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PHC NEWSLETTER

Patton Healthcare Consulting, INC

News from Joint Commission and CMS

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PERSPECTIVES:

Top Scored Standards for all 2016:
The lead article in this month's *Perspectives* is about the most frequently scored standards for all of calendar year 2016. The top 10 most frequently scored standards in the hospital program are the same as we looked at the midpoint of 2016. The only change is that many went up a percent or two in the frequency of scoring. While there are no surprises in the list, the list is unfortunately very similar to the prior year, and the year before that. In fact, if you look at the list published in Perspectives April 2014, 7 out of 10 standards on the top 10 list are identical. The repetitive nature of many of these frequently cited issues is a risk point for hospitals in that Joint Commission does consider your prior findings when rendering a new accreditation decision. If you are due for survey in 2017, we would encourage all readers to take a careful look at your 2014 survey findings and validate that the issues you described as corrected in your ESC, are indeed still corrected.

Revised Decision Rules:
There is also an article on the Decision Rules for 2017 and modifications made. These ever-changing rules are published in the accreditation manual and are traditionally one of the least read and least well understood sections of the manual. The Joint Commission is eliminating its Contingent Accreditation. This means that organizations that struggle with their accreditation with follow up survey, or have repetitive failures when implementing their ESC, no longer will be placed in Contingent Accreditation, but rather will be placed in Preliminary Denial of Accreditation (PDA) which is a more severe decision. There is also a new path to PDA status by failing two Medicare Condition level follow up surveys. Probably the most important change for 2017 is the TJC Board level accreditation committee has delegated the decision-making process to senior staff at the Joint Commission. In the past, the Board committee met a limited number of times and the time it took to render a PDA decision was sometimes many months. This administrative change will expedite the process significantly.

In addition, if you end up in PDA 02 status, meaning you have many RFI's and these RFI's demonstrate a pattern similar to your prior survey and "place patients at risk for serious adverse outcomes," you will now be required to submit a plan of corrective action (POC) within 10 business days of final report posting. There is also still a 10-day clarification window, but successful clarifications are becoming increasingly difficult with the elimination of the C audits, and the elimination of finding documents after the surveyors have left the building. Previously, PDA organizations submitted a 45-day ESC post-survey which was documentation attesting that you had completed your corrective action and it was implemented. The new POC requirement in PDA02 situation will be a plan to implement that will be verified as having been implemented during an onsite follow-up survey occurring at approximately 60 days. There are also detailed instructions on how to prepare a POC published on your Joint Commission Extranet. Remember, you have little time to get this plan together after survey. The old idea of planning a vacation right after survey should be discarded.

Insights into the 2012 LSC Changes:
The Clarifications and Expectations column continues this month with additional insights into changes to the life safety code as a result of conversion to the 2012 LSC. Everyone appears to be having difficulty getting their arms around all these changes, including TJC trying to maintain alignment with CMS, ourselves as consultants trying to understand what is a current requirement and what is soon to become a current requirement, and of course hospitals which we continue to see slammed by all these changes. Some of the changes described in this article apply differently to existing facilities or planned new construction or remodeling. However other sections of the article describe requirements that we must maintain all the time. You will want to share this article with your facilities leadership and ask them to evaluate your level of compliance. To aide in this evaluation we will pose some of the issues discussed in this article as questions to be answered.

- LS.02.01.10, EP 7: Do all of your fire doors operate and latch as they did when they were first installed or has any part of the latching mechanism been modified and potentially void your fire door warranty?
- LS.02.01.10, EP 7: Do any of your fire doors have a protective kick plate greater than 16 inches from the bottom edge of the door?
- LS.02.01.10, EP 7: Do you have any fire doors with signs that are screwed into the fire door, damaging its integrity?

- LS.02.01.10, EP 8: Do you have any fire doors with signs that are affixed with adhesive, but the sign is larger than 5% of the door face?
- LS.02.01.10, EP 8: Do you have any areas of the hospital where staff have placed paper or cardboard signs, notices or art work on the fire door?
- LS.02.01.10, EP 9: Are the fire dampers located in a 3-hour fire barrier also rated for 3 hours as required by NFPA 90A-2012?
- LS.02.01.10, EP 9: Are the fire dampers located in a wall that is rated less than 3 hours, rated for a minimum of 1.5 hours?
- LS.02.01.10, EP 10: Are the spaces around pipes, conduits, bus ducts, cables, wires or pneumatic tubes penetrating the wall or floors protected with an approved fire rated material?
- LS.02.01.10, EP 10: When you look at your sealed penetrations, is one color fire stop used, or do you see multiple colors? Do you have the manufacturers specifications for each of these materials used at different times to prove their effectiveness?
- LS.02.01.10, EP 11: This is the new catch all EP. Have you evaluated, and are you compliant with all the new CMS K tags relative to compliance with the life safety code?

Perspectives also has a link to the draft future EC/LS standards which will take effect on July 1, 2017. These standards can be found at: [redacted]

CAS Clients: We are hosting a webinar on LSC Changes:
To aide our *Continuous Accreditation Support (CAS) consulting clients* with their readiness on the continued changes in the life safety code requirements we are planning a webinar to be presented by our LSC partners, MSL Healthcare Partners, Inc. MSL life safety code specialists often work with our clinical teams in conducting mock surveys. This presentation is planned for 2 hours and will be held Friday, May 12 at 11:00 am – 1:00 pm Central Time Zone. To register simply ask your primary consultant to forward you the email notice of the webinar.

NEW FAQ'S:

History and Physical:
This month TJC posted 4 new frequently asked questions or standards interpretations, at least 3 of which are very important and frequently asked. The first discusses an inpatient who has an H+P performed at the time of admission, who will later in the hospitalization undergo a surgical procedure and, if there must be any update to the H+P. This subject was addressed in an FAQ years ago that was later removed and its return is very welcomed. The answer is no, there is no need to update the H+P for the inpatient because there are daily assessments and progress notes since the time of admission.

A second FAQ also discusses the history and physical and this one is really important to understand. They discuss the outpatient who has an H+P performed as an outpatient less than 24 hours before they come to the hospital for a surgical procedure (e.g., H&P at 4 pm the day prior to surgery scheduled at 7 am the next day), if whether that H+P requires an update or not. The answer is YES, the H+P performed on an outpatient anytime up to 30 days prior to the day of their arrival and registration, does need an update. The only way you can omit the H+P is if the patient arrives and registers for their surgery, has an H+P performed and then several hours later will have the surgery. In this case, the H+P was performed after arrival,

after registration and the patient has been monitored by your organization since the H+P was performed, thus no update is needed. This is very often a difficult issue for staff and physicians to understand.
By way of warning we would advise not trying to outsmart the system by registering the patient the day before their surgery and letting them go home, thinking you can avoid the H+P update. If the patient has gone home, has not been observed and monitored, then you are always going to need to update the H+P.

Titration Orders:
The third FAQ discusses the required elements of a complete titration order, a subject we have addressed multiple times in this newsletter. TJC states each titration order must include the name of the medication, the route, the initial or starting infusion rate, the incremental rate the infusion can be increased or decreased, the frequency at which you can adjust the rate, and the objective endpoint for the infusion such as a RASS or a blood pressure. Although not stated in the FAQ we would add that each time you adjust a rate there should be documentation that indicates why an adjustment was needed, and that the patient responded as expected. This means an assessment of need and a reassessment of effect should be documented.

So, for example if the RASS goal is -3 and you increase the rate, you want to make sure you document that the patient was not at a -3, and then re-evaluate the patient after the adjustment to see if they now reached the -3. We have seen the significant difficulty hospitals have documenting their sedation titrations completely. This problem is intensified if you are using 2 sedating agents and have indicated both are intended to achieve a RASS score. The problem is there is no guidance on adjusting drug 1 or drug 2. If one drug is really used for pain, and the second for sedation, make sure your orders state the correct indications. Also, be careful when patients have pre-existing conditions such as a head injury that results in an observed RASS that is already deeper than the prescribed goal.

Linen Management:
The 4th FAQ is not what we would call a burning issue. It deals with linen management and keeping linens clean in storage. TJC does not have any specific linen standards, but they refer readers to the CDC and the National Association of Institutional Linen Management. As you might expect they advise carts stored in hallways must be protected from contamination by using covers. However small carts used to distribute linens, out and exposed for only a short period of time, need not have covers. Our recommendation is to select a national guideline to follow, update your policy and train staff. You may want to consider a risk assessment to validate your procedures for keeping linens clean until used.

Storage of Sterile Supplies outside of Central Sterile:
There is a fifth issue that has not yet resulted in a published FAQ, but we have seen responses on the issue provided to the TJC Consultant Forum and to two different hospitals. The issue is the multiple locations in a hospital where you might want to keep a small quantity of sterile items processed by your central sterile supply department. For example, a chest tube insertion tray in a surgical ICU or a trauma tray in the ED trauma room. We have seen many RFI's on this issue for a failure to document daily temperature and humidity measurement to verify storage conditions compliant with AAMI. While this sort of monitoring is clearly required in the large centralized storage location maintained by central sterile, many organizations have struggled with these satellite locations. TJC has recognized that

these satellite locations with small quantities of sterile items need some additional flexibility, but at this time we see nuances between the different responses that don't yet make us comfortable on how to bullet proof the process from criticism.

FEEDBACK ON THE SAFER™ MATRIX:

TJC recently presented some early data to its corporate hospital group and it indicates that a relatively small percentage of total findings are ending up on the red area of the Matrix, just under 5%. However, there is another 21% of total findings that are ending up in the dark orange or mustard color section of the Matrix, which means a total of 26% of findings will require the additional content on leaderships involvement in the corrective action and the sustainability plan. In addition, these findings will require coaching sessions between the hospital CEO and Joint Commission leadership to ensure implementation of the ESC and continuing compliance.

MORE ON LIGATURE RISKS:

Last month we mentioned the *Joint Commission Online* article March 1, 2017 that talked about an increased focus on ligature risks in the behavioral health environment. Well this looks like it will be ramping up further in the level of scrutiny. At this same Joint Commission corporate hospital presentation, information was discussed that indicates Joint Commission will be looking at dedicated behavioral health space and non-dedicated behavioral health space a little differently. For example, in a unit dedicated to the treatment of behavioral health patients they appear to be looking for a ligature-proof environment. It appears that mitigation strategies will no longer prevent RFI's for ligature hazards in a psychiatric unit. In addition, it appears that these are going to be scored under EC.02.06.01 at a COP level, and in the red on the SAFER Matrix.

In the non-dedicated space, for example a medical surgical area used to house a behavioral health patient while evaluating or treating a medical comorbidity, as many ligature risks as possible should be removed and reasonable measures be implemented to prevent self-harm. TJC reportedly will consider a COP level finding based on the manner and degree of the ligature risks in this non-dedicated space. Further adding to the complexity of this subject was a presentation on hard wooden bathroom doors and how many different ways there are for a typical door to create a ligature hazard. If you have been considering alternative bathroom doors you will want to reach a decision point. If you have not been evaluating alternatives, you will want to begin to learn about the options very quickly. Lastly, Joint Commission sometimes uses these different groups as a sounding board and based on their feedback they may modify the plan going forward. This one sounds like a very important issue to be planning and preparing for, and we believe there is federal pressure to implement these changes so keep your eyes and ears open for more information on this subject.

If you have not already done so, you will want to look at the proposed refinements to NPSG.15.01.01. We learned from the booster pack years ago that TJC seemed to have a preference for structured tools for evaluating suicide risk, but it was never mandated. The proposed safety goal would call for a structured screening tool and a structured risk assessment tool to try and quantify risk. You can access the draft safety goal by clicking on Standards from the Joint Commission Home Page, then Field reviews.

EC NEWS:

This month's *EC News* has the same article previously discussed that was published in *Perspectives*, plus an article from one hospital on planning a new endoscopy center and a third article on falls and the environment of care. The falls article should certainly be shared with your falls committee for discussion and planning and as we mentioned the article on life safety code changes should be reviewed in detail by your facilities leadership.

CMS UPDATE:

There were 2 Survey and Certification memos published by CMS this past month for the hospital industry. These are both dated 3/24/17 and are SC 17-21 and SC 17- 22. Both discuss the new CMS rules on emergency preparedness. The first memo provides links to additional governmental resources for EM planning and a table of requirements by provider type. The second memo mentions a provider teaching call which will take place on April 27 if you want to participate. Your bookmark to access the CMS SC memos continues to be: *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html*

You may have to reverse sort the list presented to bring the newest information to the first page.

SGNA MULTISOCIETY GUIDELINE:

If you have not seen it, the Multisociety Guideline for reprocessing of flexible GI endoscopes was revised and published in January 2017. If you have chosen the Multisociety Guideline as your clinical practice guideline, you will want to analyze this revised guideline in detail and verify that your policies, procedures and practices remain consistent with its recommendations.

CONSULTANT CORNER

CAS Clients: We are hosting a webinar on LSC Changes.

This presentation is planned for 2 hours and will be held Friday, May 12th from 11:00AM – 1:00PM Central Standard Time.

To register, simply ask your primary consultant to forward you the email notice of the webinar.

Enjoy the spring weather!

Thank you,

Jennifer Cowel, RN MHSA
JenCowel@PattonHC.com

Kurt Patton, MS RPh
Kurt@PattonHC.com

John Rosing, MHA
JohnRosing@PattonHC.com

Mary Cesare-Murphy, PhD
MCM@PattonHC.com