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PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

This month's issue of *Perspectives* references the planned changes to the suicide and anticoagulation safety goals and provides links to find the new requirements on their Standards Prepublication page. These changes will take effect July 1, 2019 and both will likely require discussion, analysis and development of new policies, followed by staff training.

Changes to Safety Goals for July 2019 – Suicide:
NPSG.15.01.01 has a new statement on applicability that is consistent with the prior applicability statement and perhaps even clearer. The new requirement is applicable only to patients in psychiatric hospitals and patients being evaluated or treated for behavioral health conditions as their primary reason for care in general hospitals. Thus, while their Sentinel Event Alerts have suggested broadening the focus, and many EMR's do provide screening questions for all patients, the requirement remains focused on patients who present with some behavioral health need as their reason for being at the hospital.

EP 1 is significantly changed but is consistent with what you have been reading in *Perspectives* this past year, reflecting the work of their Suicide Prevention Expert Panel. The new EP is divided into two sections:

1. for psychiatric hospitals and psychiatric units, and
2. for general care units of hospitals

For psychiatric hospitals and units, it mandates an environmental risk assessment to identify features in the environment that could be used to attempt suicide. More

importantly the new EP then states: "the hospital takes necessary action to minimize the risks, (for example, removal of anchor points, door hinges, and hooks that can be used for hanging.")

The second part of the EP addresses general care units of hospitals and it requires the hospital to: "mitigate the risk of suicide for patients at high risk for suicide, such as 1:1 monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into the room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital." There is then a note explaining that the "non-psychiatric units are not expected to be ligature resistant environments. Nevertheless, these facilities should assess clinical areas to identify objects that could be used for self-harm and should be routinely removed when possible from the area around a patient who has been identified as high risk for suicide. This information should be used for training staff who monitor high-risk patients, (for example, developing checklists to help staff remember which equipment should be removed when possible).

EP 1 is directionally consistent with what you have been reading in *Perspectives* for more than a year now. It may appear new for some organizations due for survey in 2019, who have not focused on this issue since 2016, in that in the past the environmental risk assessment for the psychiatric settings would likely have recognized some hazards, but hospitals merely used a mitigation or alternative strategy rather than eliminating the potential hazard. Now it is clear, no more alterative mitigation strategy in behavioral health settings is permissible, the potential suicide hazards must be eliminated. This EP is silent on the differentiation between bedrooms and bathrooms vs. public hallways described in *Perspectives* September 2017, which allowed some leeway in public hallways for suspended ceilings, however we assume that this flexibility is still permissible. Also remember with risk assessments in the behavioral health environment, stating you plan to renovate and remove the hazards in 2020, or some other future date leaves you vulnerable for immediate significant survey findings.

EP 2 is equally significant as it mandates the use of a "validated screening tool" for identification of suicide risk.

EP 3 then requires the use of an "evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation." They further require your tool to assess for ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. There is also a note attached to EP 3 that states that a single process or instrument that simultaneously screens and assesses may be used instead of a two-step process. We believe most psychiatric settings will prefer to use a single instrument.

EP 4 then requires that the patient's overall risk for suicide and the mitigation plan be documented. Interestingly while the verb in the EP sentence says "document" there is no "D" icon in the EP. We do see this action as an important and very useful new addition as we frequently encounter hospital suicide screens that have no conclusion and no specific actions to be taken being documented. Many organizations today simple state that if the physician wants 1:1, or close observation, he/she will order it, and if they don't order it that means it was not necessary. It frequently appears as if the suicide assessment is performed because there is a requirement, but the tool isn't really used to help reach a decision about safety.

EP 5 does have a "D" icon and requires that staff follow written policies and procedures addressing the care of patients at risk for suicide. They further state that these policies should include:

- Training and competence assessment of staff who care for patients at risk for suicide (Note: This requirement appears unique in that they are they looking for a policy and procedure to include the literal content of the training program and competency assessment process.)
- Guidelines for reassessment
- Monitoring of patients who are at high risk for suicide.

We believe it is likely that many organizations are going to have to examine existing policies and procedures and they will identify gaps in meeting these requirements.

EP 6 requires policies and procedures for counseling and follow up care at discharge for patients who were identified as at risk for suicide. Previously the only requirement was to provide a phone number for a crisis hotline. Now the expectation appears much more significant and hospitals will want to consider how much

time should elapse between discharge and the first post-discharge appointment, and do you want to make the appointment for the patient or hope that they make the appointment.

EP 7 is entirely new, and you can consider it the performance improvement requirement for the safety goal. This EP requires that you monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance. The following are suggested issues you might want to consider for evaluation, none of which are specifically mandated by TJC, but are offered for your consideration:

1. Percentage of patients who have the suicide screen and/or assessment completed within your required timeframe.
2. Percentage of patients who have a documented conclusion reached on risk of suicide, and staff actions to enhance safety documented after completion of the assessment.
3. Evaluation of inter-rater reliability of staff within disciplines and across disciplines who complete the suicide risk assessment.
4. Compliance rate with staff documentation of behavioral monitoring observations both quantitatively and qualitatively.
5. Verification that staff performing safety checks according to your policies and procedures have the documented competency to do so.
6. Percentage of patients who have a suicide reassessment documented according timeframe established in the organizations policies and procedures.
7. Time to first follow up appointment for inpatients who had been identified as high risk on admission and are subsequently discharged.

Changes to Safety Goals for July 2019 – Anticoagulation:

The anticoagulation safety goal, NPSG.03.05.01 is also changed. The version posted to the Joint Commission's website at this time is an early version, not the ready for *Perspectives* version. The goal itself is changed in an attempt to make the applicability of the goal clearer. The revised goal as stated in the November 26 posting includes a note that makes it clear the safety goal does not apply to routine, short term, prophylactic use such as VTE prevention. What is missing in the new applicability note is a statement on when it does apply, so we assume it always applies except for short term prophylaxis. In the December issue of *Perspectives* there is also a summary article about the changes, but this applicability statement is different. It says the goal applies to organizations that initiate, manage or adjust dosage for anticoagulant medications and it does not apply to mechanical treatment of (bleeding)? Our follow up with TJC has made it clear that the goal does not apply to short term VTE prophylaxis and it does not apply to mechanical prophylaxis but does apply to long term treatment with anticoagulants.

The numbering of the elements of performance changes, but that is somewhat immaterial; it's the new content that is important.

The new EP 1, formerly numbered as EP 2, adds new details to the requirements for anticoagulation protocols. The new EP states the protocols and evidence-based guidelines should address initiation, and maintenance of anticoagulant therapy that address medication selection, dosing, adjustments for age and renal or liver function, drug-drug interactions, drug-food interactions and other risk factors as appropriate.

The new EP 2 now requires the protocols or evidence-based guideline to specifically address reversal of anticoagulation and management of bleeding events related to each anticoagulant medication. Previously this was presumed, but not explicitly stated.

There is a new EP 3 specifically requiring the hospital to use approved protocols or evidence-based guidelines for perioperative management of all patients on oral anticoagulants. We have noted that most hospitals today have widely divergent practices that are practitioner specific for this issue. The new EP 4 is less prescriptive, but more expansive. The new requirement is to follow written policy for baseline and ongoing laboratory monitoring. It is more expansive in the sense that it now also addresses "direct oral anticoagulants" or DOAC, which were not generally in use when the safety goal was first established.

The remaining EPs have wording changes to add clarity, but no substantive changes.

The bottom line on these two modified safety goals is that you want to start studying them now as you may need to identify newer anticoagulation guidelines and a new

evidence-based suicide-screening tool. Since most organizations are using an EMR, you may need time to embed new tools in the EMR, so reaching a decision soon is important.

Consistent Interpretation Column:
This month's consistent interpretation column is a bit more confusing than usual. It focuses on the issue of concurrent surgeries. The Senate Finance Committee had written a report on this topic back in 2016 and we discussed it in our newsletter in February 2017. At that time there was no prohibition from TJC or CMS on concurrent surgery, but the Senate Finance Committee clearly was looking for more structure. At that time the conclusion was that hospitals should develop their own policies and controls on the subject. This month's column appears to show a surveyor finding seeking prohibition for the issue and admonishment from SIG that they should not have scored it. In general, this is not a highly scored issue, so we are unsure why this was even published.

EC NEWS

Frequently Scored EC/LS Findings:
This month the lead article in EC News is a summary of frequently scored EC and LS findings and where they are placed within the SAFER™ Matrix. A very small percentage, approximately 5%, of EC findings hit the red zone and less than 1% of LS findings are in the red zone. However, there are many standards in these chapters that are frequently scored, and this often results in a Medicare Condition Level finding at §482.41 or §482.42 and a 45-day follow-up survey. We believe they are frequently scored because they are challenging, but they also are frequently scored because there is not enough internal auditing to assess compliance and detect problems before TJC does. This article is well worth sharing with your facilities team, but the bottom line has to be more than informative; hospitals need to develop strategies and reporting to leadership on what we are doing to assess for these issues before TJC finds them.

Active Shooter Drill Considerations:
There also is a poignant article from the Orlando Health Regional Medical Center where many victims of the Pulse Nightclub shooting were taken. This should be shared with your emergency management team as there are considerations for your active shooter drills that should be considered. For example, they faced road closures near the hospital that employees being called to the scene had to detour around and the organization had to get word to those employees about the road closures. They also faced huge numbers of media blocking access to one outpatient facility, trying to enter the hospital, and blocking access to the ED, making it look like the hospital was closed.

The behavioral health impact on employees, victims, and families of victims was severe and they are continuing to attempt to meet those needs. They identified they needed better means of mass communication with staff and physicians and better social media communication. One of the key take-aways is the need to plan to manage a large media onslaught.

Emergency Event Announcements:
There is a second article on emergency management addressing how to announce emergency events within the hospital. Do you use plain English such as "active shooter on the 3rd floor," or use color codes such as "code silver on the 3rd floor?" TJC had apparently taken polls during this year's Executive Briefings. It was interesting to see the regional differences with 40% New York hospitals already using plain language announcements and only 7% of Los Angeles area hospitals doing so. They had a second polling question about which format would you prefer to use for announcements and a large percentage voted for plain language. They also allowed respondents to consider a mixed approach of plain language for some announcement and color codes for others and that also earned the approval of a large percentage of participants. Again, this too should be shared with your EM Team and a determination made if you want to change any of your emergency announcements.

PATTON NEWS

Problematic Standards in our Database:
Last month we started to discuss observations we have made based on actual Joint Commission survey reports shared with us. In November, we reviewed IC.02.02.01 EP 2 (HLD and sterilization) and EC.02.06.01 (ligature risks). No other standards come near those two in terms of frequency of scoring and severity on the SAFER™ Matrix.

This month we wanted to discuss the potpourri of issues that can arise under EC.02.05.01, EP 15 (airborne contaminants) and PC.02.01.03, EP 7 (following prescribed orders).

EC.02.05.01 EP 15, we see the following mix of issues, all in the moderate, dark orange section of the SAFER™ Matrix.

- Incorrect air pressure relationship in central sterile supply clean side, multiple citations
- Failure to monitor humidity in the OR
- Failure to monitor temperature and humidity in the OR
- Failure to monitor humidity in the pharmacy, required by hospital policy
- Air pressure in large sterile storage location negative to the corridor, multiple citations.
- Sterile storage location below 20% humidity, no alerts, no action, no risk assessment
- Pharmacy sterile compounding red alarm on, no action taken.
- OR air pressure negative
- Pharmacy temperature outside of range, no action taken

So, let's think of the preventative actions that might be considered for these types of issues. First, do staff know that they work in an environment with specialized air handling requirements and what those requirements are? Perhaps this fact could be emphasized more in departmental training. Secondly, do staff know how to detect deviations from expected conditions? Is there some documentation they should be completing, is there a public alarm, is there some area remediation that can correct the problem such as closing a door or window, or must facilities be called? Is there a rapid response effort when facilities is called for air handling so that clean environments with special requirements can stay compliant, or is this handled in the same routine fashion as someone complaining about the temperature in their office? When we see these same defects on consultations there are often knowledge deficits, coupled with a lack of easy detection because there are no alarms or no required manual assessment mechanism.

PC.02.01.03 EP 7 requires staff to follow physician orders. This standard was not on anyone's radar screen 5 years ago but is very frequently scored today. Examples of issues we have noted on Joint Commission surveys include:

- Blood pressure monitoring ordered, not documented
- IV drip start rate started at something other than prescribed.
- IV incremental rate adjusted at other than prescribed, multiple citations.
- Blood administered at half the prescribed flow rate
- Sedation titration not adjusted although warranted by orders
- Sedation titration adjusted although not warranted by orders, multiple citations
- Mild pain drug given for severe pain, no policy to permit this action, multiple citations.
- Severe pain medication given for moderate pain, not permitted by standards.
- Wrong sedation scale used for sedation titration.
- Oxygen flow rate 75% of ordered flow rate.
- RASS assessment ordered every hour, performed every 2 hours
- Range order high dose administered while policy required starting low
- Pain medication administered while patient had no pain.
- Input and output not monitored although ordered.
- IV fluids ordered, not hung.
- FIO2 not consistent with physician order
- Sedation weaning protocol not followed
- Incorrect amount of fluid administered or taken off in dialysis
- Sedative PRN medication administered for reasons contrary to the order

These are interesting in that they are all "errors" identified by Joint Commission and not picked up by our hospital error detection systems. If your system is not detecting these, then one of the things we would suggest is to discuss and analyze why internal quality monitoring systems are not finding these errors. In addition, you would want to determine what must be done differently to detect these types of errors. Third, you want to consider if we have not given staff the flexibility and tools they need to optimally care for their patients. For example, administering a less potent but prescribed analgesic for a higher level of pain, is permitted by the standards, but in the example above the hospital had not created a policy to allow this. Remember however that the standards do not permit more potent prescribed analgesics to be administered for lesser pain levels. Instead, a specific order for "anticipatory pain" is needed. Some of the titration errors may be that something else was going on clinically and the nurse may have administered the medication at the

correct rate, but nurses don't have the hospitals authorization to change rates based on those other parameters. Perhaps there is no simple way to document why the medication is not administered as prescribed, or they really are just errors. Some of the respiratory weaning errors and oxygen flow rates may be staff following some invisible protocol that is not present in the chart, although all protocols must be in the chart.

We have gotten used to errors being prevented by engineering solutions like bar coding, but many errors remain common and are undetected because we are reliant on self-reporting to expose them. Perhaps we need a chart auditing technique like TJC uses to retrospectively detect similar types of errors, so we can understand the prevalence and prevent them from occurring.

CMS UPDATE

There were no new QSO memo's published by CMS for the hospital industry this past month.

CONSULTANT CORNER

Dear Readers,

We are here for you before, during, and after survey to assist you and your healthcare organization in accreditation and compliance—we can help, no matter your current state of readiness! We help simplify the many challenges, so you can deliver safe and compliant patient care.

Contact us for a confidential discussion of your needs and how we can help you achieve ongoing accreditation, compliance, and readiness.

We wish each and every one of you and your families a very happy, healthy, and safe Holiday Season and a successful 2019!

Thank you,

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