MAY 2019
PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC.

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

Two New Suicide Safety FAQs:
This month's edition of *Perspectives* holds no new mandates for the hospital industry that readers have to implement. They do provide clarity on two new FAQ's relative to suicide safety that were posted to the TJC website. The first deals with video monitoring of individuals identified at high risk for suicide. The bottom line on this is video monitoring is not an acceptable substitute for 1:1 direct visual monitoring for patients determined to be at a high risk for suicide. The only exception to this would be if it was unsafe for the sitter to be directly and closely visually monitoring the patient. If this is the case, the electronic sitter must have only one task assigned and that is continuous monitoring of the video screen. In addition, the sitter would have to be able to provide immediate intervention or obtain immediate intervention if the patient attempted self-injury.

The second FAQ discusses recommendation #1 from the task force relative to self-closing and self-locking doors. TJC makes it clear, this is not a choice or either self-closing or self-locking, it must be both, to keep patients from wandering into spaces that are not ligature safe while unsupervised.

Consistent Interpretation – Range Orders:
This month's column entitled "Consistent Interpretation" is less informative than usual, more confusing, and actually provides guidance that we believe is ill advised. This month they tackled MM.04.01.01, EP 1, scored in less than 4% of US hospitals and EP 2 scored in 0.14% of hospitals. There are 11 surveyor observations and 12 "tips" from SIG on interpretation. All of the surveyor observations are in fact scoreable, although some would fit better scored against elements of performance other than EP 1, and some

observations could use additional written details to cite the infraction more precisely, such as policy references from the hospital.

For example, the surveyor observation stating the hospital used unapproved range/double range orders is technically correct, providing the hospital had a policy prohibiting them. The advice section from SIG on this issue is what we find troubling when it states: "The Joint Commission does not have a standard or EP that prohibits a health care organization from including double range orders in its order policies." While this position on double range issue is technically correct, and we can expand that they don't have a prohibition on range orders using a single range either, the advice or guidance is problem prone. TJC does not prohibit them, but they score range orders and double range orders all the time, because of a failure to implement the ranges according to hospital policy.

In reality it would be better if they just prohibited range orders. Once you say you permit range orders, or worse yet double range orders, you invite the surveyors to assess for uniform implementation of the governing policy that guides implementation across all units and nurses in a standardized fashion. Standardizing the implementation of range orders is a very difficult task and standardizing the implementation of double range orders is essentially an impossible task. It's somewhat like saying no one prohibits pedestrians from walking across an interstate highway wherever they choose, but your chance of success is very limited.

If you permit range orders you should conduct tracers, interview nursing staff, and analyze medication administration records in conjunction with flow sheet or assessment notes to determine if your range orders are being uniformly administered. As consultants, we continue to find a wide variety of well intentioned, but inconsistent, practices where some staff give one tablet and others give two for the same pain levels, same conditions, even after prior success with the alternative selection. We also see misapplication of hospital range order policies very frequently scored by Joint Commission, just not against the standard and EP being discussed in this article.

There are opportunities for Joint Commission to score misapplication of range orders against PC.02.01.03, EP 7, and HR.01.02.07, EP 2. These elements of performance require provision of care in accordance with physician orders and practice within the scope of licensure, respectively.

EC NEWS

Danger Zones:

EC News has a great article this month entitled "Danger Zone Directives" which discusses hazardous materials and waste management plans. Readers should make sure this article is shared with the staff who manage your Hazmat Plan at your hospital. One of the best pieces of advice in the article is from Kenneth Herbert, an engineer in Standards Interpretation (SIG). He states: "The Joint Commission requires that each of these elements of performance be addressed in the management plan." He further states that prior to his work at TJC, he "used these EPs as the outline for his Hazmat and Waste Management Plan." This is great advice in that it forces you to verify that each and every element of performance is addressed in your plan. The plan document can be brief and reference more detailed policy documents, but at least it should provide a high-level summary of what you do to address every EP.

This is also a technique we have used as consultants where staff just did not know where to start in creating a management plan. You can print a copy of the pertinent standard and elements of performance from the E-Edition, save it to file, and convert it to *MSWord* to allow editing. We then interviewed staff asking them basic questions such as how do you do this? Who has the data? Where is it written that you do this? What data exists documenting your level of compliance? What is the return rate for dosimetry badges? Did anyone reach ALARA limits and what did you do? If you write just a few sentences about each element of performance, you end up with a complete management plan. This technique is far superior to the more often seen technique, which is to grab some other hospital's management plan off of the internet and place your hospitals name on it. This ends up being a compilation of things you may not actually be doing and there is no data to support the practices claimed.

The article also contains a summary of requirements relative to hazardous medications, both those that are potentially hazardous to employees and those that are potentially hazardous to the environment. This topic will likely face an increased level of scrutiny in the coming year as USP Chapter 800 takes effect and the final rule from the EPA on managing hazardous pharmaceuticals becomes more well known.

The article also has a reprint of EC.02.02.01, which discusses hazardous materials, waste management, and EC.04.01.01, which addresses collecting information to monitor conditions in the environment. These would both be good tools to self-assess for compliance, to verify that something is done, and to examine the thoroughness of your management plans.

Medical Gas Safety:
The next article is equally valuable, on Handling and Storing Medical Gas Safely. This article also includes a reprint of the governing standard, EC.02.05.09 and each of its elements of performance. Again, we would advise a thorough self-assessment against each element of performance, and not just a verification statement like "oh, yes, we do that." Rather, the validation should be able to describe specific policies that state you really do it, data that verifies you really do it, discussion of compliance verification processes, and information about how you train staff to meet the requirements. The EC News article includes some photographs that are great training aides, showing unsecured medical gas cylinders, as well as doors and equipment blocking medical gas shut off valves.

Regrettably, TJC missed an opportunity to further clarify exactly how partially full oxygen cylinders are to be stored within patient care areas. Prior to February 2018, TJC expected hospitals using a two-rack system to label one rack as "Empty/Partial" and the other "Full" so that full cylinders where in their own dedicated rack. (See EC News December 2012 and EC News February 2014). Hospitals could also use a three-rack system (Empty, Partial, Full). In February 2018, a new FAQ was posted to the TJC website that reversed the orthodoxy for hospitals using a two-rack system. It stated:

> *"Storing oxygen cylinders, as per NFPA 99-2012, 11.6.5.2, is about managing empty cylinders. Those cylinders defined as empty by the organization shall be segregated from all other cylinders that are intended for patient care use. Full and partially full cylinders are permitted to be stored together, unless the organization's policy requires further segregation."*

James Kendig, who is the TJC field director of surveyor management, commented in this May 2019 article that he has observed a "good practice" where "some organizations have painted racks green for fulls, yellow for partially full cylinders, and red for empties," implying that a three-rack system is the way to go. That may be, but it also would have been helpful had he reiterated the guidance from the February 2018 FAQ that a two-rack system is also permitted, so long as empty cylinders are in their own, dedicated rack.

CMS

Ligature Hazard QSO Memo:
CMS did issue a new QSO memo this past month, QSO 19-12, published April 19, 2019 addressing ligature hazards. It is of importance to note that this memorandum was issued in a draft status. We would anticipate that states, accreditors, and hospitals may choose to provide feedback to CMS on this memorandum. Public comments should be sent to: HospitalsSCG@CMS.hhs.gov

The first thing we noticed is that the acronym TJC developed and wrote about called an LFER, or "ligature facility extension request," has been retitled by CMS as an LRER, or "ligature risk extension request." Regardless of the acronym, this is the tool that hospitals must use if they are unable to correct the ligature finding TJC or CMS identifies on survey. Consistent with guidance issued by TJC earlier, these extension requests cannot be granted by the accrediting body; only the CMS Regional Office can grant the extension. CMS does want them to be processed through your accrediting body, but the accreditor will have to seek approval from CMS after their review.

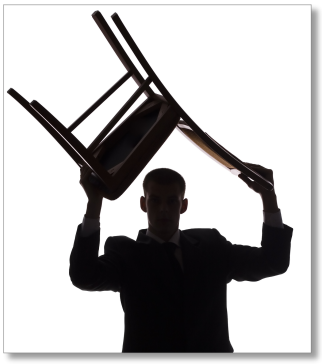
One important issue we noted relative to these extension requests is that CMS requires them to be submitted prior to your due date for becoming compliant. For example, in a normal 60-day ESC process, you can't wait until the last minute to submit an extension request and have it

reviewed by both the accreditor and CMS in time for your final submission. You would want to identify potential delays in correcting the environment early on in the process of developing your ESC.

If approved, your LRER will require monthly progress reports to the accreditor who, in turn, will share them with CMS. In addition, when you do receive new fixtures, install them, and do other necessary remodeling, there will be a need for the accreditor to conduct a one-day focused survey to verify the hazards initially seen have indeed been corrected.

Violence Hazards:
We noted that CMS goes beyond just suicide hazards in this memo to also discuss violence hazards. This is equally important, but one that we have not heard much about in the discussion on suicide hazards this past year.

For example, the interpretive guidance for tag A-0144 mentions removal of equipment that can be used as a weapon or to inflict harm. They later provide an example of light chairs that can be thrown or swung as a weapon. Tools we formerly used for risk assessing the environment had violence hazards on them and it looks like this is going to need to make a comeback.



This tag guidance also mentions video monitoring and provide the same logic as TJC that it is only appropriate when it is unsafe for the sitter to be in close proximity to the patient being monitored. This section also discusses toilet seats and there is agreement with what we have heard from the Joint Commission's Expert Panel that these are a minimal risk. But again, the language is not as clear as TJC and it seems to open this up for reconsideration if other factors are present. We are not sure what other factors might make the toilet seat a greater risk.

CMS makes it clear in their memo that they, like TJC, do not expect all medical treatment areas to be ligature free. CMS also mentioned that unlocked psychiatric units within either psychiatric or medical hospitals do not have to be ligature free. CMS does warn the industry, though, to not unlock their units just to try and avoid required renovations to the behavioral health areas.

CMS also provides guidance in this memorandum on training expectations. They require training on the assessment methods staff are to use to evaluate risk of self-harm and risk of harm to others. They require training on the identification of environmental risk factors and mitigation strategies. They advise that this training should be done at the time of hire and prior to providing care. They also include in the training expectation those employees who don't work full time on the unit but may need to come to the unit to fulfill their duties such as dietary, housekeeping, maintenance, and others.

We also noted that CMS requires policy development for assessing and reassessing those who are identified at risk for self-harm or harm to others. We have seen hospitals allowing this structured reassessment to fall through the cracks.

Bear in mind, the deadline for comments to CMS on this draft is June 17, 2019.

ELECTRONIC HEALTH RECORDS

Death by 1,000 Clicks:
Fortune Magazine, in conjunction with Kaiser Health News, published an article on March 18, 2019 entitled: "Death by 1,000 Clicks: Where Electronic Health Records Went Wrong". Our readers should take a look at this frightening article on some of the routine difficulties with EHR's and some of the lesser-known error potentials that are being discovered.

They describe entries by clinicians for lab tests that never pass through to the lab, orders for medications that don't display warnings about interactions, progress notes that disappear, and unintended merging of data among different patient records. It is almost as if the hand writing errors we sought to eliminate, and the limited access of file cabinets to sharing of patient information across providers, had been replaced by entirely new sources of error and the lack of interoperability; a substitute for the locked file cabinet.

This article is so concerning that we would encourage our readers to share it with physician and nursing leaders, IT staff, and ancillary department heads, followed by frank internal discussion about what your hospital might be seeing on this issue. The Federal government's financial incentives, software vendors, hospitals, and physicians don't escape unscathed in this article. You can find the article online using the following link: https://khn.org/news/death-by-a-thousand-clicks/view/republish/

If you would like to learn more about the concept of interoperability, a colleague and friend of ours, Michael Mytych, founder of Health Information Consulting, LLC based in Menomonee Falls, WI, wrote a compelling blog piece on this topic that we have linked to here: https://www.medaxiom.com/blog/what-you-need-to-know-about-hhs-new-ehi-interoperability-standards-rule/

Michael's blog also provides a link to new CMS proposals on interoperability that were just published in February.

CONSULTANT CORNER

Dear Readers,

Don't forget to contact us to schedule your 2020 visit! Happy spring!!

Thank you,

Jennifer Cowel, RN, MHSA
JenCowel@PattonHC.com

Kurt Patton, MS, RPh
Kurt@PattonHC.com

John Rosing, MHA
JohnRosing@PattonHC.com

Mary Cesare-Murphy, PhD
MCM@PattonHC.com