NEWS FROM TJC

Perspectives:

The July edition of Perspectives cover article is about an article Drs. Chassin and Baker from the Joint Commission authored in the May 12th JAMA. The article discusses getting physician leaders in hospital on board with quality improvement efforts and using quality improvement tools and methods such as lean, six sigma and change management. They also imply that if physician leaders don't acquire these skills there is risk to the continued concept of an independent, self-governing medical staff that is embedded in the standards and COP's. There is a link to the original article in JAMA and that original article is worth sharing with your physician leaders at the hospital. It is perhaps thought provoking and certainly a good discussion topic during the leadership session on your survey.

Changes to Perinatal Core Measure

Perspectives’ also discusses an important change in the Perinatal core measure set requirements. Previously this measure set was mandatory if the hospital had more than 1100 live births a year. Beginning January 1, 2016 that figure will be reduced to only 300 live births a year. TJC advises looking at your two most recent complete calendar years, 2013 and 2014 to determine if you will have to use this measure set effective January 1. They also provide advice on calculating live births, not deliveries, so a set of triplets is 3 live births. Hospital must adjust their measures by November 1, 2015 if they need to add this measure set.

There is also one more article on antibiotic stewardship. We have previously discussed in this newsletter how TJC and CMS appear to be “gearing up,” but there are no new standards being evaluated at this time. TJC participated in a White House Forum on antibiotic stewardship June 2 and they committed to developing new standards as rapidly as possible and to simultaneously provide new tools to help providers use antibiotics appropriately. Again, now is the time to start your discussions and planning at infection control and pharmacy and therapeutics if not already doing so.

Available OSHA Tool Kit

There is an article with links to an OSHA toolkit on Hospital Respiratory Protection Programs. The document is available through the link at: https://www.osha.gov/Publications/OSHA3767.pdf

The download should be shared with your employee health staff and infection control staff as subject matter experts. There is extensive information about fit testing programs, policy development and proper use of different types of masks for different clinical needs. As with any
new content you should ask your subject matter experts to perform a gap analysis and provide feedback about current compliance and new practices which may need implementation in your hospital.

Resource Available on Root Cause Analysis
There is a small article in the July Perspectives that you might have missed that references a new publication from the National Patient Safety Foundation or NPSF on RCA2 or RCA squared. This is a very timely article looking at taking the root cause analysis after a sentinel event to a higher, more thorough level, thus the name RCA2. You will want to download this reference and share it with your leadership and risk team. The article can be downloaded from http://c.ymcdn.com/sites/www.npsf.org/resource/resmgr/PDF/RCA2_first-online-pub_061615.pdf

They use an interesting term in this publication called “blame worthy event.” This is used to differentiate criminal, abuse, refusal to follow policy type situations from sentinel events where the system failed. While they do advise continuing to explore issues such as recruiting, training, supervising they advise prompt referral of the event to the appropriate authorities for investigation and possible actions to keep the RCA process out of the disciplinary role. There is also a nice table of actions taken that are categorized as Stronger, Intermediate, and Weaker actions which is a nice reference to evaluate your own action plans to ensure the chance for a repeat error is being designed out using stronger actions. The advice in this new publication is very consistent with the new patient safety systems chapter introductory material which talks about becoming a learning organization from the actions taken on sentinel events. Don’t just fix the location where the event occurred, fix the process throughout the organization.

EC NEWS:
Protecting Patients From Self Harm
The lead article in the July Environment of Care News is about protecting patients from self harm in behavioral health settings. This article is a keeper and one on which you should take several very specific actions. The article details the evaluation of the physical environment in which we treat patients with behavioral health disorders and features in that environment which can be used to facilitate self injury, often hanging. There is a table that identifies risk levels based on level of supervision. As you would imagine risk increases with increasing privacy in the patient room or bathroom as compared to group rooms. There is a nice, but short list of hazards in an environmental checklist to help identify fixtures in the environment that increase risk to patients. There is also a series of recommendations such as evaluating risks based on probability and severity. The authors also provide a reference to a superb document from the National Association of Psychiatric Health Systems called the Design Guide for the Built Environment of Behavioral Health Facilities. This document can be downloaded for free and it is a very thorough listing of hazards and ideas for safer and more modern design.

The most important value to a thorough analysis of this article and the reference book is that you might eliminate a patient care hazard and prevent a suicide in your hospital. Less important but still valuable by doing the risk assessment you might head off some RFI’s that you could avoid with some planning. If you look at NPSG.15.01.01 everybody knows that it calls for a suicide risk assessment and almost all organizations have built in some process or tool to evaluate patient risk. However what is very often missing is embedded in EP 1 where it states: “Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or
decrease the risk for suicide.” Almost everyone does the clinical evaluation and skips the environmental risk assessment. This environmental risk assessment is so often missed that perhaps it should be its own element of performance to draw greater attention. A second common vulnerability is doing a risk assessment in your head, instead of on a piece of paper. Remember the old adage, if its not documented it wasn’t done. In your behavioral health units, in your emergency department rooms where you might house behavioral health patients, in your medical/surgical units where you might house behavioral health patients awaiting medical clearance you should conduct this environmental risk assessment. Most importantly do not think you can skip the environmental risk assessment because you are going to use a sitter. A sitter is a mitigation strategy and the mitigation strategy should be documented on your risk assessment along side the hazards you have identified and realized you have to work around. So for example in the emergency room if you don’t have specific rooms designed for behavioral health patients you have lots of equipment that could be dangerous to a patient considering suicide. What ever is on wheels you wheel out, but you are still left with a lot of equipment and fixtures that are dangerous to the suicidal patient. Don’t just act. Think it through, document your thought process and then act. As an example consider the overhead lighting commonly found in an emergency department room. This is great for illuminating the field when suturing a patient, but the large fixture and arm are a significant ligature hazard for a patient considering suicide. As large as this fixture is, and as many times as you may have hit your head on it, the Joint Commission is going to assume you never noticed it was a suicide hazard if you don’t conduct the risk assessment. Remember the sitter is the mitigation strategy, the sitter is not an excuse to skip the risk assessment.

Use the Design Guide referenced above, use the ECRI tool or other tools. We have an Excel tool that we use to help identify hazards and rate them on scales for probability, severity and detectability but we have noticed consulting clients are often ineffective using this tool themselves. Familiarity can make it difficult to see the forest for the trees. We can perform the risk assessment for you and help you identify the risks you might overlook.

When you complete your risk assessment keep a copy in the patient care area and make sure staff know where it is and what it means. Send additional copies to your quality department and your EOC committee and set a reminder to update it a year from now. From a regulatory perspective also remember never to create a list with some future dates for action without a mitigation strategy in place today. Saying you realize the door hinges are a suicide hazard and saying you will replace them by 2018 is not a mitigation strategy. It is an invitation for surveyors to write an RFI.

EC News has a reminder article in the new Joint Commission standards for diagnostic imaging. We talked about these new standards and the recent CMS memo on radiology last month so we won’t discuss it again here.

CMS UPDATE:
Criteria for CAH Designation
The most recent hospital wide Survey and Certification letter was last months on radiologic safety. There is one new one for critical access hospitals that discusses new CMS criteria for distance from another hospital in order to continue CAH status but this has limited widespread applicability.

SURVEY PITFALLS:
Suggestions for Clinical Contracting
We wanted to use this time to talk about some common survey pitfalls that continue to plague
hospitals. Lets start with clinical contracts. TJC focuses on clinical contracts and there are some very specific requirements.
1. You should have a list of clinical contracts
2. You should have performance expectations in your clinical contracts
3. There should be an annual performance evaluation of the contractor’s performance, and the difficult part here is that the evaluation should be based on your performance expectations. Too often we see just an attestation that the contractor continues to meet our need, but no data was examined, no records, no patients interviewed, and no staff interviewed.
4. The performance evaluation should go to a senior leadership team including medical staff for review and concurrence.

On survey, with your day-one books you want to have your list of clinical contracts. The surveyors will review that list, pick a few contracts and request items 2, 3 and 4 above. The challenge here is do you have it, can you find it. Equally important is when the surveyors conduct their tracers they should not encounter contractors performing clinical or patient care services who were not on the list of contractors provided. So how do we develop a bullet proof system to make sure we have captured all the clinical contractors, have their evaluations and have access to proof they went before a leadership/medical staff committee for review?

Every hospital has an approval process with multiple levels of approval needed if you want to spend a significant amount of money on any contractor. Those approvals might include vice presidents, business office/finance, and hospital attorneys. There is likely some type of routing form for the approval process to demonstrate the required levels of approval. Our suggestion is to add an attestation from the requesting department stating something like the following:

**NON CLINICAL CONTRACT APPROVAL FORM**

I, ______________, Title________________________ request approval to develop a contract with ______________ a vendor/contactor who performs non-patient care services. Staff representing this contractor will not touch hospital patients, will not prepare any patient specific devices or treatments, will not analyze any patient specific data or make recommendations for treatment, and their services do not require any professional licensure in our state. Staff representing this contractor may bring manufactured supplies to the hospital and they may provide technical advice to hospital employees on using the device or supply, but will never direct treatment, analyze patient care data or provide treatment or make treatment recommendations themselves.

**CLINICAL CONTRACTOR APPROVAL FORM:**

I, ______________, Title________________________ request approval to develop a contract with ______________ a vendor/contactor who will provide a direct clinical service, prepare a customized clinical device, product or medication, or analyze patient care data and make treatment recommendations based on their expert analysis. As the contract owner I will, or my staff will ensure credentials and competency verification and perform an annual performance evaluation based on the performance measures I have incorporated into the contract.

Use of approval forms as above will help to identify clinical vs non-clinical contractors. The next challenge is to find an easy way to make sure you have the performance evaluations and send those performance evaluations through a leadership/medical staff committee for approval. Our recommendation is to set a schedule for all contacts, all performance evaluations, and have all of these to be reviewed at one meeting with leadership and medical staff. For example have all the performance evaluations due on November 1 of each year. That gives you two months to send out reminder notices and obtain...
any late evaluations. Then in January take all the evaluations forward to the leadership/medical staff committee for approval as a consent agenda item, pending any requests for additional information. Then when surveyors want to know was it approved by senior leadership you don’t have to search meeting minutes to find the right set of minutes, just turn to the January minutes and it will all be in one place.

**NOTE TO READERS:**
Some of our readers who started to communicate with us beginning in 2006 may still be using our old email addresses using Pattonhealthcareconsulting.com. While this address seemed like a good idea when first starting we quickly realized it was too long and difficult so we shortened the email and website to Pattonhc.com. Since then we have continued to support the first website with a pass-through to the new website. This will end later this month when we surrender the domain name Pattonhealthcareconsulting.com. So if you have any of us listed with an email address of Pattonhealthcareconsulting.com, please update your address book and delete the long name. Thanks.

Best Regards,

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*If you are in need of CMS or Joint Commission assistance contact one of us or visit our website for more information. : [www.PattonHC.com](http://www.PattonHC.com)*

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