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PHC NEWSLETTER

Patton Healthcare Consulting, INC

News from Joint Commission and CMS

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PERSPECTIVES:

NPSG Updates Published:

This month's edition of *Perspectives* starts off by discussing the changes to NPSG.7 which take effect January 1, 2018. The first important change is to the applicability of NPSG.07.03.01, where carbepenum-resistant enterobacteraceae (CRE) has been added to the list of MDRO's that are the focus of this safety goal. The second important change is actually a loosening of an existing requirement relative to education of staff and LIP's. The annual requirement has been changed to "periodically" as determined by the organization. Unfortunately, terms like periodically or regularly are actually less clear to accredited organizations than a specified point in time. The term is over used in the standards manual with periodic medication storage area inspections, periodic updates of CLIA policies, periodic evaluation of radiation safety badges, OPPE and the culture of safety survey, etc. If you set your periodic re-education point at every 10 years you are likely to get an RFI from any surveyor, but if you set it at 4 years, or 5 years you would likely only get an RFI from some surveyors. Keeping track of your re-education schedule is also more difficult. Our advice here is to keep the re-education schedule to every 3 years and every

time you change your policy or clinical practice guidelines from MDRO.

The central line safety goal, NPSG.07.04.01 is also changing, again with the same change on periodic versus annual re-education for staff and LIP's. EP 11 is changed, going back to the mandate to use alcoholic chlorhexidine, unless contraindicated, during central line insertion.

These changes are subtle and should not cause major problems for accredited organizations providing you do your edits to policies, clinical practice guidelines, and central line insertion checklists prior to 1/1/18.

Egress, Clutter, & Exiting Focus:

The Clarifications and Expectations column is present again this month and it is a *must-read* for your facilities managers. It discusses egress, clutter, and exiting, with hallway clutter being the most consistent problem for many years. There is also discussion about suites and specifically about changes from the adoption of the 2012 LSC regarding the corridor doors, walls, size of suites, partitioning, and exiting from suites. They have included new standards language now in place, new requirements scheduled to take place in 2018, and proposed language which will likely take place in the future. Lastly, they discuss new requirements that will be implemented in January 2018 relative to illumination and visibility. This defines the minimum illumination in foot-candles and stipulates that emergency lighting must be provided for at least 1.5 hours.

Improving HLD & Sterilization – *MUST READ*:

Probably the most essential article to analyze is the one on "Improving High Level Disinfection (HLD) and Sterilization Processes." This is a subject we have focused on repeatedly in our newsletter and hospitals continue to struggle. In this article TJC graphically displays the increase in scoring on these issues from 2013-2016 and it is getting increasingly worse each year. We do not believe this is because hospitals are becoming more and more lax in fulfilling expectations, but rather that the Joint Commission's surveyors are becoming more and more knowledgeable about the finer aspects of the requirements from AAMI and AORN. This is where we believe hospitals may have the greatest vulnerability. Surveyors have access to all the references, they appear to have read them carefully and they have received formal training on these references. We continue to experience many hospitals where if we ask staff performing HLD and sterilization about clinical practice guidelines, show me your AAMI ST 79, or 91 or 58, provide us the manufacturer instructions for use (MIFU); we get a blank stare.

TJC provides some very sound advice to help hospitals do better with this portion of the survey. They advise hospitals to:

- Use and follow Clinical Practice Guidelines (CPG) and Recommended Practices (RP)
- Ensure availability of MIFU
- Design and follow hospital policies based on CPG's
- Verify competency and make sure the individual assessing competency is competent

We would add to this list of suggestions that a senior leader within the organization be identified as the content expert, reviewer, administrator, assessor of all areas performing HLD and sterilization. Today there is too much variation between departments that have their own administrative reporting relationships, yet they may all be performing HLD and sterilization using different methods and degrees of thoroughness. We would encourage hospitals to think of this function like a product line, that multiple different areas provide. Also, whomever you tag for this responsibility will need the resources and training the surveyors have and preferably even more training. They need to be able to walk into any area of the hospital, observe and dialogue with staff and identify the weaknesses before TJC does.

The *Perspectives* article also includes a graphical representation of the immediate threat to life

situations declared by TJC's surveyors over the last 4 years. Fortunately, this is a low frequency occurrence with only 27 in 2016, but the percentage of these events due to defects in HLD and sterilization has grown to 70-80%. So, if you want to prevent the worst possible survey outcome, this is a critical area to focus attention on.

This same subject is discussed in the Joint Commission's Quick Safety Newsletter, Issue 33, May 2017. In this newsletter, they display the RFI history going back to 2009 when only 20% of hospitals experienced and RFI and in 2016 it was up to 60%. If you are going to make the business case argument to appoint a HLD/sterilization czar, purchase all the required references and obtain comprehensive training in your organization, this very focused newsletter is an effective and convincing component of that argument.

NEW FAQ ON STORAGE OF NEEDLES & SYRINGES:

There is one new FAQ posted this month on the storage of needles and syringes. TJC points out that there are no specific standards, however they stress the importance of secure storage to prevent tampering or theft. They advise supervised storage, where only healthcare workers have access and not patients or families. The FAQ points readers to the existing EC and LD requirements to conduct proactive risk assessments. The FAQ is silent on non-patient care staff having access however so we would encourage readers to consider that issue when conducting your internal risk assessment.

EC NEWS:

Helpful Tip on Medical Equipment Tracking & PM:

EC News has the same excellent article entitled Clarifications and Expectations that was discussed from *Perspectives*. There is also an interesting article entitled EC Toolbox discussing medical equipment tracking and preventative maintenance. Hospitals have struggled with this issue for years as equipment goes missing when clinical staff move it with the patient to another location. What belonged to the OR, ends up in the ICU and sometimes doesn't find its way back. This poses a challenge in finding equipment from year to year, but in the past EC.02.04.03 for noncritical equipment was a C element of performance permitting a 90% completion rate. With the elimination of C elements of performance this now goes up to an expected 100% completion rate. The article suggests a spreadsheet format and technique of color coding those pieces of equipment missing at this point in time and those that have been removed from inventory because the search for the equipment has come up empty. The system as described is nice, its organized, but will likely be unable to prevent RFI's in this area. Too often surveyors get lucky and find the missing item by looking at preventative maintenance due dates on equipment they find in patient care areas. This is when the missing piece of OR equipment lo and behold gets found in the ICU and it has an expired PM. The article is worth a read and the format they use is worth consideration, but formatting alone is not likely to prevent RFI's. A foolproof way of finding the missing is what is needed and that may require technology like RFID chips to assist the equipment in being located.

CMS UPDATE:

Emergency Management Interpretative Guidelines Published:

On June 2 CMS issued SC 17-29, publishing the interpretive guidelines for their new emergency management rule. Rather than including this in the general interpretive guideline for hospitals, CMS is publishing it as appendix Z, with E tags, much like the life safety code has its K tags. Since the new EM rules apply to 17 different types of providers it may make it easier to update as a standalone document as CMS has done. However, the format of Appendix Z is not what we would call "user

friendly." Each E tag is followed by a long list of CFR codes, representing the different provider types. Hospitals are covered by CFR 482.15 and critical access hospitals by 485.625. To find what applies to your unique programs you have to search each E tag to find the ones applicable to your program. The SC memo also notes that CMS has developed an Excel listing of these requirements and they provide a link to find that tool. This can be located at: *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html*

Time Out for OR Fire Safety K-Tags:

We believe this is a much more user-friendly version of the tool, because an Excel user can delete those columns or rows that don't apply to their programs. For example, if you have a hospital, a transplant program and a home health agency you can delete the other non-applicable columns and focus only on what each of your 3 programs must do. This same page where CMS posted the spreadsheet has an additional link to another resource called "ASPR Tracie." This site has some very useful resources that organizations can use to help develop their emergency management program. For example, tag E-0004 identified numerous types of emergencies to discuss and prepare for in the plan. One of these was "care-related emergencies," which we seldom see as part of a hazard vulnerability analysis. When we went to the ASPR Tracie website there were several examples of HVA's that do address some care-related emergencies.

While CMS considers the transplant program and the hospital program as unique entities within one organization, you just want to ensure that their efforts are coordinated relative to EM planning. Tag E-0002 which applies to transplant programs mandates that someone from the transplant program participates in the development of the EM plan for the hospital where the transplant program resides and tag E-0005 states the same things as required for the hospital EM program.

Organizations already accredited by the Joint Commission should be fairly well prepared for the CMS requirements. In addition, TJC will be reviewing and drafting any changes they identify as necessary to ensure they have a complete match to the CMS requirements.

Lastly, we wanted to mention an issue noted in the new LSC K tags, specifically K-933. This tag calls for a "time out" to ensure proper use of alcohol based germicides used in skin prep prior to surgery. The tag states that:

Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers:

- packaging is non-flammable
- applicators are in unit doses
- Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify:
  - application site is dry prior to draping and use of surgical equipment
  - pooling of solution has not occurred or has been corrected
  - solution-soaked materials have been removed from the OR prior to draping and use of surgical devices
  - policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use

The issue about alcohol based germicides is currently in the State Operations Manual under tag A-0951, but it is someone buried in a lot of text and we have seldom seen this issue scored on survey. Placing it as a specific K tag which everyone is studying, learning and implementing now may cause this issue to become more well-known, and thus potentially scored. It is something you likely will want to consider at each hospital, and how you might document that you implemented these

precautions. Since the alcohol based germicide is used prior to draping, you might want to do an additional time out just for this issue prior to applying the drape, or document that you considered these precautions when you did your final time out. Delaying the verification step until the final time out, while convenient, may make it more difficult to genuinely verify the product did evaporate completely and we did get rid of any solution soaked material prior to draping.

CONSULTANT CORNER

We hope everyone is enjoying the start of summer! Don't forget to contact us for your compliance, accreditation, and survey support needs! We look forward to hearing from you!

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