it. You won't get in better shape if you don't know how to use it, or don't take the time to use it.

Lets digress from EC/LS for a moment and talk about the two standards that made the hospital top 10 that don't come from these chapters. The second most frequently scored standard was IC.02.02.01 which could be low level disinfection issues, but more commonly is a deficiency in high level disinfection (HLD) or sterilization.

Some questions you should investigate:

- Do you have your HLD czar or content expert going around to every location in the hospital where HLD is performed to ensure that staff are adhering to policies and clinical practice guidelines?
- Have you made an effort to centralize HLD to the extent possible so it makes the process of standardization more practical?
- Can staff articulate the clinical practice guideline used to shape your policy?
- Do staff document on an HLD log all the required content as specified by AAMI?
- Do staff document a quality control test when opening new bottles of HLD test strips?
- Did staff receive and implement the advice from the manufacturer of Cidex OPA test strips that those test strips had a 10 month expiration date rather than 12 months?
- Do all staff who perform HLD have a documented competency?
- Did you add your manufacturers instructions for use and cleaning of the duodenoscope and its scope washer to the day one documents per CMS requirements?
- Are your scope storage cabinets properly ventilated and tall enough to hang your scopes without looping, touching the floor or



touching each other?

- Do you have adequate separation of clean and dirty activities in your scope processing area?
- Do staff wear the required PPE?
- Do you follow the manufacturers advice on brushes used in scope cleaning, e.g. single use or clean the re-usable brushes per IFU?

We can also tie this back to our earlier discussion about EC/LS do you have proper negative pressure in the scope decontamination area?

The second non EC/LS standard that still makes the top 10 is RC.01.01.01. Most often the failure point is not timing medical record entries. As consultants we still go to hospitals where the paper forms in use often do not have a time block for clinicians to use to document the time. Not doing it is one challenge, but not giving clinicians a simple reminder like a time block is inexcusable. A second tip is to audit and find out which clinicians are not documenting times on their medical record entries. Often this is not a widespread problem across clinicians, but instead it is a persistent problem with some clinicians. If you have audit data you can then work with those specific clinicians to improve their level of compliance, or coach them into greater use of the EMR.

A NEW ISSUE FROM TJC SURVEYS:

Every once in a while we see new issues popping up on TJC survey reports that we have not seen in prior years. Several years ago it was laryngoscope blades. This year we have seen multiple instances where defibrillator clocks displayed the incorrect time. Sometimes its noticed as a failure to change from day light to standard time or vice versa. Sometimes it is just a significant variance in the internal defibrillator clock from the wall clocks in the patient care areas. This issue intrigued us as there is

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professional literature published that warns of inaccuracy in these defibrillator clocks. In addition when tracking code activities you want to use a “single source of truth” namely the clock and time used to identify the patient in need of rapid response, as well as the time to various clinical interventions. Regardless of your lack of reliance on these internal clocks in the defibrillators, TJC has been consistent in demanding that they be accurate. You may want to consider checking the clock feature when you do your check on the defibrillator along with the crash cart.

Another peculiarity we have seen this year is surveyors asking to see the manufacturer’s handbook for defibrillator maintenance and then validating the process used to check the defibrillator with those manufacturer’s instructions. For those of you who have 2 (or more) different brands or models you want to verify that your usual and customary checking process actually meets both manufacturer’s expectations. If you have not validated your internal staff process with the manufacturers instructions we would urge you to do so.

DRAFT REVISION TO THE CAUTI NPSG:



The Joint Commission has posted proposed changes to the National Patient Safety Goal on prevention of catheter associated urinary tract infections. The draft identifies two comprehensive clinical practice guidelines, one from 2014 and an earlier one from the CDC in 2009 that hospitals should use in developing their prevention program. The draft also calls for education of clinical staff on prevention of CAUTI at the time of hire and annually. In addition there is a proposed element of performance for education of patients and their families about prevention of CAUTI.

There are two things every hospital should do at

this time. First is to download those 2 clinical practice guidelines and to discuss which works best for their organization if this goes forward. Secondly hospitals should discuss the implications of the draft changes in terms of benefits and workload burden and send their feedback to TJC. We don’t get the opportunity to help shape changes to the CMS interpretive guidelines, but you do get the opportunity to help shape changes to the TJC standards and safety goals, so discuss the proposal and send in your feedback.

CMS UPDATE:

There are no new Survey and Certification (SC) memos to the hospital industry since the radiologic services memo we discussed a few months ago. There is one new SC memo, directed to the nursing home industry called an Adverse Drug Event Trigger Tool. It is a tool which will be used by surveyors in the long term care program to identify patients who might be experiencing an adverse drug event. The tool looks interesting because so many hospitals struggle to identify adverse drug reactions (ADR). If your volume of ADR’s is low, you might want to use this tool proactively to try and find more ADR’s. Bear in mind also that many of the CMS hospital surveyors also do long term care, and they may use this tool in your hospital, looking for patients who are experiencing unrecognized ADR’s.

PHC Continuous Accreditation Service

We offer assistance to many organizations with survey preparation by conducting mock surveys, however we have many inquiries about providing a more ongoing support relationship. In response to these inquiries, we offer a Continuous Accreditation Support program (CAS). This program offers a smaller footprint with a more tailored agenda. Instead of a large mock survey and a potentially long report of findings, with a CAS agreement there usually is

one consultant visit a quarter which can allow for more focused corrective actions after the visit. Between visits we offer a 48 hour response turn around time for standards interpretation, going beyond just a reiteration of the element of performance by further interpreting and explaining the EP, as well as offering advice on how to achieve compliance. The visits can be conducted by one consultant or that consultant may determine that you need a life safety code specialist, an infection control specialist, medication management or medical staff expert. accreditation cycle.

We can rotate in different specialists to meet your needs. In the CAS program we also provide a userid and password to the secure site on our webpage where we have provided more than 50 different tracer tools, Powerpoint presentations, and policy statements designed to help keep the hospital ready throughout the

Best Regards,

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