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PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC

NEWS FROM CMS AND JOINT COMMISSION

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PERSPECTIVES

Top Scored Standards – EC/LS Top the List Again:
This month *Perspectives* summarizes the 10 most frequently scored standards from all of calendar year 2017. The list is similar to the last one published in September 2017 which covered only the first half of 2017. However, this list looks nothing like the ones they used to publish years ago in that there is only one clinical standard making the list with the remaining 9 most frequently scored standards coming from the EC and LS chapters. The one clinical standard that did make the list is IC.02.02.01 which is cited for a wide assortment of problems with low level disinfection, high level disinfection, sterilization and storage of medical supplies and equipment. This standard was cited in 72% of hospital surveys in 2017 so it is a huge problem. High level disinfection and sterilization issues are the ones we see most often in survey reports. A major contributing factor is simply that the Joint Commission's surveyors have become more expert, more knowledgeable about the intricacies of the AAMI and AORN requirements for high level disinfection and sterilization than are the staff performing or supervising these duties at hospitals. This disparity in depth of knowledge must be corrected. If the Joint Commission can effectively train several hundred senior clinicians and hospital quality leaders who conduct surveys, most of whom never performed HLD or sterilization in their careers, in the minutiae of these requirements, then we believe it is feasible for direct clinical staff who do these duties day and in day out to obtain a far greater depth of knowledge than the surveyors.

Be Prepared: Self-Assess Your Compliance with HLD & Sterilization:

To better prepare for your next survey of HLD and sterilization we suggest the following self-assessment questions be analyzed.

1. Have you identified a clinical practice guideline (CPG) that served as the policy foundation for each of our departments performing HLD or sterilization?
2. Do you have the latest version of that clinical practice guideline? Note in particular there was a late 2017 release of a revised AAMI ST 79.
3. Do each of the departments that perform HLD or sterilization have that CPG and policy, and have they carefully scrutinized that CPG against their policy and practice to confirm compliance?
4. Is there a hospital wide content expert with responsibility and authority to inspect each department performing HLD or sterilization to validate compliance and either directly or through other senior leaders enforce corrective actions as needed? Since any defect in the HLD and sterilization process would result in an RFI, usually in the red and at a COP level, you may want to consider using your hospital incident reporting process to track, trend and analyze self-identified noncompliance.

5. Is the hospitals internal compliance data getting to senior leadership for attention and decision making about potential consolidation, developing human resource performance plans for departmental leaders, or terminating the authority for conducting HLD or sterilization if compliance cannot be achieved?
6. Does each person who has responsibility to perform HLD or sterilization have a detailed, documented competency that is conducted on an annual basis? Remember a competency is not the same as training, and it's not the same as an orientation by a vendor to a new piece of medical equipment or product. A competency for HLD or sterilization is conducted by a knowledgeable expert who using a highly granular checklist and directly observes and interviews staff who are actually performing the process to validate compliance with each step of the process. We encourage readers to take a look at their competency assessment checklist and process. Many that we see are perfunctory, designed to put a piece of paper in front of TJC in the hope that is passes. It needs to be sufficiently detailed to enable the hospital to verify that the staff genuinely know the steps in these complex processes.
7. Lastly, if your hospital wide HLD and sterilization content expert identifies deficiencies and practice at a department level, is there a process to revalidate the training, and competency assessment? While you might not want to redo a competency after 1 failure, you would certainly want to consider this after 2 repetitive failures, or multiple different failures in the same department.

The Challenges Posed by EC & LS:

Now, let's discuss the really difficult part of this top 10 list, and that is the 9 standards in the EC and LS chapters. The scoring frequencies for these are frightening. Take for example LS.02.01.35, the most frequently scored standard with an 86% rate of noncompliance! That means only 14% of hospitals surveyed were actually found compliant. The evaluation of EC and LS compliance has been particularly problematic for almost two years now with the conversion to the 2012 version of life safety code and, perhaps even more problematically, that code's references to other newer NFPA manuals, many of which have additional changes that must be implemented. Confusing things even further has been the evolving process of change with CMS and its K tags and TJC with its standards and EPs, creating a steady drip, drip, drip of new standards, modifications and delayed publication at years end, leading to implementation deadlines scattered throughout the year. The good news is, that process of change should be coming to an end allowing hospitals to catch up and become more compliant.

In examining the elements of performance associated with each of these 9 very frequently scored standards you will find some commonalities. The first commonality is these are multifaceted requirements with a large number of different EPs often numbering 10-20 or more. When you read any standard with 20 different and unique requirements your eyes tend to glaze over. When you recover you will note that many of these EPs are one timers, meaning if you design or renovate according to the requirement you are done, and you are compliant until the next renovation or code change. This contrasts with other EPs that are performance based, meaning you have to keep something up to date every day. These are much more difficult and the ones where you want to develop an internal monitoring system, or continuous inspection system to keep them compliant. We would also suggest that you revisit the excellent column published over the past two years in EC News called "Clarifications and

Expectations" which gave detailed guidance on many of these very problematic standards.

#1 Systems for Extinguishing Fires:
#1 LS.02.01.35, 86% noncompliant, 14 EPs: We would like to call your attention to EPs 4, 5, 6, 7 and 11 in this standard. Each is performance based and each is seen being scored frequently within this standard. EP 4 is the one we see most often, and it involves a hidden defect, above the suspended ceiling where something may be connected to or draped over a sprinkler pipe. As the EP says, nothing can be connected to or in contact with a sprinkler pipe. That sprinkler pipe is very tempting to anyone working above that ceiling snaking cable of any type, or a ventilation duct because it looks like a convenient and sturdy support. Unfortunately, the code does not permit anything to be connected or even touching or laying upon that sprinkler pipe. So, now you have two potential problems, someone may have taken this shortcut long ago in the past, and someone may do this a month or 6 months from now.

There are two prevention strategies you want to implement. The first is an above the ceiling inspection process to determine where and how widespread this practice may have been at your hospital in the past so that you can eliminate these tie offs. The second prevention strategy is to eliminate the same problem from reoccurring in the future by establishing an inspection of newly completed work projects where a vendor or internal staff are working above the ceiling. This can be designed into your preconstruction risk assessment and be used as a screening for determining if vendors have met your expectations prior to payment. While you are doing this post-work inspection you can also be on the lookout for unsealed penetrations that vendors sometimes make when they must drill through your rated smoke or fire barrier walls. That perpetually thorny issue will show up later when we discuss #6 on the list.

LS.02.01.10. EP 6 is also a performance issue - the classic 18-inch sprinkler head clearance rule. These infractions can be detected and corrected on your routine EC rounds, but always be thinking, how can we redesign the storage capabilities of this area to prevent recurrence the very next day?

EP 11 is somewhat of a performance issue, but once you fix it, it should remain compliant. This calls for a type K portable fire extinguisher near grease producing devices in the kitchen and it calls for a placard near the extinguisher reminding staff to activate and allow the automatic suppression system to work first, and to only use this extinguisher secondarily if needed. We see the missing placard as the most frequent defect with this requirement because it has either fallen off the wall or was never present.

#2 – Managing Utility Systems:
#2 EC.02.05.01, 73% noncompliance, 29 EPs: This standard establishes expectations for managing utility systems in the hospital. The first 14 elements of performance ask you to design processes on how you will do this. All are excellent ways in which to describe your hospital's approach to management of your utilities plan. You likely will want to have more detailed policies and procedures for each of these EPs.

EP 5 from this first group is identified as one of the mandatory EC/LS documents to have available for review by your life safety code surveyor on day one. EPs 15 and 16 are two of the most commonly scored EPs in this entire standard. They both describe expectations for air handling including air exchanges, air pressure relationships, filtration efficiencies, temperature and humidity management. EP 15 refers to critical spaces such as a negative pressure decontamination room or a positive pressure space like an operating room. EP 16 refers to noncritical spaces. Next, EPs 17-22 describe more issues that should be detailed in policies and procedures for managing utility systems and summarized in your utilities management plan. EPs 23 and 24 discuss a hot issue from the past few years, power strips and extension cords and their requirements. These are day to day performance issues where you have to make sure staff do not connect some cord or device to a power strip they purchased at the local hardware store, or through the hospitals purchasing department, or brought from home. A well-structured policy to ensure only facility staff approve and authorize such purchases is essential. Lastly, EPs 25 and 26 then discuss requirements for more policies and procedures for management of utilities in locations were anesthesia services are provided.

While there is certainly a lot to pay attention to in developing a strategy for managing this problematic standard, a good part of this can be done well ahead of survey by creating policies and procedures that effectively

describe compliant processes. The really difficult EPs here are EP 15 and 16, both performance-oriented EPs, where anything can go wrong. In addition, the critical space EP 15 will lead to a COP out of compliance and likely a red finding on the SAFER™ Matrix because it affects all staff and patients that enter this area.

#3 Protection from Fire and Smoke:
#3 LS.02.01.30, 72% noncompliance, 27 EPs: The good news here is that many of the EPs refer to construction requirements that, if met appropriately when you built the facility, they will remain complaint until you conduct renovation in a future year. EPs 2 and 3 refer to new and existing hazardous areas in the hospital and the need for self-closing doors. While you have to install such doors, there is also a performance issue in that you have to maintain them and ensure staff don't defeat the mechanism by somehow blocking the door from closing. EP 6 discusses alcohol-based hand rub and there is a performance issue here in terms of the total volume of the rub that you can store and where you may place the dispensers. EP 20 then discusses requirements for smoke doors, their construction rating and their ability to self-close again. The remaining 7 EPs then describe more construction requirements, which if done right initially should be low risk.

#4 Infection Risk:
#4 IC.02.02.01, 72% noncompliance, 5 EPs: (*Please refer to "PERSPECTIVES: Top Scored Standards – EC/LS Top the List Again" on page 1.)*

#5 Safe and Functional Environment:
#5 EC.02.06.01, 70% noncompliance, 4 EPs: (remember that IC.02.02.01 previously discussed was #4 on the list.) This standard in years past was the catch-all standard we warned hospitals about, where anything wrong in the environment from an odor, dim lighting, to a torn mattress could be scored. However, in this past year EP 1 requiring that the environment is "safe and suitable" to patient care is the big problem. This is where a lot of the scoring of ligature risks has taken place. In 2017 TJC and CMS undertook a huge change in approach, no longer allowing routine risk mitigation strategies for ligature hazards in the patient rooms and bathrooms in behavioral health space. 1:1 supervision became the basic expectation for these areas in behavioral health dedicated space, and the routine expectation for patients at high risk for suicide admitted anywhere else in the hospital. In addition, TJC is still expecting hospitals to develop their lists of identified potential hazards, but your risk mitigation strategy is too often going to have to be 1:1 supervision and that is a major new expense. Then again, this month's *Perspectives* does summarize all of 2017's sentinel events and there were still 99 suicides reported in accredited hospitals.

#6 Fire Protection Features Minimize Fire and Smoke:
#6, LS.02.01.10, 66% noncompliance, 15 EPs: Thirteen of the EPs describe NFPA requirements that must be established during initial construction or renovation. EP #13 describes requirements for fire doors and there are performance expectations such as self-closing and positive latching devices. As doors can sometimes get out of alignment due to use and abuse, this requires routine and continuous inspection and maintenance. This same EP also describes the maximum undercut and the maximum size of protective plates which cannot be higher than 16 inches. EP 14 discusses the earlier referenced penetrations around pipes and ducts which must be sealed with fire stop. If you have vendors doing this type of work, verify that they are using your approved fire stop. If your surveyor sees blue, yellow and red fire stop material they will ask you for the specifications on each to verify that you used an appropriate product. If your vendor uses their brand and it differs from yours in appearance, you will want to keep that specification sheet on file.

#7 Manage Risks of Hazardous Materials and Waste:
#7 EC.02.02.01, 63% noncompliance, 19 EPs: This standard contains a potpourri of hazardous materials and waste requirements including radioactive hazards. How you manage these requirements should be summarized in your Hazmat management plan and supported with detailed policies and procedures that staff utilize. Having supplies to manage spills, appropriate PPE for routine use of hazardous materials and actually using them correctly is a big part of managing this standard. A big hitter on this standard is EP 5 which is the requirement to "minimize risk" associated with handling hazardous chemicals. This is frequently scored when the surveyor notes a corrosive chemical in use, and there is no ANSI/ISEA Z358.1 compliant eyewash or shower available for staff use in the event of a splash. The use of hazardous chemicals should be identified during your EC rounds and appropriate eye wash equipment installed.

We find that individual departments frequently obtain a new chemical that goes undetected and thus no eyewash station is made available. Departmental managers and purchasing staff need to be educated on the risks and

requirements if any corrosive chemical is going to be purchased. Some process to screen and as needed block such purchases without authorization and appropriate safety devices is suggested.

EPs 6, 7, 17 and 18 deal with various aspects of minimizing risk in using hazardous energy sources and worker protection from radiation. Issues such as annual inspection of lead shields throughout the hospital, proper use of dosimetery badges and analysis of the data is also covered in these EPs. A frequent issue with lead shields is finding them all, including those issued to the operating and procedural areas. Dosimetry badges sometimes have a low return rate from staff, often from areas outside of the main radiology department.

#8 Maintain Egress:
#8 LS.02.01.20, 62% noncompliance, 42 EPs: This standard describes maintaining the means of egress. The good news is that the vast majority of these EPs describe design requirements that if done right initially should remain compliant. EP 1 contains an important maintenance issue regarding not installing any locks or latches in means of egress. We can lock people out of getting into the hospital, but we can't lock or block people from getting out of the hospital. These supplemental devices are sometimes installed due to perceived security issues, but the device that you place cannot require any additional steps, keys or latches on the egress side.

EP 18 describes the requirement to have 8-foot-wide corridors and parking equipment or stretchers can cause compliance issues. Similarly, EP 24 discusses not permitting corridor projections on the walls of greater than 6 inches.

EP 40 and 41 describe requirements for exit signs and no exit signs respectively. Proper placement is an important issue but detecting problems when you work in the environment day in and day out is sometimes difficult. Surveyors are new to the area and often more effective at detecting gaps using a fresh set of eyes.

#9 Inspect and Test Utility Systems:
#9 EC.02.05.05, 62% noncompliance, 8 EPs: This standard establishes requirements for testing and maintaining utility systems. These processes should be described in your utilities plan and detailed in policy, but unfortunately each has a performance aspect also. Once you establish the requirement, you have to implement the plan and keep the documentation up to date. EP 1 in particular has an important performance aspect calling for managing risks when performing maintenance or repairs to utility systems. The EP specifically mentions infection control issues, noise, vibration, dust, and other hazards that might affect patient care. The potential hazards which might arise should be determined using a tool like your preconstruction risk assessment, or PCRA, and infection control risk assessment tool, ICRA.

#10 Maintain and Test Medical Gas and Vacuum Systems:
#10 EC.02.05.09, 59% noncompliance, 14 EPs: This standard establishes requirements for maintaining medical gas and vacuum systems. Many of the EPs are design requirements which if done correctly initially should remain compliant. EP 4 establishes a requirement for signage on locations storing oxygen. EP 11 is a frequently scored issue when medical gas shut off valves are either blocked by medical equipment or stretchers, or the signage is unclear on exactly which rooms the valve would shut off gas to. EP 12 has been a heavy hitter for the last 5 years requiring separation of full vs empty oxygen cylinders. Remember TJC has an FAQ posted to its website describing their current decision on the storage of partially full cylinders. TJC permits these to be stored in a third segregated rack, or stored with the full cylinders, which is a change from their earlier advice a few years ago.

In conclusion, focusing on making sure you are compliant with these 10 standards is the best advice we can offer. Too often hospitals call us concerned about some really obscure, almost never scored standards. When you read a standard and can't imagine what they are trying to say or what they are trying to assess, or what you need to do, remember the surveyors likely have the same difficulty too, so it doesn't get scored. But look closely at the percentage of noncompliance on these top 10. These are clearly a critical subset of the standards to focus attention on to detect and prevent known survey problems.

Sentinel Event Statistics:
The only other article we should mention from *Perspectives* this month is their summary of sentinel event statistics for 2017. This remains a concerning issue for everyone to understand and develop a prevention or risk reduction strategy for your own hospital. Unintended

retained foreign object is the #1 most frequently reported sentinel event, with 116 reported. It is important to remember with all of these statistics, is that voluntary reporting is probably just the tip of the iceberg. If 116 are reported, there are many more that go unreported. Falls where some significant injury occurred is next with 114 reported. The next two are wrong person, wrong site, wrong procedure surgery and suicide with 95 and 89 reported respectively. Many hospitals we work with sometimes struggle to identify the issue they want to analyze in their every 18-month proactive analysis of a high-risk process. This list of the most frequently reported sentinel events is an excellent start point. If other hospitals are having these sentinel events, it means there is risk and analyzing the process and potentially redesigning some part of it may help you to prevent the occurrence of the same sentinel event.

JOINT COMMISSION ONLINE

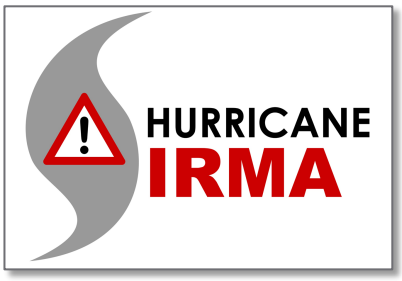
Proposed Changes to Suicide Goal NPSG.15.01.01 – Out for Field Review:

The publication *Joint Commission Online* notified readers that TJC has proposed changes to the suicide prevention safety goal #15 posted to the website. This is an important opportunity to help shape the process, so please remember to take a look and provide your comments prior to May 7.

We noted that EP 1 proposes a requirement for a screening tool for patients who arrive for treatment of behavioral health treatment. EP 2 then discusses the need to use a detailed evidence-based assessment tool to determine the degree of risk. The Joint Commission has hinted previously of its preference for the use of an evidence-based tool and, having seen many home grown tools in hospitals, we support this call for standardization. We are less sure that there will be support for a 2-step process using a screening tool, followed by an assessment tool, since the safety goal only applies to a subset of the entire patient population, those presenting in need of behavioral health treatment, who will likely all score positive on any screening tool. But take a look and provide your comments while the opportunity remains open.

EC NEWS

The lead article summarizes a debriefing TJC conducted with Florida Hospitals following last year's hurricane Irma. There are valuable lessons learned and tips provided by the hospitals that should be shared with your EM committee for their consideration and analysis against your current plans for dealing with similar emergencies.



Keep Your Life Safety Drawings Current:

There is also a very useful article on developing effective life safety drawings. LS.01.01.01, EP 3 establishes the requirement, but we often see hospitals that have ancient drawings with limited annotation that surveyors expect to see. This article provides very useful guidance on what to make sure is present on these drawings including mandatory elements and suggested elements.

The mandatory requirements include:

1. Area's that are fully sprinklered vs partially sprinklered should be identified.
2. The location of all hazardous areas and the type of hazardous area should be noted.
3. The location of all fire barriers should be identified along with their ratings.
4. The location of all smoke barriers and the compartments they create should be identified.
5. The sleeping and non-sleeping suite boundaries should be identified.
6. The location of all chutes and shafts.
7. Any approved equivalencies or waivers.

The suggested requirements to include are:

1. The occupancy type by floor, be it health care, ambulatory or business.
2. The new vs. existing construction by floor space.
3. Travel distances by floor to the nearest exit.
4. Construction type based on the occupancy and the age of the construction.

Not included but one that we would strongly suggest is having staff that can interpret and explain the drawings. Each drawing should have a key and often staff color code to add detail, but someone needs to be able to explain the key and any highlighting or colors used.

Details on Fire and Smoke Prevention:
EC News also has a detailed article on fire and smoke prevention as required by LS.02.01.70. While this was not on the top 10 list, it is an important standard for patient safety. The article lists each element and provides detailed advice relative to smoking materials and space heaters which are a common problem in colder climates.

CMS QUALITY & SAFETY MEMOS

There are no new QSO memos directed to the hospital industry this month.

CONSULTANT CORNER

To our CAS Clients:

Don't forget to check our secure resources page through the CAS Login webpage (https://pattonhc.com/cas/) for new tools and resources including a new tool designed to help you assess compliance with USP 797.

We wish you all a very happy, and warm spring!

Thank you,

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