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PHC NEWSLETTER

Patton Healthcare Consulting, INC

News from Joint Commission and CMS

INSIDE THIS ISSUE:

PERSPECTIVES:

Deletion of EPs for Nonhospital Programs

This month's *Perspectives* is voluminous, totaling 28 pages. The lead article this month is about the deletion of elements of performance from the nonhospital accreditation programs. The deletion in the other programs mirrors and evaluates the deletions discussed in the hospital program in 2016. There are also thirteen pages of listed elements of performance. We encourage readers to review the key at the bottom of each page, which advises where each EP has gone if it is gone. Some deleted EP's are actually subsumed by another EP, some are addressed by external requirements, and some are considered part of routine operations or clinical processes. That means some of these are "gone, but not forgotten." So, before you stop something you have been doing for years, consider if you were only doing it for TJC purposes, or was it valuable and you should continue to do it, and does the state or other regulations still require the process. All of these changes in your manuals will be published in the July update to the E- edition. Another article in *Perspectives* indicates that the July update should be online sometime in May.

Blood Glucose Meter Advice

Probably the two most important topics to zero-in on this month are the articles on titrations on page 26 and blood glucose meters on page 12. The glucometer article discusses single patient use and multiple patient use devices. The language used by TJC is nebulous, stating that "organizations can conduct a risk assessment on how they use fingerstick/lancing devices by determining whether staff are using single use on multiple patients." Instead, we suggest that readers go to the CDC link where the advice is more detailed and clear. Fingerstick devices should never be used on multiple patients. The CDC then discusses the blood glucose meters and indicates that some are single patient use and others are for multiple patient use. Those that are intended for multiple patient use should come with manufacturer's instructions for use detailing the cleaning requirements between each patient. Those that do not include cleaning instructions, are intended for single patient use only. There is also a second link inside the CDC memo to an FDA advisory to manufacturers about single vs. multi-patient use requirements. The bottom line is you want to check which blood glucose meter is being used in your hospital and verify it is approved for multiple patient use.

Medication Titration Requirements

The second essential article is the one on medication titrations. We have talked about this in the past as a very frequently seen problem and TJC has recently posted a FAQ to help clear up the requirements. This article goes into even more detail than the FAQ and absolutely should be discussed at a Pharmacy and Therapeutics Committee and a hospital wide quality committee. You want to verify that your mediation titration orders contain all mandatory elements including a therapeutic endpoint. Secondly, you want to verify that documentation of medication administration demonstrates that staff are adhering to the physician order parameters and adjusting the titration per that specific order. Our observation is that titrations to a specified blood pressure are usually adherent, while titrations to a specified sedation level are much more problematic. There are two tables included in the article, the first of which identifies the required data elements for a complete order. The second table identifies six different standards where some aspect of titration imperfection can be scored. There are two requirements discussed in Table 2 that are clear and appear new. The first is a requirement for competency assessment for those who administer titrations. The second is a requirement for QAPI assessment of your level of compliance with these titration parameters. The bottom line on this one is you absolutely want to evaluate your compliance and monitor seeking 100% on every aspect identified in Table 2. Remember, in 2017, 90% compliance is no longer acceptable. Everything must be 100% compliant and this one is really difficult.

Details About Doors!

Perspectives also includes another in the continuing series of articles entitled "Clarifications and Expectations." This month they discuss LS.02.01.20 on egress. This article includes draft language which is subject to further refinement to align TJC standards with the CMS K-tags. The article is good for both quality professionals and facilities leaders to understand current requirements perhaps in greater detail. In addition, it is useful for facilities leaders to understand additional details likely to be added later this year to correspond to CMS requirements. The first part of the article discusses egress doors and they identify delayed egress, access controlled egress, and a new feature - elevator lobby access door locking. The local discussion should include; do we have them, where are they, and are we compliant? They next discuss locking of patient sleeping rooms, the limited situations where this is appropriate and the requirement for all staff on the unit to have the key to unlock these doors. They also discuss single leaf horizontal sliding doors and the multiple NFPA requirements which must be in place if you are going to use these.

New Signage Requirement

There is also a new requirement for stair signage indicating the story, the stairwell, up and down and the direction to exit. This signage was previously required in buildings five or more stories and now it will be three or more stories. In addition, the floor level part of the sign must be tactile. Previously, it was thought only the exit discharge information had to be tactile. Lastly, they discuss exit passageways to a "level-walking surface." Be sure to share this article in its entirety with your facilities leadership and request feedback about your existing compliance or need for renovations.

Consistent Interpretation-Informed Consent

Perspectives published the 9th in a series of articles, which continues to confuse us, entitled "Consistent Interpretation." This month they discuss RI.01.03.01, EP13 relative to informed consent. As in the past, they list examples of surveyor observations and their guidance in a table format. The first example lists three surveyor observations. The first observation is that a patient did not date or time their signature. The second observation is that someone other than the patient signed the consent form and contrary to hospital policy that person was not identified. The third observation notes that a procedural consent form did not contain the actual name of the procedure.

The Guidance/Interpretation section states that this RI standard does not require patients to date or time their signatures, only the witness to the signature needs to date and time their signature. This seemed like important information to us because for years we have seen this RFI scored against the RC standard for patients failing to date and time consent forms. The guidance is unfortunately silent on potential scoring in the RC chapter. Oddly, the consent signed by someone other than the patient and the consent without the name of the procedure is not addressed in the guidance section.

The second consistent interpretation example identifies a patient receiving a blood transfusion who had not signed a written consent for blood. This second observation deals with a Spanish speaking patient who signed a Spanish consent form and, although it was required by hospital policy, there was no name for an interpreter. The guidance section states that TJC does not require consent for blood transfusion, unless hospital policy requires it, or state regulation requires it. We found this to also be important new information since AABB requires informed consent and the TJC/NQF blood management performance measures had required it. Again, oddly, the issue about the Spanish interpreter is not answered in the guidance section. Unfortunately, each time we read this series on "consistent interpretation" we have more questions than answers. We would encourage our readers who draw conclusions from this column to obtain standard interpretation staff (SIG) written validation of your conclusions before changing hospital policies.

SAFER™ Matrix – A Look Back at Psychiatric Hospitals

There are two additional items we wanted to touch on from this month's articles, the first of which is data on use of the SAFER™ Matrix in deemed psychiatric hospitals. The SAFER™ Matrix has been used in psychiatric hospitals since the summer of 2016. Here Joint Commission lists in table format the distribution of findings for the most frequently scored standards using the color-coded methodology of the SAFER™ Matrix. When you first look at the table, you might think the surveyor are all over the map on assigning risk. However, we can't actually draw a lot of conclusions from this table because each standard has multiple elements of performance some of which may have greater likelihood of harm than others. The one conclusion that might be drawn is that most scoring is not hitting the red zone, with the exception of EC.02.06.01. Since these are psychiatric hospitals we would assume these are ligature hazards being identified.

New ESC Format

Lastly, you will note an article on a new ESC format being used in ambulatory care and deemed psychiatric hospitals, which appears to combine the familiar, WHAT and WHEN sections into a new section titled "Correcting the Noncompliance." The WHO section gets retitled as "Assigning Accountability." Also listed is the new leadership involvement and preventative analysis requirements all programs now have when scoring is made in the red or dark mustard color sections of the SAFER™ Matrix.

We also wanted to correct an incorrect statement we made in our April newsletter about the SAFER™ Matrix requiring a coaching session between hospital and TJC leadership if scoring appears in the red or mustard color areas. That is not correct and came from our misinterpreting of new information about Intracycle Monitoring (ICM), SAFER™ and PDA requirements.

EC NEWS:

This month's *EC News* has an interesting article on the most problematic aspects of EC.02.04.03 during laboratory surveys. Laboratory findings are not a subject we usually discuss, nor is it a subject discussed often in EC News. The article is very detailed and interesting, noting that the most frequent findings under EC.02.04.03 are failure to monitor temperatures, equipment maintenance gaps and standardizing scales. This article should be shared with your laboratory director along with a request for feedback about your hospitals compliance with these issues.

EC News also provides a link this month to an extensive document prepared by the FBI on active shooter situations. This document should be shared with your emergency management committee as a resource for preparation and conducting drills. EC News also has the same excellent article on LS.02.01.20 also published in *Perspectives*.

CMS UPDATE:

Emergency Management Planning

Last month we mentioned that CMS had posted SC-22 which discussed a planned teaching call from CMS on the requirements for emergency management planning. That call was conducted on April 27, and probably the most important take away point is that CMS expects compliance with the new requirements by 11/15/17, even though the interpretive guidelines have not yet been published. Their advice was - don't wait. They expect training for involved staff, a full-scale community wide exercise and a second exercise which may be locally based. You can download the presentation materials, an audio recording and a transcript from the CMS website at: *https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2017-04-27-Emergency-Preparedness.html*

At the end of April CMS issued SC-24 on the subject of accrediting body transparency. Basically, CMS is proposing that all accrediting body survey reports be posted publically. We assume there will be advocacy both for and against this proposal, however it would seem to create an unleveled playing field in that CMS usually does not conduct full surveys of non-accredited hospitals. Thus, those who chose to not be accredited would not have their flaws publically displayed, while those that are accredited would. At the moment, this is a proposal and we would hope there would be dialogue between CMS and the hospital industry prior to any finalization of a rule.

STILL MORE ON LIGATURE RISKS AND RESOURCES:

Last month we wrote about the increased emphasis on Joint Commission surveys on the subject of ligature risks. One of the questions we get asked a lot as consultants is: where can I purchase a safer bathroom door, a safer sink, a safer shower head, etc. There are two references

we would suggest. The first is titled the Design Guide for the Built Environment. This used to be offered through the NAPHS, but now it is offered free of charge through the Facilities Guideline Institute, or FGI. You can download a copy of this document from:
https://www.fgiguidelines.org/wp-content/uploads/2017/03/DesignGuideBH_7.2_1703.pdf

A second document you should have is the New York State Office of Mental Health's Patient Safety Standards, Materials and Systems Guidelines. OMH is probably the largest state provider of psychiatric services and the regulating body for mental health services provided by acute care hospitals in NY. This document can be downloaded from:
https://www.omh.ny.gov/omhweb/patient_safety_standards/

The NYS OMH document identifies fixtures and equipment that have been evaluated by the regulatory body as approved for use in NYS and includes pictures of many of those not approved for use with meaningful advice on those not approved which is often valuable for evaluating alternatives.

Both documents provide pictures of the fixtures and furniture they deem better alternatives. Fortunately for patients, and unfortunately for those involved in facilities design, newer and better alternatives become available each year. So, as you build or renovate you will never really be done, as equipment that seems a better alternative in 2017, may not be the best in 2020. We would encourage you to keep up with both of these resources as each prepares an annual update.

In addition, our consulting clients should review our environmental risk assessment tool. Our tool identifies many of the usual hazards present in the behavioral health environment and in an Excel format allows the user to add or delete rows for items we did not list or items you don't have. Each potential hazard gets evaluated on a 3-point scale for each of three factors, probability of use, criticality of use and detectability, or your ability to see someone attempting to harm themselves with an environmental feature. There is also a column to document a mitigation strategy until such time that the potential hazard can be eliminated. While there is no longer any guarantee that this type of risk assessment will prevent findings from TJC it will help you to prioritize the most significant risks for immediate renovation or replacement and if your total risk score is low enough, your mitigation strategy powerful enough, and your plans to renovate on a near horizon, it may prevent RFI's.

CONSULTANT CORNER

Don't forget to contact us for your compliance and accreditation needs! We look forward to hearing from you!

Thank you,

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