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**PLEASE, KEEP SAFE SOCIAL DISTANCE
AND WEAR A MASK**

OPEN FOR BUSINESS



Limited Surveys Resume:

This month, some TJC surveys should be resuming on a limited basis. TJC is analyzing COVID-19 data from counties throughout the US and will begin to conduct surveys again in those counties deemed at lowest risk. In addition, TJC account executives will be reaching out to organizations to verify that the county level data reviewed by TJC matches what the organization is experiencing.

During the May Consultants Forum conference call with TJC, we learned that TJC has done some remote surveys for initial hospitals (first time accreditation) but will follow up with an onsite survey when conditions permit. In addition, TJC indicated they have applied to CMS to conduct some Medicare Condition follow up surveys and some document review remotely, but this is still under consideration by CMS.

When surveys resume, surveyors will perform social distancing and they will wear masks which should be supplied by the organization. Similarly, if the organization wants surveyors to wear scrubs, they will do so if provided by the organization. If the organization wishes to screen surveyors per organization policy for temperature or COVID-19 symptoms, they may do so. During tracers, surveyors will not seek to observe any procedures carrying a high risk of aerosolization.

Most importantly, when surveys resume TJC will NOT be reviewing data, medical records, or other information from the timeframe during the national emergency when some common practices may have been waived.

PERSPECTIVES

Federal Burden Reduction Updates:

This month's issue of Perspectives announces additional standards changes as a result of the Federal burden reduction effort at CMS. These changes are posted to the TJC standards prepublication area and a link is provided in Perspectives to the documents. The update has been divided into two sections with implementation dates of July 1st and the second implementation date of September 13, 2020. Also remember that in February, TJC had published the first and largest portion of these burden reduction standards which we discussed in our March newsletter. Since that was done just before the pandemic struck, we would suggest reviewing those changes as you download the far smaller changes for July and September.

July Update

HR.01.01.01, EP 1 has a seemingly innocuous change with the addition of Note 5. This advises that hospitals seeking deemed status accreditation should describe in approved policies the respiratory care procedures and the amount of supervision required to carry out those procedures. EP 1 requires the hospital to define staff qualifications specific to their job responsibilities, so the additional note 5 seems in keeping with that philosophy. Since this change is coming from CMS, we went to our interpretive guidance to see what CMS says about this subject and it was enlightening.

We encourage our readers to take a look at A tags 1151-1164 describing respiratory care services. These tags are very detailed in their description of policy and supervision requirements for respiratory care services. As a reminder, these tags establish requirements for the use of national clinical practice guidelines "such as" from the AMA, American Association of Respiratory Care, or American Thoracic Society. There should be an approved scope of services document describing the respiratory care services provided. There should be a physician director of respiratory care. There must be adequate, qualified staffing to meet the needs of patients. Respiratory care policies must be approved by the medical staff and services must be documented in the medical record. Documenting

services in the medical record might seem rather obvious, but we have encountered an organization where respiratory care was documented offline in a RT-specific EMR system that did not interface with the main hospital EMR system.



A change at LD.03.07.01, EP 2 requires the hospital in its PI process to give priority to high volume, problem prone processes. Now they specifically suggest, "which would include an information technology system designed to improve patient safety and quality of care."

There is a redundant change to LD.04.01.01, EP 1 which requires the hospital to be licensed, certified, or have a permit in accordance with law and regulation to provide care and the current Note 1 requires a CLIA certificate. The changed content is to add a specific statement that "laboratory services (must also) meet the applicable requirements of 42 CFR 482.27."

There is a minor modification to MM.06.01.03, EP 1 regarding self-administration of medications by a family member, to add a definition in the glossary of what a family is.



A minor modification to RC.01.05.01, EP 1 is regarding the retention of medical record information. Currently the retention requirement is to be consistent with hospital policy, law, and regulation. The change is to establish a minimum retention period of at least five years and to state that nuclear medicine reports, radiologic reports, printouts, films, scans, and other imaging records come

under this definition of medical records that must be retained for at least five years. Do remember that if your state has a longer retention requirement, the longer retention requirement would apply.

Lastly, TS.01.01.01, EP 5 currently requires training for staff in the use of discretion and sensitivity to the circumstances, beliefs and desires of families regarding organ donation. Normally around the country these conversations with families about possible organ, tissue, or eye donation is delegated by the hospital to staff from your regional Organ Procurement Organization (OPO) under your OPO agreement. With this change, TJC is pinpointing that if your hospital has designated certain staff to participate in these conversations, these staff must be formally educated and trained, complete (we presume) with documented competency validation.

September Update

The second set of changes includes a minor refinement to LD.04.01.10, EP 2 requiring senior leadership to "examine the emergency management planning reviews at least every two years" instead of annually as before.

In February, TJC had added content that permitted outpatient departments to perform a medical assessment prior to a selected set of approved procedures where the medical staff permitted an assessment in lieu of a complete history and physical. The new requirement added for September is that if you permit this assessment, it must be documented after registration but prior to the surgery or procedure. Thus the <30-day rule you use for a history and physical would not apply to this brief assessment. The assessment must be done just prior to the procedure.

While trying to remember that all of these changes are part of a Federal "burden reduction" effort, we note what might be a more important change at PC.04.01.01, EP 32. This

will now state that for hospitals seeking deemed status accreditation, the patient's discharge plan must include a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals that are available to the patient. The current requirement is for the hospital to document in the medical record that this list was presented to the patient or the patient's representative. What appears different is now, the actual list is to be included as part of the discharge plan in the medical record. This sounds like added complexity, not "burden reduction," so keep your eyes open for clarifications, FAQs, and literature further discussing this issue.

PC.04.01.03, EP 2 currently requires the hospital to identify any needs the patient may have for psychosocial or physical care, treatment or services after discharge or transfer. Effective September 13 this is expanded upon to further state that the "identification of needs also includes hospice care, post-hospital extended care, home health,

and non-healthcare services, as well as the need for community-based providers. The hospital determines the availability of the post hospital services as well as the patient's access to those services."

There is a refinement to PC.04.01.03, EP 3 to add Note 4 stating that "discharge planning is performed by, or under the supervision of a registered nurse, social worker, or other qualified person." PC.04.02.01 also has a minor refinement to EP 1. Currently, the EP requires the hospital to inform providers in the discharge setting with information about the patient status. The refinement is to also provide the post discharge provider information about the patient's "treatment preferences."

RI.01.01.01, EP 10 currently requires the hospital to allow the patient to access medical record information, request

amendment to, and obtain information about disclosures in accordance with law and regulation. This regulation concept has been expanded upon to state in a new note: Access to medical records, including past and current records, is in the form requested by the patient (including electronic form when available) within a reasonable time frame (that is, as quickly as the hospitals record keeping system permits). If electronic is unavailable, the medical record is in hard copy form or another form agreed to the by organization and patient.

Lastly, the September changes also include some EP deletions, most but not all for swing beds. The deleted EPs include: PC.02.02.09, EPs 1 and 3; PC.04.01.01, EP 26; and RI.01.05.01, EP 21.

Changes in Titrations:

Perspectives includes a three paged article on changes they are making to standard MM.04.01.01, EP 2 regarding medication titrations. The changes are complex and you will want to analyze the changes in detail with your pharmacy, intensive care nursing, and medical staff.

The first change is simple and has long been anticipated for them to include language in the body of the EP stipulating the mandatory data elements for a complete titration order. A FAQ had explained this more than a year ago, but now you have clarity directly in the EP.



The second change is far more complex and this is one you will want to analyze with the ICU team to determine if it has applicability and value in your organization. TJC has added

two notes to the EP authorizing the use of block charting for documentation of the titration administration for up to a four-hour block. Additional four-hour blocks may be used if the patient's condition is emergent requiring near constant adjustments of the titratable medication. In addition, TJC has identified the following minimum elements which must be documented for each block charting note:

- Time of initiation of the charting block
- Name(s) of the medications administered in the block
- Starting and ending drip rates during the block
- Maximum dose given during the block
- Time of completion for the block
- Physiologic parameters evaluated to determine the administration of the medications

The third change is even more complex and will likely be featured in additional articles or FAQs to help explain what they really are authorizing. It appears that in ICU settings, TJC is authorizing therapeutic duplication for titratable vasoactive, pain, and sedative medications, with the

intensive care nurse selecting “between the ordered agents based on the patient’s condition and unique physiologic response if all the following criteria are met:”

- An order exists for the medication that is written in accordance with policy
- It is not prohibited by law
- It is allowed by hospital policy or the medication order
- Competency, as defined by the organization, is complete and documented
- The nurse must stay within the parameters of the order

TJC further explains that “situations can occur where similarly acting agents are ordered or medications are ordered for the same indication for the same patient. To ensure compliance with TJC standards, organizations should have a process where all care providers are aware of the intent for multi-modal therapy versus unintended therapeutic duplication.”

We see this type of issue come up often during tracers where the patient has simultaneous orders for multiple sedative agents such as dexmedetomidine, propofol, and/or midazolam. During discussions about this duplication, the ICU nursing staff consistently have a sound logic to how these medications are being chosen and managed. It would appear that going forward this logic would be acceptable providing it meets the five bullet point requirements.

There is also a fourth change, also complex, but an issue that comes up almost every day when patients are going

through a spontaneous breathing trial and/or sedation vacation. These clinical procedures may result in titratable medications being paused temporarily, that subsequently need to be restarted. TJC makes it clear that such a temporary pause in the medication does not require a new physician order to restart. However, there must be an order and organization policy on how to restart a paused medication.



Such methods might include restarting at the prior-to-pause rate, restarting at the initial titration rate, or requiring a new order. This is also an issue we see come up often during tracers with prior rate, half prior rate, and initial starting rate being the most frequent responses heard from staff.

This fourth issue you will want to discuss with your ICU team soon. While the first three changes appear to open up new flexibilities, this one shines light on what might become a new scoring opportunity.

We have had questions about these changes that we have discussed with our team and likely you will also have questions. More importantly, it is likely to cause some confusion and questions among the surveyor workforce also. The good news here is that such confusion can lead to a diminishing scoring frequency until clarity is achieved.

Behavioral Health Care Name Change:

Many of our readers have programs accredited using the TJC BHC program standards. That program name is being changed to Behavioral Health Care and Human Services Accreditation Program. TJC’s BHC program does accredit a wide array of provider types including child welfare agencies. This name change will better reflect this wider applicability. Very few of our readers will have a direct impact in terms of standards applicability, however, everyone will see changes in the standards applicability grids that are published with the manual. Your E-Edition should already filter to your unique service array, but when looking at print manuals you will want to check the Standards Applicability Grid to determine if a standard that seems to be new even applies in your setting.

Falls, New Sentinel Event Definition:

In the June issue of Perspectives, TJC announced a new definition for a fall event that also meets their sentinel event definition. Previously, a fall with injury had to cause death, permanent harm, or severe temporary harm to qualify as a sentinel event. The new and much more detailed definition, adds more clarity: "Fall resulting in any of the following: any fracture, surgery, casting or traction; required consult/management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury; or a patient with coagulopathy who receives blood products as a result of the fall; death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)." The new definition is aligned with the National Database of Nursing Quality Indicators, NDNQI. In addition, the National Quality Forum supports the use of the NDNQI definition.

There is an action item to start on now as a result of this change and that is to refine your sentinel event policy to utilize the new definition. Your PI team or falls analysis committee should also begin to utilize the new definition, which may result in the need to perform additional formal root cause analyses over time.

Consistent Interpretation – Victims of Abuse:

This month's column focuses on PC.01.02.09, EP 1 regarding identification of victims of abuse. TJC reports that this EP is scored in just under 6% of hospital surveys. Our observations from mock surveys in outpatient and procedural settings, as well as among pediatric populations, indicate that this may be missed more than 6% of the time. TJC makes it clear in the guidance section that this requirement applies in all patient care areas, not just inpatient. We often find outpatient settings where the EMR fields do not correspond to the inpatient area and the routine screening question or observations are not prompted.



Pediatric settings pose a challenge also in that many organizations use a screening question such as, "Do you feel safe at home?" Such a screening question is not going to be adequate for a nonverbal child, thus some observation-based screening is required.

EC NEWS

Alternate Care Sites:

The lead article in this month's EC News is a case study describing the process of establishing an alternate care site at the convention center in New Orleans. The authors describe the issues they managed such as ventilation, oxygen supplies, air pressures, electrical support, and a fire watch process they initiated because their site was not fully sprinklered.



Contained within the article is a useful chart from the Army Corp of Engineers where they establish the following four criteria for an appropriate alternate care site:

1. Must have a complete, operational sprinkler system that is compliant with local fire codes
2. Must have a complete, operational interior fire alarm system that is compliant with local fire codes

3. Must have at least 2 exits per story
4. Must be free of asbestos, mold, and lead

Given that many hospitals experienced the need for alternate care sites during the peak in the COVID-19 outbreak, this is useful reading for planning purposes as you get ready for the next need.

Most Frequently Scored EM Standards:

Consistent with the first article, there is also an article on the most frequently scored emergency management standards and EM.02.01.01 tops the list. In addition, there are two elements of performance (EP 14 and 12) in this standard that are #1 and #2 in the most frequently scored list of EM elements. EP 14 requires the organization to have a procedure for requesting an 1135 waiver, which you would need to establish an alternate care site, absent a CMS national or blanket waiver. The EC News article does include a template letter to CMS summarizing required content in a letter to CMS requesting an organizational waiver.

EP 12 describes the continuity of operations plan (COOP) and delegation of authority or succession planning. This is an issue we have discussed previously in this newsletter, observing that many organizations had not prepared a COOP thinking it only applied to the scenario of a plane crash or some disaster befalling the C Suite staff. In actuality, this continuity of operations plan is designed to handle many simpler issues such as senior staff being on vacation, unable to report to work due to sickness or quarantine, or other reason for non-availability.

EM Top 10 Frequently Scored:

1. EM.02.01.01, EP 14: *1135 waiver request procedure*
2. EM.02.01.01, EP 12: *Continuity of Operations Plan*
3. EM.03.01.03, EP 1: *Twice a year drills or activations of the EOP*
4. EM.02.01.01, EP 3: *What you plan to do if the community can no longer support your operations*
5. EM.03.01.01, EP 3: *Your documented review of the adequacy of the emergency inventory. Our advice on this issue is to ensure that there is some mathematical use or burn rate analysis in support of your inventory, and your determination of its adequacy*
6. EM.01.01.01, EP 8: *Details what should be in the documented emergency inventory including PPE, water, fuel, medical/surgical supplies, and medication. Please note, other elements of performance also reference food, medical equipment, linens, and beds*
7. EM.03.01.01, EP 2: *Annual review of the scope and objectives of the EOP. Using good performance improvement techniques each drill and each actual activation of the EOP should be analyzed so that you can conduct a thorough review of the EOP and make necessary, incremental improvements*
8. EM.01.01.01, EP 2: *Conduct a hazard vulnerability analysis. Remember CMS and TJC had added a requirement to include an infectious outbreak due to high consequence infectious disease in the HVA, not just the usual weather-related disasters*
9. EM.02.02.13, EP 2: *The medical staff bylaws must identify those individuals responsible for granting disaster privileges*
10. EM.03.01.03, EP 2: *At least one of your drills should include a potential influx of simulated patients*



Elevator Doors - Warning:

There is an enlightening article on elevator doors in this month's EC News. TJC reminds us that elevator doors are required to be fire rated and such doors cannot have combustible signage, papers etc. hung on them. They point out that many of the beautiful, marketing vinyl wraps that hospitals are using to adorn their elevator doors may be a problem. TJC advises that they are keying up their surveyors to be on the lookout for these pretty vinyl wraps to determine if they are UL listed. We have to admit, we have seen these wraps in many client facilities and we have admired them, found them attractive and clever, but did not previously think of potential noncompliance issues. Be sure to take a look at yours and find the necessary documentation that they are UL listed.



CMS

Nursing Home Industry Memos:

At the time we are writing this newsletter, there are no new QSO memos for the hospital industry. There are, however, three new memos directed to the nursing home industry that, as time permits, you may want to review because of their discussion about COVID-19 issues.

On 4/24/20, CMS issued QSO-20-28 which is identified as talking about the 5-star rating system, but more importantly has 12 pages of frequently asked questions about COVID-19. These FAQs include discussion about when the nursing home can accept a COVID-19 patient back from a hospital admission, how to handle visitors, screening of healthcare workers, and other pertinent issues.

The second CMS memo, QSO 20-29 issued on May 6th, also addressed to the nursing home industry. It is an interim final rule that will have a comment period and it describes new nursing home regulations for reporting COVID-19

data to the CDC. There is an attachment to this memo which is an updated CMS Focused Survey for Nursing Homes looking at infection control issues related to COVID-19. This might be of interest to your infection control team for the types of issues CMS surveyors may be looking for.

The third memo, QSO 20-30 dated May 18th, provides guidance to the state and local officials on relaxing certain COVID-19 restrictions while mitigating the risk of resurgence. The factors they are recommending for consideration include the case status in the community, case status in the nursing home, adequacy of staffing, access to testing with at least 48-hour reporting, source control and wearing of masks, access to PPE, and local area hospital capacity. There is also a detailed table of guidance broken into three phases for reopening. Again, this may be of interest to your infection control team as you analyze loosening restrictions in your organization.

Thank you,

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