JULY 2018
PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

New FAQs on Ligature Safety:
This month's *Perspectives* starts off with 17 new FAQ's further explaining the requirements for ligature safety for patients at risk for suicide. These same FAQ's are also posted to the Joint Commission's Interpretation website. The first FAQ is probably the most enlightening. Back in November 2017 when TJC published the first 13 recommendations, the first recommendation discussed those areas that must be ligature resistant and they identified:

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

The asterisk had an associated note that stated that corridors and common areas could be evaluated differently in that the suspended ceiling could be considered acceptable if it was under constant observation, and they referred the reader to additional details in recommendation 6. There was also a bold printed statement in recommendation 1 that said nursing stations with an unobstructed view (so that a patient attempt at self-harm could be easily seen and stopped) and areas behind self-closing and locking doors did not need to be ligature resistant and would not be cited. In this new FAQ we learn that TJC was referring to ligature hazards inside the nursing station, not potential ligature hazards that staff might see in the hallway from the nursing station.

The 5th FAQ published discusses minimum height to be considered a ligature risk. This is an important one to read, as many clients we encounter look at ligature hazards very low to the ground and discount them as unlikely to be useable for self-harm. This FAQ discusses the "alligator roll" where a

patient ties to a very low-level ligature risk, and then spins their body to apply pressure to the throat causing asphyxiation. This FAQ reminds us that none of these close-to-the-ground ligature hazards can be ignored.

FAQ's 9, 10 and 11 are important to the emergency department environment. FAQ 9 states that emergency departments do not have to be ligature resistant like an inpatient behavioral health unit, however you must implement alternative safeguards to protect patients at high risk of suicide or self-harm. We believe that this blanket statement may be misleading if you have genuinely created a psychiatric ED with a locked unit inside a larger, general ED. Joint Commission appears to have dropped the use of the terms dedicated and non-dedicated space, but we believe a locked psychiatric ED would in essence be a psychiatric unit.

FAQ 10 then states emergency departments do not have to include a behavioral health safe room. However, we would advise if you call something a safe room, it better be completely safe, not just better than average. If your so called "safe room" still has some ligature risks, you still need supervision for the patients who are high risk for suicide, and you may be cited by Joint Commission for a behavioral health bedroom or bathroom that is not ligature resistant. It may be preferable to inform TJC that you have a general ED examination room that has the ability to more easily contain common hazards using the garage door mechanism, however it may be used for medical patients as needed, and thus is not "designated" behavioral health space.

FAQ 11 then clarifies that not every psychiatric patient who enters the emergency department needs to be placed on 1:1 supervision, only those with serious (or high) suicide risk (meaning, patients having been assessed to have a "plan and intent") would require such monitoring.

Consistent Interpretation – More Guidance on Sterile Compounding:

The column entitled Consistent Interpretation provides additional valuable guidance on what TJC is looking for on sterile compounding. Again, hospitals are at a disadvantage because TJC has started a rigorous evaluation of sterile compounding, but unlike their home care program, TJC has not embedded the sterile compounding standards in the hospital manual. They are thoroughly evaluating them in stealth mode however. These requirements all come from USP Chapter 797, which has only been superficially evaluated for the past decade. Today's review is far more exacting on the detailed compliance requirements in USP Chapter 797.

The column identifies a potpourri of issues that can be scored in the infection control chapter. These include:

- Failure to wear proper PPE when performing sterile compounding, in this example a hair cover.
- Failure to document the hood and clean room cleaning as required.
- Identification of rust on the IV hood that cannot be cleaned properly.
- Staff wearing makeup while performing sterile compounding.
- Not having dedicated mops to clean the buffer and anterooms.
- Having a fabric backed chair in the compounding room that cannot be adequately cleaned.
- Using an alcohol swab to clean more than one critical site (port or vial top)
- Donning shoe covers as the last step in the garbing process instead of the first.
- Compounding staff having an exposed neck rather than a snug sterile gown around the neck.

Again, we would advise readers to obtain a copy of the home care medication compounding standards or the medication certification standards TJC has developed. These do a nice job of breaking out discreet concepts in elements of performance that is clearer that reading the lengthy narrative USP 797 document.

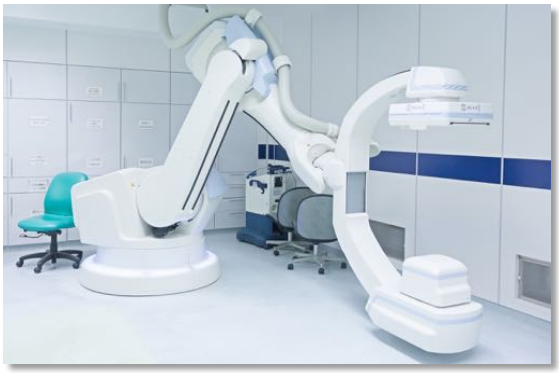
NEW STANDARDS FOR 2019

Naming Newborns – A Standardized Process:

There are two new sets of standards discussed in the July *Perspectives* that must be implemented by January 1, 2019. The first is a requirement to standardize the process naming of newborns under NPSG.01.01.01, EP 3, who do not yet have a name determined by the parents. TJC provides an example of an acceptable naming convention, using "Smith, Judy Girl" which is the mothers name and sex of the child, or in the case of multiple births using "Smith, Judy Girl A, and Smith, Judy Girl B." TJC also includes a note requiring a "name alert" visual warning to staff if there are multiple newborns who may have the same or similar names. There is also an R3 Report published in June 27 on this same issue, but the report does not shed any additional light on the requirement over and above the *Perspectives* article.

New Requirements for Fluoroscopy:
The second set of revised standards is for organizations providing fluoroscopy services. While there is an article about the new requirements, the requirements themselves are not published in *Perspectives*, you have to go to the Joint Commission website and download them from the standards prepublication page. The first revised standard is EC.02.04.03, EP 21, which strangely does not discuss fluoroscopy, but rather CT. EP 21 currently requires 11 physicist-performed annual tests on the proper functioning of CT equipment using 11 unique terms that are frequently difficult to identify in the physicist's annual report. Well, in 2019 TJC is eliminating the requirements for "slice thickness accuracy and slice position accuracy." This will be replaced by "scout prescription accuracy." You will want to share this prepublication list with your employed or contracted physicist and either ask them to use the terminology in the EP or provide you with a cross walk table between the TJC term and the terms they use instead.

There is also a new EP 34, which is conceptually similar to the CT requirement in that it establishes a requirement for another physicist report on the fluoroscopy equipment detailing seven specific performance characteristics which must be evaluated and described in the physicist's report. This EP also has two notes associated with it, the first of which authorizes the physicist to use supportive personnel in conducting the evaluation, providing these personnel have the training and skills required by the physicist. Bear in mind if you use such support personnel the surveyor will of course want to see what the training requirements are, and evidence that the individual has met those requirements. The second note indicates that this new EP does not apply to fluoroscopy equipment used for therapeutic radiation treatment planning.



There is a revised HR.01.05.03, EP 14, again referencing CT services. This EP discusses the Image Gently and Image Wisely low dose training requirement and there is a simple change removing the term technologists and replacing it with "individuals." Then the new EP 15, establishes a requirement for "individuals" who perform fluoroscopy services to also acquire the knowledge that could be obtained from the Image Gently, Image Wisely online education. Joint Commission describes the requirement for "individuals" as applying to technologists, physicians and ancillary personnel.

We must mention that on consultative surveys we find some hospitals use the online Image Gently, Image Wisely programs, and others try to provide similar content using programs developed locally. We would advise that if you develop your own program do include some reference to or evaluation of the content as compared to the "brand name" product. Also, documentation of this training usually resides in the departmental employee competency file. With the addition of physicians in the EP, you will want to determine how you will document evidence of this type of training them, given they do not typically have a departmental competency file.

There has been for many years federal requirements for a radiation safety officer and now there is a new EP 25 at LD.04.01.05, establishing the requirement to have a radiation safety officer.

There will be a new EP 13 at PC.01.02.15 establishing a requirement to have a cumulative air kerma or kerma-area product documented in a retrievable format. If your fluoroscopy equipment cannot display this, TJC indicates that an acceptable alternative is fluoroscopy time and number of images acquired which should be documented in a retrievable format. We assume that most of our readers, like us are now wondering, "What is air kerma?" We looked it up in Wikipedia, and very generally understand it as some measure of ionizing radiation. Your radiology staff and physicist will certainly understand the terminology and know if your equipment can display that information.

PC.01.03.01, EP 25 is revised in its format but not its content. Previously this EP described the requirements for CT imaging protocols and it included 5 content requirements separated by commas. The new EP 25 bullets out the 5 requirements as:

- Clinical indication
- Contrast administration
- Age, to indicate pediatric or adult
- Patient size and body habitus
- Expected radiation dose index range

So, you may be wondering what the significance of this formatting change is. Our advice is that if TJC bullets out 5 specific requirements like that, then you better make sure your CT protocols have all 5 requirements spelled out. While it was required previously, the 5 bullets make it more likely that someone might ask to see them.

There is a new EP 30 for PC.02.01.01 establishing a requirement for hospitals that provide fluoroscopy to identify the radiation exposure and skin dose threshold levels, that if exceeded, trigger further review and/ or patient evaluation to assess for adverse effects. Here your radiation safety officer and committee can certainly help establish this threshold.

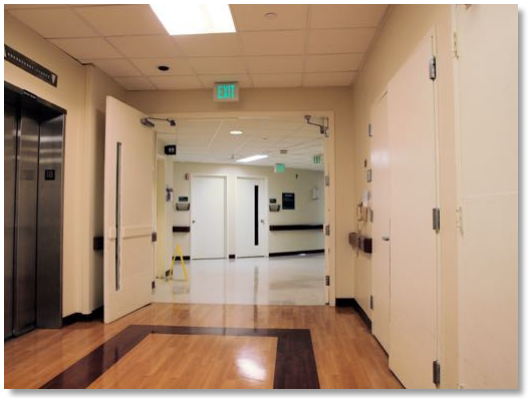
Lastly there is a new EP 20 for PI.02.01.01 that establishes the requirement for hospitals that perform fluoroscopy to review and analyze instances where the radiation exposure and skin dose threshold levels you have established, are exceeded. So, think of this as one more mandatory PI data element for review that might be examined during document review in your PI book, or discussed at the data use system tracer or in the visit to radiology.

The most important aspect of preparing for these fluoroscopy changes is to start discussion with your radiology staff, physicist, and radiation safety committee now. All of these requirements have to be up and running by January 1, 2019. We encourage readers to put together an evidence binder with these new requirements, followed by a paragraph each describing what your hospital did to implement each new requirement. These are very detailed and very technical requirements, similar to the last round of radiology standards implemented in 2016. We visit many organizations where radiology staff we interview know somebody worked on it, but they are not here today so no one knows what was done. If you put together the suggested evidence book, regardless of who is on duty, any of the radiology administrative or section heads can point to the book and use it to inform the surveyor about what your process is.

EP Review Project, Phase IV – More Consolidations:
Perspectives also has an article on another round of EP consolidations, this time effecting the MM, NR and PC chapters. The largest number of EP deletions and consolidation is in the MM chapter which had many EP 's establishing a policy requirement and a second EP requiring that you implement your policy. These two concepts are being collapsed into one EP instead of two. The impact or preparation for these changes should be negligible.

EC NEWS

Means of Egress in Ambulatory Healthcare:
The lead article in this month's EC News is about the means of egress in ambulatory healthcare occupancies. At first glance the beginning of the article looks like just a republication of standard LS.03.01.20. Near the end of the article there is a very useful chart defining terms that seem somewhat synonymous, but each of which have unique definition and meaning. The terms explained include means of egress, exit access, exit discharge, and exit. The discussion after the diagram describes the challenges of maintaining the means of egress in ambulatory healthcare occupancies, but perhaps even more importantly is the section of the article entitled "Defining the problem - ambulatory healthcare occupancies." This topic has been confusing with CMS and TJC each having unique interpretations, followed by CMS taking a very rigid definition, followed now by CMS and TJC somewhat getting on the same page. The basis for the confusion is the long-standing concept that 4 or more patients rendered incapable of self-preservation was the key criterion separating ambulatory healthcare occupancy from business occupancy. The Life Safety Code and CMS use this "4 or more" language, but CMS also states that any ambulatory surgery center must be an ambulatory healthcare occupancy as well as any hospital-based outpatient surgical department, regardless of how many patients are rendered incapable of self-preservation. The graphic labeled as Sidebar 1 in this article also identifies any emergency department, even free standing, must be an ambulatory occupancy. So, defining what is and what must be an ambulatory healthcare occupancy instead of a business occupancy is likely the more critical content to focus on in this article.



Changes to the LS/EC Document and Review Tool:
EC News also reprints a copy of the LS/EC Document and Review Tool. They state that it was updated in March and this reprint includes underlined content that did not exist in the prior tool. In addition to not existing in the prior tool, some of the content does not exist in the standards and EP's either, so some findings from TJC may surprise you. Take a look at EC.02.03.01, EP 3. This discusses the requirements for unannounced fire drills and points out the existing requirement to hold these drills at unexpected times and under varying conditions. TJC has been citing hospitals for quarterly fire drills at nearly the same time every shift, conditioning staff to conclude, "oh, it is just a drill." We recently saw a survey report where the organization was cited for holding 2 quarterly drills less than 1 hour apart. Say for example 11:15 pm in quarter 1 and 12:05 am in quarter 2. While you might think those are at different times, you should note the language TJC has added to the document tool stating: "greater than one hour apart."

Also take a look at EC.02.05.01, EP 14. The language of the EP states the hospital should minimize pathogenic biological agents in cooling towers, domestic hot and cold water systems, and other aerosolizing water systems. Now take a look at the documentation tool. TJC is specifically requiring you to show them your facility risk assessment to identify legionella and other opportunistic infections and your water management program that considers ASHRAE industry standard and the CDC toolkit, and your testing protocols and acceptable ranges for control measures, as well as documented results of testing, corrective actions taken.

Do take a careful look at this documentation tool and in particular all the underlined content, which is new.

CMS UPDATE

Legionella – Revised Recommendations from CMS:
Speaking of legionella, CMS has one somewhat new QSO memo this month, QSO-17-30 revised 7/6/18. This is actually an update to the memo they issued in 2017. CMS states in their new memo that it clarifies expectations, but, does not add any new expectations or requirements for hospitals. As is usual with CMS red content is new and on page 3 there is one new statement: "Facilities must have water management plans and documentation that, at a minimum, ensure each facility" and then they reference 3 content expectations for the plan that were in their earlier memo, and these are identical to the content requirements described above from the TJC EC/LS document review tool. CMS deviates a little on page 4 from TJC when it states "CMS does not require water cultures for legionella or other opportunistic water borne pathogens. Testing protocols are at the discretion of the provider."

CONSULTANT CORNER

Dear Readers,

As a reminder, we do not publish a Newsletter in August and will see you all in September for more exciting 2019 news. We wish you all a wonderful and safe rest of your summer!

Thank you,

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