MARCH 2019
PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

Sentinel Event Statistics:
The lead article this month is about Sentinel Event statistics. Last year, a total of 801 sentinel events were reported to the Joint Commission, 87% of which were voluntarily reported. Interestingly, another 9% were directly reported by patients, families, and staff. It would appear that some patients and staff must be reading your websites, patient rights posters, or APR policies. Sadly, wrong site surgery was reported in this article 94 times and suicide 50 times, despite more than a decade of focus on prevention of wrong site surgery and the past year's focus on ligature resistant environments. A percentage of the suicide sentinel events are likely suicide within 72 hours of discharge from a hospital, but the break down between inpatient and outpatient is not identified. We do notice TJC scoring the universal protocol with some frequency due to staff inattention during time out processes, and we see this same thing often during our consultation visits. This is where the staff root cause analysis often leads back to leadership indifference permitting the inattentiveness.

Quick Safety Issue 47:
Perspectives also summarizes a Quick Safety Issue 47 that TJC published in January on de-escalation in health care. The article provides some good insights as well as references and resources that may prove helpful to staff at your hospital that are designing or planning hands on training on this important issue. There are multiple web links included in Perspectives to these resources.

Food and Drink Safety:

There is also a very useful article on "Food and Drink Safety for Clinicians," more often referred to as "Food and Drink Prohibitions in the Workplace." This is a hidden issue in the standards manual, much like cardboard boxes that we often get questions about. While neither issue has a standard in the TJC manual detailing the expectation, it is an issue that TJC surveyors and state surveyors score with some frequency. TJC points the restrictions back to an OSHA requirement that prohibits consumption of food and drink in work areas where toxic or infectious materials could lead to contamination. This sounds reasonable and TJC suggests that hospitals designate safe "hydration stations" for staff, but just don't do it where lab specimens are handled.

For TJC, you could use your risk assessment methodology to designate what you have identified as the safe space for food or drink for staff. Unfortunately, application of this requirement is more of an oral tradition than written standards or CoPs. We often see state surveyors taking a broader approach where they prohibit food and drink in what is called a "patient care" area. State surveyors sometimes factor in drink lids, which at times they or employees perceive as helping to prevent contamination, but OSHA does not appear to support the lid concept as preventing contamination. The good news is OSHA does take a similar stance to TJC, allowing the organization to decide where staff may and may not consume beverages. OSHA has a web posting of correspondence directly on this issue, somewhat like an FAQ where they say:

> "*The employer must evaluate the workplace to determine in which locations food or beverages may potentially become contaminated and must prohibit employees from eating or drinking in those areas. An employer may determine that a particular nurse's station or other location is separated from work areas subject to contamination and therefore is so situated that it is not reasonable under the circumstances to anticipate that occupational exposure through the contamination of food and beverages or their containers is likely. The employer may allow employees to consume food and beverages in that area, although no OSHA standard specifically requires that an employer permit this. OSHA standards set minimum safety and health requirements and do not prohibit employers from adopting more stringent requirements.*"

This may be viewed at: *https://www.osha.gov/laws-regs/standardinterpretations/2006-05-17-1*

Environmental Risk Assessments:

Perspectives also identifies a new note added to the planned revision to NPSG.15.01.01, EP 1 regarding environmental risk assessments. The note makes it clear that "outpatient behavioral health settings and unlocked psychiatric units do not have to be ligature resistant." That is the good news; the more difficult challenge is that you still have to conduct the environmental risk assessment and keep patients safe. In an outpatient setting, it is likely that you will identify a wide array and number of potential ligature hazards. The environmental risk assessment will have to list each along with your mitigation strategy to keep patients safe. To a large extent, those patients at high risk for suicide are going to be transferred to a higher level of care as a mitigation strategy. The risk assessment is still going to require you to identify all these potential hazards. Too often, staff look at a potential ligature hazard and, in their mind, discount it because it is unlikely or that no one has ever attempted to use it. Remember, if you do not list it, TJC will assume you never noticed it, never considered it, and were unaware that it was a potential hazard.

Consistent Interpretation:

Perspectives also has yet another "Consistent Interpretation" column that is even less clear than usual due to all the footnotes and EP notes on a myriad of diverse subjects. The one take-away that seems valuable is that, despite having seen this issue scored in hospitals, TJC does not actually require the name of a translator to be documented unless it is in hospital policy. So, next time you or we see it scored we know there is a clarification opportunity.

EC NEWS

Eyewash Stations:

The lead article this month is entitled "Demystifying Eyewash Stations." This is particularly helpful for what should be a simple issue but remains much more frequently scored than it should be. The author points out that TJC often finds eyewash stations where they are not needed and finds them missing where they are needed. Think of this as problem #1; in your inventory of plumbed eyewash stations, try to identify why you have each station. We are concerned about what the chemical is and are we still using that chemical in this location? Then examine the SDS for that chemical. If it is corrosive, or very acidic (low pH) or is caustic or very basic (high pH), then you do need an ANSI Z358.1-2014 compliant eyewash in the immediate work area. In addition, you will need goggles, facemask, and other PPE appropriate to the chemical in use. TJC also advises access to the eyewash station in 10 seconds (about 50 feet) or less. You need to think of situations where the chemical might temporarily blind the employee and they need to find the eyewash immediately. Going down the hall and through locked doors is not going to provide appropriate access.

Problem #2 is the frequently scored issue with eyewash stations involving a failure to test the station weekly with a more in-depth inspection, at least yearly, to flush potentially stagnant water and verify flow and temperature. The water coming out of the eyewash must be tepid, (60˚-100˚) which would allow an employee to keep flushing their eyes for 15-20 minutes. If the water is too hot, or too cold that will not be feasible. Thus, there should be an automatic mixing valve to control temperature in almost all parts of this country. The documentation of the weekly test is sometimes missed and sometimes it is so carefully documented that future dates are even checked, or it has been checked for 52 weeks by the same employee, never missing time for vacation. There must be internal validation of the credibility of the documentation.

As you compile your list of eyewash stations and the chemicals used in that work area, you may encounter some that are no longer needed and could be removed and reinstalled elsewhere. One area to take a look is outpatient settings. We often find outpatient departments directly purchasing hazardous chemicals that are not formally approved for use, but also not barred by the purchasing department by any control mechanism.

We recommend sharing this article with your facilities team or environment of care committee for additional analysis at your organization.

Equipment Maintenance:

EC News also has an article that is general in nature in a discussion about equipment maintenance (EC.02.04.03), and more detailed about the new EP 34 for physicist testing of fluoroscopic equipment. The EP was new January 1 of this year, and the test must be documented sometime prior to 1/1/20.

This article does point out that the requirement is in effect in all locations using fluoroscopy except devices used for therapeutic radiation treatment planning or delivery. Thus, fluoroscopy equipment in main radiology, cardiology, urology, or other areas does require this annual evaluation by the physicist. As was noted when the similar requirement was put into effect several years ago for physicist testing of CT equipment, your physicist may use terms that are synonyms, but not consistent with the TJC requirement. You will want a translation table so that the non-physicist staff person can explain what was tested and verify meeting the TJC requirement.

There is also a boxed section in the article on equipment maintenance that provides potentially useful links to online resources about equipment maintenance. Those that link to Federal databases are free to download, but those that link to AAMI or NFPA provide links to for-sale publications that you may already have.

Fire Drills:

The last article in EC News covers fire drills and there are four important "Tips for Success" that some might refer to as hidden requirements.

1. Tip 1 deals with EC.02.03.03, EP 1 which in note 2 permits drill conducted between 9PM and 6AM to use "alternative methods" to notify staff instead of audible alarms. The "tip" or hidden requirement is that only the sound may be turned off. All other devices such as strobes, central station signal, and magnetic locking releases must still be activated. In

addition, the tip points out that you cannot conduct the drill at 1AM and then activate those devices after 6AM and try to associate that back to your 1AM drill.

2. Tip 2 deals with EP 3 on scheduling fire drills. The EP states that they must be conducted at unexpected times and under varying conditions. The "tip" explains an issue we see scored very often and that is the hidden requirement to hold these drills at least one hour apart. Thus, a 1AM drill followed by a 1:30AM or 1:45AM would not be acceptable.
3. Tip 3 discusses fire drill critiques as required by EP 5 and is somewhat of a "gotcha" preventative measure. Some organizations identify in their ILSM policy that they will conduct one extra fire drill for all construction projects. The "tip" points out that some surveyors will ask to see evidence of an extra drill for a construction project that might only be a few days old. You would want to be clear in your policy that there will be an extra drill within the calendar quarter, not immediately at the start of the project.
4. Tip 4 discusses the fire response plan which should explain to staff what they need to do with any rolling equipment or carts that might be in the hallway. The policy should detail who removes it and where they move it to.

This article should be shared with your facilities team along with feedback about current compliance with these "tips." There is also an attached matrix that can be downloaded and used to assist in scheduling your drills.

TJC FAQS

TJC posted two new FAQs in three locations. The first deals with suicide prevention and it was posted in the EC and NPSG chapters. Basically, it eliminates video monitoring for patients identified at a high-risk for suicide, instead requiring direct 1:1 in person supervision. The second FAQ is in the life safety code chapter and it somewhat loosens scoring of extraneous materials in exit stairwells. The life safety code prohibits storage of anything in exit stairwells that might interfere with exiting. This can include evacuation sleds, because of the space they take up. However, the loosened interpretation will now permit video cameras and Wi-Fi routers as long as they don't interfere with egress.

FREQUENTLY SCORED

Day-One Documents:

In our last 3 newsletters, we have been discussing actual observations from Joint Commission surveys identified in survey reports that have been shared with us. This month we wanted to do something a little different and discuss an issue that we don't see directly scored by TJC, however it is important to the survey process and may lead to requirements for improvement in a wide variety of different standards areas. In addition, we see flaws in this area quite often during consultation visits.

The problem area we wanted to discuss is the "Day-One Documents" list. The TJC Survey Activity Guide, or SAG, identifies 57 specific documents they want placed in front of the surveyors that very first morning of the survey. Strangely, during mock surveys we sometimes see organizations view the list as documents the surveyors might ask for. In reality, there is no optional nature to this request. A blank space where a document should be indicates a lack of readiness, carelessness, or perhaps you really do not actually have or meet the requirement. They all should be organized and ready to go. Our advice is that these are "first impression documents," which along with your orientation in that first hour, provide some insight to the surveyors about how organized or ready you really are.

Another important consideration is how you want to provide the documents to surveyors. We see three common techniques: 1) one huge 3-ring binder with all documents, 2) multiple smaller binders with specific content as required, and 3) individual file folders with all the required content. As you plan how you want to organize these documents you should consider how large a team will be visiting from TJC. If you have two clinical and one LSC, organizing two large clinical binders and one LSC document binder might work acceptably. If you have eight clinical surveyors and two LSC surveyors, one huge binder is clearly going to be inadequate—the surveyors will tear it apart to find the desired content, some content will get misplaced, and those who are the second or third surveyors to tear into it will assume required content is missing. If you have a really large team scheduled, hanging file folders with one topic per folder might be the best method. Consider having more than one box of file folders depending on how large your team is.

You also want to look at each document your colleagues in the hospital have sent for inclusion with the day-one documents. As you are reviewing the content, there are two essential factors to consider. The first consideration is: what does this document say about our organization?

Does it demonstrate we are on top of requirements and managing effectively or does it say we have problems that appear to be unaddressed or unresolved?

For example, if required document #20, patient flow data, shows enormous delays in door-to-provider time or decision-to-admit-to-actual-admission time, you might want to consider including action plans, evidence of improvements, and prepare for how you might address this issue during the orientation, data use, or leadership sessions. So, think through what follow up issues this document is going to create due to the information we have just shared with TJC.

Another example is required document #56, which calls for your certification reports of primary and secondary engineering controls for sterile compounding. You will note that the 2019 day-one document list also says, "Including any documentation of remediation/retesting conducted based on reported results." These documents often identify testing problems, either with the air filtration systems or with microbial contamination, and almost always the remediation actions are missing. That is informing the surveyors we did not address the problem and then you are scrambling at the last minute to try and find evidence and prove that you did.

The second consideration is to look at the day-one list and try to determine why TJC may be asking for this document. Take a simple one like item #1, the hospital license, for example. Why does TJC request this? Two things come to mind: is the licensure current and is the organization actually licensed as a hospital, thus scheduling a hospital team was appropriate. Item #13, the list of contracted services, is a little more complex. In this case, the surveyors want to review your list, select one or two clinical contractors to examine the contract for performance expectations, and then to look at the evaluation that was done and approved by senior leadership. In addition, surveyors may look to see how complete the list looks, and do they encounter other clinical contractors performing patient care services during tracers, but they were not listed and presumably not evaluated. Each and every item on the day-one list is there for a reason and each one provides clues to the surveyors about your state of compliance and potential follow up activities during tracers.

CMS

QSO Memo:
There were no new QSO memos published this month directed to hospital providers.

Wall Street Journal:
On March 5, the Wall Street Journal did publish yet another article detailing their perceptions about what is wrong with accrediting bodies and their perspective on accrediting bodies owning consulting divisions. You might remember that back in December, CMS asked for public comments on accreditors also owning consulting services. CMS has posted the public comments provided by your colleagues in the hospital industry and by different professional associations directly on this website: https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&dct=PS&D=CMS-2018-0158

The comments from the WSJ article appear more mixed to us than you might believe. Accrediting bodies with consulting arms, like TJC, are of course in favor of continuing the practice. Accrediting bodies without consulting arms are not supportive, professional associations who participate in many Joint Commission processes are supportive, and our peers who work in hospitals have both good and bad experiences relative to consulting and accrediting entities being owned by the same company. Take a look for yourself. Digesting and analyzing this diverse feedback will likely take some time and drawing conclusions will be difficult.

EDITOR'S NOTE

A QSO memo was published after this month's newsletter was authored. It will be discussed in our April issue. Thank you for your consideration.

CONSULTANT CORNER

Dear Readers,

We thank you for your patience last month while our website was under maintenance. We invite you to view our improved website at https://pattonhc.com/. It may look familiar, but you should notice an improvement in its functionality.

Please join us in welcoming Andrew Morley, Jr., MD, FAAFP to the Patton team! Dr. Morley is a nine-year Joint Commission surveyor veteran and came to join the Patton Healthcare Consulting team at the beginning of March. We are very excited to share his expertise with you. Please visit us at https://pattonhc.com/team-bios/ to view the biographies of our surveyors to get to know a little bit more about them!

Have a wonderful month!

Thank you,

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