



Patton Healthcare Consulting Newsletter December 2016

NEWS FROM TJC

Effective Immediately - ILSM Expectations

The December edition of Perspectives and the November 23 edition of JC Online describes the changes planned for evaluating ILSM's, or interim life safety measures. Effective immediately if TJC identifies a life safety code defect during a survey, surveyors will discuss that defect with the organization and ask which of your interim life safety measures are going to be implemented in order to protect patients, staff and visitors until the defect can be corrected. The chosen ILSM should come from your ILSM policy. The one piece of good news from this process change is that it will force organizations to evaluate these defects as a failure to consider ILSM has been a weak point for many years. Too often in the past ILSM was only considered for large construction projects, but it was also intended to be considered for any life safety code defect. A second advantage is that you will be forced to go through the motions and document the assessment. Another weak point in the past has been evaluating ILSM in your head, and not documenting the evaluation process on paper in accordance with your policy.

New Jan 9, 2017: New EP for Scoring Governing Body

Perspectives also mentions a new element of

performance they will be placing into the hospital manual on January 9, which borrows an EP from the home care deemed status manual. Basically the new EP is intended to provide a more specific location to score COP level noncompliance relative to governing body performance. As you know when a COP is scored non compliant there is a secondary COP scored out for governing body failure to implement the requirement. Interestingly the article does not actually state the EP wording, but we looked it up in the home care manual and basically it says: "The organization has a governing body that assumes full legal authority and responsibility for the operation of the organization." While this is a technical change on where something at a COP level will be scored, the change does not involve any greater work or risk.

Perspectives also discusses that the Focus Standards Assessment tool, or FSA will be unavailable from December 30 through January 9 at 8:00 am. This timeframe will enable TJC to update the standards, eliminate the scoring categories, MOS requirements and partial compliance options. In addition they will be incorporating the SAFER Matrix into the tool, and each standard you score as noncompliant will allow for an optional evaluation of potential harm and scope. The Plan of Action tab will be automatically set to 60 days, and the Evaluation method and MOS will be changed to "How will compliance be sustained".

READ: Revised Life Safety Expectations

The Clarifications and Expectations column resumed this month in both Perspectives and EC News. If you have access to both, we would suggest reading the EC News version as it has some boxed tips and photographs that add depth to the article, but they are not placed in the Perspectives version. This month they provide a detailed explanation of LS.01.01.01 and that is particularly helpful because this standard was modified when TJC eliminated the plan for improvement (PFI). There are now 6 elements of performance with EP's 2, 3, 5 and 6 being new and EP 4 being substantially modified to accommodate the recent changes relative to plans for improvement. Even though EP 1 is not new, the article does provide useful insight into expected documentation on who you have assigned to assess life safety code compliance and manage the ESOC. They specifically suggest letters of assignment, position descriptions, or documentation of meeting minutes. This is intriguing since this is not an element of performance designated as requiring a D for documentation.

Be sure to share this article with your facilities leadership and talk it through. Perhaps the most complex new EP is EP 3 which specifies what should be noted on your facility diagrams or plans. TJC expects that the plans include guidance on which areas of the hospital are sprinklered and which are only partially sprinklered or not, locations of all hazardous storage areas, locations of all fire rated barriers, locations of all smoke rated barriers, sleeping and non sleeping suite boundaries, locations of designated smoke compartments, locations of chutes and shafts and any approved equivalencies or waivers. Finding the legend on the facilities diagrams that describes how these are represented is often a problem.

Changes to the Clarification Process – Need to Clarify More During Onsite Survey

Perspectives also discusses the changes to the clarification process for 2017 and one change dramatically changes the advice we have given to clients for years. We have always advised against getting into standards interpretation arguments with your surveyors, and to instead rely on the post survey clarification process. That has to change in 2017 as TJC aspires to hash-out disagreements on the spot with the Standards Interpretation Group (SIG), the surveyor, and you through a conference call. We see potential risk in this in that you might win the battle, only to lose the war when the defeated survey team then begins to identify more and more issues that may have previously gone unnoticed or uncited. The new process is somewhat analogous to getting pulled over by a police officer for a traffic violation that you feel is incorrect. Previously you had your day in court later, whereas now you will need to talk it through with the police officer and his or her boss on a conference call. As we have previously discussed the C audit opportunities are also gone, as is the “we found it” option when a policy could not be located. Now you will have to negotiate a deadline to find the policy with the survey team during survey and bring it forward to them for review in that timeframe.

In this article on clarifications Joint Commission also discusses a new “Checklist of Required Documents” it has created. This basically is a list of D elements of performance and elements which state: “the organization has a written policy that states...”. While there is no need to compile all these and place them in a binder for your surveyor, you do want to have them at your fingertips. More importantly this is a really good time to verify you really, really do have these required policies or documentation. We would suggest that in addition to asking department heads or chapter leaders to ID the policy, ask

them to print it out and highlight the specific section that actually states the TJC requirement. Too often we are shown policies that people believe address a specific TJC requirement, but when asked to point out the section that really says it, they are unable to find it. As we learn more in the new year from our clients undergoing survey we will publish updates and recommendations on strategies for success.

The Final Word on Text Messaging

We have previously mentioned the changing landscape on text messaging in the accreditation process and TJC and CMS have been discussing a common solution. Well, this month's Perspectives provides this solution and its an easy one to remember. No text messaging of protected health information from a personal mobile device and no text messaging of orders regardless of platform. The article points out the benefit of being able to immediately clarify telephone orders with the prescriber, and the distinct advantage of CPOE directly.

EC NEWS:

Helpful Links on Falls Prevention & Sterile Compounding

This month's EC News provides a few internet links to resources that should be helpful to our readers, so you will want to read this online for ease of accessing the tools. The first link takes you to a monograph developed by the TJC Center for Transforming Healthcare on falls prevention. It discusses a collaborative effort between 5 different hospitals on strategies to prevent falls in hospitals. The second is from ISMP, which has issued a 2016 update to their 2013 document on Safe Preparation of Compounded Sterile Preparations. This monograph does not get into sterility issues like USP 797 does, but does

discuss error prevention strategies during product preparation. The most significant of these strategies is to employ bar coding verification when placing products to be compounded into the hood work area. While many hospitals now employ this strategy for bedside administration, it is not always used in product compounding. They discuss a particular medication error where a skeletal muscle-blocking agent was compounded into an IV by mistake which could have been prevented through the use of bar coding. They also suggest large, bold warning labels and physical segregation of these skeletal muscle blockers with signage that states: WARNING: PARALYZING AGENT – CAUSES RESPIRATORY ARREST. This ISMP document should be shared with your pharmacy director to perform a gap analysis as required by MM.08.01.01, EP's 5 and 6, and plans to become compliant over time should be developed.

CAUTI NPSG CHANGES FOR 2017: More Detail Required

NPSG.07.06.01 has been changed for 2017, and while conceptually it is the same, there are a few new "score-able hooks" or "gotcha's" that you will want to prepare for. EP 1 establishes a requirement to educate staff and LIP's involved with indwelling urinary catheters about the importance of infection prevention. They further state that this education should occur at the time of hire, or initial granting of clinical privileges. Then to further complicate the situation TJC states that ongoing education and competence assessment occur at intervals established by the organization. As you know, education and competence assessment are two different concepts with competence assessment being a more rigorous requirement. For those of you that utilize computer based training, adding a test to the training would be an easy way to accomplish this requirement.

EP 2 then establishes a requirement to educate patients and families and TJC provides a weblink to resources to help accomplish this. Neither EP 1 or EP 2 have a D for documentation icon, but thinking of how this finding usually unfolds - a surveyor interviews a staff member, physician or patient who responds that the hospital never taught them anything about this. Thus we would recommend that you develop a method to document that you did this. For patients who have a urinary care plan this education could become a standard intervention in the care plan.

EP 3 establishes a new requirement to develop written criteria using evidence based guidelines for placement of an indwelling urinary catheter. This will require discussion with a medical staff committee to identify the guideline and indications. Last years iteration of this safety goal had requirements to insert and manage based on evidence based guidelines, however this year's version seems more focused on patient selection.

EP 4 establishes a requirement to "follow written procedures" for inserting and maintaining an indwelling urinary catheter. This combines last year's EP 1 and EP 2 requirements to insert and manage, but the potential gotcha is to make sure your procedures address each of the bulleted items in the EP. These are:

- Limiting use and duration
- Performing hand hygiene prior to insertion or maintenance care
- Using aseptic techniques for site preparation, equipment and supplies
- Securing catheters for unobstructed urine flow and drainage
- Maintaining sterility of the urine collection system when required
- Replacing the urine collection system when required
- Collecting urine samples

EP 5 is almost identical to last years EP 3 with

both requiring measuring and monitoring of infection prevention processes. However the 2017 version now also establishes an additional requirement for "having a consistent method for medical record documentation of indwelling urinary catheter use, insertion and maintenance." You likely will need to discuss and decide where all staff will be guided to place this documentation.

NEW CDC GUIDELINE ON VACCINE STORAGE:

The CDC has published to its website a new vaccine storage guideline and toolkit that updates information they had published back in 2012. You can obtain the toolkit at: <http://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf>

This guideline has a huge amount of information about vaccine storage refrigerators, freezers and maintaining proper temperature. This is only a guideline, but as IC.01.05.01, EP 1 states you are to use evidence-based guidelines when developing infection prevention and control activities. Page 13 of the new guideline begins the discussion of the equipment that CDC "recommends." This includes a stand alone refrigerator, stand alone freezer, digital data logger and a certificate of calibration for the sensor. CDC introduces a new term called a "purpose built unit," also known as pharmaceutical grade refrigerator specifically designed for the storage of biologics. CDC recommends using a "purpose built" refrigerator or freezer, but if you must use a household unit, use one that is either a household refrigerator or freezer not a combination. They further state that if you must use a combination household device, do not use the freezer portion; rather, obtain a stand alone freezer for frozen vaccines. In bold print CDC also states: "Do not store any vaccine in a dormitory style or bar style combined refrigerator/freezer unit under any

circumstances.” This language is interesting because while this is only a guideline the bolded language is very emphatic.

CDC provides detailed advice on the digital data logger, stating that it should record temperatures at least once every 30 minutes, use a buffered temperature probe, and be accurate to +/- 0.5 degrees C. CDC also includes advice and photographs of thermometers which should not be used, again in bold font to provide emphasis. These include portable wheel thermometers and the common Hi/Low recording devices we frequently see in hospitals.

Pages 13 through 31 of the guideline discuss refrigerator, freezer, temperature monitoring and storage in detail, including where within the refrigerator to place the vaccines. Although CDC recommends the use of a temperature recording device, they also recommend a twice daily physical recording of temperature for redundant oversight. They also advise to retain the temperature data for 3 years, or longer if required by your state.

This information is extremely complex and detailed and should be analyzed by your pharmacy staff and infection control team. There may be significant cost implications in order to become compliant with this guideline.

CMS UPDATE:

CMS Doing More Testing of the Infection Control Worksheets

There is one new Survey and Certification memo, SC 17-09 dated November 18th that does not appear to have a large workload burden or implications for our readers. It discusses additional testing that CMS will conduct on the infection control worksheet, and, in particular, testing during handoffs between nursing homes and hospitals. It further states that there is no concrete plan at this time to continue using the worksheet in the future.



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