PHC
PATTON HEALTHCARE CONSULTING, INC.
Accreditation | Compliance | Patient Safety

News from The Joint Commission and CMS

The Patton Post | October 2020

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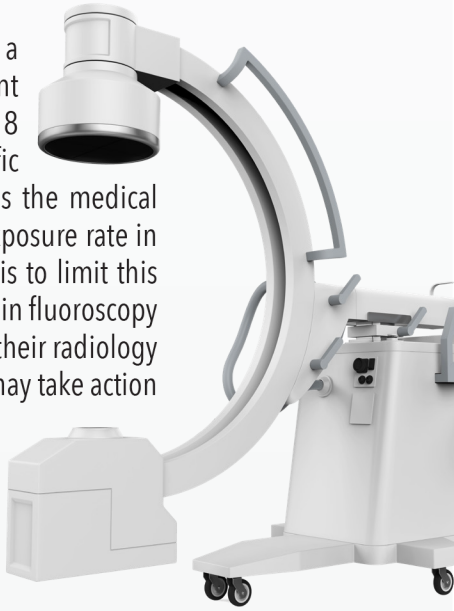
PERSPECTIVES

Fluoroscopy Services:



The lead article in this month's Perspectives is a simplification of a relatively new requirement first posted in prepublication format on 6/25/18 dealing with fluoroscopy services. The specific standard is EC.02.04.03, EP 34, which requires the medical physicist to annually measure the maximum exposure rate in all imaging modes. The change TJC is making is to limit this assessment to only the maximum exposure rate in fluoroscopy mode. Readers will want to send this change to their radiology leadership team and medical physicist so they may take action on this simplification. TJC has announced this change with an effective date of 1/1/21. The rationale for the change is that the feedback from the industry has been that the burden of the requirement outweighed its benefit.

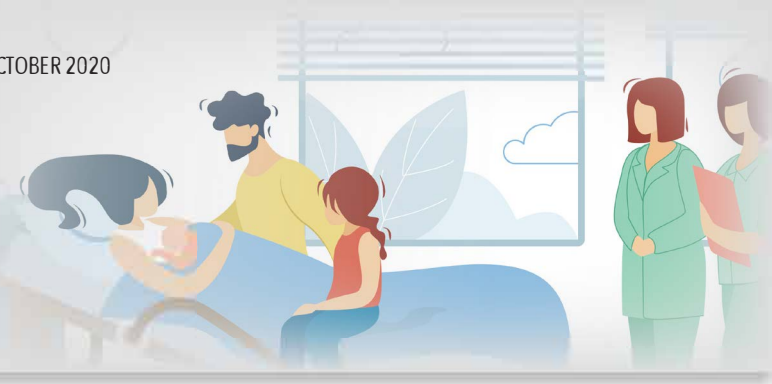
Consistent Interpretation - Maternal Safety Standards:

We often are perplexed by this regularly scheduled column in Perspectives and this month is no exception, however this month the Guidance/Interpretation column is essential reading. This month they focused on the new maternal safety standards that were to be implemented in July 2020, but due to everyone's focus on Covid-19 the planned implementation date was delayed until January 2021.

The surveyor observations section remains confusing because these standards have not yet been implemented but these look like the types of things surveyors might score deficient once they are implemented. The guidance section is very informative and adds important depth to the understanding of these new requirements. Even with the additional time to prepare, if the burden of Covid-19 delayed implementation of these new requirements at your organization, you now have just the next three months to get ready.

This is a fairly extensive set of new requirements that require identification and selection of expert practice guidelines, development of new policies and procedures, staff and patient education, drills,

adverse event evaluation, monitoring of patients at risk using guidance from your chosen clinical practice guideline, and procedures to obtain expert medical consultation. This column is really useful this month because you see the language of each of the thirteen new elements of performance, followed by guidance/interpretation that helps add detail to the types of things that TJC surveyors will be looking for when they evaluate compliance with the new requirements.



PC.06.01.01

The first new element of performance is PC.06.01.01, EP 1 which requires the hospital to identify an evidence-based tool for determining maternal hemorrhage risk on admission to labor and delivery and the postpartum unit. TJC makes it clear that this is two unique assessments, one upon admission to labor and delivery and a second upon admission to the postpartum unit.

TJC suggests three different tools for these assessments from The Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN,) the American College of Obstetricians and Gynecologists (ACOG), or the National Association for Healthcare Quality (NAHQ).

ACOG also has a phone application called the "Safe Motherhood Initiative," or SMI, that is available through your phone's App Store.

EP 2 calls for the use of evidence-based procedures for stage management of pregnant and postpartum patients who experience maternal hemorrhage with eight very specific details, plus a nineth implementation requirement embedded in a note on who to include from your hospital in the planning effort. One of these detailed requirements is for the blood bank to have a plan and response for emergency release of blood products and how to initiate the hospitals massive transfusion procedures. An interesting feature in the guidance/interpretation section is that staff must also be able to describe the plan. This implies successful competency validation following teaching staff about the plan.

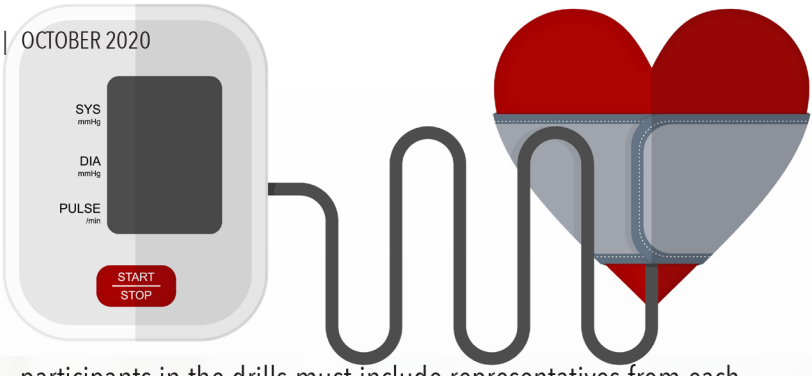
EP 3 requires each OB unit to have a standardized, secured, and dedicated hemorrhage supply kit that must be stocked per the hospitals defined process, which must include the emergency supplies selected by the hospital as well as the hospitals approved procedures for severe hemorrhage response. In the guidance section TJC points out that there must be an established restocking process for these hemorrhage supply kits, including medications.

EP 4 requires education of all staff and providers who treat pregnant and postpartum patients about the hospitals hemorrhage procedures. TJC also states this training must be done at orientation, whenever changes occur, and at least every two years. In the guidance section, TJC notes that this education must be role specific so that everyone receives only the information they need about their role in the hemorrhage event. The good news here is that TJC also provides guidance stating this new education requirement does not have to be completed until January 2022.

EP 5 establishes a requirement for annual drills and the drill must include a team debriefing. The guidance section then clarifies that the first drill must have been completed by 12/31/21, within that first year of implementation. The drill must also include representation from each department listed in the hemorrhage response procedures. They further explain that this means 100% of the departments must participate, but this does not mean 100% of the staff have to participate. However, TJC adds that hospitals must present lessons learned from drills to the entire team.

EP 6 requires each hemorrhage case to be reviewed to evaluate the effectiveness of the care provided by the hemorrhage response team during the event. The guidance then describes the need to establish criteria that automatically generates a quality improvement review. In addition, the hospital must disseminate key findings and improvement opportunities to pertinent staff and providers.

EP 7 discusses patient and family education and the guidance here is somewhat confusing. It first says that documentation of education need not be in the medical record, however surveyors may interview patients to determine if the hospital provided education specific to the signs and symptoms of hemorrhage during hospitalization and post discharge. So, while the education may not have to be documented, it does have to be effective and the patient must have acquired some knowledge to be able to describe the signs and symptoms of hemorrhage. Developing competence in patient education is a difficult step. Our advice may be that you want to provide written materials in languages matching your patient populations that the patient may be able to refer to during any inquiry with a surveyor.



PC.06.01.03

EP 1 states that there should be written, evidence-based procedures for measuring and remeasuring blood pressure. These procedures should include criteria that identify patients with severely elevated blood pressure. The TJC guidance section then states the hospital should develop clear instructions for what to do for an abnormal BP. These instructions may include but are not limited to, when to retake BP, what to do if the measurement remains elevated, and what to instruct the patient.

EP 2 states the hospital should develop written evidence-based procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that include:

- Evidence-based emergency medications and immediately available
- The use of seizure prophylaxis
- Guidance when to consult additional experts and consider transfer to a higher level of care
- Guidance on when to consider emergent delivery
- Criteria for when a team debrief is required

The guidance section then restates all the key departments that must be involved in the development of procedures and provide feedback to include anesthesiology, emergency department, laboratory, nursing, obstetrics, and pharmacy. They also advise that the plans must list items staff must do or obtain for patients at high risk for seizures such as padded bed rails, quiet/private rooms, and magnesium sulfate.

EP 3 then adds a requirement to provide "role specific education to all staff and providers who treat pregnant and postpartum patients about the evidence-based hypertension/preeclampsia procedure." This education must occur at orientation, when changes occur, and at least every two years. Again, the guidance section states the formal documentation of this education does not have to be completed until January 2022.

EP 4 next discusses the drill requirements for severe hypertension/preeclampsia and the need for a team debrief. TJC does not prescribe a specific number of drills, however the hospital should determine that based on staff proficiency. The participants in the drills must include representatives from each department assigned to respond to an actual event. In this case, the documentation of the drills is not required to be complete until December 31, 2021. Lessons learned from drills should be presented to the entire team.

EP 5 requires a review of severe hypertension/preeclampsia cases that meet criteria established by the hospital to evaluate the effectiveness of care provided to the patient during an event. The guidance section states the hospital should have criteria that automatically generates a quality improvement review and that the hospital should have a mechanism to disseminate improvement findings to the staff.

EP 6 requires hospitals to provide printed education materials to patients and families that includes signs and symptoms of severe hypertension/preeclampsia that should alert the patient to seek immediate care and when to schedule a follow up appointment. These printed materials may help with the potential surveyor interview with a patient we discussed earlier.

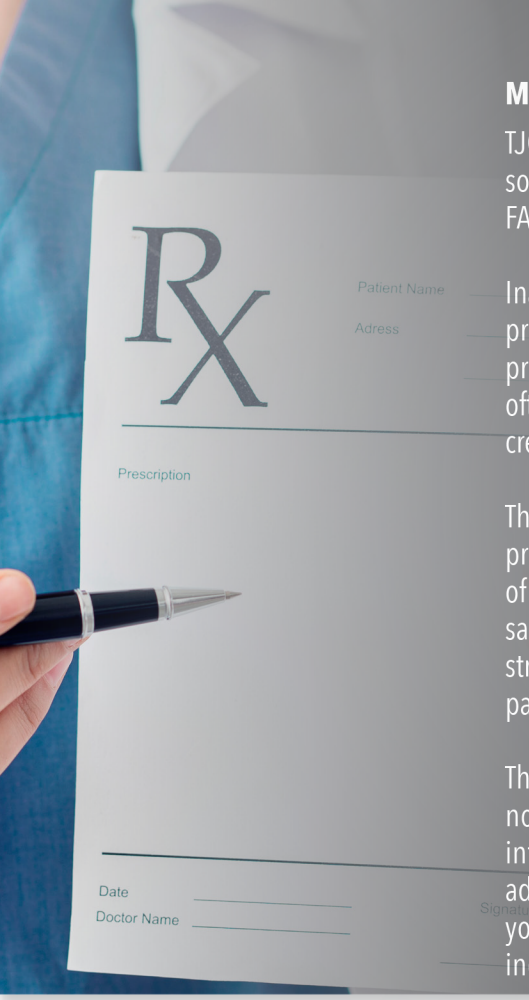
So, most importantly if you still have a lot of work to do to launch these new standards, you can consider this a road map on how to get there. As you circulate the Perspectives article to your key team members, think about assigning responsibility for specific elements of performance to key staff along with due dates to come back to the leadership team to collaborate and share plans.

If you are not due for survey until 2022 or 2023, we would not advise delaying the implementation of these new requirements. New detailed requirements like this carry risk management implications as they establish a new "standard of care" and you never want to be delayed in implementation of a new standard of care for such high-risk services.

FAQs

Expired Credentials:

TJC posted a new FAQ of interest this past month on expiration of certification of credentials such as BLS or ACLS. At the moment, this FAQ can also be found in the "New" section of the FAQ listing, but depending on when you search for it, it may have been moved to the Human Resources chapter. During the Covid-19 National Emergency, the certification providers have been waiving expiration dates, however, they have announced there will be no more extensions. CMS has stated that there are no waivers of this requirement for hospitals, although one does exist for ESRD providers. Thus, you are going to want to tackle this task in the coming weeks to get staff certifications refreshed.



Multimodal Therapy:

TJC posted another new FAQ on Therapeutic Duplication vs Multimodal Therapy that will require some thoughtful analysis. At the time of this writing it can be found in the "New" section of their FAQs. At a future time, it may be found in the medication management chapter listing.

Inappropriate therapeutic duplication has been a frequently scored issue for our entire professional careers. Multimodal therapy is a newer concept where two or more drugs are prescribed simultaneously and the intent is to give them in combination. These medications often have different mechanisms of action in treating an issue such as post-operative pain but create a synergistic effect when used in combination.

The challenge in the FAQ is that the organization must be able to differentiate between accidental prescribing error and intentional multimodal therapy. One of the easiest examples of therapeutic duplication to identify is when two or more drugs are prescribed PRN, for the same indication (such as pain) and the nurse or patient is to pick one. Such orders should be stratified by the prescriber, stating which one should be tried first and second, or stratified by pain levels.

This contrasts with multimodal therapy where two or more drugs are prescribed, often but not always, on a scheduled basis and the intent is to administer them simultaneously for the intended effect. Unfortunately, they might not always be given simultaneously, but rather administered at different times due to different durations of action. As you consider this FAQ, you might want to create some indication in the EMR or MAR medication notes section that indicates there is intended multimodal therapy, not unintentional therapeutic duplication.

EC News

Cybersecurity:

The lead article this month in EC News is about Preventing Cybersecurity attacks. Being that it is in EC News, they take an interesting approach to the issue, pointing out some of the ways in which hackers can gain entry to your IT systems through the physical environment software in use in your hospital.

They mention things such as your emergency power systems, building automation system, or any other system connected to the internet. Many types of medical or office equipment have software that has to be updated and they warn about both callers and impersonators of vendor representatives showing up to conduct software updates. They advise knowing your vendors and not letting any strangers conduct any updates. The authors suggest a periodic conversation between facilities leadership and IT as well as some limited cybersecurity training for staff. While this article is outside the usual quality realm, it is definitely worth sharing with the facilities and IT leadership teams to help get the conversation started if there is not already a strong relationship.

Documentation:

There is also an article entitled "Not Documented, Not Done" which the authors point out has been the mantra for surveyors for many years. The article briefly summarizes some of the written documentation which must be available during the EC/LS document review, but more importantly the article provides a link to the Joint Commission's comprehensive EC/LS documentation tool. This tool is particularly helpful on survey and provides an excellent self-assessment verification that you actually have everything needed before survey. It's also a lot easier than wading through the standards one more time to try and pick out the ones that require some written policy, evidence of completion, or plan.

Medical Gas Checklist:

There is also a brief article, or promotion for a new book from JCR, about medical gas systems. More importantly there is an excellent tool from the book that is reprinted in EC News called a Piped and Cylinder Delivered Medical Gas Compliance Checklist. The many detailed requirements for medical gases from NFPA 99-2012 that LSC surveyors evaluate are summarized here in a checklist format. This is an excellent self-assessment tool that should be shared with and completed by facilities staff to verify compliance.

CMS

Emergency Preparedness Drills:

CMS issued two QSO memos during the past month of interest to hospital readers. The first of these was QSO-20-41 dated September 28 describing guidance to the hospital industry on emergency preparedness drills. To some extent, readers should already be familiar with the content of this memo because it relates to the burden reduction update CMS issued back in last September and the Joint Commissions updated 2020 standards which resulted.

At that time, numerous changes were made to the emergency preparedness regulations. One of the changes CMS describes in this memo is an exemption for an organization from their next required full-scale exercise during or after an actual emergency if that emergency caused activation of their EM plan. CMS mirrors the longstanding Joint Commission approach that if you had an actual emergency, activated your plan and evaluated your response, you were exempt from your next planned drill as a result.

In this memo CMS provides definitions of the types of drills and created some synonyms for those definitions. Basically, CMS identified two broad categories as follows:

1. Full scale, functional and individual facility-based exercises (synonym: Required)
2. Mock disaster drills, table-top exercises and workshops (synonym: Exercises of Choice)

Unfortunately, the synonym "exercise of choice" does not mean it is optional. It is mandatory however you get a choice among several alternative types of simplified exercises. These choices include mock drills, tabletop exercises, or a workshop. Each year hospitals must perform one full scale, functional, or individual facility-based exercise, plus one exercise of choice.

As a result of the Covid-19 National Emergency, this memo explains you are exempt from your next required full-scale exercise, which is the more difficult or complex of the two broad categories above. The rationale is that during the national emergency, if you activated your EM plan and evaluated your performance, you in essence did a full-scale exercise. CMS provides colorful graphics in the memo to help explain the timeline. As you read this memo be sure to focus on the inpatient provider category that covers hospitals.

In the first inpatient scenario, the organization performed a full-scale exercise in January 2020 then the national emergency hit in March 2020. The next full-scale exercise should be due in January 2021, however as a result of the national emergency, the organization is exempt from this planned event until January 2022.

This approach is somewhat different than you are likely and previously used to with Joint Commission where you just did two exercises a year and most organizations used a calendar year or fiscal year. In this CMS approach, you will note that they used fixed dates, meaning if you did one full scale or functional exercise in January, your next full scale or functional exercise is due again in January of the following year.

You will want to share this memo with your emergency management leadership team for them to discuss and analyze. Depending on how long your EM plan was activated during the national emergency, you may want to take advantage of the exemption in the coming year or not take advantage of the exemption if your evaluation identified multiple flaws.

Covid-19 COPs:

The second QSO memo of interest is QSO-21-03 dated October 6, 2020. This memo discusses the new COP for transmission of Covid-19 bed utilization and capacity data. This memo includes detailed definitions of all the data elements CMS is seeking, plus six additional data elements relative to influenza that will be optional as of October 19, 2020 but made mandatory at a later, and as yet unspecified, date. The CMS posting also includes a colorful graphic that explains the enforcement and potential termination activities that could result from noncompliance. If you study this graphic you will be able to succinctly summarize the memo to just a few words, much like the Nike slogan, "Just Do It." Readers will want to verify that their organizations data is flowing to avoid this becoming an enforcement activity.

Thank You & Well Wishes.

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