NOVEMBER 2017 PHC NEWSLETTER

Patton Healthcare Consulting, INC

News from Joint Commission and CMS

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PERSPECTIVES:

Recommendations for Reducing Suicide Risk:
In the November edition of *Perspectives,* The Joint Commission unveils its conclusions on reducing suicide risks in inpatient hospital settings. These conclusions are not as simple as things were a year ago, but they are greatly improved and clearer than they were 2 months ago. The Joint Commission utilizes a term called ligature resistant, instead of ligature free as does some of the current literature, basically because nothing is foolproof and patients who are intent on self-harm are unfortunately very innovative at times. They define the term ligature resistant to mean: "without points where a cord, rope, bedsheet, or fabric/material can be looped or tied to create a point of attachment that may result in self harm or loss of life." As you are evaluating your inpatient space, you may want to actually carry a thin cord or cloth with you to test the safety of your fixtures, in particular your doors. Using this technique, we have identified doors and hinges that hospitals purchased in the belief that they were safer, but we find they still permit an easy tie or pinch point. The other readily noticeable change in the expectations is to eliminate the terms dedicated and non-dedicated spaces, as these were not universally used.

Inpatient Psychiatric Units:
The first recommendation is for inpatient psychiatric units in both psychiatric hospitals and general medical hospitals. They require that the following areas be ligature resistant:

- Patient rooms
- Patient bathrooms
- Corridors*
- Common patient care areas*

The asterisk after corridors and common patient care areas refers to the solid ceiling type that is required in bedrooms and bathrooms vs corridors and group rooms where a drop or suspended ceiling is "permitted". These are permitted only in areas that are fully, visible and where there are no objects that a patient could easily use to climb on to gain access to the ceiling tile. In addition, TJC now states that "nursing stations with an unobstructed view (so that a patient attempt at self-harm at the nursing station would be seen and interrupted) and areas behind self-closing/self-locking doors do not need to be ligature resistant and will not be cited for ligature risks. So, this means 2 important things. First, if your risk assessment identifies a ligature risk right in front of the nursing station where it can be easily seen and the patient protected, it does not need to be eliminated. If you have been using our risk assessment tool, this is the "detectability" factor on the spreadsheet. The second important conclusion here is that a group room could have ligature hazards providing patients are never left unsupervised in the group room. Our advice here is to make sure your staff are trained, competent, you have a solid documented mitigation plan and that concept is in policy and practiced every single day. The Joint Commission will have recommendations in the future on acceptable mitigation plans for areas that are not ligature resistant. Stay tuned for this.

Recommendation 2 states: "In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, the doors between patient rooms and hallways must contain ligature resistant hardware which includes, but may not be limited to hinges, handles and locking mechanisms." Here is where walking around with your own cord comes in handy as you can easily test the safety of hinges, door handles and locks by trying to affix your cord to the potential hazard. This is also where trying to find safer alternatives may require some research. We recommend two sources for identification of safer alternatives. The first is the FGI Design Guide for the Built Environment. You can download the 2017 edition free from the FGI website. The authors of this document were on the Joint Commission's ligature task force.

The guide can be downloaded at: https://www.fgiguidelines.org/resource/design-guide-built-environment-behavioral-health-facilities/

The New York State Office of Mental Health, an operator of, and regulator for psychiatric hospitals in NYS, also has a nice purchasing guide identifying fixtures and hardware that is ligature resistant. Their 2017 edition can be downloaded for free from: https://www.omh.ny.gov/omhweb/patient_safety_standards/

Recommendation 3 is somewhat of a refinement on recommendation 2 in that it states the top of the top of the corridor door does not need to have a risk mitigation device installed that would identify a cord or pressure placed on the top of the door. They do require that hospitals identify the corridor door on their risk assessment and describe the mitigation strategies used such as regular rounding or leaving doors open.

Recommendation 4 highlights an important difference between corridor doors and bathroom doors in a bedroom. Here the door must be ligature "free." This one becomes complicated and potentially expensive. Solid wood doors would need to have hinges that do not create any tie or pinch points. This might be a continuous piano hinge or a pin hinge, but unfortunately, we have seen too many pin hinge bathroom doors that have a gap at the top allowing a cord to create a tie or pinch point. In addition, TJC says that a solid bathroom door would need to include a sensor device at the top to alarm if weight is placed on the sensor. Be careful here with angle cut wooden doors also. These usually just move the pinch point a foot lower, but still represent a significant ligature risk. TJC is recommending removal of the door entirely, or replacement of the door with a light weight partial door connected to the frame with magnets. One last option they suggest is to deny patient access to the bathroom by locking it unless staff are present to ensure safe use. TJC also advises checking your state regulations before eliminating the bathroom doors, as some states do not permit their removal.

Recommendation 5 mandates that the bedroom and bathroom ceiling in psychiatric units or hospitals must be a solid ceiling. No drop or suspended ceiling is permitted in the bedroom or bathroom even if using tile clips.

Recommendation 6 elaborates on the permissibility of a drop ceiling in the hallway stating the hallway must be visible to staff and that there must be no object in the hall that would enable the patient to easily climb up to the ceiling to attempt removal of a tile. If your hallway makes a right-angle turn, TJC states this should be noted in your risk assessment and an appropriate mitigation strategy put into place. TJC suggests that these tiles might be clipped or glued into place or installing tamper sensors or using another "harm resistive strategy." Furthermore, TJC states the acceptability of the mitigation strategy depends on the physical capabilities of the patient population. This recommendation seems less clear and objective than the others, so hopefully additional advice will be forthcoming about camera monitoring, mirror monitoring and stationing employees in the hall at the right angle turn to seen in both directions.

Recommendation 7 addresses the beds in use in the inpatient psychiatric unit. It says that if beds with potential ligature risks are needed to provide medical care, then there must be an appropriate mitigation plan and safety precautions in place, but these are not defined. This recommendation does not have the same degree of clarity some of the other recommendations had in terms of what an appropriate mitigation plan might be. For example, on an acute medical floor, it is clear in subsequent recommendations that 1:1 supervision is needed.

Recommendation 8 eliminates the concerns TJC and CMS voiced at the start of this enhanced examination of suicide hazards last spring about toilet seats. TJC makes it clear that toilet seats and toilet seat lids are not going to be cited, and they don't even need to be noted on the risk assessment.

General Acute Inpatient Setting:
Recommendations 9 and 10 address the management of psychiatric patients being treated on acute medical floors. Recommendation 9 basically says it is understandable that the physical environment is not going to be ligature resistant. Recommendation 10 then addresses the minimum requirements to safely serve patients with severe suicidal ideation. This will require documented mitigation strategies including:

- Removing all non-essential medical equipment that can be removed
- Implement 1:1 monitoring
- Assess items that visitors may be bringing in with them
- Have a supervision protocol in place to make sure the patient remains safe if they leave the unit for a diagnostic procedure for example
- Have policies and procedures in place for training and monitoring to ensure it is done reliably.

Emergency Department:
Recommendations 11, 12 and 13 address the emergency department. Recommendation 11 states that the ED does not have to meet the same rigorous physical environment standards that inpatient psychiatric units must meet. Then recommendation 12 basically says you could create a safe room, make the room safer by removing non-essential medical equipment in conjunction with 1:1 or continuous observation, or keep the patient in the "main area" of the hospital. They do state that continuous 360-degree video monitoring of these patients is permitted, however the person monitoring the video must be continuously observing and be close enough to immediately intervene if needed. Thus, remote tele-monitoring would not be permitted. In addition, we do not recommend video monitoring, because we have never seen it work successfully for psychiatric patients. The staff doing the observation are too easily distracted or bored, or called upon to fulfill other duties like answering the phone or patient call lights.

They also state that in the ED all patients presenting with psychiatric disorders should be screened for suicidal ideation. Those that screen positive must undergo a secondary screen. A risk assessment needs to identify which items must routinely be removed for patients with suicide ideation and you must have a protocol for monitoring patients and keeping them safe when in the bathroom, when they move from the ED to another area of the hospital and when visitors are present. Finally, you are required to train staff and have documented competencies.

In conclusion, this is good news and it starts to lend some degree of clarity to organizations anticipating a survey, but there will be more questions coming in and hopefully FAQ's will be developed explaining those details.

FAQS:

The Joint Commission posted 10 new FAQ's relative to the new pain management standards that take effect January 2018. Many organizations we visit are currently discussing and planning their implementation effort at this time. Seven of these FAQ's are from the leadership standards associated with the pain management standards, one from performance improvement and two from provision of care. The responses addressed here are a little unusual in that they don't seem to be addressing any questions we have actually heard clients ask. In addition, the questions each appear to be asking; "what is the minimum I have to do in order to be compliant"?

LD.04.03.13, EP 3:
Question: Relative to staff and LIP education and resources: Are there specific resources that must be made available and what options may be considered for delivering this information?
Answer: No, you decide based on your services and needs and for content you may choose online resources or clinical practice guidelines on safe opioid prescribing, modalities of treatment, multi-modal pain management, and assessment criteria.

LD.04.03.13, EP 1:
Question: Since the new requirement states leadership is responsible for developing, implementing and monitoring performance improvement activities specific to pain management, is having a policy sufficient?
Answer: No, they will be looking for active leadership, sustainable improvements and accountability across disciplines.

LD.04.03.13, EP 4:
Question: In regards to having consultation available to staff and LIP's, does that mean internal or external consultation?
Answer: Either or both is expected as needed to meet staff and LIP needs. They advise that staff and LIP's should be knowledgeable about available services and resources for continuing care upon discharge. In addition, Joint Commission indicates that compliance will be assessed through interview of staff and LIP's.

LD.04.03.13, EP 2:
Question: Since organizations are required to provide non-pharmacologic pain treatment modalities, what exactly is TJC talking about and is there any evidenced based literature to support the efficacy of these non-pharmacologic modalities?
Answer: Here the Joint Commission responds to the first portion of the question, but is silent on the second part concerning efficacy. TJC does identify options such as transcutaneous electrical stimulation, acupuncture, chiropractic therapy, osteopathic manipulative treatment, massage therapy, relaxation therapy, music therapy, aromatherapy, cognitive behavioral therapy, etc.

LD.04.03.13, EP 6:
Question: Please explain what is meant by the requirement for the hospital to facilitate practitioner and pharmacist access to Prescription Drug Monitoring Programs. Does this mean the organization is required to access the PDMP for every patient receiving opioids?
Answer: Facilitating access simply means facilitating access such as shortcuts to the PDMP database on hospital computers, links from the EMR, education of staff and LIP's on how to access, demonstration/return demonstration competency and periodic monitoring of compliance as defined, and compliance with state law or regulation that may mandate accessing the database prior to discharge with a narcotic prescription. Most importantly here, TJC states that the requirement does NOT apply to patients receiving short term opioids during their hospital encounter. Lastly, if your state does not have a PDMP, then the requirement does not apply.

LD.04.03.13, EP 5:
Question: How does the organization demonstrate compliance with the requirement to identify opioid treatment programs that can be used for patient referrals?
Answer: This may be difficult for individual clinicians to do, so the hospital should create a list or database. TJC suggests looking at the SAMHSA directory of opioid treatment programs.

LD.04.03.13, EP 7:
Question: Does TJC have any specific recommendations or standards concerning the monitoring of post-operative patients on opiates, and specifically anything about pulse oximetry?
Answer: Here the Joint Commission discusses risk assessment to help identify those patients are greatest risk. In addition, they identify 6 references to help develop policies, protocols and quality indicators. We

would like to suggest one that is not on their list and that is the CMS Survey and Certification memo 14-15, issued March 14, 2014. This memo does an excellent job of describing risk assessment methods and measures hospitals can take to reduce risk from opiate administration.

PI.01.01.01, EP 18:
Question: Since one of the HCAHPS measures does ask about pain management, would the use of this measure suffice for the new performance improvement standard?
Answer: No. TJC points out that HCAHPS only evaluates inpatient discharges and they want this PI standard to address both inpatient and outpatient populations. In addition, they call for the measurement activity to be broader in scope. For example, they suggest use of Naloxone, incidents of respiratory depression, and practitioner prescribing practices.

PC.01.02.07, EP 8:
Question: Who is responsible for providing the patient education required by this standard?
Answer: TJC does not specify who is responsible, but they do make it clear that documentation of the education must appear in the medical record. Hospitals will need to think this through in the context of their EMR capabilities. Many will easily permit this to be documented in a care plan tab, and others have an education log where this can be documented. We would encourage readers to identify the specific location where this documentation should be placed, not allowing it to be in one of several different locations. You want to be able to find the documentation upon request, and knowing where to look is essential.

PC.01.02.07, EP 1:
Question: What is the difference between screening and assessment?
Answer: The answer is basic, important and a core concept spread throughout the Joint Commission standards in several performance areas. Screening is looking for the potential presence of a problem and assessment is the more in-depth evaluation of that problem. In addition, TJC reminds the industry that different assessment tools should be used for assessment of pain, for the very young, elderly, and those without the ability to respond directly to questions.

EC NEWS:

The Clarifications and Expectations column returns this month, for what may be the last edition since the author has left TJC. In this column, George Mills explains 10 draft requirements on fire safety that have been created to further connect TJC requirements with CMS K tag requirements. At this time, TJC is still awaiting final approvals from CMS, but since 2018 is only 2 months away, we would recommend that this article be shared with your facilities leadership team to determine if you are compliant or how to become compliant.

There is also an article on one hospital's activities to make hospital safety fun and meaningful. We wanted to highlight that the hospital shared a copy of an EOC checklist they use to help identify deficiencies through self-audits. This is a two-page, 56 question checklist that appears easy to use, and would help to identify EOC vulnerabilities. If you don't already have a similar tool you may want to use this one, and if you do already have a tool, you may want to look at the questions asked to see if any should be added to your existing checklist.

CMS UPDATE:

There were no Survey and Certification (S&C) memos to the hospital industry posted in the past month.

TRENDS ON SURVEY FINDINGS:

We maintain a database of survey findings so that we can keep up with new issues we see being scored and advise clients and readers about developing trends. The issues you see in the Joint Commission's frequently scored standards listing, ligature issues and the IC and air handling issues we have written about many times the past few years remain very problematic. We also see some other issues bubbling up, although they have not made the top 10 list yet.

Dialysis Focus:
Dialysis appears to be an issue TJC is spending more time examining, in particular what to do when the routine colony counts are above 50 CFU, or above 200 CFU and what the policies are that are implemented

when this occurs. We also see dialysis findings where the physicians' orders don't match the treatment plan administered, either for flow rates or contents of the dialysis bath. Another issue that surfaces more and more often is interesting in that the citation is for a failure to follow AWHONN clinical practice guidelines. This intrigues us, as the finding never states that the hospital has adopted or committed to compliance with AWHONN CPG's, only that the facility failed to follow them. The most recent example was a "failure" to follow their CPG for magnesium sulfate administration. We don't know if this has become a de-facto standard from TJC where all surveyors expect compliance, or if it is just one surveyor citing this issue. If it is just one surveyor, this individual seems to be conducting surveys at an alarming rate.

Open Electrode Packages:
The open electrode package issue we first spoke about several years ago seems to be gaining traction also. If you did not either switch to the smaller packages, or initiate an expiration dating process already, you will want to get this done soon.

Protocols:
We have written about the focus on clarity of medication titration orders and adherence to the monitoring parameters specified by the physician. Well this good idea has now spread to oxygen orders also and we see many hospitals with "protocols" that respiratory therapy staff use, but the protocol sometimes does not actually exist in writing, or a copy of the protocol is not present in the record, or the protocol is not actually being followed.

Clarity on Clarifications:
Lastly, we encounter many hospitals that believe clarifications are no longer part of the Joint Commission process, or they try the onsite clarification process and find it to be "one sided" with the surveyor affirming that they are correct and they have verified this with SIG. If a finding is wrong, then we would encourage hospitals to go through the formal clarification process. Trying to fix something that is not broken, or trying to implement something not actually required, and in some instances trying to implement something that is clearly wrong is a mistake on the hospitals part and diminishes the credibility of the entire process. TJC will work with you if you can describe good supporting documentation and more precisely what your process is.

CONSULTANT CORNER

Happy start to the holiday season!

If you haven't done so yet, check out our new Blog at https://pattonhc.com/patton-healthcare-consulting-blog/. You may also enter your email address to receive notifications of new posts by email so you stay current.

We are scheduling all 2018 surveys, so please contact us soon to reserve your time. Your compliance is our importance!

Have a wonderful month!

Thank you,

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