



## Patton Healthcare Consulting Newsletter January 2017

### NEWS FROM TJC

#### TJC SURVEY ACTIVITY GUIDE (SAG):

Happy New Year everyone, and so we begin anew to seek compliance and success with everything Joint Commission and CMS have in store for the healthcare industry in 2017. We usually start our newsletter discussing the most recent information from Perspectives, however we wanted to break from that routine this month to talk about the new hospital customer survey activity guide for 2017. The survey process is equally important, if not more important than the standards because it describes the activities the surveyors will use to explore compliance with the standards. New standards that are not identified in the guide to be explored in specific tracer sessions don't really get focused on. We have also noted that important changes to the survey activity guide often get missed because they are not detailed in Perspectives. For example, last August TJC updated the survey activity guide to include three additional documents to the mandatory day-one document list. These were items 46, 47, and 48 requiring three policies. The first of these was the medication management policy (which defines what is a complete medication order and therapeutic duplication). The second was the abuse and neglect policy for inpatient and ambulatory sites and the third was the fall risk assessment policy. Although these additional documents were requested as of August 2016, only one hospital we visited in the fourth quarter

of 2016 had noted this change and added these to their day-one document folders. In addition, even the one that did add the policies did not do a word match within their medication management policy to verify that they had indeed defined therapeutic duplication and, indeed, it was missing. So our advice on this is to catch up with the August 2016 change, and then take a look at the intense focus on antimicrobial stewardship in the 2017 SAG.

#### Focus on Antimicrobial Stewardship

Two things jump out at you when you start to review the 2017 customer SAG. The first is the amount of focus on antimicrobial stewardship. There are six additional mandatory documents to have available that first hour for the surveyors. These are identified in the SAG as documents 49-54 and they require:

- Three specific lists of patients receiving antimicrobials including emergency department patients who are prescribed antimicrobials, ambulatory and clinic patients prescribed antimicrobials, and inpatients who will be discharged on antimicrobials.
- Documents demonstrating leadership support for the organizations Antibiotic Stewardship Program. (ASP)
- A document describing how the organization is using the CDC Core Elements of Hospital Antibiotic Stewardship Programs.
- A document identifying any hospital approved ASP protocols, policies, procedures or order sets.

- A copy of your ASP data
- A document documenting your ASP improvements. TJC further states that if your data supports that ASP improvements are not necessary make sure the surveyor is informed. (Given that the standards did not become effective until January it is likely you will not have data concluding anything at the beginning of the year, but you may have some goals established for your team.)

The Joint Commission then added something that was missing with other complex and difficult requirements, such as the medication reconciliation NPSG, and that was to build in exploration of ASP issues in six different tracer sessions. These include individual patient tracers, competence assessment session, medical staff session, data management system tracer, medication management system tracer and lastly the leadership session on the last day. So clearly getting ready for these new standards is going to be far more complex than anyone might have anticipated based on past experience.

During the medical staff session surveyors are prompted to ask about education that has been provided on antimicrobial resistance and your ASP, as required by EP 2 of MM.09.01.01. Surveyors will then be exploring this same issue during the HR competence assessment session. However, in both instances TJC states that individual staff files should not be examined for documentation of this education. Our assumption here is that this is because it is a brand new requirement and hospitals will not likely have a track record at this time. During the MM System tracer session surveyors will explore the documents you provided in your day-one binders and discuss with you the multidisciplinary team you put together for ASP. Here, be sure to review EP 4 to make sure your team members include an ID physician, your ICP, a pharmacist and a practitioner. This same discussion and exploration will also take place during the data use system tracer and since a

different surveyor may conduct this you will want to be ready to discuss this in both sessions. Then, during the last day leadership session leaders will be expected to discuss how they demonstrated that ASP was an organizational priority.

During the individual patient tracers surveyors will use those lists of patients you provided them on day-one to explore the education provided to emergency department patients, ambulatory and clinic patients and hospitalized patients who were prescribed antibiotics. This exploration relates to EP 3, which does not have a D for documentation, however we would strongly recommend that you build in this documentation in your EMR patient education tab so staff don't have to struggle saying, "yes I did it, but I don't document anything." During these individual patient tracer surveyors are prompted to interview staff, licensed independent practitioners, families, and patients who will be discharged on antibiotics about education that was provided. Here again there is an advantage to documenting such patient and family education in the EMR for those who may not be able to recall the information when interviewed by a surveyor.

So we believe that with these changes TJC is learning to be much more effective at implementing genuine changes in hospital practice and evaluating these changes. If an intense focus like this had been implemented when medication reconciliation was first started a decade ago, it might not still be a work in progress that everyone continues to struggle with.

## **PERSPECTIVES:**

### **SAFER MATRIX Explained, Again**

The lead article this month is on the new SAFER Matrix and TJC tries to apply some operational

definitions to the “likelihood of harm” and the “scope” on the X and Y-axis on the matrix. TJC also discusses educational materials that it has placed on each organization’s secure extranet to help understand the SAFER Matrix. We would strongly encourage readers to share these educational materials with department heads and senior leadership to firm up their understanding of the new report format. Then have some fun by asking department heads and senior leaders to take the quiz TJC has developed and posted to the extranet. As consultants we took the quiz and quickly discovered how difficult it will be for TJC to implement this tool with an acceptable level of inter-rater reliability. We found that our individual experiences, biases, and opinions played a role in our placement of issues along the two axes. Clearly, discussion and consensus among the survey team members is going to be critically important. In the end, the final product TJC has developed which places each of your findings in one, risk-adjusted matrix should prove useful to in helping hospitals focus energy on the highest risk, most widespread problem areas.

## **ILSM Requirements Highlighted**

The “Clarifications and Expectations” column resumed this month and there is a very detailed discussion and explanation of the requirements for interim life safety code measures (ILSM) under LS.01.02.01. You may remember that last month we discussed in this newsletter some of the changes for surveyor-identified life safety code deficiencies and the new requirement to have each one evaluated on the spot for the need to implement ILSM. This article is excellent and should be share with your facilities leadership team, who should verify that their policy, evaluation tool and implementation process are consistent with the advice provided in this article.

## **Changes to Behavioral Health Manual**

### **— July 2017**

Perspectives also discusses some changes taking place in the behavioral health manual (CAMBHC) that take effect July 1, 2017. Many of our readers are accredited under both the hospital and behavioral health manual. There is a relatively simple change to CTS.02.01.05 and CTS.02.01.06. These are the standards that establish the requirement to conduct a health screening to determine the need for an actual history and physical, and the need to actually conduct the history and physical when the screening identifies that one is warranted. The change occurs in Note 2 for both standards and it is a wording change without really changing the expectation. In both standards, instead of saying the standard is not applicable if you require an H +P for all new patients, the new note states that you are compliant if you require and H+P for all patients.

There is another change at CTS.03.01.03 that will likely be more challenging. In EP 2 they added a forth bullet point describing goal setting in the treatment planning process. The additional requirement will be that “the plan of care, treatment or services includes: the criteria and process for the individual’s expected successful transfer and/or discharge, which the organization discusses with the individual.” This new requirement is additionally challenging when coupled with the existing requirement under this standard to express goals in a manner that captures the individual’s words or ideas.

Last, in the CTS chapter there is one more change to CTS.03.01.07, however this only applies to behavioral health opioid treatment programs. The new requirement will be to educate all women of child bearing age about neonatal abstinence syndrome, but again this only applies to the specially accredited opioid programs. There are minor changes to EC.02.04.03 establishing a requirement for equipment inspection and maintenance programs, but this

should be simple in those organizations that are already a part of a hospital with an existing biomed program. Last, there is a minor editorial change to HRM.01.06.01 to document an initial assessment of staff competence. Previously, the wording on this required that initial assessment of competence occur as part of an employee's orientation. Inexplicably, the CAMH manual for the same standard continues to tie initial assessment of competence to the orientation period (HR.01.06.01 EP 5 "Staff competence is initially assessed and documented as part of orientation.") We are left to wonder if the variation introduced by this change is intended or not.

## **Bigger Changes for Behavioral Health – Coming Jan 2018**

### **Use of a Standardized Tool & Analysis of Data**

In a second article TJC describes a recently approved change to the BHC manual that will be effective January 1, 2018. This one will have major implications for behavioral health programs accredited using the CAMBHC. The change takes place at CTS.03.01.09, elements 1, 2, and 3. EP 1 currently requires an organization to monitor a patient's progress in achieving goals, and the new requirement is that organizations will have to use "a standardized tool or instrument to monitor" that progress. There is a note that describes that the tool may be general/global or focus on a specific diagnosis or population. EP 2 then establishes the requirement to gather and analyze the data generated through standardized monitoring, and to use the results to inform the goals and objectives of the treatment plan. EP 3 then requires the organization to aggregate and analyze all the data collected. Organizations have a year to get ready for this one but finding tools appropriate to your patient population and acceptable to clinicians may take considerable time.

## **Immediate Post Op Note – Two Thorny Issues Clarified**

This month's "Consistent Interpretation" column does shed new light on a persistently difficult standard, namely, the immediate post-operative note required by RC.02.01.03. TJC makes two thorny issues crystal clear, the first of which is, what is the "next level of care" as described in EP 5? During the Fall Executive Briefings 2 years ago TJC staff speaking from the podium got into a debate between themselves about the meaning of this phrase which confused many attendees at that time; one said that the PACU was the same level of care as the OR while the other stated it was not the same. Subsequent questions our clients submitted to SIG had equally confusing responses including 2 different responses back to the same client, one stating PACU was the next level of care and one stating it was not. Now, in Perspectives it is official; PACU is the next level of care and the immediate post operative note should be written prior to transfer to PACU, unless the surgeon or anesthesia provider accompanies the patient to the PACU to do a verbal handoff, in which case the the immediate post-operative note may then be completed in the PACU prior to the patient being transferred to yet another level of care.

The second important official stance relates to the content of the immediate post-procedure note. RC.02.01.03 EP 6 states that the data elements for estimated blood loss and specimens removed is only mandatory if there is any blood loss and if there are any specimens removed. However, we have nonetheless seen many organizations dinged for failure to mention EBL and specimens even for procedures for which no blood loss or specimen would be expected. Now it is official, EBL and specimens only need to be mentioned if there was blood loss or specimens. Joint Commission does mention in this article that if your policy requires or implies that EBL and specimens be documented in all cases and

you fail to do so, it remains score-able. So take a look at your policy to ensure you did not create a de-facto standard they will hold you to, and simplify as needed. Also keep this article handy in case you need a reference during the on site clarification process that is expected this year.

## EC NEWS:

### Refresher on Portable Fire Extinguishers

This month's edition of EC News has a refresher article on inspecting, maintaining and documenting portable fire extinguishers. This should be shared with your facilities staff although it is likely content with which they are already familiar. There is one section of the article though that reminds us of what should be looked for when documenting the monthly inspection per NFPA 10-2010 7.2.2. This includes that the fire extinguisher is not obstructed from access or visibility. We see on client survey reports that blocked access to portable fire extinguishers is scored more often than any other failure.. Quite likely when doing internal monthly inspections the staff inspector deals with any identified blockage each month by simply moving the piece of equipment that is preventing him/her from conducting the inspection. It may be worthwhile to track these episodes of blockages to see who is doing it, why, and how often so that meaningful corrective action can be targeted

### Evaluating Your Emergency Management Program

There is also an article from one hospital's emergency management consultant that describes methods they use to evaluate and improve their emergency management program. Again, much of the content is likely a refresher, but it should be shared with your emergency management director. They discuss specific FEMA training they make mandatory for their team members and they discuss field trips they take to other nearby hospitals to share knowledge and experiences that are used for program improvement.

## CMS UPDATE:

### Small Change for Small Critical Access Hospitals

There is only one new CMS Survey and Certification memo SC 17-10 and it addresses only a small segment (<10 beds) of the critical access hospitals. Basically it would allow these very small CAH's to have a clinical nurse specialist available on call and immediately available instead of an NP or physician, but there are many caveats and exclusions including beds, population density, approval by your states rural health plan and governor, and state laws and regulations.

## BEST WISHES FOR A SUCCESSFUL NEW YEAR!

We would say good luck in 2017, but only the well prepared have good luck so stay ready throughout the year. This being January also make sure your annual evaluations are submitted on time.

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