NOVEMBER 2018
PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

A Quiet Month for Change:
This month's issue of Perspectives does not have a lot of content or changes that would warrant immediate concern and change this month. The lead article is about a potential future change to the safety goal regarding critical tests, to incorporate response to test results in general. They mention a field review comment opportunity, and this is always important, however we followed the link and it appears that the concept is in a very early development stage without potential requirements to critique at this time.

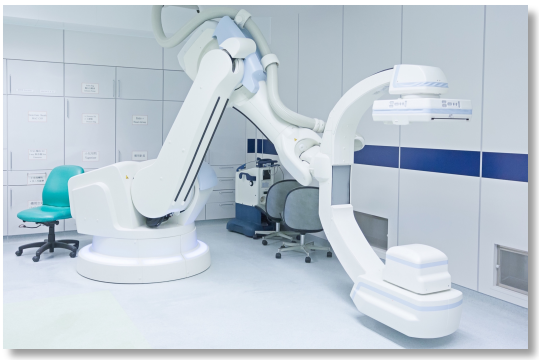
9 New EPs for 2019:
TJC did announce anticipated publication dates for their 2019 manuals and shipments to subscribers of the print editions. We have noticed that the 2019 database for hospitals is available for review. Again, this year we set the filter in the E-Edition to only identify the new requirements for 2019 and it identified 9 new elements of performance in 6 different chapters. The new content is in the EC, HR, LD, NPSG, PC and PI chapters and much of it deals with fluoroscopy services. This is a good time to print and review these new requirements to verify that you are ready for 2019. Remember 1/1/19 is the date everything new should be in operation, not the day you start to consider the new requirements.

As a reminder these are the new changes for 2019:

1. Fluoroscopy - Annual Testing
   EC.02.04.03, EP 34: This establishes a new requirement for an annual performance test by your

physicist of the fluoroscopic imaging equipment. As was noted back in 2015 when Joint Commission published similar test requirements for CT and MRI equipment there are 7 specific performance test elements Joint Commission expects to see on these reports. We noted that when the 2015 requirements were first published is took hospitals a considerable amount of time to start using the same terminology as Joint Commission or to obtain a translation table of terms from your physicist. We encourage readers to test the process and verify that you can locate these 7 very technical items (terms) being evaluated. As always, we advise using the "show me" technique rather than just getting an email that says, "yea, I'm sure we have that stuff."

2. Fluoroscopy - Annual Training
   HR.01.05.03, EP 15: This establishes an annual training requirement for staff who operate fluoroscopic equipment to learn the "Image Gently" techniques and tools for dose optimization for both pediatric and adult patients. We noted that this EP is applicable to both physicians and other staff and you are going to want documentation that this was done. Joint Commission published the link to www.imagegently.org and if you go to their website you will find 3 detailed training modules that you can download and a nice one-page checklist for physicians performing fluoroscopy. Note that this is an annual requirement and you are going to want easy access to documentation that it was completed.



3. Medical Staff Lead to Consult with Board
   LD.01.03.01, EP 13: This was the change we discussed just last month required by CMS to have the physician who is responsible for the organized medical staff consult with the governing body. Readers will want to get this activity on people's calendars for 2019. CMS has more details on this expectation in tag A-0053 and also provides examples of survey procedures, or questions surveyors may ask about this consultation.

4. Radiation Safety Officer
   LD.04.01.05, EP 25: This formalizes a TJC requirement to have a radiation safety officer at each hospital; most organizations are already compliant with this requirement.

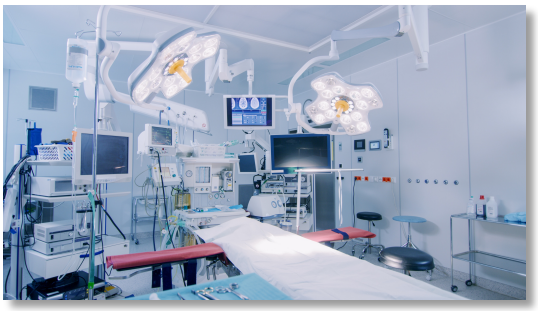
5. Distinct Identification of Newborns
   NPSG.01.01.01, EP 3: This requires hospitals to use "distinct" methods of identification for newborns. In addition, they require standardized practices for identification banding and establishment of communication tools (name alert warnings) for staff when there are patients with similar names.

6. PC.01.02.15, EP 13
   This also applies to fluoroscopy services and requires the cumulative-air kerma or kerma-area product to be documented in a retrievable fashion. There is an option for equipment that cannot display or provide this information to track fluoroscopy time and number of images in a retrievable format such as in a picture archiving and communication system. Readers will want to discuss this feature with their radiology staff to determine how you will accommodate this new requirement.

7. PC.02.01.01, EP 30
   Another new fluoroscopy requirement to establish a radiation exposure level and skin dose threshold that if exceeded would trigger further review or patient evaluation. The EP lists references and this will require discussion and approval by your radiology leadership.

8. PI.02.01.01, EP 20
   One more change for fluoroscopy services requiring the analysis of instances where the radiation skin exposure threshold you established was exceeded. You can think of this as one more mandatory PI measure that you should have, and don't forget that zero is a meaningful data element that should be documented if this is your experience.

9. Mandatory Emergency Equipment in the OR
   PC.03.01.01, EP 8: This is the new requirement for access to mandatory emergency equipment in each operating suite. The EP is clearer than the original text first published months ago in that it includes translation tables for some older terms used in the EP. The required equipment includes a communication system into and out of the OR, cardiac monitor, resuscitator, defibrillator, suction machine and tracheotomy set.



E-Edition:
While looking at the E-Edition changes and our newsletter from October we noted that the E-Edition did not pick up the minor change we discussed last month for EC.02.03.01, EP 9 calling for a content change in the fire response plan to include "cooperation with firefighting authorities." We also noted it did not pick up the minor note 2 and 3 changes at LD.04.03.01 regarding emergency services in hospitals. We assume the filter in E-Edition did not pick up these changes because they were so minor in nature.

Consistent Interpretation:
This month's column focuses again on sterile compounding requirements. This edition really seems focused on guiding surveyors where to properly score defects in sterile compounding processes. Getting dinged in the right EP is less important to readers than knowing what you can be dinged for, so focus on the right-hand column where they provide the guidance/interpretation. We noted 2 issues where TJC advises their surveyors to call back to central office for guidance. These circumstances include failure to certify the hood and inappropriately stating the risk level of the sterile compounding (i.e., low, medium, high) as defined in the current version of USP Chapter 797. We assume this advice to call the home office is due to the potential significance of the citation and suspect that an immediate jeopardy or immediate threat determination is at risk here. Both issues could be very significant; one being you don't really know if your hood is providing ISO 5 air, and the second, potentially meaning the techniques used for that risk level of sterile compounding may not have been rigorous enough. For example, performing compounding of IV or internal organ irrigations using non-sterile ingredients and not recognizing the need to treat this as high-risk compounding with end product sterilization would warrant an immediate threat finding. Remember you are also required to report to TJC on your application the risk levels of sterile compounding that you perform. If you are doing high risk compounding it changes the requirement for media fill and fingertip testing to every 6 months.

JOINT COMMISSION ONLINE

The November 7 edition has a critique of a recent British Medical Journal article that had identified no significant difference between accredited and non-accredited hospitals in 30-day mortality rates. For those of you who advocate for accreditation, Joint Commission provides some very valid points about what they see as the flawed methodology of this analysis and differences in the hospitals and populations served between non-accredited smaller non-teaching hospitals and the larger and often academic medical centers that TJC accredits. The link to the BMJ article is provided as open access. You may want to save this rebuttal from TJC along with the BMJ article in the event the issue comes up at your hospital in the future.

EC NEWS

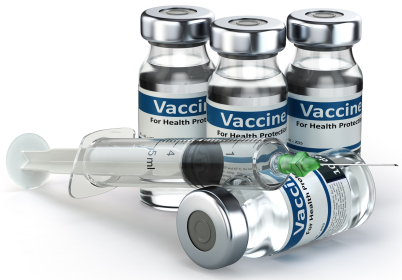
Reopening After Disaster:
This month EC News is equally light in terms of new and worrisome content. The lead article is about the incidence of suicide in hospitals, and while a very important topic, it is a reprint of the same article referenced in the October issue of Perspectives. There is also a 10-page checklist that is very pertinent to a small subset of hospitals that have been closed due to some disaster like the floods in the south. The checklist provides a lengthy listing of considerations both clinical and environmental issues that should be evaluated before reopening and beginning patient care again. This list may seem somewhat immaterial to organizations that have never experienced a closure but would be particularly valuable to organizations that have. Our advice is to share it with your emergency management team and have them keep it on file for post disaster recovery planning if that occurs in your hospital.

Vaccine Storage:
TJC had mentioned during this year's Executive Briefing presentations that they will hold hospitals to the CDC Vaccine storage requirements for proper storage of any vaccines received through the Federal vaccines for children program. This appeared to be somewhat of a relaxation from findings in survey reports we have seen in the past where TJC cited any storage of vaccines that was inconsistent with the CDC Guideline. There is a new 2018

version of the CDC advisory. You can obtain a copy of the 2018 guideline from: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf

This guideline advises digital data loggers rather than other types of thermometers and they advise there should be a current certificate of calibration for that device. CDC further advises what they call "purpose-built units" or refrigerators that are just refrigerators and freezers that are just freezers. They also advise against the use of "dorm style" refrigerators.

Since the CDC publishes what could be considered best practices it would be worthwhile to review them in detail and to the extent possible use that advice everywhere you store vaccines. If this cannot be done, TJC is at the moment saying this will be acceptable, except for the vaccines obtained from the vaccines for children program.



Frequently Scored, Higher Risk, Frequent Pattern, Red and Orange:

Many organizations share their survey reports with us and we maintain a database of redacted or de-identified findings that is shared with our consultants as examples of what TJC is currently scoring along with the risk levels on the SAFER Matrix. We have 10 months of findings from 2018 thus far and 2 standards jump out at us in both frequency of being scored, and the number of times they are scored red or dark orange meaning high risk with pattern or widespread. These 2 standards are EC.02.06.01, EP 1 (ligature risks) and to no one's surprise IC.02.02.01, EP 2, (HLD and sterilization). The number of organizations that have not yet eliminated the ligature hazards in the behavioral health environment is surprising, but the number that have not documented the ligature risk on a risk assessment with mitigation strategy is even more surprising. Several factors seem to be at play here, with some organizations genuinely not recognizing the potential hazard, some organizations not knowing how to do a behavioral health risk assessment with mitigation strategy, and others appear to be hoping TJC does not notice the hazard. Hoping TJC does not notice seems like a lost cause especially given the frequency with which they are scoring these issues. Not being able to self-identify the potential hazards can be overcome by reading the FGI Design Guide for the Built Environment, or by using a checklist like the one developed by the VA to search for known ligature hazards. The third potential reason is not knowing how to do a risk assessment with mitigation strategy and to have access to it when you need it. We find on many of our preparation mock surveys that clinical staff when asked about the risk assessment don't have a copy of that document, have never seen it, and don't know what it says. Sometimes it is with facilities, sometimes with the safety officer, but often not on the unit. In addition, when a document can be obtained, many times it is missing an actual mitigation strategy or details on how we will keep patients safe until this hazard can be eliminated.

Remember, documenting that a renovation will take place in 2020 is not a mitigation strategy; it's a long-term plan. Mitigation strategies should identify what we are going to do today. For hazards in the behavioral health hallway such as a suspended ceiling, TJC will permit mitigation through constant observation and removal of items that might allow a patient to climb or access the ceiling panels. Hazards in the behavioral health bedrooms and bathrooms are more difficult because TJC expects you to eliminate those known hazards. That can be expensive and time consuming, but it's much easier to fix before Joint Commission conducts its survey and you have a 60-day deadline, or less to correct the issues.

IC.02.02.01, EP 2 is a large potpourri of issues related to sterilization or high-level disinfection. The array includes multiple examples of dry and contaminated equipment, not following MIFU, not testing washers for effectiveness, expired test strips, not properly using test strips, mixing chemicals without measuring, cross contamination of clean and dirty processes, and equipment maintenance not performed on schedule. There are also a few examples of improper use of enzymatic cleaners that could be eliminated with TJC's new kinder/gentler approach of just keep it wet with a towel. These types of issues are much more difficult to correct because they are reflective of the actions of many different staff throughout the organization. The only long term and effective corrective action is repetitive competency assessment and repetitive oversight of process with accountability. The missing component seems to be oversight in many organizations. We have written before about having an HLD Sterilization czar, a content expert that is overseeing the process across multiple departments. But such content experts often lack management authority in individual departments to have sufficient impact. Perhaps what might help reinforce correct practices would be reporting by the content expert to the C-Suite leaders and having those leaders leading the corrective action in the departments where they are at the top of the table of organization.

CMS UPDATE

CMS did publish an updated Appendix A, or State Operations Manual for Hospitals in October. This updates the last version, which was 12/29/17. In the past CMS has used red color fonts to identify new content but unfortunately some of the new content from 2017 did not get changed to black font prior to publication of the 2018 edition. In particular some of the survey procedures bullet points and some references have remained red, although the content is no longer new. There is one section that is entirely new and that is Tag A-1500 discussing swing beds. Swing beds can be acute beds some time and extended care beds at others. They are more commonly seen in critical access hospitals, but this tag advises that they are also possible in smaller, rural acute care hospitals. This tag discusses the requirements to operate swing beds and incorporate both acute and SNF concepts.

Link to Appendix A: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

CONSULTANT CORNER

Dear Readers,

To our CAS Clients, please check out our Tools Page at https://pattonhc.com/cas/ as we are in the process of updating several documents and this helpful document is completed:

- HR – Files, Staff Orientation, Training Tracer

In addition to this tool, you will see that you have access to more than 125 more tools at your fingertips. Being a CAS client provides you with ongoing assessment, preparation, industry updates and a long-term strategy for successful survey outcomes. To learn more how we can help you become a CAS client, please contact us as ExpertAdvice@PattonHC.com and one of our Principals will contact you to build your custom site plan to achieve your organization's goals.

Follow us on LinkedIn at https://www.linkedin.com/company/patton-healthcare-consulting!

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