NEWS FROM TJC

Perspectives:

The June edition of Perspectives cover article is about their revised sentinel event policy and the definition of severe maternal morbidity. There is a slight change in the definition of severe maternal morbidity that took some careful reading to identify. If you go back to Update 2 published in January with the new chapter they defined severe maternal morbidity as: "Severe maternal morbidity is defined, by the American College of Obstetrics and Gynecology, the US Centers for Disease Control and Prevention, and the Society of Maternal and Fetal Medicine, as a patient safety event that occurs intrapartum through the immediate postpartum period (24 hrs), that requires the transfusion of 4 or more units of blood products (fresh frozen plasma, packed red blood cells, whole blood, platelets) and/or admission to the intensive care unit (ICU). Admission to the ICU is defined as admission to a unit that provides 24-hour medical supervision and is able to provide mechanical ventilation or continuous vasoactive drug support.

This coming Fall in the next update they are going to refine the definition of severe maternal morbidity to state: “Care that is unexpected and not directly related to the condition of the patient on admission, and that results in admission to the intensive care unit and or transfusion of 4 or more units of packed red blood cells PRBC would be a patient safety event viewed as sentinel and require a comprehensive systematic analysis.

So there appears to be two changes in the definition. The first being that a planned admission of someone known to need ICU level care and 4 or more units of PRBC due to their underlying condition is not included in the definition of a sentinel event. They provide an example of a patient with known placenta previa who presents with brisk vaginal bleeding requiring a cesarean and transfusion would not be a sentinel event. This appears a reasonable change so that hospitals who provide care to such complex patients do not have to perform RCA’s on this planned care. The second change is very subtle in that the type of blood product in the definition appears now to be limited to just packed red blood cells or PRBC, not whole blood, not fresh frozen plasma and not platelets.

The good news is that most organizations we have seen on consults have not made the first change in definition, so many will not have to do repeat work to revisit the subject. However readers should be reminded to address this new definition now in their sentinel event policies.

Perspectives also includes clarification of an earlier article (March 2015) on organizations...
applying for their first accreditation. An initial organization that receives an onsite survey recommendation of preliminary denial of accreditation may withdraw from the accreditation process prior to submitting their ESC. If they withdraw prior to the submission of their ESC they will not risk an actual denial of accreditation decision. If they submit their ESC and fail to change the outcome they will receive a denial of accreditation decision.

There are also changes to the core measure set for breast milk feeding with TJC announcing the retirement of PC-05a which required capturing data on mother’s preferences to not exclusively breast feed. PC-05 which is performance on exclusive breast feeding will continue and national performance on this measure continues to be less than 50%. As a result TJC will not include this measure in the Top Performer on Key Quality Measures recognition program. In addition this measure will not be included in the composite rate standard PI.02.01.03, EP 1.

EC NEWS:

This month's EC News has an article on Defeating Infant and Child Abduction, which summarizes the recent update from the National Center for Missing and Exploited Children (NCMEC) and some of their resources. The Guidelines were updated in 2014 and they also publish a self-assessment tool that is an excellent resource for conducting your own proactive risk assessment. This tool allows you to analyze and compare your state of readiness against their essential requirements and more general recommendations. The EC News article also mentions the nursing competency checklist that is available from their website which is another excellent tool for a hospital to use where children are served. These tools are very helpful and we have used them to help us conduct assessments in these areas for clients. The starting point to locate these tools is to go to the NCMEC website, then search for resources and you will see the section for health professionals. Here is the direct link to the reference document: http://www.missingkids.com/en_US/publications/NC05.pdf


Both documents should be shared with your infant/pediatric clinical unit leadership and safety committee. Most importantly we would advise an annual proactive risk assessment to determine your state of readiness using the second tool above, take action to mitigate or eliminate any identified gaps in security, and have the safety committee approve the risk assessment results and overall infant/pediatric security plan.

CMS UPDATE:

On May 15 CMS issued Survey and Certification memo 15-35 focusing on radiology services. Much of the content of this memo is directionally consistent with the revised radiology standards TJC will begin to evaluate in July 2015. For example the physicist reports TJC discusses in significant detail are also required per this memo without the specific measures that TJC discusses. As you might expect CMS does include some concepts not specifically addressed in the revised TJC standards. For example in the introductory discussion, section 482.26 CMS states: “Hospitals
are expected to take a consistent approach in their policies and procedures for radiologic services safety and personnel qualifications throughout the hospital. This may be accomplished in several ways, including by having one organized radiologic service under the direction of the radiologist who supervises all ionizing radiology services or by the governing body ensuring a uniform approach to radiologic services that are offered in multiple departments of the hospital.” This particular requirement is conceptually consistent with the TJC leadership requirement LD.04.03.07 that requires the hospital to provide the same standard of care to patients with similar needs throughout the organization. Here however CMS includes policies and procedures for radiation safety and employee safety. We mention this requirement because we sometimes see partitioning of oversight for radiologic services where the main radiology service does not provide oversight for the radiology services provided in the OR, or cath lab, or pain center or sometimes even outpatient locations. While CMS would not prohibit location specific oversight, they would look for the governing body to ensure consistency and uniformity of policies, procedures and comparative radiologic safety.

The CMS memo also provides a great description of “What is Radiologic Services”. For those staff who don't know a lot about radiology, this is nice introduction and basic description of radiography, DEXA, CT, fluoroscopy, radiation therapy, brachytherapy, ultrasound, and MRI. This introductory material also includes an orientation to which type of imaging is best for which organ, body part or system.

Under tag A-0529 CMS introduces content under the survey procedures section advising their surveyors to: “ask the hospital for evidence of the scope and complexity of the radiologic services” and then “ask how the hospital has determined that the services meet the needs of the patients.” It might be good to document an appraisal of the scope of radiology services in the minutes of a medical staff committee to prepare this documentation.

Under 482.26(b) CMS includes a lengthy discussion of its standard for safety of patients and personnel. They discuss the risks associated with various procedures, the role and qualifications of the physicist and reporting of adverse events to QAPI. This QAPI reporting is likely a standard component of your incident reporting system, but CMS specifically states there should be: “policies and procedures to identify patients at high risk for adverse events for whom the radiologic study or procedure might be contraindicated, e.g. pregnant women, individuals with known allergies to contrast agents, individuals with implanted devices, etc. Policies would address the steps to be taken, and by which personnel, if an order is written for a radiologic study or procedure for an individual identified in the radiologic services policies as potentially at high risk, e.g. notify the ordering physician, cancel the procedure personally, etc.” These screening procedures are well ingrained in the radiology staff but verify you have the policies and procedures that state what to do when the screening contraindicates the procedure. Later in this section CMS states there should be monitoring of the quality and safety of the radiologic services and they provide
examples of indicators that could be monitored including: “improper patient preparation, such as inadequate intravenous access, or lack of premedication such that the procedures must be cancelled or reordered.” They also cite: “reports of the same studies in the hospital for the same patient within a short time span, which may be an indicator of poor image quality.” Lastly they suggest QAPI reporting for “diagnostic imaging studies or therapeutic procedures performed in a manner inconsistent with the applicable hospital written protocol.” While this all seems appropriate, look into your data to see if you have any examples that have ever been reported through your incident reporting system. It may be possible that such events have never occurred, or it may be that such events are being handled outside of the hospital reporting process. This same reporting expectation is later discussed for nuclear medicine under tag A-1026.

Under tag A-0538 CMS discusses appropriate use of the radiation safety badges and specifically that all staff be trained in proper use and storage of these devices. When you think of all the staff in your hospital that wear a radiation safety badge consider where you might find evidence each person was trained on proper use and storage. Our advice would be to also look at non return rates for radiation safety badges. This is a frequent problem seen when looking at dosimetry reports where the user has not returned their badge and the report highlights that fact for your surveyor. If this is seen it is likely the next step is to ask for the evidence of training.

Tag A-0546 states that the “medical staff must establish the specific criteria related to education and experience that must be met in order to be privileged as a radiologist in the hospital.” This is a good concept that is probably done informally, but where would you read these criteria? Sometimes there are criteria on privileging forms for category 1 or category 2 core privileges, but not always. Make sure you have this documented somewhere that is retrievable. Later in this same section CMS advises its surveyors to: “review the credentialing and privileging file of the supervising radiologist to very that he or she meets the qualifications established by the medical staff and has been granted privileges as a radiologist.” In this same section CMS provides further guidance to surveyors to: “determine whether the medical staff has reviewed and approved a policy identifying the types of diagnostic imaging tests that require interpretation by a radiologist.” We have never seen such policies and procedures, but we also have never looked for these policies, but with this guidance from CMS it is likely to happen so make sure you have them. Later in this memo, tag A-1027, CMS discusses the same expectation for the medical staff to define the qualifications of the director of nuclear medicine.

Come July the Joint Commission will begin to survey against its new radiology standards. In anticipation of that deadline there will likely be surveyor training and these new requirements will be in the forefront of surveyors minds so this will be a focus of attention soon. It is also possible that some of the nuances CMS discusses in their memo may be incorporated by surveyors, just like we will do as consultants to make sure that both CMS and TJC expectations are met.

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 passthrough to
the new website. This will end later this summer 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,

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

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