PATTON HEALTHCARE CONSULTING, INC.

INSIDE THIS ISSUE

2022 SURVEYS

COVID Vaccine Mandate Scorings:

The survey reports we have started to see in 2022 are significantly voluminous and issues relative to the Covid worker vaccination program we discussed in our *Patton Post* newsletter last month have jumped to the forefront. The process/policy expectations for tracking, confidentiality of information, managing the program, and exemptions are being frequently scored.

This initiative was rapidly sprung on the industry and during the frequently changing public health emergency, healthcare organizations managed new and changing information on a daily basis, perhaps with less focus on formal documentation of policy conclusions. It appears from these reports that TJC is looking for formal policies. The thoroughness of the program data is also under scrutiny with anything less than 100% compliance being scored noncompliant.

Our suggestion here is to review our February *Patton Post* again and ensure that you have the processes/policies hard wired and if possible, bring the decision making about possible exemptions to a conclusion. If you have made a conclusion about a requested exemption, you are compliant. If your decision is still pending you are not going to be 100% compliant.

MIFU Noncompliance Findings:

Later in this newsletter we discuss the most frequently scored elements of performance including noncompliance with manufacturer's instructions for use (MIFU) on sterilization or high-level disinfection. The number of MIFU findings we have seen thus far this year is astounding. Healthcare organizations have got to find a way to get this information to users and be implemented. Findings of failures to follow MIFU are all being scored in the red zone of the Joint Commission's SAFER™ Matrix because the deficiency potentially affects all patients served by the practice.

One other issue we are seeing is the widespread use of the "double ding" (a term we have not used in several years) where one issue gets scored in several different standards chapters. For example, a failure to follow MIFU is one finding, leaders not leading is the second finding, competency failure is the third finding. Then one more branch of this tree we have seen in 2022, is an additional ding against the infection prevention leader for not being on top of the issue.

Surveyors should not be more knowledgeable about the MIFU for a device sterilized or machine used at your organization every day, but too often they are. Surveyors acquire the MIFU during their surveys, take them back to their hotels, or read them on the planes traveling to the next site and they remember minutia from the MIFU that they can then build into their tracer discussions.

Readers have to find a way to incorporate these detailed MIFU into organization procedures, teaching and competency assessments, at a minimum for all aspects of high-level disinfection and sterilization. Often today, we see a branching out of this MIFU adherence even to the kitchen where cleaning and disinfection chemicals are being used at less than the minimum temperature required by the MIFU.

PERSPECTIVES

Top 10 Frequently Scored for 2021:

The April edition of *Perspectives* includes an article on the full year scoring data from 2021 including the top ten most frequently scored elements of performance for each accreditation program. Each EP also identifies the frequency of scoring moderate or high risk on the SAFER™ Matrix by surveyors.

When you look at hospitals, critical access hospitals, and behavioral healthcare settings it is clear that there are still a lot of performance gaps in completing the requirements of NPSG.15.01.01, with multiple elements of performance being very frequently scored in those three programs.

In the hospital accreditation program, EPs 1, 5, and 4 which respectively require the environmental risk assessment, a suicide screening/assessment, and mitigation of risk, each made the top ten. In behavioral health care, EPs 1-5 are actually the top five most frequently scored elements of performance. EPs 1, 5, and 4 have the same expectations as in hospitals. EP 3 requires an evidence-based suicide assessment, and EP 4 requires an overall risk conclusion after assessment.

So, you might wonder what is going wrong here? The requirements are no longer new and to support that understanding TJC has a second article in the April *Perspectives* providing a timeline and brief summary and history on how these safety requirements evolved since 2016. This second article is particularly valuable because there have been so many publications, *Perspectives* articles, safety portal

guidance, and standards FAQs on the issue of suicide safety since 2016. This month in *Perspectives*, the Consistent Interpretation column is thematically focused on NSPG.15.01.01, as it also was in March.

Going back to NPSG.15.01.01, EP 1, we see a variety of performance gaps with this EP, the requirement for the environmental risk assessment. In most organizations we are able to find a document, however the ability of staff working on the behavioral units to locate this essential document is often lacking. Frequently it has been performed by a facility's subject matter expert or consultant, and then it has been locked up and preserved for the day some inspector asks for it, but finding the individual who has this document is often a struggle.

Our advice on this issue is that any risk assessment should be readily available to the unit leadership and staff, facilities leadership, and the organization's QAPI team. All three groups should have a basic knowledge about when it was done, what was found, and how we are mitigating the risks identified.

A second vulnerability with the environmental risk assessment is a failure to identify some item in the environment that published literature is identifying as a ligature or safety hazard. Sometimes this is attributable to overthinking the purpose of the environmental risk assessment and concluding: "I see the potential risk point, no one has ever attempted to use that here, therefore I don't have to include it on my environmental risk assessment."

This is clearly the wrong conclusion and leads to a lot of scoring due to gaps in the environmental risk assessment. If you see it, it's a theoretical risk, a very low risk or an actual risk; document that you have noticed it and it is a risk that you can mitigate.

Also bear in mind the detailed guidance from TJC on the need to eliminate environmental risks in the more limited observation bedrooms and bathrooms in behavioral health units. The group rooms and hallways have much more detailed, nuanced conclusions from TJC and the second *Perspectives* article as well as the Suicide Safety Portal provide that detailed guidance on what is or is not permitted in supervised, easily viewable areas of the behavioral health units.

NPSG.15.01.01, EP 5 requires the policies and procedures for care including competency expectations for staff, reassessment requirements and monitoring made number 9 on the top 10 list for hospitals. As you might imagine there are many failure opportunities with this requirement including missed or delayed reassessments, lack of competencies, or inadequate monitoring.
NPSG.15.01.01, EP 4 lands as number 10 on the hospital most frequently scored list. It requires documenting the patient's overall risk conclusion and how you plan to mitigate that risk. Some assessment tools lead you to a conclusion but some acceptable assessment methods do not lead to a conclusion, they require the clinician to reach a conclusion based on their interpretation of responses.

NPSG.15.01.01, EPs 2 and 3 made the behavioral health care top ten list, but not the hospital list. EP 2 requires the use of a validated screening tool and EP 3 an evidence-based assessment method. While these did not make the hospital top ten, they can't be far behind as we see these same issues frequently scored noncompliant. Sometimes we see there was a failure to conduct the required screening or assessment, or one of these was delayed outside of your policy expectation. We also see screening and assessment tools built into electronic medical record applications that may have been derived from published, evidence-based tools, but neither the EMR or policy identifies the reference and it is not apparent to the surveyor where your questions or process were derived from.

Many of these detailed requirements for suicide safety are frequently scored in the red area on the SAFER™ Matrix or can even be scored in the immediate threat category, similar to the CMS immediate jeopardy situation. More importantly as we mentioned just last month, TJC continues to receive or learn about a significant number of suicide sentinel events each year, meaning a continued focus on this issue is needed.

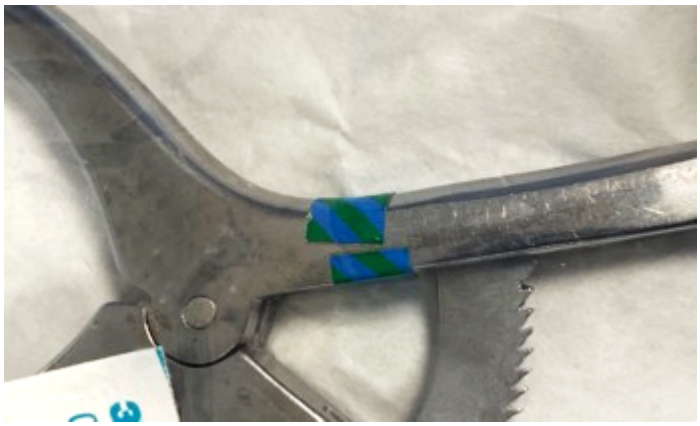
A second major and persistent focus area from the top ten is infection prevention which holds the 1st, 7th and 8th places on the list. As we have seen for several years IC.02.02.01, EP 2 describing high level disinfection and sterilization is a very frequently scored issue with very frequent scoring in the red, high-risk area of the SAFER™ Matrix. It appears from the TJC graphic that nine situations with this standard were scored in the immediate threat category.

We have discussed the risk points in these processes at length for several years and each year it appears the surveyors are getting better at finding new and different weaknesses in these processes. There continues to be a focus on strict adherence to your chosen clinical practice guidelines such as AAMI and to manufacturer's instructions for use (MIFU). Surveyors will often ask to see the MIFU for a device you are processing and unfortunately staff are very often unable to produce the MIFU or even know what it is the surveyor is requesting. When they do have access to the MIFU, we often see a failure to adhere to the guidance provided by the manufacturer.

We are seeing two new situations in scoring this standard this year. The first is the unauthorized practice of reprocessing single use devices. During the pandemic, hospitals were reporting supply chain issues and many organizations had to find new sources for surgical instruments. These sources sometimes provided reusable equipment that can be sterilized and sometimes they provided single use devices which cannot be reprocessed per the manufacturer and FDA.

Unfortunately, when these single use devices get placed on the back table during a procedure, they make their way to central sterile and are inadvertently reprocessed. If you reprocess the device or instrument, you are doing so in violation of the FDA device labeling and without any authorized sterilization guidance. Reportedly this is leading to some of the immediate threat conclusions. In February, TJC published a new issue of their Quick Safety on this very subject.

A second sterilization issue we are noticing recently with some frequency is a close examination of sterile instrument identification tape. This too comes with manufacturer's instructions for use and surveyors will look to see that the tape has been applied correctly according to the MIFU. Another risk point with this tape is that over time it can degrade, loosen, chip or flake and this degradation poses a risk to proper sterilization and/or breaking off during a surgical procedure. If you are using instrument tape, we advise that staff should be carefully inspecting it to verify it has been applied correctly and is not coming lose or chipping in any way.



The remainder of the top ten most frequently scored elements of performance should all be familiar to our readers as classics. The 3rd most frequently scored EP is MM.06.01.01, EP 3 which requires that medications be verified as right patient, dose, frequency, route, time and this is where titrations that don't match the order in the medical record are frequently scored. For example, is titration amount or rate is changed, but the physiologic parameter specified in the order does not justify the adjustment, or is entirely missing from documentation.

EC.02.06.01, EP 1 is a perennial generic favorite where anything in the environment that looks out of sorts can be scored. This EP made number 4 on the hospital list. The array of issues can range from stained ceiling tiles, to cracked flooring, to a torn mattress on a stretcher, to porous surfaces that cannot be cleaned. The key here is self-identification of such issues and prompt repair or replacement.

EC.02.05.01, EP 15 made number 5 on the top ten list and this establishes requirements for controlling airborne contaminants in critical spaces through temperature and humidity management, air pressure relationships, air exchanges and filtration. One of the more frequent issues here is a failure to maintain the appropriate air pressure relationship, be it negative or positive.

All too often we see this scored by TJC or by our consultants and the organization has not provided staff any tools such as an alarm, pressure meter, ball in the wall or other device to know if the air pressure relationship in their area is correct. We see this situation very often scored as a Medicare condition of participation, which means TJC will need to return for an additional fee to verify corrective actions have been taken.

EC.02.02.01, EP 5 made number 6 on the top ten list. The EP requires safe management of hazardous chemicals and we often refer to this EP as the eyewash EP. There are multiple potential failure points in this EP such as not having access to an eyewash where hazardous chemicals are being used in the workplace.

Staff need to be looking at the safety data sheet for chemicals they use to determine if an eyewash is needed. Those responsible for purchasing such chemicals should verify with area management that an eyewash is in the immediate work area if a request is submitted to purchase a new corrosive chemical. Staff performing environmental, quality or infection prevention rounds should be testing the process, examining chemicals and verifying access to an eyewash.

Unfortunately, this is only half the battle in meeting the hazardous chemicals requirement. The eyewash needs to be tested, provide a tepid water temperature which usually requires a mixing valve, allow for one motion activation, not operating multiple levers and be immediately accessible to the employee who might be temporarily blinded by the chemical, meaning it needs to be within 50 feet (10 seconds) and can't be behind locked doors.

Another infection control chapter standard, IC.02.01.01, EP 1 made number 7 on the top ten list. This EP is also somewhat generic and governs infection prevention practices of any sort. This could be adhesive residue, anything dirty or dusty, improper storage, improper routine disinfection of surfaces or improper practices. IC.02.02.01, EP 4 made number 8 on the list and this is also somewhat generic, governing storage of medical equipment, supplies and devices.

Numbers 9 and 10 were previously discussed about the suicide safety goal. If your organization has multiple programs such as behavioral health, home care, laboratory or other, the top ten lists are published in the April *Perspectives* for each of these programs. These lists should be shared with your program managers in these areas to help them prepare.

What Are You Going to Do About It?

This is really the important issue for all accreditation programs. The top ten list is interesting reading, but today we are seeing a very wide array of findings that we might not have seen from TJC a decade ago. While the top ten is not all you have to worry about on survey, it is a large component of many surveys and we believe that when surveyors see this so called "low hanging fruit" being scored, it may cause them to form a negative perception about your state of readiness or your thoroughness of preparation.

While it is a very complex task to try and prepare for 2000 unique elements of performance, knowing that these ten issues are scored very frequently should allow you to be ready for these most probable, known risky issues during your own preparation activities. When you do rounds of any type this is an opportunity to look for these issues. When you do annual training, you can focus on these likely suspects. When you do internal competency assessments, you can validate staff are competent to meet your expectations on these ten issues. You might want to consider forming a checklist for these top ten issues for those conducting rounds within the organization.

Initially you are likely to find multiple issues from this list in multiple locations to help establish a baseline. Over time your reviewers and your staff should both get so attuned to these preventing these issues that the number of findings should go down.

EC NEWS

Causes of Ventilation Failures:
The lead article in this month's edition of *EC News* is aimed at Ambulatory Surgery Centers (ASC) and Office-Based Surgery (OBS) centers, however the guidance therein on EC.02.05.01 is valuable for hospital audiences also. The problem issues are comparable, it's just that the ASC and OBS rely on different codes for the ambulatory setting, so TJC has unique EPs for ambulatory.

The issue we mentioned earlier in our discussion of the top ten most frequently scored EPs is also important for the ASC and OBS setting. Temperatures, humidity, air pressures, air exchanges, and filtration are challenging for an ASC, OBS, or hospital setting. This article provides some guidance on potential root causes for ventilation failures including failed preventative maintenance, lack of pressure meters, and flawed leadership or ownership of the issue.

Workplace Violence Standards:
EC News also contains two articles on workplace violence, one from the author of a book on healthcare and hospital security and a second announcing that OSHA is beginning to plan for development of a workplace violence standard. The timing of these articles is useful because as you know The Joint Commission has new workplace violence standards that took effect in January of this year.

We have not yet started to see heavy scoring of these new standards by TJC, but there is room for improvement based on the state of readiness we see during consultation visits. With any new set of standards there are multiple opportunities to explore the issue. For example, a discussion of workplace violence could be initiated during a leadership session discussion on the culture of safety. The depth of this initial discussion could increase to requesting an actual look at some of the initial workplace assessment data during the data use system tracer.

Exploration could also occur during patient tracers, asking frontline staff about potential issues they are working on to reduce the risk of workplace violence, or understanding what they have learned from the worksite assessment. Incident reporting and OSHA worker injury reports are another opportunity to discuss workplace violence. Examination of policies including visitation policies to understand how patients and family members exposed to domestic violence are being managed to avoid bringing those issues into the hospital.

Lastly, the HR competency session is one more opportunity to explore the issue by examining training records or discussing training curricula. This month's *EC News* articles are thought provoking and include a boxed insert reminder about earlier *EC News* articles published over the last few years that may be useful to your program development. These articles should be shared with your team working of development of your program, and remind different groups of staff for survey issues of the efforts on workplace violence prevention.

Fire Department Connections:
The April issue of *EC News* also contains an article on Fire Department Connections and Locking Caps. We found the discussion of the TJC requirement under EC.02.03.05 to inspect these connections quarterly very informative. We have heard facilities managers question what they should be looking for during these inspections beyond "yes I see it, its accessible and it appears functional."

The article provides direct guidance from NFPA 25-2011, section 13.7.1 with eight (8) required elements that should be examined during these quarterly inspections. These include:

1. "The FD connections are accessible and visible"
2. "Couplings or swivels rotate smoothly and are not damaged"
3. "Plugs or caps are in position and not damaged"
4. "Gaskets are correctly situated and in good condition"
5. "Identification signage is in place"
6. "The check valve does not leak"
7. "The automatic drain valve is in position and operating appropriately"
8. "The FD connection clapper is correctly situated and operating properly"

CMS

Surveying Laboratories Resumes:

There was one new QSO memo published in the past month, QSO-22-14 dated March 22, 2022. This memo focuses on the laboratory setting and is directed to state survey agency directors. Basically, it says that it is time to get back to surveying laboratories, eliminating any limitations enacted during the public health emergency. This will include initial, recertification, complaint, validation, follow up surveys and surveys for certificate of waiver and provider performed microscopy labs.

CONSULTANT CORNER

Dear Readers,

We have exciting news to share with you! We are now an affiliate of Healthcare Building Solutions, Inc., an industry leader offering project management, medical equipment planning, transition planning, facility activation services, and turn-key development capabilities to health systems.

Patton will now be able to help our current and future clients achieve success on a broader scale as our affiliation with HBS provides additional resources to help our clients meet their regulatory and patient safety goals. This new partnership will not affect the way we provide our services as HBS will add synergies, valuable resources, and a support structure to complement our mission for accreditation, compliance, and patient safety. With this partnership, we will be able to offer additional solutions and connections to the organizations we support.

Read the press release to learn more. We can't wait for you to see what more we can do for you!

Thank You,

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