NOVEMBER 2019
PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC.

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

ORYX: Sometimes Forgotten, but Not Gone:
The lead article in Perspectives this month is an acronym filled discussion about changes to the 2020 ORYX requirements. It has been a long time since we have heard of ORYX measures being an issue on survey, however your performance is still important for CMS's value-based purchasing program and measures displayed publicly on Hospital Compare.

One change for 2020 is that the performance measurement systems will no longer be used after their transmission of 2019 data, required by April 2020. All data sent to TJC will now be directly submitted by the hospital using the "direct data submission platform." The basic requirement for acute care hospitals with an average daily census in excess of 10 is to choose 4 electronic clinical quality measures from the 10 available. In addition, hospitals with an average daily census greater than 10 that provide obstetrical services must submit a chart abstracted for measure PC-01, the "elective delivery" measure. If this hospital performs more than 300 live births, they must also report PC-02, PC-05 and PC-06. These are "cesarean birth," "exclusive breast feeding," and "newborns with "unexpected complications" respectively.

The precise definitions and data elements required for these measures is critically important and TJC has made a specifications manual for its measures available at: [redacted] This can be downloaded in one searchable PDF document.

There is also a specifications manual available for the national hospital inpatient quality measures that can be downloaded in a zip file at:

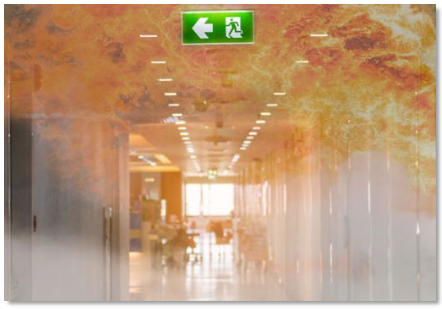
[redacted]

This file is not consolidated into one PDF, but rather a series of individual documents. After downloading, if you have an advanced PDF software tool you can consolidate or merge these if you wish.

The requirement for free standing psychiatric hospitals continues to be the 4 hospital-based inpatient psychiatric services, or HBIPS measures. Critical access hospitals, hospitals with an ADC less than 10 and specialty hospitals are still required to collect data on a least 3 measures, but there is no requirement to submit that data to the Joint Commission.

Sentinel Event Definitions:
The Joint Commission announced that they have revised three definitions in their sentinel event policy for fire, hemolytic transfusion reaction, and invasive procedure. The current definition of fire was "fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care." While the intent of this definition was to examine operating room fires, there was confusion where some expanded the definition to include other fires such as in a closet or elevator on a patient care unit that were not truly sentinel. There was also confusion where some narrowed the definition to exclude fires present in the vicinity of the patient, when staff were not present providing patient care.

Thus, the new definition will be: "Fire, flame or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the organization. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present." They also created a unique definition of fire for the home care program which is: Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care. This includes any fire in the patient's home that is related to care or treatment ordered by a provider, including home oxygen administration as part of home care services, regardless of whether a home care staff member was present.



The current hemolytic transfusion reaction definition was "hemolytic transfusion reaction involving administration of blood products having major blood group incompatibilities (ABO, Rh, or other blood groups). This was determined to be too narrow a definition so the new definition is intended to be more expansive by stating: "Administration of blood or blood products having unintended ABO and non ABO (Rh, Duffy, Kell, Lewis and other clinically important blood groups) incompatibilities, hemolytic transfusion reactions, or transfusions resulting in severe temporary harm, permanent harm or death." This new definition was not immediately clear in how it was more expansive. The Duffy, Kell and Lewis reactions are just types of transfusion reactions. The examples of new, broadly defined sentinel events included one that helped explain how this definition differed. The example described a patient having a reaction to a transfusion with platelets contaminated with gram negative bacteria. This fits the last portion of the sentence in the new definition that says: "or transfusions resulting in severe temporary harm, permanent harm, or death." You will want to discuss and understand this new definition by talking with your laboratory staff and revising your own sentinel event policies.

The third revised definition deals with invasive procedures, but after re-reading this section of the article several times, we believe the revised definition may not be any clearer to the industry then the prior definition was. Part of our confusion was just the formatting of the article. The new definition states: "Surgery or other invasive procedure* performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient+." The little asterisk and the cross then refer you to the bottom of the page and additional text in a tiny font where a new definition of invasive procedure is actually described: "Invasive procedure is defined as a procedure in which skin or mucous membranes and/or connective tissue are incised or punctured; an instrument is introduced through a natural body orifice; or foreign material is inserted into the body for diagnostic or treatment related purposes. Examples of invasive procedures include central line and chest tube insertions, biopsies and excisions, and all percutaneous procedures (for example cardiac, electrophysiology, interventional radiology). Exclusions include venipuncture which is defined as collection of blood from a vein."

This definition does appear clearer than the one currently defined in the accreditation manuals glossary which states

simply: "The puncture or incision of the skin, insertion of an instrument, or insertion of foreign material into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, and cardiac catheterization. Venipuncture is not categorized as an invasive procedure."

The article then includes some examples of what would constitute a sentinel event and what would not. One exclusion is an X-ray performed on the wrong site, and one inclusion is CT with contrast performed when not intended. Both of these examples involve subjecting the patient to ionizing radiation, but the CT with contrast example includes a medication not intended for the patient. We assume that TJC did not intend to expand its sentinel event definition to every incorrectly administered IV medication, so it is unclear what is otherwise different about these two examples.

One of the things you will want to be sure to do is update your hospitals sentinel event policy with these new definitions. The last time we saw a modification to the Joint Commission sentinel event policy relative to maternal morbidity, we did see some findings for failure to update the hospitals policy consistent with the revised policy from TJC.

The Role of the Consultant:
Perspectives also includes another article on the role of the consultant. We thought that TJC had overcome their concern about consultants given that they now freely meet with us and share new information that is helpful to customers we share. Apparently, there are still some concerns.

In this article they state that consultants may not be identified in the extranet as the primary contact at the healthcare organization. This is not a concern for us as we tend to work with larger organizations that always have a staff person fulfilling that role. However, we have seen smaller hospital organizations, some international hospitals, and some non-hospital organizations that do use a local consultant as their primary point of contact for all things Joint Commission.

This article indicates that TJC would consider this inappropriate. We expect that TJC wants to ensure there will be representative of the healthcare organization receiving important notices and communications from the Joint Commission at all times. We do wonder where this places physicians who have privileges, but are not employees, when that physician assumes a leadership role within the hospital. Sometimes these leadership roles are voluntary and sometimes they received a stipend of some sort but may still not be the required formal employee of the organization. Anyway, it is unlikely any of our readers are affected by this prohibition.

New Payment Address for TJC:
While there are no new requirements in this article it is important to note that TJC has a new bank and payment address for receivables. While this seems simple enough, we learned during our own ownership transition how difficult it is to remove something that is embedded in a computer database somewhere. Since nonpayment of invoices is one of the issues that can lead to denial of accreditation, you do want to make note of this change and make sure your business office makes the change. The correct and new address for payments to TJC is:

The Joint Commission Receivables
PO Box 734505
Chicago, IL 60673-4505

BoosterPaks and Leading Practice Library are Retiring:
The November edition of Perspectives announced that the BoosterPaks were retired effective October 28. These were useful documents describing issues in detail, but the formal formatting and structure of these lengthy documents made updating difficult. Also, the Leading Practice Library is going to be retired effective the end of 2019. We have heard many clients speak proudly of a surveyor suggestion to add a policy or form to the Library, but we seldom speak with organizations that routinely search and use this database of policies and practices. But if you want to see what is out there before it goes away, you can still access the data from your extranet.

Consistent Interpretation:
This month they discuss EC.02.03.01, EP 12 and IC.02.01.01 EP 1 regarding proper use of flammable germicides. There is a lot of good content from surveyor observations and

there is good content Guidance or Interpretation alongside it. The key take-away is to be sure to let the antiseptic dry before draping or starting any procedure and to read the manufacturer's instructions for use. The guidance points out that improper use might be scored under the EC standard as a fire hazard or under the IC standard as an infection control hazard. The guidance section also provides a nice listing of possible ignition sources that might be present in the operating room.

PDF Manuals are Back!

JCR has an advertisement on the last page of this month's Perspectives and EC News announcing the availability of PDF versions of the accreditation manuals again. These have been gone since the introduction of the E -Edition. A PDF is a searchable format that just about everyone knows how to use, which may hopefully again facilitate departmental access to the standards. We very often encounter department heads that never learned how to use the E-Edition or were never shown how to use the E-Edition. Anything you can do to help facilitate access to the standards that you expect everyone to comply with, the better.

Quick Safety:

Issue 51 was published in October on the proactive prevention of maternal death from maternal hemorrhage. We had previously mentioned in our September newsletter an R3 publication by TJC in August 2019 dedicated to this same subject. Do take a look and use this Quick Safety and the R3 as resources as you are planning out your approach to the new standards on perinatal care that take effect July 2020. These standards were posted by TJC on August 21, 2019 in a prepublication version. Discussions we have had with most hospitals so far indicate planning is still in the very early phase, but we are now only 7 months away from required implementation.

EC NEWS

Fire Extinguishers:

The November edition of EC News has a brief article clarifying that if a fire extinguisher is clearly visible, there is no need for addition signage pointing out the fire extinguisher. The reference for this conclusion is NFPA 10-2010 section 6.1.3.3.2. TJC does point out however that a sign is needed for fire extinguishers that are recessed in a wall such as in a flush mounted cabinet or one that protrudes a few inches into the hallway. They state that signage is also needed if a visual obstruction blocks the view of the fire extinguisher.

EC and LS Most Frequently Scored:

There is also an article on the top scored EC and LS findings that discusses in detail just a few of those findings. There is a table of the most frequently scored EC standards that also lists the most frequently cited EP within each of those standards. Those most frequently scored standards are:

- EC.02.06.01, EP 1: ligature issues
- EC.02.05.05, EP 6: inspection, testing and maintaining non high-risk utility system components
- EC.02.05.01, EP 9: utility system controls and labeling
- EC.02.02.01, EP 5: minimizing risks when handling hazardous chemicals, often eyewash issues
- EC.02.05.01, EP 15: ventilation in critical areas, usually incorrect air pressures, temperature or humidity issues
- EC.02.03.03, EP 3: quarterly fire drills unannounced and varied times, often sequential fire drills not separated by at least an hour
- EC.02.05.09, EP 11: piped medical gas shut off valves, usually blocking or mislabeling issues
- EC.02.05.09, EP 12: medical gas cylinder policy, usually comingling full and empty cylinders or improper storage without support by a rack or carrier
- EC.02.05.01, EP 16: ventilation in noncritical areas, usually incorrect air pressure, temperature or humidity
- EC.02.04.03, EP 3: high-risk medical equipment inspection and testing, usually a failure to check or find this high-risk equipment

The article also highlights one problematic LS standard, LS.02.01.35 and its two very commonly scored EPs, 4 and 5. The standard deals with maintenance of fire extinguishment systems.

EP 4 addresses the need to not clamp or rest any wires, supports or duct work on sprinkler pipe above the ceiling. This is an especially problematic issue as it is invisible except when you go above the suspended ceiling to look. The second very frequently scored is EP 5 which identifies sprinkler heads needing to be free from corrosion, dust or

any foreign material. Again, this is not always noticed and it's not the type of device you can just swing a dust mop at to clean it.

Since these standards plague hospitals throughout the nation, we would certainly suggest vigilance and frequent monitoring. This is especially important if you were previously scored for one of these issues as you don't want to obtain repeat findings. Too often TJC finds some problem and hospitals choose to fix that problem only in the specific area where TJC cited it. We would encourage readers to look for that same problem throughout the hospital, not just in the one location.

Minimizing Construction Risks:
EC News has another good article on the pre-construction risk assessment, or PCRA, process and the infection control risk assessment which is an important component of the PCRA. Think of the PCRA as broad, including infection control issues, noise, vibration, function of fire suppression systems, ventilation, utilities and medical equipment. Depending on the nature of the planned construction any of these issues may be affected.

This is also not just an issue you can hope the life safety surveyor does not notice as many of these PCRA type issues sometimes jump out at any of the clinical surveyors visiting these patient care areas. Dust trailed down the hallway from the construction site, noise and vibration of jack hammers in the NICU are not hard to find. Too often these issues were not analyzed at all, inadequately analyzed prior to the project starting, or not adhered to during construction.

CMS

There are no new CMS Quality and Safety Memo's pertinent to our readers this month.

IN OTHER NEWS…

Vending Machines, Ice Machines, and Water Fountains:
We wanted to thank one of our business partners on the life safety side of consulting, MSL Healthcare for helping to clarify an issue that pops up on survey from time to time regarding ground fault interrupter outlets or plugs. We have seen EC.02.05.05, EP 8 being scored which simply requires compliance with NFPA 99 2012. The issue that arises is the need for GFI receptacles or outlets with vending machines, ice machines and water fountains. All 3 of these devices do require ground fault protection. Vending machines built since 2005 should already come with this protection in the plug, but older ones do not. There may also be some newer machines that have been modified to remove this required device. Anyway, since this is popping up on survey, it's worth looking in your hospital to verify GFI protection on the receptacle or plug.

CMS A-Tag Review:
Throughout 2019 the Joint Commission's surveyors have been examining compliance with addressing what are called the CMS A-tags. Surveyors had a list of medical record documentation requirements, most of which, but not all were routinely explored on tracers anyway. This list has now been added to the organizational survey activity guide as of July 2019. We suggest that readers take a look at this list and ask yourself, "do we all know how to find evidence of compliance somewhere in the medical record for each of these issues." Also, ask this question of staff on the units who may be involved in tracers to see if they can find all of these required documents. You might even want to consider a scavenger hunt with staff to see how many they can find, or plan on using some IT experts or superusers to assist staff on tracers.

CONSULTANT CORNER

Dear Readers,

We wish you, your families, and friends a Happy Thanksgiving!

Thank you,

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