JANUARY 2019
PHC NEWSLETTER

NEWS FROM CMS AND JOINT COMMISSION

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SENTINEL EVENT ALERT

#60 – Developing a Reporting Culture:
Probably the most important article this month is on page 11 discussing the newest Sentinel Event Alert publication #60 on Developing a Reporting Culture: Learning from Close Calls and Hazardous Conditions. As with all TJC Sentinel Event Alerts, you want to read and formally analyze the advice it contains. There are five specific recommendations in the Alert and while you are not mandated to implement all 5, you do want to be able to say you evaluated each recommendation and if you choose not to implement one or more it is because; we had an alternative, we had already done this, or it was not applicable to our services. There is only one really wrong answer on survey about these Alerts and that is to say we never saw it; we never considered the advice.

Within the article is sidebar 5, which contains links to 3 different hospital-developed videos where senior leaders are seen talking about their just culture for reporting and learning. We would suggest you even consider starting here before reading the entire Alert. These are excellent examples of what could be explained to new employees during orientation and what needs to be explained to existing employees about just-culture. If you have the resources to develop a similar video for your hospital this could be an excellent starting point.

This Alert goes hand in hand with the earlier TJC Alert #57 on the Role of Leadership in Developing a Safety Culture. Readers should remember that the Joint Commission's day one document list was revised last year to include the results of your most recent culture of safety survey. This

area of inquiry was to become a key portion of the last-day leadership session on survey, but surprisingly we do not yet see any RFI's arising from these leadership standards. This contrasts with our consultation visits where many organizations are not yet prepared to discuss any results from their culture of safety survey. A key question on a culture of safety survey is staff's perception of the event reporting culture and fear. AHRQ published their summary results in March of 2018 and this question had a positive perception in only 47% of hospitals using their tool.

One of the issues organizations often struggle with is how to respond to errors and in particular willful noncompliance with organizational policy and safety requirements. The Alert discusses two methods for stratifying errors, one by James Reasons and the second by David Marx. These resources help make it clearer what types of errors are blameless and what type are blame worthy, and how you can differentiate the two.

A second important theme from the Alert is the concept of increasing event reporting for what is called a "good catch." These are instances where your staff and systems identified an error about to happen, but the process worked, and staff were able to prevent the error from reaching the patient. Here Joint Commission advises incentivizing reporting of such near misses and even rewarding staff for bringing the issue forward. In addition, they advise a feedback loop to the reporter, letting them know what the organization may have been able to do to increase safety, or strengthen the system as a result of their report.

#1: The first specific recommendation is to review Sentinel Event Alert #57 in conjunction with this newest Alert. If you already documented your analysis of #57, this analysis can be reviewed, and if there was no formal analysis you can review the source documents together.

#2: The second recommendation is to communicate leadership's commitment to building trust and reporting through the safety culture. Here TJC points to the videos mentioned in sidebar 5. We would also advise doing this after re-reviewing the last two culture of safety surveys and evaluating efforts made to improve staff response about their perception of the safety of the reporting environment. If you were not able to move the bar on these results previously, you might want to consider some focus groups to find out why there was no improvement.

#3: Recommendation 3 is multifaceted, on the incident reporting process itself. Here TJC advises the inclusion of close calls or near miss events, staff recognition for reporting and a feedback loop so staff can know that their effort lead to an improvement. Perhaps most important is the last bullet point under this recommendation is to use the data to identify error prone situations, the frequency of occurrence and the potential severity. We see organizations struggle to select their required proactive intensive analysis, or FMEA project every 18 months and this might be a great source for multiple redesign projects throughout the year.

#4: Recommendation 4 is described as holding managers, leaders and staff accountable for addressing and eliminating errors and hazards. It could also be labeled as continuing the momentum of a robust reporting process by providing feedback to staff and making improvements with recognition of those who helped get the improvement started.

#5: Recommendation 5 advises teaching and verifying that all leadership levels understand and apply your accountability process to differentiate blameless errors from blame worthy errors. You can start staff out in the right direction during orientation, but that effort can be undone by a reactionary manager applying the old culture approach of just "writing everybody up for making a human error." Gossip about personal experiences that undermines your safety culture can often spread faster and more effectively than the message your senior leadership team wants to disseminate.

The Sentinel Event Alert closes with a republication of key leadership standards that were supposed to become the focus of the last day leadership session discussion. As your team gathers to consider the recommendations in the Alert, it would be useful to also review these selected standards and self-assessing your current status to identify issues in need to additional focus.

PERSPECTIVES

This month's issue of Perspectives also has an article about some simplification of the ORYX reporting requirements and elimination of the third-party performance measurement vendors. However, ORYX appears to play such a minor role in the entire Joint Commission process, all we can really say is - there are still requirements and don't lose track of them.

New CDC Infection Control Resource:
There is an interesting article about a CDC infection Control resource that has been developed for free standing ambulatory care sites and a link is provided to that resource. The document has an appendix checklist that is perhaps of value to all readers including hospital-based ambulatory sites that may not have as much access to infection control support as inpatient programs. There is also an editable PDF version of the checklist that readers may find useful for all remote sites to complete. The CDC has also developed some specialty resources for orthopedic, pain, hemodialysis, oncology and podiatry clinics. The links to the dialysis resources are particularly helpful as this is a major focus of attention on all hospital surveys.

Pain Management Standards Changes – Home Care, Behavioral Health, & NCC:
Perspectives also announces new pain management standards for home care, behavioral healthcare and nursing care center accreditation. These new standards will take effect July 1, 2019. The changes are most significant in the nursing care centers program, less significant in the home care and hospice programs and minimal in the behavioral health program, particularly the non-24-hour behavioral health program. There is also a lengthy list of the non-nursing home care services where the new pain management standards have no applicability.

Fluoroscopy Standards Modification:
There are also minor edits to the recently revised fluoroscopy services, simply broadening the training reference to include both Image Gently and now Image Wisely. There is also a note modification on the applicability for the requirement to measure cumulative air kerma to exclude a fluoroscopy device called a "mini C arm."

Two New FAQs on Suicide Safety – Note Changes:
Perspectives identified two additional standards FAQ's on environmental safety in the behavioral health environment. The significant new one deals with suspended ceilings in the behavioral health environment. TJC is now making it clear that constant observation by staff of this potential hazard is not required. Rather frequent observation through safety rounds can be sufficient, providing this is the approved mitigation strategy in your environmental risk assessment. There is now a total of 20 FAQ's on the website on this issue. We would encourage you to print each out, verify your compliance and "save to file." These FAQ's do change over time, and sometimes they disappear without warning because what is contained is no longer current policy. For example, constant supervision of the hallways with suspended ceiling tiles could come back because it is announced, or it could come back because this FAQ disappears.

Consistent Interpretation:
The column is back again this month and it again provides notice to surveyors to score issues against more specific and directly applicable EP's. This parsing is less important to hospitals to understand than it is to surveyors. The issues identified are all score-able, just not scored in the best place at EC.02.04.03, so don't spend a lot of time dwelling on this article.

WALL STREET JOURNAL

Continuing Focus on TJC:
The Wall Street Journal continued its crusade against the Joint Commission with another hit piece about a psychiatric hospital in the Dallas area that had multiple CMS and licensure violations for some very significant patient care issues but maintained accreditation. What is not discussed in the article is what the state licensing agency or CMS did to report such violations to Joint Commission, so that they could coordinate efforts. The nation's bifurcated complaint management process is clearly flawed in that complaints can come into either the accrediting body or the state/CMS directly. The accrediting body is required to share any survey findings with CMS, however there is no reciprocal requirement that CMS or the state licensing authority share their findings with an accrediting body.

When things start to go wrong in a hospital, both entities should share information so that they can get on top of the

situation quickly and bring about corrective actions. Both CMS and Joint Commission have features in their process that can help to effect change at the organization. The CMS authority to deny Medicare reimbursement is a huge motivator for rapid change. The Joint Commission as a private sector accrediting body is less influenced by local or national politics where elected officials may be concerned about job loss or important donors in their community. What both CMS and TJC really need to implement is a process to make hospitals implement effective and rapid change to improve patient care.

There was also a second Journal article on December 26 discussing innovations in stroke treatment and criticizing the Joint Commission for "over certification" of stroke centers. This over certification criticism appeared to be aimed at the notion that there are too many varieties of stroke certification and too many hospitals with some level of certification. Given the Joint Commission's involvement with the American Heart Association and American Stroke Association in the development of these programs we assume this concern can be resolved.

EC News

Top Cited EM Standards:

This month there is an in-depth article on the most frequently cited EM standards, elements of performance and their distribution along the SAFER™ Matrix. This article should be shared with your EM team for information and for self-assessment. The table of most frequently cited elements of performance is most useful for this self-assessment. Sadly, EM.03.01.03, EP 1 requiring two drills per year, while one of the most basic requirements is one of the most frequently scored elements of performance.

EM.02.02.13, EP 2 regarding LIP privileges and EM.02.02.13, EP 5 and 8, regarding ID requirements and licensure verification within 72 hours are numbers 4,6 and 7 respectively on the top 10 list. The privileging requirement in EP 2 to identify those responsible for granting emergency privileges must be detailed in the medical staff bylaws and how you will implement the process should be in your Emergency Operations Plan (EOP). We see on consults that there is sometimes an omission in the bylaws to describe the requirement, and sometimes the bylaws conflict with similar content in the EOP or other policy. Elements of performance 6 and 7 precisely describe the requirement to verify identity and to perform licensure verification. All that needs to be done is to basically copy the verbiage from the EP directly into your bylaws, EOP, and policies.

Workplace Violence:

There is also an article on workplace violence excerpted from a book developed by JCR. While the article is also somewhat of a commercial for the book, it does look like potentially valuable information for consideration. The article includes a section on assessment of risk with an interesting perspective on the types of risk that different areas of the organization may be most vulnerable for. EC News then concludes with a new "toolbox" for evaluating environmental risks for workplace violence. This should clearly be evaluated by your safety team with your assessment, improvement and mitigation strategies documented.

Frequently Scored

We have been discussing frequently scored standards we see in our database of actual TJC reports shared with us. In November we discussed EC.02.06.01, EP 1, which is where ligature risks are scored, and we discussed IC.02.02.01, EP 2 where flaws in high level disinfection and sterilization processes are scored. Both were very frequently scored in the Red Zone on the SAFER™ Matrix. In December we discussed PC.02.01.03, EP 7 regarding following orders or protocols, and EC.02.05.01, EP 15 regarding air pressures, temperature and humidity. This month we wanted to discuss EC.02.04.03, EP 5 and IC.02.01.01, EP 1.

Infection Prevention:

IC.02.01.01, EP 1 is where a wide variety of infection control related issues are scored. Basically, anything the surveyor believes looks "yucky" or actually violates some long-standing practice expectation about contaminating patients or the patient care environment. These issues usually score in the dark orange or yellow sections of the SAFER™ Matrix. Most of these issues do not require an infection control expert to identify as they might be considered common sense infection control issues. For example:

- Clean medical equipment stored in the dirty utility room and dirty equipment stored in clean utility room

- Uncovered linens
- Ice machine tubes with slime
- Dust on the medical gas boom, RT difficult airway box dusty, pharmacy hoods dusty
- Kitchen clean pans stored near dirty washing area, clean pans stored with pooled water
- Carts and mattresses with peeling dirty labels, tape repairs, tears, and adhesive residue
- Kitchen dirty rollers, failure to record kitchen water temps for wash or rinse, and water temps documented not reaching required thresholds
- Exposed dirty wood in patient care sink area
- Medical refrigerator with black substance inside (mold?)
- Pharmacists wearing jewelry while performing sterile compounding
- Pharmacy hood power strip contaminated with dust and fluid stains
- Pharmacy hoods not in buffer or segregated compounding area
- No monthly documentation of cleaning pharmacy buffer area
- Artificial nails on direct patient care staff
- No bottom liner on wire storage rack

Identification and prevention of many of these findings at your own hospital can be done by area managers, adjacent partner area managers, infection prevention staff, quality staff, administrative rounding, or perhaps just inviting your mother-in-law in to inspect your work area.

Dialysis Machine and Water Findings:
EC.02.04.03, EP 5 is much more technical dealing with dialysis machine and water maintenance and testing. Dialysis is also one of the areas of focus for TJC at this time. These findings were scored as more significant on the SAFER™ Matrix, with red and dark orange for almost all of them.

- Staff not evaluating residual chlorine test strip after 20 seconds per IFU
- Dialysis machine not bleached after being out of use for extended period
- Dialysis water temperature recorded but not in required range
- Dialysis RO water with high colony count, no action taken
- Dialysis Ph test strips expired
- Phoenix meter not calibrated per IFU
- Dialysis RO holding tank not disinfected every 7 days per AAMI

These dialysis findings require content experts to know what should be performed and how it should be performed. The CDC resources for dialysis we discussed earlier in this newsletter may prove useful to being able to more critically evaluate dialysis services. The CMS ESRD standards are another valuable resource for understanding these very technical requirements.

CMS

Federal Register Announcement:
There were no new QSO memo's published by CMS for the hospital industry this past month. CMS did however post an announcement in the Federal Register in which they are seeking input about potential conflicts of interest when accrediting organizations also operate consulting businesses. As former Joint Commission employees we know that TJC was pretty effective at using a "firewall" to block any direct sharing of organization specific data, but conflict of interest is in the eyes of the beholder, it's more of a perception thing. The CMS comment period closes February 18, 2019 if you are interested.

EPA

Federal Announcement – Hazardous Drug Waste:
There was also another important Federal announcement last month, not from CMS but from the EPA. After many years in draft status, they have developed a final rule for hazardous drug waste. You can find a copy of the rule at: https://www.epa.gov/hwgenerators/final-rule-management-standards-hazardous-waste-pharmaceuticals-and-amendment-p075.

The rule was posted in a "prepublication format" and will eventually be published in the Federal Register. With current Federal Budget issues at the forefront this may not occur in the first quarter as originally anticipated, but you can start studying the rule now.

The rule is almost 500 pages long, however with a quick read we did not yet identify any flash points or significant new requirements that would surprise readers. However, do ask your pharmacy management team to be on the look-out for new journal articles and continuing education opportunities on this new rule. In addition, it would be wise to touch base with your current hazardous medication waste hauler to find out if they have identified any required changes in the process.

The timing of this final rule does pose a bit of a challenge to hospitals that are now gearing up for implementation of USP Chapter 800, which focuses not on medications which are hazardous to the environment, but rather medications that are hazardous to employees. You will need to be compliant with both sets of requirements, but most hospitals have a head start on compliance with the EPA requirements, while the USP requirements are newer and will require more significant practice changes this year.

These USP Chapter 800 standards focus on the NIOSH Hazardous Medication list. At this time the most up to date list is 2016. A new list was anticipated in 2018 but did not materialize, although NIOSH did post a proposed list of additions in 2018 in the Federal Register. Remember MM.01.01.03, EP 1 does require the hospital to develop a list of hazardous medications. Quite often this list is either not developed, or contains only medications hazardous to the environment, not those identified by NIOSH as hazardous to employees. Now is a good time to verify you actually have a list, and even more importantly you have a process to communicate these hazards to staff so that they can protect themselves appropriately.

CONSULTANT CORNER

Dear Readers,

Happy New Year! Don't be unprepared when TJC shows up at your door! Please email us at ExpertAdvice@PattonHC.com or call us at 888-PHC-INC1 (888-742-4621) to schedule your mock survey to best prepare your organization for a successful year.

Thank you,

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