NEWS FROM TJC AND CMS

Patton Healthcare Consulting Newsletter
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NEWS FROM TJC - PERSPECTIVES:

2012 LSC - Somethings to Note:

The lead article in this month's edition of Perspectives is about the adoption of the 2012 Life Safety Code which we have previously discussed. This article does mention 4 aspects that are different in the new code and these are:

1. Roller latches are only prohibited on doors to corridors, and rooms containing flammable or combustible materials.

2. By 2028 buildings taller than 75 feet will be required to install automatic sprinklers

3. Facilities must initiate a fire watch or evacuate if a fire sprinkler system is out of order for longer than 10 hours. (more flexible than the previous 4-hour requirement)

4. In new construction window sills must not be higher than 36 inches above the floor.

Clarifications and Expectations: Fire Hoses, Dampers and More

Perspectives this month restarted the Clarifications and Expectations series, focusing this time on EC.02.03.05, EP's 17-20, and EP 25. EP 17 discusses the requirements for fire hose testing every 5 years. Many hospitals don't have fire hoses in their connection cabinets because the local fire department prefers to bring their own hoses to any fires. This has been and continues to be acceptable, however TJC points out in this article that the hospital must have a letter from the local fire marshal authorizing this arrangement.

EP 18 establishes the requirement to operate fire and smoke dampers one year after installation and every 6 years thereafter in hospitals and every 4 years in non hospital facilities. This discussion brings up the need for an inventory of fire and smoke dampers, which is a consistent requirement throughout EC.02.03.05 that hospitals often overlook. It is not sufficient to say we tested them all. Each device in any of the EP's for this standard should be identified in an inventory or diagram and validated as having been tested and passed.

In some instances it will not be possible to access every fire and smoke damper as access may be blocked. TJC allows hospitals to place these inaccessible dampers on the Part IV, Plan for Improvement to permit inspection at a later time, when construction or renovation is taking place allowing access to what was previously inaccessible. Be sure to give yourself plenty of time on the PFI to visualize the operation of these inaccessible smoke and fire dampers. As always, do not let these deadlines pass without requesting an extension if your planned construction did not take place.

EP 19 requires the annual testing of smoke

detection shut down devices for air handling equipment. The advice here is to not confuse EP 19 with the requirements of EP 3. More importantly TJC provides discussion about the survey process for this EP explaining that the surveyor will want to check and verify that for each detector triggered, the appropriate air handler shut down as programmed.

EP 20 deals with the annual testing of sliding and rolling fire doors that are not connected to the fire alarm system. If they were, they would be tested each time you pull your fire alarm for drills. However there are many such doors that are not connected to the main alarm system, thus there is a need to test their functionality. Again, the same advice for this EP, namely to have the inventory of any such doors, and to have your documentation of your test within the past year.
The discussion on EP 25 does not really provide any additional advice or insight. This is the EP that requires 6 specific things on the documentation of testing including the name of the test, the date, the required frequency, name/ contact information/affiliation of the inspector, NFPA reference standard and the results. Sometimes the name of the inspector is left off the inspection report or it is illegible, but the most frequently missed piece of information is the NFPA reference standard for the test. The requirement has been in effect for at least 5 years, and to date most vendors who perform these tests seem unaware of the requirement. As a self protective measure we suggest keeping your test documentation in 3 ring binders, each with a cover page, where you have included the NFPA reference, which you can obtain from the individual elements of performance.

Lastly, as soon as your test is completed ask the vendor if any portion of the test failed and if so plan with the vendor to correct that defect immediately, and to document that the corrective action took place on a specific date and time, who performed the corrective action and validation on retest that the corrective action worked effectively.

Environment of Care News:

The lead article in EC News discusses a violent attack at a surgical center in Texas that resulted in the death of a nurse and the critical wounding of 3 others, one of whom died 9 days later. The frequency with which healthcare staff report incidents of violence is at a frightening level and every provider has to be ready. The key part of this article is the sentinel event analysis the organization performed and their action plan. Their action plan is well worth taking a look at and consider proactively adopting some of the items they implemented at your organization.. Their plan of action included:

1. Revising the Code Silver, active shooter plan to an Armed Assailant plan because the weapon may not be a gun.
2. Initiated de-escalation training
3. Increased security rounds
4. Established RFID badge access to clinical areas to prevent unauthorized access
5. Installed additional security cameras
6. Designated safe rooms using silver stickers on the door frames
7. Locked down the freight elevator with RFID and installed fire proof peep holes in doors.
8. Installed keypad access on all incoming stairwell access entries
9. Placed security radios in multiple locations
10. Retested and serviced panic buttons to ensure audibility and response.

CMS UPDATE:

Order sets, Protocols and Standing Orders

There were no new CMS Survey and Certification memos issued of interest to hospital readers this month. However we wanted to discuss a new feature that CMS has where they have created a

question and answer process similar to the Joint Commission SIG question form. We tested it out last month and got a quick response to our question, but the response has implications for our readers. Tag A-0457 establishes authorization to use preprinted or electronic order sets, protocols and standing orders. This corresponds to the Joint Commission's standard MM.04.01.01, EP 15. CMS states that such orders are acceptable provided that the order sets, protocols, and standing orders in use are reviewed and approved by the medical staff, nursing and pharmacy leadership. Seems simple enough but in some EMR platforms physician can take an approved order set, modify or edit it and resave it as their own "favorite" or create an entirely unique "favorite." Well the question we asked was, do "favorites" need to go through this same review and approval process. The response was yes. Given how often EMR vendors provide and hospitals use "favorites" functionality this may prove problematic for hospitals. We have not yet seen this issue scored by CMS or TJC, but its something to start thinking about.

However, we have seen another issue scored with some increasing degree of frequency and that is a requirement to get the actual protocol in use into the medical record. When you look at this same tag, under section (iv) it mentions that such protocols should be "signed, dated, and timed by the responsible practitioner and promptly placed in the medical record." We have seen the absence of the actual protocol in the medical record scored by TJC on numerous occasions thus far in 2016. This appears to be part of the reason why PC.02.01.03 has suddenly made the top 10 in the most frequently scored standards list. Protocols are often a different sheet of paper, kept in a binder, or, in an EMR environment they appear as a hyperlink to the detailed protocol, but that protocol itself is not actually a part of the medical record. One surveyor even related a story that the hyperlink itself is insufficient because it links to the protocol in effect today and the protocol may change over time, thus there is no easy way to track back which protocol was actually implemented if it is not in the EMR record itself. This is another difficult issue we encourage readers to think about, read about, and keep track of. We would not suggest panic yet, but if this feedback from a single surveyor is accurate this will require some focused effort to change.

OBSERVATIONS FROM TJC SURVEYS THIS YEAR: Trouble With 2 Standards

We are seeing a high degree of consistency occurring on hospital surveys this year in terms of frequently scored IC and EC standards. These two chapters of the accreditation manual are causing havoc on survey and we wanted to share these common findings with you, while still protecting the confidentiality of the hospitals hit by these issues. This month we are going to discuss just two standards and two EP's, EC. 02.05.01, EP 15 and IC.02.02.01, EP 2. Both of these issues will score out at a COP level, thus inviting TJC back for a revisit in 45 days or less. The issues we are going to discuss next are appearing on more surveys we review than not, so preparing to prevent these same hits is important.

EC.02.05.01, EP 15 - Airborne Contaminants, AKA Air Pressure Relationships

A finding scored against this EP will usually result in the physical environment Medicare COP being scored noncompliant, along with a secondary hit at leadership/governance. If you can correct it immediately and show the correction to the surveyor, you will usually be able to prevent the COP level finding, but the RFI will remain. The affected rooms are widespread including dirty utility rooms which should be

negative, OR's which should be positive, scope decontamination rooms which should be negative, the clean side of central sterile which should be positive, and the dirty side of central sterile which should be negative. Although not seen yet from TJC, we have seen situations on our pre-survey preparation reviews where the air pressure relationships in the pharmacy sterile IV rooms and chemo rooms are inappropriate or mislabeled on the pressure meter, leading to the conclusion that the pressure relationship is incorrect.

So the question here is, are you going to do something to prevent this at your hospital, or do you like to gamble? We see situations on many of our reviews where the air pressure relationship is out of alignment and no one knows. It is suggested (but not mandated) that air pressure relationships be tested at a minimum of once annually, but a lot can happen during a year. So the prevention strategy is more frequent validation of the appropriate air pressure relationship. Ask yourself, do we have a gauge on the wall, do we have a sensor, do staff understand the special air handling expectation and do they even look at the gauge? Is our system stable across all variables, such as seasons of the year, whether doors are propped open or not, or does air pressure vary by the time of the day (e.g., as the sun moves from east to west across our windows does the call for more air conditioning throw air gradients off)? Many times there is a need to train staff who work in these areas on the importance of air pressure relationships. If you don't have a gauge, or you don't have a ping-pong ball in the wall device what are you going to do to check it more frequently? We have seen several practices in hospitals that can help to prevent this finding from appearing on your survey. The simplest and most innovative we have seen is the nurse manager walking around to all OR's each morning with a piece of toilet paper taped to the end of a broom handle to verify outward air pressure from each OR. We have seen facilities staff performing a smoke test on each special room once weekly to validate air pressure and we have seen both clinical staff and facilities staff using a vaneometer to measure the air pressure relationship. These devices can be purchased for as little as $34 on Amazon.com.

On this issue about air pressure we have also seen hospitals somewhat throw their hands up in the air and do nothing even when they know the air pressure relationship is incorrect, because they realize that correcting it is going to be expensive. There is of course an advantage to fixing it proactively in that you have the luxury of time. If you wait until TJC scores it, you have 45 days to fix it and any opportunities for competitive bidding or better pricing are lost. We have also seen many hospitals who like to take their chances with a once a year or once every two-year air pressure check by an outside vendor. We believe this is risky too in that things can change, belts can break on air handlers, duct work gets opened or closed by someone who is too hot or too cold and the air pressure relationship can get unbalanced. The most unusual problems we have seen with this issue are lab coats stuck up in the duct work because someone was cold, and OR equipment parked directly up against the intake vent that said: "Do Not Block." There are too many easy ways for this not to work correctly so our advice is to prepare now.

IC.02.02.01, EP 2 - High Level Disinfection

This standard and EP are far worse than the previously discussed air pressure relationship issue because there is just such a wide array of different and difficult issues relative to high level disinfection and sterilization. It is essentially a potpourri of traps you can fall into that makes preparation much more difficult. Training, competency validation, appropriate forms design and intense supervision and oversight are needed for any staff in any area performing high

level disinfection or sterilization. As we have previously mentioned in this newsletter if you are not providing key staff with access to the AAMI manuals for sterilization, high level disinfection and scope processing you are setting these staff up for failure. Surveyors know many of the fine-points of the AAMI recommendations and survey to them to a high degree of precision. All of the observations we are about to discuss, and there are many, come from actual TJC surveys conducted just in 2016.

Pre-cleaning and transport of instruments: So, what could go wrong with this process? Well, apparently a lot. The instruments used in procedures that become contaminated with bioburden must be pre-cleaned "at the point of use" prior to transport to central sterile supply. Using a commercially prepared spray is one way to pretreat the instruments and keep them moist, but using a spray that keeps the instruments wet for 12 hours, when you have a pick up every 24 hours isn't sufficient. Even when you have the appropriate spray and policies in place we have still seen findings where the surveyor goes to central sterile processing to watch staff open up instrument cases to conduct decontamination and precleaning and find that these instruments have dried blood or other crusty material on them, meaning staff in the originating unit did not use the tools you supplied them with. If these instruments are not opened up allowing the spray product to cover all surfaces, the surveyors will score this here. The containers used to transport instruments to central sterile are also important. We have seen findings related to sharps being sent to central sterile in plastic bags, risking puncture. Similarly we have seen surveyors noting sharps being returned in the reused peel pouch. Joint Commission surveyors insist that a rigid, covered container marked with a biohazard sticker or other known process to identify the contents as hazardous is used as the instruments are transported to central sterile processing or a soiled utility room where it will be subjected to high level disinfection. . We have seen survey reports where surveyors have cited the fact that the pre-cleaning step was merely a soak in water, and worse yet, where staff attempted to transport the contaminated instruments in a rigid container filled with water allowing spillage along the way.

Once the instrument gets to central sterile supply it has to be appropriately washed and sterilized and surveyors are very aware of all the requirements including biologic and chemical indicator requirements. Thus far this year we have seen hospitals scored for not performing a TOSI test per washer manufacturer instructions, not performing biologic indicator testing of the sterilizer (or maybe it was just a failure to document biologic indicator testing), mixing lot numbers of biological controls, or just failing to document the lot numbers for the biologic indicators.

Problems with high level disinfection are scored against his same standard and EP. The process of using glutaraldehyde, OPA, or other high level disinfectants is complex and strict adherence to the manufacturers requirements is essential. One such requirement is the need to test the efficacy of the test strips when first opening the bottle. This test requires 3 test strips dipped in full strength disinfectant and 3 strips dipped in a 50% solution of disinfectant and water. The surveyor simply picks up the bottle of test strips, notes the day of opening and says: "show me what you did on May 2 when you opened these." A blank stare followed by the question, huh; usually follows. You need to be able to show the surveyor the evidence that the test was performed and verbalize the 3/3 technique. We see the forms in use often don't help guide the staff to doing this correctly. Usually staff are trying to document this QC test on the same form they use to document day to day processing of instruments, which is a one strip test. The form doesn't remind them it's a 6 strip test, and the documentation doesn't make it clear that 6 strips were used. Thus when the nervous employee

fails to describe it appropriately there is no documentation to correct the misstatement. What works more effectively is a different form, or on the top of the daily form a special test strip QC section that clearly has 3 spots to check the positive control and 3 spots to check the negative control and to document the date and operator initials. Then when the surveyor asks to see the documentation of what was done on May 2nd it is self-explanatory. Another simple problem we have seen in 2016 with these strips is the need to establish an expiration date 90 days after opening. Staff need to be careful with this step, its not just the same date, 3 months out, it needs to be precisely 90 days and surveyors have been seen scoring the 92 day expiration date. In addition, another problem is once you have established the correct 90 day expiration date, you have to adhere to it by disposing of that container of test strips if they are not used up in 90 days.

Another log documentation issue is the expectation established by AAMI for cycle documentation to be able to track equipment back to the patient. This means the daily log has to include a patient identifier and an equipment identifier to do so. Many logs we see, and seen in the first half of 2016 by TJC, omit this information. The high level disinfectant solution, to work effectively, should be used when the temperature is 68 degrees or higher (or whatever the manufacturer recommends). If you don't track the temperature on your log you are vulnerable for an RFI here. Similarly if you track the temperature and you do document that the temperature is 63, you are documenting a process that has not been proven to be effective. For those that use the Trophon system there is a chemical indicator that is placed in the machine used to disinfect the probes. This chemical indicator must change color, indicating the cycle worked effectively. Well in 2016 we have seen TJC score hospitals for documenting a failed chemical indicator, without documentation of reprocessing that probe.

These two standards are literally a minefield and when you think of the Joint Commission's new Safer Matrix these issues usually don't just indicate a problem for one patient or one area. If high level disinfection or sterilization processes are flawed, or air pressure gradients found out of conformance, or staff fail to follow a written high level disinfection or sterilization procedure, it is likely the defect is widespread and significant and will force your surveyors to place these findings in the red zone. At a minimum these are going to be CoP level findings, but this could get worse if immediate threat is considered, so now is the time to bullet proof these processes.

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