NEWS FROM TJC

Change in Decision Process for AFS and PDA

APRIL NEWSLETTER

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This month's edition of Perspectives summarizes the Top 10 most frequently scored standards from all of the full surveys in 2014 in all accreditation programs. This list for hospitals should not surprise any readers. Do note that 8 of the top 10 are EC and LS issues, however several we discuss are controlled by clinical staff. Also take a look at the extraordinary percentages of hospitals that are experiencing difficulty with these standards. The key is trying to figure out how you are going to prevent these from appearing in your hospital. This is particularly important if you had some of these findings on your last full survey. You want these issues to be closed, permanently.

Hospital Top 10

#1 56% EC.02.06.01: Safe & Functional Environment
This is somewhat of a catchall standard talking about a safe and functional environment. But the critical EP in this today is EP 13 dealing with temperature and humidity. Operating room environments, sterile storage, central sterile supply clean and dirty all have special requirements relative to temperature and humidity. Task 1 is to make sure staff and physicians that work in these areas know the required parameters and that they don't personally do something to make the situation worse. Task 2 is to note the temperature and humidity on a log each day, which may be maintained on paper or done through automation. Task 3 and really the most important is to do something about it, if the temperature or humidity are outside of the required settings. Over the past decade a lot of improvement has been made in logging food and medication refrigerator settings using automation support. Some of these systems are really good and they pester identified leaders until such time as the leader makes an intervention and documents this intervention. This same persistence is essential with temperature and humidity readings in sterile storage, decontamination or procedural settings. Purchasing automation support without a mandatory feedback and documentation process is a waste of money.

#2 53% EC.02.05.01: Risks with Utility Systems
This is the standard, EP 15 where TJC is scoring problems with pressure differentials. Much like #1 above staff need to know what their special pressure relationship is, either positive or negative and what they can do while working in that environment to maintain the appropriate pressure, such as by keeping doors closed. In addition you want staff in these areas to know what the pressure is when they are working. A
meter, a ball in the wall or performing a tissue test are all appropriate means to determine air pressure relationships. Assuming the relationship has stayed stable 6 months or a year after it was last validated is a design for failure. This one has a double hit in that TJC will score this as a Medicare Condition of Participation out of compliance for infection control, and give the secondary COP hit at leadership, just like CMS would do.

#3 52% IC.02.02.01: Reduce Risk of Infection
This is where issues about high level disinfection are scored. Any deviation from perfect compliance in procedure and documentation is going to result in an RFI and a Medicare COP out of compliance for infection control and leadership. To the extent you have lots of locations and lots of staff performing high level disinfection (HLD) you have lots of risk. This makes rounding and supervision of the process more complex. We even go to locations in the hospital that are soaking medical equipment in Cidex OPA and no one seemed to know that department was doing it. You might want to work with purchasing to put a stop to ordering of Cidex (or other brands of high level disinfection products and chemicals) unless the process is reviewed and approved by infection control. If you don't have the AAMI ST 58 2013 you want to purchase a copy because it appears to be the gold standard TJC surveyors are using to evaluate high level disinfection. You want to continuously audit quality control documentation of the process to validate compliance with ST-58. Also important here is to understand the difference in training and competency validation. Training means I listened, competency validation means I listened and learned and demonstrated I could do the task appropriately. TJC will expect a highly detailed competency validation based on all manufacturer instructions for use and applicable portions of AAMI ST-58 for anyone performing HLD.

#4 50% LS.02.01.20: Not Blocking Egress

The standards phrase is maintain the means of egress. The easier reminder is keep junk out of the hallways or moving down the hallways at least every 30 minutes. Crash carts and infection control isolation carts which are in use are the approved exception.

#5 49% RC.01.01.01: A Complete & Accurate Medical Record
The primary culprit here is timing of medical record entries, EP 19. To the extent you still have any paper, you have risk. Not timing medical record entries is problematic, but so too is careless timing. Putting down a time on a pre-anesthesia assessment after a procedure is over, or timing a post procedure note before the procedure is conducted is even more problematic than not timing because TJC may view this as falsification. Its one of the worst audits possible, but this can be potentially clarified by auditing charts for a percentage of compliance with timing of entries.

#6 48% EC.02.03.05: Maintain Fire Safety Features and Equipment
This is an open book test that almost half the hospitals in the nation are failing. This is the standard, which requires testing of all the fire suppression and fire detection devices in the hospital. The most common flaw is just disorganization in that these tests are often done by vendors and sometimes the vendor combines two tests in one report. These then get filed appropriately in a folder or binder against one EP and there is failure to make a copy and file it against the second EP. The disorganization can also be the internal, having done the tests, but filed the documentation in different offices or office stacks of paper and no one can find them upon request. Another common flaw is doing the tests by saying something like “all strobes” tested and passed. But TJC is looking for a complete and
detailed inventory of strobes, alarms, detectors, etc. Lastly TJC added a requirement (EP 25) a few years ago to identify the NFPA code pertinent to each test performed. The vendors that perform these tests have somewhat accommodated this need, but not always. An easier way to be sure is to file your tests in one binder with a cover page for each EP and required test where your staff have placed the NFPA reference.

**#7 46% LS.02.01.10: Building Features Minimize Effects of Fire & Smoke**
This standard is usually scored at EP 5 for fire doors, or EP 9 for penetrations. The fire door issue is often that the door does not close and latch appropriately. This happens in a large hospital with doors being banged into by carts and stretchers even though there is often a robust internal inspection process. If you have 200 fire doors its not unheard of that 2 might fail on survey because they just broke recently. This is a C element of performance and most hospitals have no numerator/denominator data to use for clarification purposes. There is a process for inspection, but not data flowing in that says we inspected 50 doors this month and 49 passed, 1 failed and we immediately repaired it. If you modify your inspection process to provide this data you may be able to overturn a finding on clarification.

**#8 43% LS.02.01.30: Protect Against Hazards of Fire & Smoke**
Another door issue is the usual problem, in this case smoke doors with too large a gap between the doors or too large a gap under the door. Use the same process suggested above for fire doors to try and provide yourselves some opportunity for clarification.

**#9 43% LS.02.01.35: Maintain Systems for**

### Extinguishing Fires
We often see this at EP 4 which prohibits tying other things above the ceiling to a sprinkler pipe. Contractors and staff placing cables or wiring often tie these off on or drape them over the sprinkler pipe, which is prohibited.

**#10 36% EC.02.02.01: Manage Risks Related to Hazardous Material & Waste**
This standard has an assortment of EP's all dealing with hazardous waste and hazardous product management. Quite often the finding is related to hazardous chemicals and not having an eyewash in the immediate area where the corrosive chemical is being used. If you don't have a process to evaluate new products before they are purchased, you have vulnerability here. Corrosives should not be permitted to be purchased in an area that does not have a plumbed eyewash. After you install the eyewash another common flaw is not inspecting it and documenting that inspection. You will also see hazardous radiation issues scored against this standard, either staff not returning their dosimetry badges or failure to inspect lead shields each year.

### Behavioral Health Top 10
The top 10 for behavioral health have two standards that are frequently scored and consistent with mock findings we see. NPSG 15.01.01.01, is the third most frequently scored BHC standard at 22%. The common finding here is a failure to risk assess the physical environment for behavioral health patients to detect potential suicide hazards. The 8th most frequently scored standard is EC.02.06.01, “the organization maintains a safe, functional environment”. This is usually the same issue just scored in 2 different locations depending on surveyor preference. It’s a failure to identify and risk assess potential suicide hazards in the
physical environment. When you next go to your behavioral health units ask leaders for the current risk assessment of the physical environment for suicide hazards. Most times they will look at you like you are speaking a foreign language. This risk assessment should itemize all the potential ligature points that exist in the physical environment and each should be risk assessed. We suggest evaluating for probability, criticality and detectability. For example a ligature point in the day room where patients watch TV in the presence of staff is less probable to be used, and more easily detectable if it were to be used. Now compare that with a ligature point in the patient’s own bathroom, now behind the door to the room, and the door to the bathroom. Its much more difficult to detect use in this location. After you create your itemized list, identify a mitigation strategy for keeping patients safe. For example you might use your clinical suicide screening tool to determine a level of precautions such as 1:1 or q 15 minute checks. You might also use that tool to identify who should be moved to one of the more environmentally safe rooms you have constructed. What you don’t want to do on this list is just state this will be fixed in 2017 or 2019. A future construction date is a plan, but its not a mitigation strategy.

**Sentinel Event Statistics**

Perspectives also has an article summarizing the sentinel event statistics from 2014. Keeping with the same theme in the paragraph above, the third most frequently reported sentinel event last year was suicide with 82 individuals suffering permanent harm or death while inpatients. The most commonly reported sentinel event last year was unintended retention of a foreign object. This would appear to indicate that the post procedure count is being short changed or glossed over after surgical procedures. Also take a look at the most commonly reported root causes from the hospitals that reported these events. The number one most common root cause is human factors such as staff supervision. This is an interesting find because I don’t think we have ever seen the end of year staffing analysis for EP 14 at PI. 02.01.01 conclude staff supervision or competence was an issue in major events.

**EC NEWS:**

This months EC News has a good article on lessons learned relative to Ebola management in hospitals including advice on waste management for patients with Ebola. These might be good referrals to your infection control and EC teams. There is also a good reference on workplace violence that should be discussed at a safety committee meeting. There is a checklist tool article and a download of the tool for documenting compliance with EM.03.01.01, your emergency management exercises that would be useful for those who manage the EM program and a useful reporting tool to the leaders who must be involved with the program.

**CMS UPDATE:**

On April 3, CMS issued S&C 15-32 relative to CRE infections and endoscopic retrograde cholangiopancreatography, or ERCP. This memo basically advises that CMS will be looking for compliance with the recently released CDC, FDA and multi society professional advice on cleaning these scopes. CMS summarizes advice from these groups in a listing of their advice, which you want to make sure are incorporated into policies and procedures for cleaning these scopes. On the last page of the memo CMS states: “Hospitals are expected to strictly and meticulously follow the manufacturers instructions for cleaning and reprocessing endoscopes, and to adhere to nationally recognized practice guidelines such as the current nationally recognized recommendations
found in the Multisociety Guidance document. .... Failure to adhere to these instructions and practice guidelines poses a significant risk of serious harm to patients’. The memo also states in bold print that CMS surveyors will ask at the opening conference if duodenoscopes are used. The surveyors are then advised to ask for a copy of the manufacturers instructions for use and the Automated Endoscope Reprocessor (AER) instructions for use. Surveyors must observe endoscopes being processed and should ask staff to demonstrate and explain how they are adhering to the IFU and the Multisociety Guidance recommendations. Lastly CMS states “any identified noncompliance must be cited accordingly, and the increased risk to patients resulting from improper reprocessing should be taken into consideration when determining the appropriate level of citation”. Our interpretation of this is that there is risk for immediate jeopardy if there are flaws in this process.

Our advice here is to rewrite policies to incorporate this latest advice. Secondly, redo the competency validation for staff including the steps advised by FDA, manufacturers and the Multisociety guideline into your checklist. After revalidation of competency continue to drill, test, and interview staff since staff need this rehearsal to be ready to verbalize and demonstrate their new process for TJC or CMS.

**SENTINEL EVENT ALERT 54**
**MARCH 31:**
This sentinel event alert points out new sources of error being introduced in the healthcare industry as a result of automation. They start off by discussing 3 specific instances of error, but then identify 120 reported sentinel events from 2010-2013 where some weakness in the IT infrastructure contributed to the event. The alert includes a review of an article summarizing the literature on Health IT events in hospitals. TJC then provides advice in 3 major areas, safety culture, performance improvement and leadership. In this advice area they bullet out 3 specific suggestions for the safety culture, 18 for performance improvement and 6 for leadership. As with any Sentinel Event Alert you want to examine your existing processes against this advice to identify any gaps and document what you find. Next you want to determine what you can change, who will change it and when they will change it to close those gaps. Your patient safety committee or an ad hoc committee of safety and IT experts should sit down to analyze these recommendations.

Best Regards,

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