

# APRIL 2019

## PHC NEWSLETTER



NEWS FROM CMS AND  
JOINT COMMISSION

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### PERSPECTIVES

#### **2018 Scoring Patterns:**

This month's edition of *Perspectives* summarizes the full year scoring patterns for all accreditation and certification programs for the full calendar year 2018. The most frequently scored hospital standards are to a large extent the "usual suspects" that you are already familiar with. We noted that IC.02.02.01, the standard where issues relative to HLD and sterilization are scored, fell from number three during the first half of 2018, to number five. There is a change in percentage of hospitals scored noncompliant on this standard from 74% in the first half year to 71% for the full year. This means there was an approximate drop of 6% during the latter half year. Our assumption is that the change in focus from clinical practice guideline minutia to MIFU causing some surveyor confusion is likely the reason.

One standard, IC.02.01.01, which had been scored in 61% of hospitals in the first half year, fell from number nine to drop out of the top ten. This is a catch all standard where any kind of potential infection control hazard can be scored, from adhesive residue to cardboard, to mixed storage of clean and dirty supplies. Dropping out of the top ten may not be significant however, as number ten in the new listing is still scored in 62% of hospitals, and if IC.02.01.01 remained scored in 61% of hospitals it just means it got replaced by an even more frequently scored standard, not that it is unimportant. This new number ten is EC.02.05.09, which had not made the previous top ten lists.

EC.02.05.09 is a complex standard with 14 diverse elements of performance dealing with medical gases including piped gas and stored cylinder gases. In our experience the three most frequently cited issues are EP 12 on comingling of full and empty cylinders, EP 6 describing an excessive number of cylinders stored, and EP 11 about

blocking medical gas shut off valves. In addition, there are some newer expectations that some organizations may have missed during the conversion to LSC 2012 including EP 1 on categorization of medical gas systems, and EP's 4 and 5 relative to labeling doors where medical gases are stored.



This new arrival to the top ten list, as well as all nine of the other usual suspects, should be subjected to a complete self-assessment and continuous review during EOC rounds, tracer rounds, administrative rounds and any other periodic inspection processes. The frequency of scoring these issues is huge, with 88% of hospitals failing on LS.02.01.35 and 9 other common standards falling between 61% to 80% noncompliance rates. For the most part, this is not because these issues have never been examined and corrective actions taken, but rather maintaining continuous compliance with these issues is so difficult. The only solution is to inspect, probe, test, re-verify and re-educate over and over again until you stop finding these common flaw issues in your organization.

In this most recent listing TJC, also included a grid displaying the most frequently scored standard by accreditation program in a side-by-side comparison. If you have multiple programs this is a nice tool to help focus. You can see the similarities in scoring hospitals and critical access hospitals, and to a lesser extent ambulatory facilities. What was surprising is the infrequent cross over with more commonly paired or tailored programs like hospital plus behavioral health, hospital plus home care, or hospital plus nursing care center.

### Infection Control Requirements:

*Perspectives* also has a particularly useful article on Clarifying Infection Control Requirements. They display a hierarchy of requirements from rules and regulations to COP's to manufacturer's instructions for use to clinical practice guidelines and how all of these requirements should help shape your policies and procedures. The article really points out the complexity of compliance and process design in that you have to be adherent to all of these different requirements, not just the clinical practice guideline you adopted. While we all have seen several years of survey findings scored for some failure in compliance with AORN or AAMI expectations, Joint Commission's focus is now much broader than just CPG's. Rules and regulations

might include your own state department of health, state boards, or federal agencies like OSHA. We suggest that readers take a look at their current HLD and sterilization policies to determine if they are indeed inclusive of all the criteria TJC is examining from rules and regulations to COP's to MIFU to your chosen evidence-based guidelines, to your chosen consensus documents.

## EC NEWS

### Fire Doors:

The lead article in EC News is about the use of fire doors where they are not required. Sometimes organizations install fire door assemblies in areas that don't actually mandate a fire door. This pops up in survey reports when the organization fails to maintain this door as a fire door, because it is not intended to be a fire door. TJC offers some simple advice in this article to just place a sticker over the rating label to hide the fire door label. Review your life safety drawings to ensure that the opening does not require a fire or smoke door.



### Fire Sprinkler Systems:

There is also a good article in fire sprinkler systems and the pitfalls that are identified on survey. The pitfalls are linked to LS.02.01.35, which we mentioned earlier as the number one most frequently scored standard for hospitals. This is where issues like using sprinkler pipe to support other material such as cables, ventilation ducts, etc. is scored. The sprinkler pipe must never be used to support anything else.

They also discuss other common problems such as dust accumulation on sprinkler heads, missing escutcheon plates and the perennial favorite, the 18-inch rule to allow sprinklers to function properly. Preventing staff and contractors from tying new cables or duct work to existing sprinkler pipes is a perpetual problem in hospitals.

The very next article authored by a hospital director of support services, discusses a process they have designed for an "above the ceiling permit and policy". There is a template notice that can be provided to contractors, a template policy and an example of a ladder tag that is visible by any hospital leaders, when any work is being

conducted above the ceiling, just by walking through the area. These are all great ideas; worthy of consideration if you don't already have such practices in place in your hospital. With 88% of hospitals being scored deficient in this standard, getting a handle on the risks with sprinklers would be very helpful.

### Risk Assessment:

The April EC News also has a real keeper of an article in risk assessment. This is an issue we find in general that hospitals struggle to perform, struggle to document, and struggle to find when asked to show the risk assessment.



TJC points out 9 specific areas, just within the EC chapter where their surveyors are looking for documented risk assessments. These areas are:

1. Safety
2. Security
3. Fire safety
4. Hazmat
5. Medical equipment
6. Utilities
7. Preconstruction
8. High risk locations and populations
9. Emergency management

Joint Commission also points out the need for risk assessments for any other vulnerable process or high-risk procedure including ligature points and infection prevention. These risk assessments might include issues where you want to evaluate needed change and issues where you might want to formally document that existing processes are safe and effective.

As we have stated many times in this newsletter, surveyors may sometimes identify risks and ask the hospital if they have conducted a risk assessment. The failure to have formally thought the issue through in a risk assessment and document your conclusion leads TJC to believe you never considered the risk. The hospital then obtains an RFI for the risk perceived by the surveyor. This takes the issue out of the realm of surveyor "opinion" and into the failure to identify and consider potential risk.

The authors then provide 7 sequential steps to conducting the risk assessment and these are:

1. Identify the issue
2. Develop arguments in support or against the issue
3. Objectively evaluate both arguments
4. Reach a conclusion
5. Document the process
6. Implement change, if any
7. Monitor and reassess the conclusion to ensure it is correct

We would add three additional recommendations to this list, and that is to provide staff and managers in the area affected by the risk assessment with a copy, as well as the hospital quality department and the EOC team. Secondly staff in the work area, facilities and quality should be trained about the risk assessment process, its conclusions and know where this is filed in their area. Third, we would encourage readers to update their risk assessments periodically, and we suggest annually because conditions change, areas get repurposed; processes change, and the risk assessment may need to be updated based on these changes.

### Preventing Patient Suicide:

EC News also has an article on preventing patient suicide, which is being used to promote a new reference for sale by JCR. We normally would skip discussion of these types of promotions, however the issue about suicide hazards in the physical environment is still a very hot topic, one that many organizations have been slow to resolve. We continue to see hospitals being hammered by TJC or CMS due to ligature hazards that are being slowly eliminated, but not yet completely eliminated.



Too many organizations are considering their anticipated due date for the next survey and designing a timeline to complete elimination of hazards prior to that date. Unfortunately, TJC may come early, TJC may come based on a complaint, and CMS may come based on a complaint or an actual event and the findings can be very damaging.

This article contains a grid or table of frequent hazards in the behavioral health environment along with recommendations on how to manage the hazard either through elimination or documentation on the risk assessment and appropriate supervision of patients. We suggest readers use this as a reminder to accelerate their



construction timeline and verify that your environmental risk assessment includes an acceptable mitigation strategy.

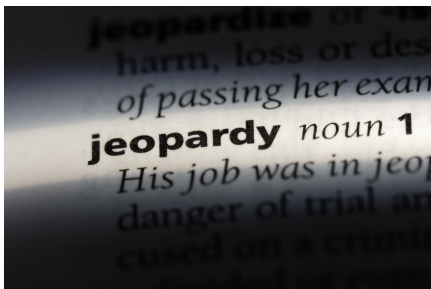
As a reminder, it is not an acceptable mitigation strategy to state the area will be renovated in 2020 or 2021. Patients must be kept safe until then and TJC and CMS have agreed the behavioral health bedrooms and bathrooms must be ligature resistant.

## CMS

### **Calling Immediate Jeopardy:**

CMS did issue a new QSO memo this past month, QSO 19-09, discussing the dreaded subject of immediate jeopardy determinations. The IJ process is described in Appendix Q of the State Operations Manual. This memo reads as if the changes CMS describes may be a step in the right direction, adding more consistency and structure to the determination of immediate jeopardy. CMS describes three key components of immediate jeopardy, which must be present, and these are:

1. Noncompliance
2. Caused harm or created a likelihood of serious harm, impairment or death to patients. Likelihood is further defined as a reasonable expectation that harm would occur.
3. Immediate corrective action is necessary.



In addition, the prior concept of culpability has been removed. CMS states that the term culpability is not in the underlying regulations, thus they removed it. In addition, we believe the concept of blame worthiness is likely not pertinent at a hospital level, as the patient is in your care and if something goes wrong, you own the issue regardless of culpability.

CMS further states in section V of the memo that hospitals may not claim that properly trained and supervised individuals acted as rogue employees and violated a regulation, to avoid organization findings of noncompliance. CMS also discusses psychosocial harm as one of the forms of harm that could rise to the immediate jeopardy level. CMS describes that making this determination may be difficult in some instances, when the patient has cognitive impairments and when the surveyor cannot interview family or a representative of the patient.

In such circumstances CMS advises that surveyors should apply a “reasonable person approach”. We will refrain from any editorial commentary on this concept, but we assume readers may have their own opinions.

To add structure to the process, Section VI describes the procedures that surveyors should undertake to declare an immediate jeopardy situation. CMS provides on the last page of the transmittal a template for surveyors to use that documents the noncompliance, the injury or likely risk of injury, and the need for immediate action to be taken. This will enable the surveyors to think through the details, and then CMS requires the on-site surveyors to call their respective state agency for authorization to declare the immediate jeopardy situation. CMS notes that some state agencies require consultation with the CMS regional office, while other states make this determination themselves. CMS also states that the identification of the IJ should be made by the team while onsite at the organization. However, CMS also notes that in “rare” instances, the IJ may be identified by the state or regional office after the survey team has left the organization.

Section VII discusses removal of the IJ. CMS requires that the survey team should confirm the IJ with the state agency or regional office, if required by the state and inform the organization immediately. CMS calls for a “removal plan” from the organization to describe the steps they will take to ensure that no patients are suffering or likely to suffer serious harm, serious impairment or death as a result of the noncompliance. They further state that unlike a plan of correction, not all noncompliance must be eliminated prior to removal of the IJ, but rather the steps must ensure that serious harm or likelihood of harm will not occur. Furthermore, the removal plan must include a date by which the organization states it will eliminate the likelihood for harm. As is often the case, CMS notes that if the removal plan cannot be implemented prior to the exit conference, the IJ continues until a revisit verifies the date that the IJ was eliminated. During the onsite follow up surveyors will verify that all the steps have been implemented in a manner that eliminates the likelihood for harm.



If you would like to learn more about this IJ process, CMS has created an online training website, intended for



surveyors, but also open to organizations. The training can be obtained from: <https://surveyortraining.cms.hhs.gov>. With this process being conducted by 50 different state agencies, we assume there will be some variability in application of this memo. The training will certainly help surveyors, but we have already noticed some variation in the process since publication of the memo on March 5.

While the training is open to organizations, there is a downside to becoming more expert in the expected process

depending on how you choose to “correct” the surveyors in the actual required process. In addition, the IJ situation is likely a situation more than 95% of our readers should never experience and hopefully by the time you do, many years in the future, there will be additional revisions to the process. Spending more time now on the top ten most frequently scored standards might be a better utilization of time.

## CONSULTANT CORNER

Dear Readers,

We are scheduling now for the remainder of 2019 and beginning of 2020. Please don't miss your opportunity to have a team of our expert consultants visit your organization to better prepare you for your TJC or CMS survey!

You can either email one of our Principals below or fill out our web form on our Contact Us page at <https://pattonhc.com/contact-us/> to request your mock survey visit.

We look forward to hearing from you soon!

Thank you,

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