NEWS FROM TJC AND CMS

Patton Healthcare Consulting Newsletter
July 2016

NEWS FROM TJC - PERSPECTIVES:

New Antimicrobial Stewardship Standard:

This month's Perspectives announces the 1/1/17 implementation date for the new antimicrobial stewardship standard, MM.09.01.01. There are 8 elements of performance, the first of which requires that leadership establish antimicrobial stewardship as a priority. Requirements like this are sometimes confusing on exactly how you go about doing this. The good news is TJC supplies a note with this EP stating 6 examples of how leadership can provide evidence of doing this. They include as examples:

- Accountability documents – in other words a statement of accountability, a charge to a committee or individuals.
- Budget plans – provide funding and a cost center for the new program
- Infection prevention plans – the 2017 IC plan could make the implementation of the program a goal, and could even include some planned measurement of effectiveness
- Performance improvement plans – the 2017 plan could make the implementation an organizational priority.
- Strategic plans – the board approved strategic plan including the implementation of an antimicrobial stewardship program would sent a strong message.
- Using the EMR to collect antimicrobial stewardship data – This seems like somewhat of a given, but the 2017 IT budget or goals to make this happen would be one way to show commitment to this new priority.

EP 2 requires the hospital to educate staff and LIP's about a*ntimicrobial ordering, dispensing, administration, monitoring of antibiotic resistance and the antimicrobial stewardship practices*. This education should occur at the time of hire or initial granting of privileges and "periodically" thereafter based on organizational need. Periodically is always a difficult term because of subjectivity on what frequency is sufficient. Since the program will be new in 2017 in most hospitals, and refined during the year before 2018, it would seem reasonable to educate for 2017, and refresh that education with changes to the program for 2018. We would also suggest using an agenda template or training template that specifically mentions the 5 training concepts TJC included in this EP as underlined above.

EP 3 requires education of patients and families regarding the appropriate use of antibiotics. One such mechanism to doing this is a CDC document entitled Viruses or Bacteria, What's got you sick? The link to that document is: http://www.cdc.gov/getsmart/community/downloads/getsmart-chart.pdf There is no mention of a D for mandatory documentation, however since patients may not recall that they received any education, having some notation in an education log that the brochure was provided and explained would be a protective measure.

EP 4 sets the requirements for the stewardship team, but does provide a caveat, "when available," so a small and rural hospital without these resources could have an alternate team membership. TJC suggests an ID physician, infection preventionist(s), pharmacist(s), and a practitioner. TJC also mentions that telehealth consultants could participate on the team as members.

EP 5 establishes the core requirements for the program and these requirements correspond with the requirements published by CDC and NQF. The CDC document can be found at: http://www.cdc.gov/getsmart/healthcare/pdfs/core-elements.pdf

The program requirements include:

- Leadership commitment, and EP 1 explained how to document this.
- Accountability – Appointing a single leader responsible for program outcomes
- Drug expertise – Appointing a single pharmacy leader working to improve antibiotic use
- Action – Implementing recommended actions such as systemic evaluation of ongoing treatment need after a set period of initial treatment, sometimes referred to as the antibiotic "time out." Here we would advise caution in the development of a grandiose program design, to make sure you are actually capable of doing what you say you are going to do.
- Tracking – Monitoring the program for prescribing and resistance patterns.
- Reporting – Regularly reporting information on antibiotic use and resistance to doctors and nurses
- Education – Takes the education discussed in EP 2 a step further to include education on resistance and optimal prescribing.

EP 6 then establishes requirements for hospital approved protocols which may include formulary restrictions, assessment of antibiotic appropriateness for community acquired pneumonia, skin and soft tissue infection, UTI, C diff, guidelines for adult antibiotic prescribing, pediatric antibiotic prescribing, pre-authorization, and use of prophylaxis. This EP does have a D for documentation.

EP 7 requires the hospital to collect, analyze and report data on the antimicrobial stewardship program. This also has a D for documentation.

EP 8 requires the hospital to take action on improvement opportunities identified. As always you be careful what you document and how you document your minutes.

So now is the time to start your planning for program design if you don't already have something started. If this is new for you a logical start point is to identify a planning team to consider what can reasonably be developed at your hospital. Large teaching hospitals are likely to have very sophisticated programs, while smaller community hospitals might have fewer resources, program features and more modest goals. When you have identified the basic skeleton for your program the next step would be to take the proposal to leadership to see what can be authorized for implementation. Consider the advice from TJC in EP 1 at this point for a statement of authorization, budgeting, including references in the IC plan, PI plan, and hospital strategic plan and working with IT to help support the data needs of the program. This is a significantly complex program with only 6 months to launch. If yours was already up and running it will be far easier than if you are starting with a blank sheet of paper.

Unique Medical Device Identifiers

Perspectives also includes an article on capturing medical device identifiers in the electronic medical record. The article discusses FDA amendments to House Bill 3580 from 2013 which established the regulatory requirements

for UDI, or unique device identifiers. Basically manufacturers would have to create a unique identifier for their device and enter it into a Global Unique Device Identification Database (GUDID). While the FDA has authority to regulate device manufacturers, they don't have authority to regulate hospitals, but the Office of the National Coordinator for Health Information Technology, ONC does through its EMR incentive payments program. Bottom line: this article has important implications for your meaningful use incentive payments program. The article includes a Joint Commission point person in their Washington Office and 7 references for more information.

One More Change - Diagnostic Imaging

There has also been another change in the diagnostic imaging standards, specifically the note at HR.01.02.05, EP 19 which required CT technologists to obtain advanced level certification by January 1, 2018 has been deleted. In addition, EP 26 which then required the advanced level certification has also been deleted. What remains in HR.01.02.05, EP 19 is the more basic requirement to either have that advanced level certification or state licensure authorizing performing CT exams along with documented training, or registration and certification in radiography by ARRT with documented training, or certification in nuclear medicine technology by ARRT, or NMTCB and documented training on the provision of diagnostic CT exams. This information should be shared with your radiology department manager, but the good news is this should simplify the requirement, not make this more difficult.

EC NEWS: Detail on 2012 LSC

The lead article is about the adoption of the 2012 life safety code and should be shared with your facilities director. There is useful information about some exceptions from full adoption of the 2012 code and what to do with any categorical waivers you may have opted to implement, which now become moot. One important change discussed in our CMS section below is while the regulation takes effect July 5, 2016, CMS and TJC will not begin to survey using this newer code until November 1, 2016.

A Trip to the Lab by LSC?

There is also an interesting article describing an EC tracer to the laboratory to explore issues relative to hazardous chemical use and storage. Its informative because you might not think of the Joint Commission's life safety code surveyor going to the lab. The tie-in is, first the LSC reviewer notes the hazardous spill data with the safety officer and notes several spills in the lab. The LSC reviewer next looks at the EC rounds process to see what is explored when EC staff visit the lab and notes several opportunities to improve the process. Then while in the lab the surveyor explores proper storage of hazardous materials, tests the SDS process, the back up in the event of an internet failure, identifies some expired hazardous material and questions the removal process, and lastly identifies some tripping and physical constraint issues which may be contributing to the frequency of spills in the lab. There is a chart of potential questions for the safety officer, lab manager and lab technicians you may find useful. This article should be shared with the lab manager and EC committee who in turn should use this to self-assess their level of readiness for such a review.

CMS UPDATE:

There is one new CMS Survey and Certification memo this month, SC 16-29 dated June 20, 2016, which discusses the implementation of the 2012 LSC, which CMS has delayed until November 1, 2016. CMS advises if you are surveyed and an issue is identified that would be compliant under the 2012 edition of the LSC, then discuss that with the surveyor and you will not be cited. CMS is developing a 20-hour training program which should be available in September and all state

agency surveyors will need to complete and obtain a passing score on the test prior to conducting surveys against this new code in November. The link to the Survey and Certification memo is: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-29.pdf

Reader Feedback & Additional Clarity on "Physician Favorite" Order Sets:

Last month we discussed the subject of electronic order sets and a response we had received from CMS relative to physician favorites in the EMR. Thanks to Nancy Sigillito, a careful reader from Barnes Jewish Hospital in St Louis, she questioned the guidance we described, given the way CMS blurs the lines of distinction between standing orders, protocols and order sets. The interpretive guidelines make it clear that CMS's intent is to establish a vetting or review process involving medical, nursing and pharmacy leadership for any "standing order" which would authorize a nurse to take action prior to the order from a practitioner. While the regulation uses the terms interchangeably, the interpretive guidelines specifically state: "Not all pre-printed and electronic order sets are considered a type of 'standing order' covered by this regulation. Where the order set consists solely of menus of treatment or care options designated to facilitate the creation of a patient specific set of orders by a physician or other qualified practitioner authorized to write orders, and none of the treatment choices and actions can be initiated by a non-practitioner clinical staff before the physician or other qualified practitioner actually creates the patient-specific orders, such menu options does not create an order set that is a standing order covered by this regulation."

We sent this refinement back to CMS with our question about physician favorites and they responded that as long as the physician favorite does not include any actions to be taken before the physician authorizes their orders, then this would not be subject to the review process by medical, nursing and pharmacy leaders.

Given the potential for confusion by reinforcing the current lack of distinction between standing orders, protocols and order sets, we are suggesting that some group of experts try to define a nomenclature that is clearer and differentiates these types of orders. Many years ago there was some distinction that has gotten lost over the years and perhaps Joint Commission through its PTAC which includes CMS representatives as well as medical, nursing and pharmacy leaders could re-establish some distinct terminology. As a starting point for discussion, many years ago we defined these types of orders as follows:

Standing Orders: Orders which could be initiated by a nurse for a patient based on medical staff approval of a screening criteria and indication for all patients who meet the screening criteria and are not contraindicated. Classic examples might include influenza vaccine, pneumonia vaccine, hepatitis B vaccine, erythromycin eye ointment and vitamin K in newborn, or aspirin for individuals presenting in the ED with symptoms of an MI. Standing orders were rare, limited use situations.

Protocols: Detailed guidance on how to administer, dose or adjust a medication after an order to implement the protocol was authorized by a physician (or LIP). For example, vancomycin, dosing per protocol, heparin drip per protocol, ventilator management per protocol, etc. In these situations, the medical staff was asked to approve the (usually) evidence-based guidance in the protocol in advance of its use, usually through a review and recommendation of the P&T committee to the MEC, and then once approved, whenever indicated for a particular patient an LIP is required to order the protocol

prior to the protocol being acted on (by pharmacy, nursing, radiology, respiratory therapy, etc.)

Order Sets: Compilations of orders on paper or electronic that may be ordered as a group by a physician or specific orders to be selected on the order set could be authorized by the physician. In either case nothing was administered until ordered. CMS would describe these as "menus of treatment or care options designated to facilitate the creation of a patient specific set of orders by a physician or other qualified practitioner authorized to write orders." Practitioner "favorites" created within an electronic CPOE system would fit into this category.

While readers may recall from their practice slightly different terminology, creating an understandable lexicon seems like a worthwhile issue to pursue. If you agree, bring it up when TJC hosts its consultant forums, executive briefings, corporate forums, hospital advisory groups and the previously mentioned PTAC. Putting some distinction in the CAMH glossary seems like it might be helpful.

OBSERVATIONS FROM TJC SURVEYS THIS YEAR:

Last month we started to discuss some EC and IC findings we are seeing in 2016 with a high degree of consistency during TJC surveys. 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. Last month we discussed two standards and two EP's, EC.02.05.01, EP 15 and IC.02.02.01, EP 2. This month we will discuss 2 standards and another two elements of performance that are causing an array of issues on survey.

IC.02.01.01, EP 1: This EP requires the hospital to implement its infection control plan to reduce the risk of infection. It becomes somewhat of a dumping ground for any issue, which seems risky and could lead to infection. For example, we have seen multiple findings relative to the use of skull caps in the OR instead of a bouffant cover over all hair and failure to use a beard cover, or a beard cover that is improperly adjusted so it does not actually cover the beard. This EP is also where we are seeing the ever-present adhesive residue, which cannot be easily cleaned and grabs hold of dust and hair. This is also where the perennial favorite about storing clean supplies directly on the floor gets scored. Each time someone wet mops the floor you are potentially contaminating the clean supplies. A companion issue to storage on the floor is an equally old time issue regarding mixed storage of clean and dirty supplies in the same location, leading to potential confusion on which is clean and which is not, or cross contamination. This same EP is where one of the most frequently scored issues in physical therapy settings is scored, a failure to clean the hydrocollator in accordance with manufacturers specifications. This is the large silver colored box containing a water bath for heating hot packs in PT. In the small print from the manufacturer it recommends cleaning out the water every two weeks. Many organizations are used to doing this only once a month, or fail to document when they do it. The last sort of potpourri issue on this same EP we have seen this year is a failure to clean dishes in accordance with the dishwasher manufacturers specifications for temperature of the water. Hospitals often have a log for documenting the temperature of the water each cycle. Unfortunately, the same risk you have with medication refrigerator temperature, food refrigerator temperature, and warmers is that someone documents a temperature that is outside of the acceptable range, but fails to note this or do something about this. Designing these logs with clear demarcation of the out of range zones can help, but it is not always successful. Too often staff view the task to record the temperature without understanding the reason the temperature is being examined at all. EC

rounding and IC rounding should help to identify some of these issues before TJC sees them, if the checklist you are using includes a reminder to look at these issues.

IC.02.02.01, EP 4: This is the safe storage of medical supplies EP and again, a potpourri of issues has been noted. Several years ago TJC began to look at storage of laryngoscope blades but unwrapped ones still pop up on survey. Taking this concept a step further we now see TJC looking at plastic, disposable oral airways, which many times are purchased in bulk bags and once removed, there is no protective cover to prevent contamination. Another item that seems frequently present in the crash cart is the Magill forceps, which as a semi-critical device must also be kept wrapped to prevent contamination after processing. We have also seen the surveyors looking at the semi critical devices used in the ENT clinic, to make sure they are staying wrapped and clean until use. Another classic, which has been looked at for an entire generation is a closed bottom shelf on supply carts and linen carts. If you use wire rack storage without a hard bottom shelf, again with wet mopping, this will contaminate the bottom row of clean supplies. Last but not least is expired suture material and laryngeal airway masks, or LMA's. A process needs to exist to search for these each month. A technique surveyors and consultants often use is just to look for different colors in packages of medical supplies, from suture material to blood collection tubes. Picking up the odd color package often identifies an out of date product. However, getting staff to actually look at the dates is the preferred method. EC and IC rounds may pick up some of these, but the first line of defense is a monthly process in each department to look for these types of storage issues.

Kurt A. Patton MS RPh Kurt@PattonHC.com
Jennifer Cowel, MHSA JenCowel@PattonHC.com
John R. Rosing, MHA JohnRosing@PattonHC.com
Mary Cesare-Murphy, PhD MCM@PattonHC.com

If you are reading this newsletter because it was forwarded to you and you would like to be added to the subscribers list, just send any of us an email and we can do that for you. Also, visit our blog at: http://pattonhcblog.wordpress.com
www.PattonHC.com