MARCH 2017
PHC NEWSLETTER

Patton Healthcare Consulting, INC

News from Joint Commission and CMS

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PERSPECTIVES:

New Survey Notification:
This month we are going to depart from the usual format of our newsletter and limit our discussion of Perspectives and EC News to allow time to discuss what we are seeing thus far with 2017 surveys. *Perspectives* discusses an enhancement in how TJC notifies organizations that an unannounced survey is going to begin. Previously this was just posted to your extranet and most organizations were checking the extranet every morning as their survey date approached. Now TJC will also send an email to the CEO, accreditation contact, and corporate contact as applicable. However, this email will go out at approximately 7:30 am in your time zone, right after the extranet posting. If the surveyors arrive at 7:45, that doesn't leave a lot of time to get organized. While this enhancement will be somewhat helpful, the key is to always be ready to go with your day one documents and your orientation content. We have also seen some surveys this year that were very early in the accreditation cycle, meaning well before the 36-month period. This has been planned for a long time, and it appears to be happening this year, particularly if your last outcome was adverse and you worked your way out of that situation.

Recall on Powdered Glove Reminder:
Perspectives also has a reminder about the FDA recall on powdered gloves. Each organization should have a mechanism to receive recall notices relative to medical devices and act upon these recall notices. These gloves with powder have been banned by the FDA and the instructions were to remove them and dispose of them. You cannot try to use up existing supplies. We have seen this appearing in 2017 survey reports already where these gloves were still available for use.

Sentinel Events Still Require an MOS:
There is also a clarification in this month's edition stating that the MOS for sentinel events has not gone away. These are still applicable and due to the Joint Commission. Survey related MOS have gone away for 2017, but not the SE MOS.

EC NEWS:

Focus on Infection Control and Hazardous Medications:
The lead article in EC News is entitled IC in the EC and that concept ties in well with how many environmental issues we are seeing scored against IC standards thus far in 2017. The Clarifications and Expectations column continues with an article on some key changes in the life safety code, which also ties in well with what is being seen thus far in 2017, but perhaps the article has too narrow a focus as it concentrates on openings in walls, fire doors and smoke doors and the new things hospitals are being hit with is far broader. There is also a small announcement in EC News indicating that NIOSH has published a new list of hazardous medications which you will want to make sure your pharmacy staff takes a look at. We still see RFI's for failure to have a list of hazardous medications the hospital stocks and this document will also be useful as you prepare for USP Chapter 800 which takes effect in mid 2018.

SENTINEL EVENT ALERT #57:

Recommendations Regarding Role of Leadership in Safety Culture:
On March 1 Joint Commission issued Sentinel Event Alert #57 entitled, "The Essential Role of Leadership in Developing a Safety Culture." This alert notes on page one that leadership's failure to create an effective safety culture is a contributing factor to many sentinel events reported to the Joint Commission. It is important to note this is not merely the conclusion of the Joint Commission; this is the conclusion of your peers who have actually experienced these sentinel events. The alert discusses tools and techniques that hospitals use to improve their safety culture. One tool mentioned we were not familiar with is the "Incident Decision Tree" developed by the United Kingdom's National Patient Safety Agency; it looks quite interesting. This tool helps to sort out systems failures which may range from blame free on the individual to willful or purposeful noncompliance with policies and procedures designed to facilitate patient safety. There are 11 specific recommendations in the Alert and as with any of the Sentinel Event Alerts you want to read and evaluate these recommendations to consider if you already do this, or have an acceptable alternative, or are useful ideas to add to your safety culture. This particular alert is probably a good one to evaluate at a staff level, a manager level, and senior executive and board level, using the lower level feedback to help shape the upper levels evaluations.

It is also very likely that this Sentinel Event Alert will become a topic of discussion at your last day of survey Leadership interview. If you are due for survey in 2017 it would be wise to conduct your evaluation of this sentinel event alert early so that you can talk confidently about your evaluation and actions taken during this session.

SURVEY FINDINGS SEEN IN 2017:

Longer Reports, More LS/EC Findings, Scoring on the SAFER™ Matrix:
Thus, far we are not seeing any surprises come out of the SAFER™ Matrix. Surveyors seem to be judicious in deciding when to place issues in the red zone, with relatively few that we are seeing at this time. However, we do see a very liberal sprinkling of findings in the dark orange/mustard color area, which just like the red zone, requires management intervention in the ESC, and a discussion of preventative analysis. In addition, there will be the conference calls with the CEO about these findings and the repeat analysis will be in sharp focus the next time you are surveyed. We are also seeing an increase in scoring of issues at a COP level with very frequent scoring of the physical environment COP, the infection control COP, the surgical safety COP, and the governing body COP.

Remember also that 2017 is the first year when we have lost the C elements of performance where 90% compliance was acceptable. Today's surveys are scored on an absolute 100% performance expectation with single observations leading to an RFI. Seeing a 70 page or greater survey report is not that unusual this year. So many findings make the post-survey ESC a much more labor intensive project than in past years. The number of EC/LS findings we are seeing thus far is "off the charts." We see a significant increase in findings, including at the COP level with these chapters, and it appears that TJC has now achieved its goal of scoring these issues as often as CMS. Organizations are going to need to step it up in order to avoid these heavy hitters.

New Requirements: Inspection of Exit Signs & Testing Battery Specific Gravity:
There are also new requirements as a result of the conversion to the 2012 edition of the life safety code that appear to be surprising people. For example, EC.02.05.07, EP 1 and EP 4 had new requirements, which were to have started January 1, 2017. EP 1 was a long-established requirement to check battery powered exit lighting once a month, but they added a second aspect to this EP to also require a visual inspection of Exit signs. Forms that were in use in hospitals made it easy to document the inspection of the battery-operated lights, however many organizations failed to add the second component, which was a visual inspection of the Exit sign itself. If you did not change your process January 2017, you will not be able to create a complete track record for this year. Thus, any surveys conducted in 2017 will likely have this EP scored noncompliant if you missed adding this feature. EP 4 is another new requirement to test the batteries used to start your emergency generator. For many years hospitals have been testing their emergency generators and had forms to document these tests. Unfortunately, these forms in use did not include documentation of checking either the specific gravity of an unsealed lead-acid battery, or conductance of a sealed battery.

Installing Manual Stop Station on Generator:
Another new requirement established as a result of adopting the 2012 LSC is in EC.02.05.03, EP 10. This requires installing a manual stop station on the emergency generator to prevent unintentional operation. There was not much time to install this device after publication of the new requirement and prior to the beginning of 2017, but it's a new "gotcha" in that it has been missed by many organizations.

Other EC/LS Frequent Hits:
There are also some miscellaneous issues popping up in EC/LS that are not necessarily new, but are appearing at a frequency which is concerning. The height of fire extinguishers is one. These are supposed to be hung on the wall at a height of less than 5 feet. Well, surveyors appear to be measuring this and

some are just above 5 feet high and need to be moved. Misidentified breakers are showing up this year along with unlabeled breakers found in the "on" position, meaning they are in use, but unlabeled. Another new one is the need to protect medical gas cylinders from direct exposure to the sun. There should be an awning or roof over your outdoor tank farm to protect from direct sunlight. Another medical gas issue that is being seen is the failure to remove the plastic mesh many vendors use to prevent the tanks from rattling around against each other. Apparently NFPA 99 Sec 5.1.3.2.5 views this as hazardous and wants that plastic mesh removed once tanks are stored in the hospital. There also seems to be a re-emphasis on eyewash stations again this year, searching for chemicals that might be corrosive to the eyes. Hospitals should explore chemicals in use in all areas and study whether there is a need to install an ANSI compliant plumbed eyewash to serve an area, and then establish mechanisms to prevent departments and clinics from purchasing new corrosives that do not have an eyewash available where they will be used.

Continued Focus on Air Pressure, Temperature, Humidity:

EC.02.05.01, EP 15 was a heavy hitter last year, and it only appears to be more difficult in 2017. This EP gets scored non-compliant for defects in air pressure relationships or temperature and humidity deviations in critical environments. Previously, we have written about and spoken about the need to check air pressures more often than an annual air balance report. We have seen hospitals move up to testing monthly, weekly, daily and even several times a day when they are trying to clear a COP finding or an AFS survey. None of these increases in inspection frequency seem to be working successfully as air balance still gets out of alignment and either the LSC surveyor scores it or one of the clinical surveyors scores it non-compliant. As a result, we are suggesting that if your hospital does not already have an anemometer, or a "ball in the wall" to allow staff to always know that the critical air pressure relationship is working, then you want to install something that gives you this constant feedback. Since there is always a chance that someone may fail to notice the ball in the wall is on the incorrect side, we suggest something that will alarm locally so staff can react.

In addition, clinical staff need to be better trained to understand and trouble shoot temporary deviations in air balance. One of the problems that occurs on survey is when your facilities staff accompany the life safety code surveyor and they evaluate air balance. The facilities staff can trouble shoot and find simple temporary issues like an exterior door open causing a hallway draft that is adversely impacting air balance. The LSC surveyor is attuned to looking for this and your facilities staff are attuned to looking for this. However, the clinical staff working here may not be as comfortable in troubleshooting. For example, when one of the clinical surveyors goes to central sterile supply and notices the air balance is off, clinical staff have been known to say, "Oh, I have to call engineering to correct it." Unfortunately, you just earned an RFI at a COP level and most likely in the red or orange zone of the SAFER™ Matrix.

Our suggestion is to have facilities staff train the clinical staff to at least look up and down the hallway, feel the breeze going by and try to fix the issue on the spot. This same element of performance is being scored very frequently for a failure to document temperature and humidity or a failure to maintain temperature and humidity in accordance with clinical practice guidelines and policy. The failure to document temperature and humidity can be overcome with simple automation using a data tracker that can be as low tech as a thumb drive that automatically records temperature and humidity. The second part, reacting to temperature or humidity fluctuations, is more difficult to accomplish. You need people to look at the temperature and humidity fluctuations

and react per your policy and clinical practice guidelines. Oversight of that process is essential to ensure completeness. Everyone has their existing duties and views this as a tedious addition, but it has become an essential addition. We have seen hospitals employ a "checkers, checking checkers" technique where someone is assigned to check the temperature and humidity and a supervisory individual is validating that it has been done per policy. A second technique some hospitals are employing in 2017 is to place compliance in the performance evaluation for a department head or even VP over an area. In turn, that individual is then invested in achieving compliance. Either method is boring, redundant and of questionable clinical value, but you are avoiding COP findings and red or orange/ mustard color findings in the SAFER™ Matrix is important.

More Sophistication Mandated in High-level Disinfection & Sterilization:

Last year one of the most frequently scored standards was IC.02.02.01, EP 2 dealing with defects in high-level disinfection or sterilization. That is continuing this year, but the sophistication and array of different issues scored against this EP is much more diverse. No longer is it just a simple Cidex test strip issue. More often today we see noncompliance with:

- manufacturer's instructions for use (IFU) to pre-clean or sterilize
- failure to pre-clean per evidence-based guideline (e.g., AAMI ST79)
- failure to transport in a covered, rigid container
- failure to label that rigid container with a biohazard label
- arm hair exposed in the sterile prep and pack area of central sterile supply
- failure to maintain sterilizers and washers per IFU
- failure to perform and document biological indicator testing properly (e.g., having the control and load BI lot numbers not match)

Probably the two greatest risks we are seeing right now is a failure to use a covered, rigid container or include a biohazard label on that rigid container. This does not just apply to the OR area, but every clinic using non-disposable surgical instruments and every bedside procedure. You want to know that you have given staff in these locations the tools they need to achieve compliance. You can't carry a sharp from the bedside to the dirty utility room in your hand or in a towel. It must be in a rigid container with a biohazard label. Once you have moved the item from its point of use to the dirty pick up point you also need to ensure that pre-cleaning takes place that is appropriate for that instrument and that the pre-cleaning agent is appropriate to keep the instrument "moist" for the duration that the item will sit in the dirty utility room until pick up for processing.

Emphasis on Ligature Risks in Behavioral Health Areas:

The Joint Commission announced in its publication *Online* dated March 1 that surveyors would be placing additional emphasis on assessment of ligature risks in behavioral health areas. Specifically, TJC stated that they would evaluate 3 aspects of this:

1. Determine if the organization has previously identified these risks
2. Evaluate existing plans for removing the risk
3. Evaluate the organizations environmental risk assessment process

Well, we are already seeing more frequent scoring of this process. Problem #1 is a failure to identify the risk. By that we mean a failure to document that you have noticed the potential risk and you have a mitigation strategy that will keep people safe. One of the best tools to use to help identify potential risks is the FGI *Design Guide for the Built*

Environment. This is available as a free download from the FGI website. In the sentence above we used a term, "failure to document you have noticed the potential risk." This is an all-too frequent occurrence because staff look at something and conclude it is not really a risk because no one has every hurt themselves with that, or no one would ever be able to hurt themselves with that. That's not good enough. You must document you have recognized it and you have evaluated it and concluded that you can safely manage patients despite that potential risk. Let's take a classic example like regular door hinges on the shower room in a geropsych unit. Regular door hinges are a known risk as a ligature point, but staff ignore these hinges because in a geropsych unit the patients are never allowed in the shower room by themselves. They are medically weak and require supervision and assistance during the shower. In this case those hinges never make it to their environmental risk assessment which may make sense to you, but TJC is going to conclude "you never noticed." Staff conducting the risk assessment need to stop thinking about the "but, but, but" issues that they have already analyzed in their heads. If there is a risk, document it and in your evaluation of the risk, document your "but, but, but" logic.

We suggest for environmental risk assessments of the behavioral health environment to evaluate against 3 criteria; probability that someone will use it, criticality if someone did use it, and detectability if someone attempts to use it (i.e., would we be able to intervene before actual harm occurs). So, in this case the probability that someone will use those door hinges to harm himself or herself is low, because it has never happened and the patient is on one-to-one during the shower. The criticality would be large, but the detectability is larger because the patient is on one-to-one. Therefore, we can safely conclude this is not an issue, not a danger and we can keep patients safe because we have a documented mitigation strategy. So, the key here is don't fail to document that you know there is a potential hazard and don't fail to document your mitigation strategy. TJC in their article in Joint Commission *Online* threw in one additional criterion which we have avoided in the past because, frankly, it is often part of the problem with any risk assessment, and that is your plan to remove the risk at some far-distant time. For example, "we will remove and replace those hinges in our construction project planned for 2019." To state a future date while not also documenting a current mitigation strategy will likely lead to an RFI. Saying you will eliminate the hazard in 2 more years is still score-able absent a documented risk assessment, but it appears that TJC is now looking for a future plan to make the environment perfect. You are going to want to establish an annual review process for these risk assessments, so if your 2019 construction slides into 2020, your risk assessment reflects that correct date.

Other Environmental & Safety Risks Scored This Year:

Another heavy hitter this year is a potpourri of environmental safety risks that are inadequately managed. These include blanket warmer temperatures, food refrigerator temperatures, breast milk refrigerator temperatures, paraffin temperatures, and hydroculator temperatures (and that you have changed out the hydroculator water every 14 day. The common denominator here is a failure to document or manage temperatures per policy. You will notice we did not mention medication refrigerator temperatures because most hospitals have migrated to passive, electronic 24-hour data loggers to maintain this process. It appears that it is time to expand this automation or provide more rigorous oversight of the manual process.

The open package of EKG electrodes without a new date of expiration that we mentioned last year is an expanding concern this year as we have seen this appear in several reports already in 2017. Either establish a dating process or purchase these in smaller packages

and discard any open ones. Sedation titrations remain the most frequently scored medication management issue and the common flaw is a failure to document a RASS that justifies adjusting the rate of infusion for the sedating agent. In instances where the patient may also be receiving a paralytic, or have a head injury, RASS by itself may not be the most appropriate monitoring parameter so customize the order so it makes sense for this patient titrating to ventilator synchronicity or pain, or some other measure.

New Focus on Waste Medication Security: Lastly, we have seen the same new RFI's popping up in multiple reports for medication security, but this is a new perspective on medication security. Surveyors appear to be looking at where waste medications, both sharps and hazardous pharmaceutical bins are being stored. If they are in unlocked rooms like a dirty utility room and the surveyor notes how easy it is to remove the waste bin top, you will be cited for unsecured medications. They have even been citing these in operating rooms that are abandoned after use. You will want to consider keeping these things in your medication rooms until picked up for disposal. Also, be sure to take a look at where these things are stored before the waste vendor comes to take them off premises to make sure they are in locked storage. Putting them out on the loading dock is not an acceptable storage location. Also take a look at how they are moved through the organization during collection processes as we have seen large carts full of these materials appearing to be abandoned in the hallway while staff are picking up from a unit.

So, there are multiple new challenges to prepare for in 2017, and some long-standing problems that remain unresolved. New in 2017 is that the ESC you submit for issues identified in the red or orange/mustard zone of the Matrix™ do require identification of senior management intervention in the resolution of these issues. Best to avoid that consequence!

CMS UPDATE:

There are no new CMS Survey and Certification memos to the hospital industry at this time. There are 2 new ones for nursing home providers, but the hospital industry is taking a breather at the moment.

CONSULTANT CORNER

We have a new website with new resources for our readers and clients. Check it out! (*https://pattonhc.com*) Our prior newsletters are displayed with a topic list for easy searching and easy reference under the Newsletter tab (*https://pattonhc.com/newsletters*).

For our Continuous Accreditation Support (CAS) clients, we have a new login for our tool and resource library. We have added many new tools and updated the former favorites. We now have 100 tools and resources for your use. Our CAS Client tab (*https://pattonhc.com/cas*) will take you to a new customer specific login and password. Contact any of us and we will send your new login information. As in the past, the tools are fully customizable and can be downloaded.

Thank you,

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