JUNE 2019
PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC.

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

Again, this month *Perspectives* does not include any new mandates for hospital accreditation, however there is new content for disease certification programs and office-based surgery accreditation. *Perspectives* does have news about the FSA tool being offline in July and two thought-provoking articles, one on disinfection of ophthalmology devices and the second on prevention of drug diversion.

Ophthalmology Disinfection:
The article on disinfection of ophthalmology devices refers to the Quick Safety publication #49 produced and posted by TJC in May. The source for Quick Safety #49 is an article in *Ophthalmology* published December 2017. We suggest that you read and study the *Perspectives* article, the Quick Safety #49 publication, and the *Ophthalmology* article and then analyze your current processes. The Quick Safety #49 article points out that medical devices that touch the eye should be subjected to high-level disinfection between patients.

The reference on disinfection of tonometers published in the *Journal of the American Academy of Ophthalmology* points out the ineffectiveness of alcohol wipes as well as the damage that can be done to the tonometer prisms during soaking in other more potent chemical disinfectants. The conclusion from the *Ophthalmology* article is that a 1:10 dilution of bleach is recommended by CDC, but the article advises soaking not to exceed 5 minutes because of the risk of the bleach dissolving the glue in the device and allowing bleach to enter the device and potentially leach back out during use. They further advise a close inspection of devices to identify potential cracks, warping, or opacification of the tip. Consistent with prior advice, TJC also recommends that users follow manufacturer's instructions for use (MIFU). Another potential solution is

consideration of disposable tonometer covers or single use tonometers, but both would have cost implications.

We can foresee how this complex issue could become a new and frequently scored "gotcha" just like scope processing did five or more years ago. We would advise careful review of the Quick Safety and the Ophthalmology articles in conjunction with your MIFU's, ophthalmologists, and infection prevention committee to decide upon a course of action or validation of existing processes.

Preventing Drug Diversion:
Perspectives also highlights a second Quick Safety (#48) published in April on drug diversion. There is a lot of good advice in the Quick Safety on hospital practices that may inadvertently facilitate drug diversion or be indicative of a behavior that warrants closer examination to determine if drug diversion is occurring. Several of these good suggestions could also be RFI's waiting to happen, such as poor control of prescription pads/paper, improper wasting procedures, unauthenticated telephone orders for controlled drugs, automated dispensing cabinet over-rides, and inaccurate inventory in non-controlled drugs. The diversion practice they warn about in this last one is staff pulling a second agent and administering it to the patient, while diverting the narcotic that was ordered to be administered and saving it for personal use. This article is certainly worth discussing at a Pharmacy and Therapeutics Committee meeting to determine what additional safeguards you might want to institute.

Consistent Interpretation – Power Strips:
Perspectives also has the usual "Consistent Interpretation" article. The guidance/interpretation column has some clear advice on what to look for relative to power strips in the hospital. They identify only 2 types that are permissible in patient care areas, the UL 1363A and the UL 60601-1. They also state a reference from CMS prohibiting the mounting of power strips to a wall. You sometimes see these walls full of power strips in the "cow pasture" used to recharge computers on wheels.

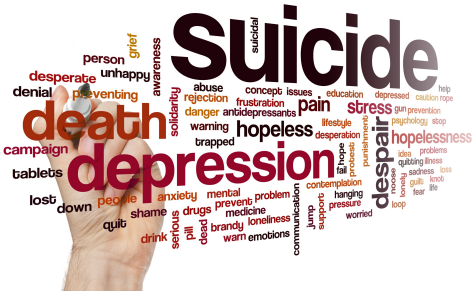
Intracycle Monitoring Suspension:
The last page of *Perspectives* describes recently approved but not yet publicized policy changes as well as future standards being considered. We noted in the "approved column" that APR.03.01.01 is being suspended for an undetermined period of time. This is the requirement for intracycle monitoring. This suspension applies only to accreditation, not to certification.

FAQs

Ligature Risks:
TJC continued to build upon its list of frequently asked questions (FAQs) relative to ligature risk and the revised NPSG.15.01.01 that becomes effective this July. There are now 21 ligature FAQs and an additional 10 FAQs relative to the safety goal. You should be signed up to receive alerts when they post new FAQs, but the "NEW" red identifier does not stay long before it disappears and then the content gets lost in the hundreds of other FAQs posted to their website.

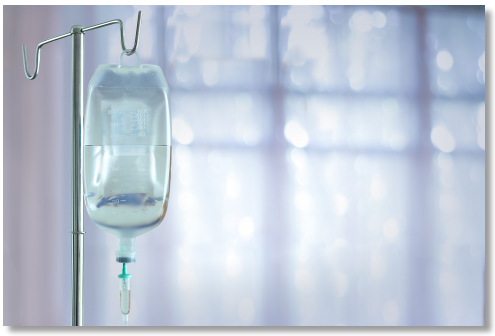
As we were drafting this newsletter, we also noticed a new red identifier, "FEATURED" for NPSG.15.01.01 EP 3. The content appears identical to the content that previously existed (i.e., it is not "NEW" or revised). This content is quite interesting, however. In the Joint Commission's R3 publication on suicide safety released last November and in this FAQ, TJC states that the validated suicide risk screening tool you've selected cannot be modified, however the evidence-based assessment tool you use can be modified, providing your edited tool still assesses 6 elements: ideation, plan, intent, behaviors, risk and protective factors.

We are not sure why anyone would want to modify an evidence-based, nationally accepted assessment tool, but it's also not clear why you cannot modify a screening tool given the flexibility they grant for hospital-specified edits to the assessment tool. Anyway, with 21 FAQs, 10 of which are for a revised safety goal just developed and published, plus the suicide portal content, this entire subject is just becoming more and more complex. While this is certainly a very important issue for patient care, the level of minutia in the rules is becoming excessive.



Pre-Spiking IV Bags:
We also noted one significant "FEATURED" and "NEW" FAQ posted this past month on pre-spiking of IV bags. This is a practice we sometimes see in infusion clinics and operating

room areas where you anticipate a high volume of morning patients and someone wants to get ready by pre-spiking and readying a case of IV fluids for the arriving patients. Sometimes you see the 20 IV bags hanging in the medication room, and sometimes, if visiting late in the day, you just see the med room coat hooks lined up where bags had been.



A decade ago, USP Chapter 797 had an FAQ on this subject and they prohibited it at the time. Later USP decided that plain IV fluids (not compounded) were not in their purview so they removed their guidance on this subject. Well, TJC has reintroduced it using the logic that the IV bag is a single dose vial, without preservative, therefore it should only be penetrated outside of an ISO 5 environment 1-hour or less prior to actual use. If you have seen these coat hooks in your hospital, or you have seen an IV pole full of pre-spiked IV fluids, you will want to modify that practice.

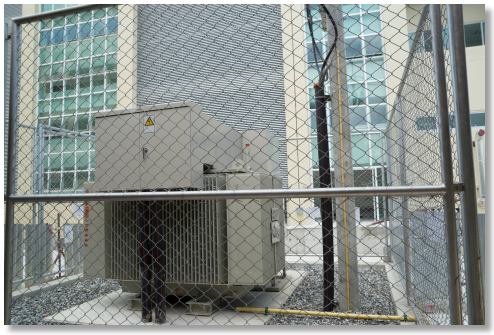
E-EDITION

New Standards to Take Effect July 1:
We noted the CAMH *E-edition* now includes the standards applicable as of July 2019. The only two significantly modified requirements are in the anticoagulation safety goal and the suicide safety goal. These are NPSG.03.05.01 and NPSG.15.01.01, respectively. We also noted that the CAMH update document indicated revised categories in EC.02.05.09, EP 1. This is the requirement to categorize medical gas and air systems relative to risk. Previously there were three risk categories, including major injury/risk of death, minor injury to patients, and discomfort. As of July, they have added a fourth category called "no impact on patient care."

There is also a new introduction to standard LD.04.03.13 relative to pain management. This new introduction describes the Joint Commission's philosophical perspective on the responsibilities of leaders in the oversight of pain management to support safe patient care. Given the national discussions on who is responsible for the nation's problems relative to opioid abuse, Joint Commission is pointing out the key role that hospital leadership plays in creating safe practices relative to opioid use. We suggest that you share this revised introduction with your leadership team assigned to implement the 2018 revisions to the pain management standards.

EC NEWS

Emergency Generator – Remote Stop Stations:
Again, this month EC News appears to have far weightier content than *Perspectives*. The lead article is about the mandatory "remote stop station" for the emergency generator. The key problem that keeps showing up on survey reports is a failure to actually have the stop station remote from the generator. This is a requirement that was new in July 2016 when CMS switched to the 2012 version of the life safety code. TJC embedded this requirement in EC.02.05.03, EP 11. The EP states the stop station should be "remote" and it references NFPA 110 2010 edition, section 5.6.5.6. The article mentions an annex note for this section that is "advisory" which CMS has interpreted to mean the stop assembly cannot be attached to the outside of the generator enclosure. Unfortunately, this is less than totally clear but we do see it scored often by TJC. This article should definitely be shared with your facilities team to verify your stop station is actually "remote" and secure, but accessible by the responsible staff.



COOP Requirements:
There is also a great article on "Continuity of Command" during disasters. When CMS issued its standards for emergency management, the Joint Commission had to add a requirement for a continuity of operations plan, sometimes referred to as a COOP. This was placed at EM.02.01.01, EP 12 and this is one of the few standards in the entire chapter that is scored with some frequency. Many hospitals missed this requirement and some wanted to avoided creating a plan because they thought of catastrophic business disasters or sudden death of key executives rather than the far simpler concept that key executives might not be available during disasters and someone has to have authority to assume their roles in managing the disaster. The article makes clear that succession planning does not need to focus on death of a leader, but rather just a lack of availability of that leader during the disaster. The author of the article suggests a three-deep line of succession so that there is adequate back up to the back up. You will want to share this article with

your emergency management team and verify you have the required COOP and test it's functioning during one of your drills.

HCID Preparation:
There is a second emergency management feature describing how Mass General Hospital (MGH) prepares for High Consequence Infectious Diseases, or HCID. This might be infection such as Ebola or Middle East Respiratory Syndrome. One of the interesting ideas they discuss is what they call a "no notice" exercise—15-minute drills in the emergency department to help focus staff on actions to initiate in the event of a potential HCID patient. They found that this brief training exercise was more effective than classroom training, and the ability to repetitively and quickly drill was better than solely relying on twice a year, large scale exercises. They also discuss the tabletop, focused drills, and full-scale drills that they do perform. MGH included in their flow chart of how patients are triaged and evaluated for HCID.

TJC included a list of weblinks to additional resources for emergency management planning to treat HCID patients. This includes a CDC listing of worldwide epidemics that is useful for identification of travel related diseases. There is a link to another flow chart developed by the Minnesota Department of Health and an HHS Playbook for special pathogens which includes more valuable links to infection control resources. Your emergency management team and your infection prevention team should receive this article and both groups should explore the resources provided to help shape your plans.

CMS

Draft QSO Memo – Co-Located Hospitals:
CMS did publish a new guidance memo QSO 19-13 on May 3, 2019 discussing co-located hospitals. This memo has also been released in draft form and the comment period to CMS is open until July 2, 2019. We see this often; usually an LTACH inside of a full-service acute care hospital, but it can also be co-located outpatient services with a unique CCN number situated in the same building as the hospital. If you have such arrangements, you will want to share this memo with the other entity and discuss potential implications for your arrangement together.

One point of emphasis for CMS is that both entities should have their own designated clinical space for patient care. Shared public space is permitted as is public paths of travel to the designated space. However, CMS states that a path of travel through a clinical hospital department such as a nursing unit, a clinic, imaging, operating room, PACU, or ED, would not be acceptable. CMS indicates that their surveyors will ask to see floor plans and these plans should distinguish the functional space of each entity. If there is any shared space and the CMS surveyors identify standards deficiencies in that space, they can score it against both entities.

It remains acceptable for the smaller guest entity to obtain some services under contract from the host hospital such as laboratory, dietary, pharmacy, maintenance, housekeeping, and security. The guest entity is responsible to evaluate the quality of the services provided through its own QAPI program. CMS advises it surveyors that they are also responsible to survey any onsite contracted services, but not responsible to survey any offsite services. If CMS identifies deficiencies, they can potentially be scored against both entities. In addition, the guest entity would receive an additional deficiency scored against their governing body if CMS finds flaws in the contracted service. CMS advises its surveyors to call the state agency or regional office to open up a complaint against the host hospital. Similarly, CMS advises accrediting organizations (AO) to treat such deficiencies as "complaints" and manage using the AO complaint process.

Staff that might be shared by both entities has an additional layer of complexity to manage. CMS permits staff sharing but requires that the individual be scheduled and assigned to work for either hospital A (the guest hospital) or hospital B (the host hospital) at any specific day and time and cannot "float" back and forth between assignments and patients during the day. CMS identifies a different approach for the medical staff, if credentialed and privileged by each entity, they may float back and forth at both co-located hospitals. We are curious to see if this policy remains the same after the comment period. Historically, physicians

have been non-salaried, independent practitioners with privileges, not staff of the hospital, but in more recent years physicians are frequently employees of the hospital, in addition to having privileges.

Lastly, the draft memo touches on emergency services. CMS requires every hospital to provide emergency services, but they do not necessarily have to each have an emergency room. At a minimum, CMS advises the smaller guest hospital to have policies and procedures for identifying when a patient is in distress; staff should know how to initiate an emergency response, how to initiate emergency treatment including CPR and AED, and how to transfer to another facility to receive appropriate treatment. It remains permissible, according to this memo, for the smaller guest hospital to have arrangements to transfer to the larger host hospital, providing the emergency treatment is initiated as described above at the guest hospital.

While you have the opportunity to review and comment we would certainly encourage readers who are either host or guest hospitals to review, analyze, and comment if you foresee any difficulties with the guidance.

CONSULTANT CORNER

Dear Readers,

CMS or state survey trouble? Contact us for a confidential discussion of your needs and how we can help you. We can provide the expertise and support you need – when you need it!

We are here for you before, during, and after survey to assist you 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.

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