JULY/AUGUST 2019 PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC.

NEWS FROM CMS AND JOINT COMMISSION

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PERSPECTIVES

Square Footage:
This month's edition of *Perspectives* announced a new EP 7 at LS.01.01.01. The new EP seems innocuous in that it only requires you to maintain the basic building information with the statement of conditions, and you already do that. However, the announcement states that the BBI is being changed to require specific square footage rather than ranges. So, while the EP does not make this clear, you may have to spend some time calculating more precisely exactly how much square footage you have in each building. This change becomes effective January 1, 2020.

Patient Feedback – Qualitative Data Collection:
There is also an article on changes being made in the primary medical care home standards for hospitals, critical access hospitals and ambulatory care organizations that request this optional survey. There is a link provided to the prepublication standards noting additions in the LD, MM, PC and RC chapters. These revisions will also become applicable on January 1, 2020. In the prepublication summary you will see new requirements in leadership, LD.03.07.01, EP 21 to use what they call "qualitative" data collection methods for patient feedback. By this term TJC is expecting focus groups, or telephone surveys, not just written questionnaires.

E-Prescribing:
In the medication management chapter, MM.04.01.01, EP 21, TJC expects that the organization have E-prescribing capability.

Patient Self-Management:
In the provision of care chapter, PC.01.03.01, EP 44 TJC will require patient self-management goals to be developed in partnership with patients based on criteria established by

the organization. There is also a new PC.02.03.01, EP 28 requiring the primary care clinician and team to educate the patient on self-management tools and techniques. The third new requirement under provision of care is PC.02.04.05, EP 6. This will require the interdisciplinary team to track internally and externally any referrals made to other care providers, including acting upon recommendations for care including laboratory tests and imaging recommendations. The last change is in the record of care chapter, RC.02.01.01, EP 26 which requires the organization's medical record to include self-management goals and progress made toward achieving those goals. While all of these requirements sound like good things to do, remember the actual requirement only applies to those organizations that voluntarily request the primary medical care home evaluation, in addition to their regular accreditation survey.

Anticoagulant Therapy:
Perspectives' also includes a link to what looks like a very useful resource for the changes made to the anticoagulation national patient safety goal.
https://www.jointcommission.org/npsg_030501_support_resources/

This extensive document provides links to many different clinical practice guidelines, and more importantly they published a table of references aligned with each new element of performance. Many hospitals have struggled to find the appropriate guidelines to help in managing patients on newer anticoagulation medications, and perioperative management of anticoagulants, and this will help fill that need. This entire compendium should be shared with members of your pharmacy and therapeutics committee or other team working on implementation of this safety goal.

FAQS

Tamper Resistant Electrical Outlets:
As we are writing this newsletter, there are no FAQ's posted as new, but as we have mentioned previously that "NEW" marker attached to a FAQ disappears even faster than your paycheck. During the past month we did note one important new FAQ that flashed by in the National Patient Safety Goal chapter under Ligatures and suicide risk reduction. The topic they address is the need for tamper resistant electrical outlets as well as arc fault and ground fault interruption outlets.

Tamper resistant requires a plug to be inserted into both holes simultaneously, which somewhat reduces the risk of children trying to injure themselves with a paper clip being inserted in the outlet. The arc fault feature further helps provide additional safety should an adult figure out how to manipulate around the tamper resistant feature.

It is likely that many readers may have missed this new FAQ, so be sure to go to the Joint Commission's website to download a copy. This should be shared with behavioral health and facilities leadership to determine if you already have these types of outlets in all behavioral health settings. We suspect many do not as previously the key requirement was tamper resistant screws on the faceplates. Take a look in your behavioral health areas. You may have to add this to your documented risk assessment and work to replace these outlets if you do not already have tamper resistant, arc resistant, ground fault interrupter outlets.

EC NEWS

Interim Life Safety Measures:
EC News leads off this month with a great article on interim life safety measures or ILSM. A decade or more ago many people mistakenly thought of ILSM for construction only. Then TJC beat it into everyone's heads through repetitive scoring that it also applied to renovations, and later it was learned that it also applied to self-identified life safety code defects that you might previously have placed on your PFI. But this article points out that some flaw in the plan, or in executing the ILSM plan is still noted in 13% of hospital surveys. If we look at this requirement, LS.01.02.01 there are 15 elements of performance.

The first EP defines when ILSM should be put into effect, as previously noted during construction, and when self-identified life safety code defects cannot be immediately corrected. While it doesn't specifically say during

renovations, these renovations are "construction" in a sense and may cause time limited, self-identified life safety code defects while renovating.

EP 2 discusses a certain type of life safety code defect when a fire alarm is out of service for more than 4 hours/24, or when a sprinkler system is going to be out of service more than 10 hours in an occupied building. When such a situation exists, the requirement is to evacuate the building or notify the fire department and conduct what is called a fire watch. The EP also requires that you document your call to the fire department and document implementation of the fire watch.

EP's 3-15 then describe other enhanced safety measures you might take that are appropriate to the nature of your project or self-identified defect. The selection of measures you chose to institute usually comes from a grid. EP 15 is a catch all element of performance that allows you to create and select other enhanced safety measures that are not specifically mentioned in EP's 3-14. This article helpfully highlights 23 potential safety measures that you might consider for some projects.

The article also has a really nice ILSM assessment checklist that should be shared with facilities leadership. The checklist asks questions about the nature of the project, and if you are answering yes to any of these questions, then this leads to the conclusion that yes, ILSM should be implemented. Always using a form like this can help lead to appropriate decision-making. Too often we see organizations believe that the project is so minor, I don't have to evaluate it, or it will be completed so quickly I don't need to do anything additional. These quick, in your head assumptions prove incorrect far too often.

Lastly, this article has a reminder to consistently monitor the ILSM's that are in place. This means if you say you are going to do something extra, as in EP 4 stating you are going to inspect exits daily, document that every day of the week. Having a great policy is only part of the battle, having a great implementation with thorough documentation is the other important part.

We also encourage organizations to keep their documentation together, along with your ILSM evaluation. Sometimes the safety office staff is inspecting, or sometimes facilities, but regardless of who does it, you want the documentation that it is being done as stated in your policy. Another suggestion we have is to post your ILSM and ICRA evaluations at the job site. That way any member of the quality, or administrative staff can walk by and know that the evaluation was done, and also see if the plans from either evaluation are actually being implemented.

Heliports?

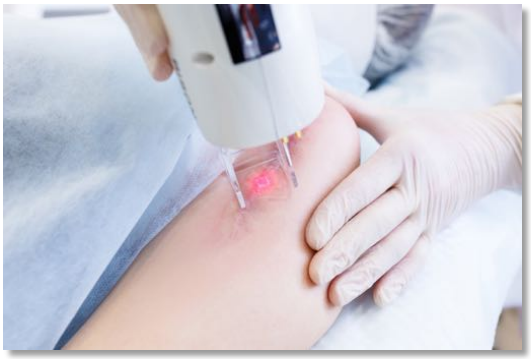
We as consultants and many of our readers have been involved with regulatory compliance and accreditation activities for many years, and we gain a certain confidence that we know a lot about this business. Well, every once in a while, you get reminded about some obscure requirement you have never seen cited and knew nothing about. This month's EC News has just such an article on heliport registration. Apparently, each hospital with a heliport is supposed to register their "airport" in a Federal Aviation Administration database using FAA form 5010 to do so. This registration allows the FAA to warn drone operators of the existence of your airport and keep unmanned aircraft away or allow the operators to advise the hospital if they will be operating near your airport. It looks as if we were in good company in not being aware of this requirement because NASA has issued an alert estimating 1600-1800 hospitals with heliports are not currently registered in the database.

The article provides a website where hospitals can check to see if their heliport is in the database. If it is not, you will have a 2-step process to follow with the FAA, first to fill out form 7480-1, basically notifying them of "construction" of your heliport. This may trigger an inspection, but once analyzed they will probably simply provide you with the form 5010 you need to register your heliport.

In addition to not being registered in the FAA database, the article points out that some files in that database have not been updated in 20-30 years. This may mean key contact individuals; phone numbers and even precise locations of the heliport may have changed in that timeframe. Fortunately, if you have a 5010 on file, you can search the data to determine if it is still accurate. The author even suggests an annual validation process to ensure the data is

accurate. If you have a heliport, be sure to share this article with that person, and validate or correct based on what is learned from their analysis.

Laser Safety:
EC News this month also has a very informative article on laser safety. We might all think we know more about medical lasers than we do heliports, but this article is still enlightening. While The Joint Commission standards may not directly say anything about laser safety, the issue falls under a general catch all requirement in EC.02.02.01, EP 7 which requires the organization to minimize risks associated with hazardous energy sources. Lasers fall under this general description of being a hazardous energy source.



In OSHA's standards, 29 CFR 1910 does address some general safety requirements such as PPE when using lasers. More detailed requirements get pulled in from ANSI Z136 because OSHA does require employers to consider industry consensus standards. This ANSI standard contains detailed requirements for laser safety in health care settings.

The FDA classifies medical lasers into 5 categories, Class 1, 2, 3R, 3B and 4. Types 3B and 4 have the most risk to operators, patients and nearby staff. A very basic expectation for hospitals using 3B and 4 type lasers is the requirement for a laser safety officer (LSO). The LSO should be your chief content expert working to develop safe policies and procedures as well as to audit compliance with these policies and practices.

One such practice described is the process of credentialing individuals to safely be involved in working with or around lasers. Another safety practice would be the hospital provided safety training expectation and ensuring that the staff working with and around lasers have such training. They also discuss the risk of surgical fires and even potential perforation of endotracheal tubes during shared airway surgery. ANSI Z136.3 does require the use of an FDA approved laser resistant tube with a fire-resistant design.

The article points out that NIOSH has advised smoke from lasers and electrosurgical units be evacuated since 1996. They also mention the incidence of respiratory problems in nursing staff exposed to surgical smoke.
At a minimum, this article should be shared with your laser safety officer, if using 3B or class 4 medical lasers, and the findings, conclusions and self-assessment of compliance reported back to an accreditation or patient safety meeting.

NEW USP MANUALS

New Requirements Effective December 1, 2019:
The much-anticipated final versions of USP Chapters 795 general compounding, 797 sterile compounding, 800 hazardous compounding, and 825 radioisotope compounding have been released.

USP is presently offering a free download of these materials, which later on will be for-sale publications. We encourage readers to get the materials so they can see what changed from earlier versions and to continue their internal analysis of readiness while this offer is available. The USP does have a link, where you can register for the free downloads at: http://go.usp.org/l/323321/2019-05-31/2dfgwl

Remember, the implementation date for these new requirements is 12/1/19.

CMS

Emergency Medical Treatment & Restraints:
CMS did publish a new guidance memo QSO 19-14 on June 4, 2019 discussing CMS defined complaint investigation timelines for potential EMTALA violations and restraint related deaths. These timelines are expectations for the state agencies to conduct their investigation, not any timeline for hospitals to act, other than to be ready should the state come to investigate an EMTALA or restraint death issue.

CMS considers these violations as potentially reaching the immediate jeopardy thresholds and they seek to have the state arrive on site to conduct such restraint death investigations within 2 business days of receipt. The potential EMTALA violations require the state to send them to the CMS regional office for triage as either potential IJ or not potential IJ. If triaged as a potential IJ High, CMS will notify the state and expect an investigation within 2 business days. If not a potential IJ High situation, the regional office will notify the state and expect an investigation within 45 days.

Since much of the QSO memo discusses state and regional office responsibilities this may be of little importance to most readers. However, CMS also included Appendix V

which details the investigative procedures state surveyors are to go through in conducting an EMTALA investigation. This includes a CMS definition of when a hospital department is essentially acting like an emergency department. For example, a labor and delivery unit would be an emergency department if 1/3 of all visits are unscheduled ambulatory patients.

Opening Conference Documents:
CMS discusses the documents they want surveyors to request at the opening conference and these include:

- Dedicated ED logs for the past 6-12 months
- Dedicated ED policy/procedures manual including triage and assessment of patients presenting to the ED with emergency medical conditions, assessment of labor, transfers of individuals with emergency medical conditions.
- Consent forms for transfers of unstable individuals
- Dedicated ED committee meeting minutes for 12 months
- Dedicated ED staffing, physicians and practitioners for the past 3 months and nursing staff for the past 4 weeks, or more if appropriate
- Bylaws/rules and regulations of the medical staff
- Minutes of medical staff meetings for 6-12 months
- Current medical staff roster
- Physician on call list for the past 6 months
- Selected credential files including ED Director and ED physicians
- QAPI plans
- QAPI minutes
- List of contracted services
- Dedicated ED personnel records
- In-service training records, schedules, reports
- Ambulance trip reports and memoranda of transfer
- Ambulance ownership information

CMS further states in this memo they will review at least 20 records in depth and the types of records they will seek include transfers, gaps, return cases, refusals of examination, treatment or transfer, leave without being seen (LWBS) and against medical advice (AMA), and patients returning to the ED within 48 hours.

Your ED leadership team should receive a copy of this entire memo to review the details of the techniques CMS will be using to try and uncover potential EMTALA violations. In conjunction with the hospital quality department and perhaps your legal team, we would suggest you use the same techniques as CMS to determine if you have potential vulnerabilities.

CONSULTANT CORNER

Dear Readers,

Patton's very own, Kurt Patton, recently published "USP <800> How to Prepare for the New Hazardous Drug Requirements". This will help you understand the best practices for handling hazardous drugs and guides on USP compliance from the perspective of a TJC survey. Available here: https://hcmarketplace.com/usp-800

As a reminder, this month's newsletter is a July/August edition. We look forward to providing you with more exciting news in September! We would like to wish you all a wonderful and safe rest of your summer!

Thank you,

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