



Patton Healthcare Consulting Newsletter September 2016

NEWS FROM TJC - PERSPECTIVES:

Hopefully all of our readers had an enjoyable summer and have returned to work reinvigorated and ready to take on new challenges from TJC and CMS. Autumn starts a new school year, renewed enthusiasm and ability to focus on finishing up the current years assignments, while preparing for the new issues the regulatory or inspection agencies have in store for us.

Statement of Condition Changes

The August issue of Perspectives had articles on changes to the Statement of Condition, eliminating long duration plans for improvement to self identified life safety code deficiencies. This was widely reported in everyone's newsletters and list serves and directly by TJC, but bottom line do you know how your organization dealt with this? The Clarifications and Expectations article in August went into specifics on how to manage through this change and as is customary, TJC came up with several new acronyms you will want to familiarize yourself with including TLW for "time limited waiver," and SPFI for "survey related plan for improvement," and SCD for "scheduled completion date."

The first important change is that life safety code deficiencies identified by TJC on survey will now only have 60 days to correct. If you identify that you will be unable to correct this deficiency within 60 days after survey, then by the 45th day

post-survey you will want to request a TLW, or time limited waiver. TJC will forward this request to CMS for their review and approval. The advice from TJC on this issue is very interesting. They advise that if you don't hear from CMS, then "assume the request is approved." In addition TJC will allow for an "equivalency," which is different from a waiver, in that the equivalency states we have an alternative approach that promotes an equivalent degree of safety for the life safety code deficiency. So if you receive a requirement for improvement and you are analyzing corrective actions or equivalent systems you will have a 2-step approach. First step is to apply for the TLW in 45 days, and second step is to apply for the equivalency, which also has to go to CMS for their approval.

The second important changes deals with life safety code deficiencies you discover on your own through routine inspections, i.e., not on survey. These can still be entered as PFI issues; however the content you enter will be "isolated" from surveyor review. It is unclear to us what the perceived value is of this functionality however, since there is no longer any protective nature to this self-identification. The Perspectives article theorizes that it might be a useful management tool at the hospital.

So there are a few action items to consider. If you have open PFI items right now, how quickly can you get them fixed and when is your next survey? Ideally you would like to get them all fixed before that survey or if noticed by TJC you will be cited and only have 60 days to fix it, or you will be

requesting a TLW and possibly and equivalency, both of which will involve CMS. For those of you going through survey at the end of 2016 or early in 2017, time to get life safety code deficiencies corrected before survey is limited.

Accreditation Leader Action Item....

At a minimum this article should be shared with your facilities leadership and two questions should be asked:

1. Do we have any open PFI items now and when will they be completed?
2. Do we have any life safety code deficiencies now that might be seen by TJC on their next visit and can we get it corrected before they arrive.

In addition, once you know the answers to these 2 issues a meeting should be scheduled with senior leadership to let them know what the future holds in store for you. They may decide that this is an unacceptable risk and they want to expedite funding or contracting plans to implement the corrective action.

Sentinel Event Statistics for 2016

August Perspectives summarizes the sentinel event statistics for the first half of 2016. The top 5 most common sentinel events identified so far in 2016 are:

1. Unintended retention of a foreign object
2. Falls
3. Wrong patient, site or procedure
4. Suicide
5. Delay in treatment.

Each of these 5 issues also has a recent reference from TJC either as a Sentinel Event Alert, a Quick Safety Newsletter or Targeted Solutions reference. We would encourage all of our readers to look at the references and discuss their own risks and what might be done to reduce them.

Some observations we often make during our consult work relative to falls is fall precautions that don't get implemented even though the risk is identified. More problematic is continuing issues with wrong patient, site or procedures, more than a decade after the universal protocol was first launched. Too often we see "rolling time outs" where staff are clearly involved in other activities and not focused on the time out activity. We also see non-adherence to UP.01.01.01 which calls for a pre-procedural verification process. The rush to turn over cases combined with decisions to obtain pre-procedural paperwork or documentation after the patient is already transferred to the OR is another common flaw. Unfortunately people are checking boxes and not conducting critical analysis or comparison of information as part of the process.

Suicide in an inpatient setting remains a frighteningly frequent sentinel event, again more than a decade after implementing the NPSG to try and prevent it. We see two very common flaws in the process the first of which is a failure to actually conduct the environmental risk assessment as required by EP 1 of NPSG. 15.01.01. Staff look at environmental defects and disregard them assuming there is nothing we can do about it, so why document that we noticed it exists. At a minimum you should identify every physical plant issue that might facilitate self injury and either eliminate it, or identify a meaningful mitigation strategy that can be implemented that will enable you to keep patients safe even though the physical defect exists. The second flaw we often see is the clinical assessment of suicide risk is done, but no meaningful action is taken to implement an enhanced safety strategy for the patient assessed at high risk. Care givers don't have many options, but the few that do exist include moving the patient to a location with greater physical plant safety because you have already hardened that environment following your risk assessment. In addition, application of 1:1 supervision by a person trained for this purpose or direct line of

site supervision should perhaps be applied more often. Too often everyone gets a 15-minute observation regardless of what was learned from the suicide screen.

So take a look at these frequent sentinel event alerts and consider them for proactive risk assessment at your own hospital. Designing in enhanced safety measures is a great idea rather than waiting for the same thing to happen at your hospital.

Top Scored Standards in 2016

The September edition of Perspectives has the summary statistics for survey compliance data during the first 6 months of 2016. This data is very similar to what you read in Perspectives back in April when they summarized all of calendar year 2015's findings. In addition the data is quite similar to the year before that with one important exception, which we will discuss. The risk to having such similarity is that it means in many instances there are repeat findings occurring, which is a potential decision outcome problem for you. If you have repeat findings it means your ESC failed long-term, meaning the improvement was not sustainable.

The important exception to this consistency is PC.02.01.03, which we commented on in April, as a surprise. This standard has now moved from the 9th most frequently scored standard to the 6th most frequently scored standard. In addition when you look back to what TJC reported in September 2015, this was not even on the horizon, failing to make the top 10. We have gotten used to oxygen tank storage, and air pressure differentials, and high level disinfection problems, but what is it with this standard? Here the culprit appears to be EP 1 which states: Prior to providing care, treatment and services, the hospital obtains or renews orders from and LIP. Unfortunately there are two aspects to the scoring of this EP, one of which is somewhat clear

and one of which is not. A situation, which can cause this EP to be scored, is when staff provide treatment, prior to a physician order and this is an issue we see very frequently in our consulting work. For example the patient shows up in the day surgery center for their procedure and nursing staff start a saline lock or an IV to get the patient ready for their procedure, however there is not actually an order on the chart to do so. However staff frequently reports Dr. X always wants an IV started or IV access with a saline lock so we automatically start his/her process in anticipation of Dr. X's arrival, when he/she will write the orders. This is almost easy to correct by changing the process, getting pre-procedure orders sent as part of the scheduling process and as Nancy Reagan used to say: "just say no" to facilitating behaviors that cause these orders to be missing.

The second issue with this standard is not nearly as clear and it requires some detective work to figure out what is going on. While it would be clearer if TJC would add a unique EP or a web based interpretation, we have seen this EP being used to score the failure to include in the medical record a copy of the protocol or standing order implemented in the medical record. If you examine the Joint Commission's standards to COP crosswalk at the end of the CAMH you will see a link between PC.02.01.03 and CMS 482.23(c)(1). When you go to this section of the interpretive guidelines you will note an additional link from this portion of the regulations to the medical records regulations under 482.24(c)(3)(iv) which talks about all practitioner orders getting into the medical record. So what's happening to protocols and standing orders? Sometimes they don't really exist, they are mislabeled routine treatments for which there really is no underlying official protocol or standing order. Sometimes there is a printed protocol or standing order, but a copy of it is not getting into the record as it is "off line" in a book somewhere. This is somewhat like driving through thick fog, but bottom line, as best as we

can tell from the scoring we are seeing, it appears TJC is looking for the printed protocol implemented to appear in the medical record, not be off somewhere else. This is likely to cause some headaches for readers using an EMR, because this is going to necessitate some infrastructure development to get the actual protocol into the chart, not just visible at the time of protocol implementation as a hyperlink that is not retained in the closed electronic record. It appears that writing an order that says implement vancomycin protocol or MI protocol is not sufficient because these may change over time and they want the current, actual protocol that was implemented in the record.

EC NEWS:

ESOC Changes and Fire Drill Matrix

The August issue of EC News contains the same important, but complicated article on changes to the ESOC. There is also a useful article and tool for creation of a Fire Drill Matrix. This matrix appears to be a very useful tool to log and track the fire drills to ensure that none are missed. The September issue of EC News has an informative article on EC.02.03.05 (mis-labeled in the table of contents as EC.02.03.01). EC.02.03.05 has many EP's and is the standard that requires documentation of testing components of fire safety systems like alarms, strobes, fire suppression equipment, etc. EC.02.03.05 scoring in hospitals is high, but it is no longer in the top 10 for hospitals. The scoring in critical access hospitals however remains huge with 73% failing on one or more of the requirements of this standard! The Compliance checklist published in this month's EC News includes 13 self assessment measures to determine if the inspection reports you have obtained from your vendor who conducts the testing of fire safety systems is going to pass muster. One such example is the first self-assessment question posed in the checklist: "Do you have a complete

inventory of all devices to be tested"? We first noticed TJC teaching its surveyors on this nuance and beginning to score the need for this inventory back in 2007, however there was never a new EP developed or an FAQ/Interpretation developed to share this critical information. There were other reminders about the need for this inventory in other publications, but no one-stop shopping. What this means is when a vendor comes in to test alarm pulls, it is not sufficient to say: "all alarm pulls passed." TJC is looking for an inventory of alarm pulls and a test of each documenting that each specific alarm pull worked. The same expectation applies to any devices where there are many scattered throughout the hospital to ensure that none are missed.

CMS UPDATE:

On August 19th CMS issued Survey and Certification memo 16-35, which is really more internal direction to its surveyors and should not cause any additional new difficulties for hospitals on survey. The first change is the reprinting of earlier advice given to their life safety code surveyors on information gathering. This advice had been inadvertently omitted from appendix I of the State Operations Manual. Experienced surveyors probably never noticed it was missing and continued to use their existing skills and techniques to gather the information they needed to start their surveys. The second change is another update to Appendix I of the SOM regarding the authority for CMS LSC surveyors to cite specific tags along with their findings. CMS has given them authority to do so, but because CMS may reassign a particular finding to a different tag, some surveyors may be reluctant to share such information. Neither issue however should cause readers to implement any additional preparation steps.

CMS Emergency Preparedness Requirements

On September 8th CMS issued SC memo 16-38 announcing the implementation of their new Emergency Preparedness requirements effective November 16, 2017. Readers may remember that back in 2013 CMS had issued draft regulations for comment and the fact that nothing was ever finalized made us think it had fallen off the table. Well, that's not the case. The SC memo directs you to the Federal Register where you can read the full text of the new rules. Accredited hospitals and other types of health care

organizations will likely find this easier than those that have not been accredited. Implementation is a year away and we would anticipate TJC and others doing more complete analysis prior to implementation. At present our advice is to have your EM leader download the text from the Federal Register and begin the analysis locally to determine what additional enhancements your program may need.

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