



## Patton Healthcare Consulting Newsletter March 2016

### NEWS FROM TJC

#### Diagnostic Imaging - new standards

The March issue of Perspectives does not contain a lot of surprises or difficult new expectations. There is an article on the latest change in the diagnostic imaging standards that have new requirements effective September 2016. Fortunately you have hopefully been reading and anticipating these for a long time as they have been in development and published by TJC on several occasions. There are two new HR requirements and one update to an existing MS standard that will require a small effort this year. The first change is at HR.01.02.05, EP 19 and this will require your CT technologists to obtain advanced level certification from the American registry of radiologic technologists (ARRT), or the nuclear medicine technology certification board (NMTCB), or they must meet alternative criteria involving state licensure and documentation of training. The second new HR requirement is for technologists who perform diagnostic CT exams to participate in education that prepares them to achieve advanced level CT certification by January 1, 2018. This basically means that if they don't have the advanced level certification today, but they meet the alternative criteria permitted by EP 19 of HR.01.02.05, there is an end date when alternative criteria will no longer be accepted.

The last change to mention is the Medical Staff requirement MS.03.01.01 to approve the job

descriptions and competencies for radiology staff who use equipment and administer procedures. Now there will be a note added stating that the CT technologists will at a minimum meet the new requirements stated above for EP 19 of HR. 01.02.05.

The **action item** here is to share the new standards with your radiology administrator asking:

1. Do the staff already meet the new advanced level certification criteria specified in HR. 01.02.05 EP 19?
2. If staff do not have the advanced level certification stated in EP 19, do they meet the alternative criteria which is sufficient until 1/1/18?
3. If staff meet the expectation using the time limited criteria, is there an action plan to enable them to meet the advanced criteria by 1/1/18?
4. Does the HR file for these staff include evidence that they meet the criteria?

Then based on what you hear from the radiology administrator, tickler a date to verify the paper trail is sufficiently clear to you, and in turn to a surveyor to pass muster on survey.

#### Clarification on Pain Standard

There is also an article on clarifying the intent of Joint Commission Pain Assessment Standards. As you read this article you might wonder where it comes from and why it was written. To understand the Joint Commission article you will

have to read the reference, an editorial written Ballantyne and Sullivan, NEJM Nov 26, 2015. In this article the authors point out that pain scales and a goal of zero pain may not be the best approach for patients with chronic pain. The authors do mention that when TJC introduced its pain management standards, the hospital industry chose pain scales as a chief metric. In the Perspectives article TJC concurs with the authors and points out that the standards do not mandate pain scales, but rather adherence to the hospitals pain assessment criteria and process. For most readers the bottom line is you don't have to change anything or introduce any new requirements. For a subset of readers that have been considering alternative approaches to chronic or acute pain management, you would want to read the Ballantyne/Sullivan article and this Perspectives article. There is room for flexibility on approach, however once you define your requirements, TJC would look for adherence to your policy and procedure.

There is a brief article stating that consultants may be seen, but should not be heard on survey. This isn't really an issue for us at PHC, or most accreditation consulting firms because we help organizations be prepared for survey, we don't participate in the actual unannounced survey. However some smaller hospitals may have consultants assisting them in more of a staff role that might be impacted by this policy. If you have a consultant who is there a couple of days every week, or scheduled for several days every month, you will want to examine their role, method of payment, and potentially discuss this individual's role in your organization and potential participation in your survey. Some of the consultants we see in smaller hospitals function as infection control nurse, or a data manager, etc. and they might be functioning like staff in this role, while they are technically a consultant.

### **Standards Interpretation Guidance**

Perspectives continues its new series on consistent interpretation. This series remains

confusing on what it is attempting to say. There are 6 examples of surveyor findings accompanied by advice which really fine-tunes where to score the issue, rather than supplying guidance on if finding is well-founded in the first place. For example the first observation discusses paper goods being stored under the sink. The guidance/interpretation section first states that there is no standard that says you can't store paper goods under a sink, but then there are 6 different examples of where or how this could be scored. Its worth a read, but don't walk away thinking you can begin storing material under sinks based on this article.

### **EC NEWS:**

The lead article in EC News discusses a hospitals "PreparAthon" or staff education developed to improve knowledge and awareness of environmental safety issues in the hospital. The article is of general interest, but there is a very nice Fire Drill Observer Reporting Tool on page 4. One of the issues we see many hospitals struggle with is the annual evaluation of their EC plans. This tool, if consistently used would provide excellent feedback about the success of the fire safety program throughout the organization.

### **Assessing Infant Abduction**

There is also another article of general interest on infant abduction, and again there two very useful tools to cut out and share with staff involved in EC rounds or Quality department tracers relative to infant protection. Hospital staff sometimes want to assess performance, but are not sure what questions to ask on rounds about a particular subject or how to evaluate responses. Here there are some great probe questions to ask staff about protecting infants, and then strengthening security measures as appropriate.

### **Sentinel Event Alert- Suicide Risk**

On February 24th TJC published Sentinel Event

Alert 56 on Detecting and treating suicide ideation in all settings. Like all the Sentinel Event Alerts you will want to assign a team to review and analyze the information in the alert and to implement those recommendations that will help improve care in your organization. As with all alerts, there is no mandate to implement all the advice, but there is an expectation that the advice be considered, so be sure to document your team's analysis and conclusions. The importance of this alert is driven home by the continued high level of reporting in the sentinel event reporting program of suicide taking place in hospitals. TJC indicates he has received 1089 reports of suicide taking place in hospitals since the start of their voluntary reporting program, and this remains one of the more frequently reported sentinel events. A key root cause consistently reported is the assessment process either being delayed or inadequate at detecting the risk.

One aspect of your analysis is going to be the applicability of the safety goal requirement to your hospital and the applicability of this advice, entitled Suicide prevention in all settings. NPSG. 15.01.01 is prefaced by a note that states: "This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals." It is also applicable to organizations accredited under the BHC manual. This Sentinel Event Alert clearly looks for organizations to broaden their screening procedures to patients beyond just those who come for treatment of their behavioral health disorder, which will have significant implications in outpatient settings where staff working in that setting may not be licensed to conduct patient assessment.

One thing you will also want to do with this alert is to read it online directly. There are a large number of internet links to great tools and resources that you can link directly to online. Links are provided to several different screening tools and programmatic guidance developed by the VA and DOD on prevention of suicide.

In the Sentinel Event Alert there are **8 specific recommendations** and some are broad in scope so you might want to assign subcommittees of a larger team to analyze some of the recommendations.

Suicide prevention is a national concern and, based on the number of sentinel events which continue to be reported from 24-hour care providers, demonstrates that we must do more to prevent suicides in our organizations. TJC mentions the frequency of its surveyors scoring NPSG.15.01.01 which underemphasizes the actual number of suicide prevention-related findings since unaddressed environmental risks/issues are scored frequently under EC.02.01.01. We continue to see on mock surveys suicide screening tools being completed because it is mandated, but no process to analyze, quantify or take action on the results obtained. We also frequently see patients placed on q 15-minute observation because that is the minimum for a newly admitted patient, but no formal method to upgrade the level of supervision until later that day or the next day after the patient is seen by a psychiatrist. A last performance gap often seen is the physical environment and self identified defects which are slated for improvement in budget year 2017, 2018 or later, but no mitigation strategy is identified to keep patients safe until the environment is improved.

## **CMS UPDATE:**

### **Important Memo For Critical Access Hospitals:**

There is only one new CMS memo this month and it is directed to critical access hospitals only, not regular acute care hospitals. For those readers who work in a critical access hospital, this memo is critically important to your future. This memo states that CMS will be evaluating critical access hospitals authority to remain functioning as a critical access hospital. The CAH criteria include

being located outside of an MSA, being a Necessary Provider, converted to CAH status prior to January 2006, being inside an MSA, but reclassified by the Division of Financial Management as rural meeting a distance requirement from the nearest full service hospital. If you are a critical access hospital you will want to carefully evaluate this memo to verify you continue to meet the criteria as a CAH.

## EKG Electrodes

Often we see an opened package of self-adhesive electrode patches on top of code or EKG carts, or in drawers in procedural areas. Various vendors manufacture these patches and many offer no explicit instruction on the package on how long they remain safe to use once the package is opened. Some go to the other extreme by instructing “do not use if the package is opened,” an instruction that many ignore thinking about the waste of throwing away seemingly good unused patches, rationalizing, why worry; if they stick well enough they most certainly are still good to use. However, recently we’ve seen an uptick in survey findings on this issue as

surveyors seem to be aware that, depending on the vendor and style of electrode, online or package insert instructions actually do specify that the patches need to have new expiration date applied once the package is opened. For example, the 3M brand “red dot” patch allows for the following:

*3M bulk pack ECG monitoring electrodes (30 or greater/bag) have a 30-day open bag guarantee with the exception of the 2560 and 2570 which have a 45-day guarantee. The 2360 has a 7 day out-of-bag claim. The following electrodes do not have any out-of-bag claim: 2258, 2269T, 2280, 2282, 2283, 2284, 2330, 2352, 2660, and 2670.*

Thus we advise informing the product evaluation committee or similar group to look into the instructions for use for the make and model of electrode patch(s) used in your hospital to study whether an expiration-dating process and procedure is needed wherever a package of electrodes is opened but not immediately used in their entirety.

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