PATTON HEALTHCARE CONSULTING, INC.
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PERSPECTIVES

When you review this month's edition of *Perspectives*, you will note that the only new requirement announced this month is a reminder that the new Emergency Management chapter standards take effect July 1st. The *Perspectives* lead article briefly describes the achievements of colleagues in the industry that were recognized by TJC and NQF for their accomplishments. You can read this at your leisure and there may be some initiatives described that you wish to consider for your own organization.

Perspectives also mentions the anticipated arrival of the new ORYX direct data submission program, along with training materials becoming available over the next few months. Details are not yet available, but are reported to be coming in an upcoming edition of *Perspectives*.

Suicide Safety Performance Improvement:
As usual, the *Consistent Interpretation* column sheds new light on TJC's thought process in scoring an existing standard, this month they focus on NPSG.15.01.01, EP 7. This is the performance improvement EP for the suicide safety goal.

Usually with performance improvement expectations the organization gets to identify its priorities for what they choose to monitor and measure. Although the EP describes the entire spectrum of implementation requirements, it would not be unusual for an organization to identify only perceived weaknesses and prioritize those for their PI focus.

The guidance/interpretation section in this column identifies that surveyors should score this performance improvement EP noncompliant if the surveyor identifies implementation gaps, and there is missing PI data for that particular aspect of the safety goal.

Since the other EPs describe the general expectations for screening, assessment, mitigation, and actions to be taken for those at risk, and your

own policies then provide the details on how those expectations should be carried out, who should perform those tasks, what skills these staff need to possess and how timely those tasks need to be completed and then documented, this EP creates a much more robust PI expectation.

We would encourage our readers to look at this article and re-review your existing PI measures for the suicide safety goal to determine if they are granular enough to evaluate your policy expectations and if there are sufficient measures being collected, including observational measures, to be sure you are actually compliant with all aspects of the safety goal and your policies.

EC NEWS

Fire Safety Testing:

The lead article in the June issue of EC News is somewhat of a promotion for an upcoming educational program JCR is doing on the EC and LS chapters, but the article is also highly informative. They focus on standard EC.02.03.05, EPs 1-6 and 9-12 and provide detailed guidance on what needs to be done to document the detailed expectations of the tests for all your fire safety devices.

Recently, TJC publications have been providing readers with a listing of the most frequently scored elements of performance and no single EP from this standard made the top ten for hospitals. However, given that this standard has 26 total elements of performance, and given that in the past the standard appeared annually on the top ten standards most frequently scored, this article should be circulated to facilities leadership, analyzed and the guidance implemented.

The article is also a great primer on this standard for clinicians or administrators who may not have a facilities background. Each of the elements of performance in this standard are drawn from more detailed NFPA manuals and the EP task description is sometimes brief or too cryptic to understand the totality of the expectation. This article brings forth depth of understanding and details about each expectation.

Another frequently seen compliance flaw we see is just the ability to bring forth the specific test documentation when asked for it by a surveyor. Fire safety systems can involve water supply, electrical, HVAC, plumbing, fire panels, strobes, alarms, door releases, etc., and often these inspection tests are performed by multiple different vendors, who may be coordinating with multiple different subject matter experts at the organization. This can create a very difficult situation for the organization to quickly gather all the evidence of required testing.

We know from experience that each subject matter expert maintaining their own evidence file doesn't work, nor does one massive chronologic file. The task seems appropriate for automation, but finding the specific document the surveyor is requesting, even with automation is sometimes difficult.

Aggregating the test data from your subject matter experts and contractors into one EP based evidence file or computer database seems to work best. Then, when the surveyor asks for some specific test data, all you have to do is verify with them which EP they are asking about and bring forth that EP's evidence.

Emergency Power Systems:
EC News also has an article targeted to readers in ambulatory and office-based surgery (ASC, OBS) programs on the requirements for emergency power systems including generators and battery-operated lighting.

The focus of the article is to describe issues and elements of performance that are found to be particularly challenging in an ASC or OBS program. These programs frequently have fewer facilities resources than would a hospital, however the pitfalls described are pertinent to the hospital setting also.

Everyone knows that the emergency generator has to be inspected and tested, however the details on how to conduct the inspection and test is where the gaps usually appear. For example, the monthly generator test must be at 30% of the nameplate rating of the generator or reach a specific exhaust gas temperature.

If you are unable to meet the 30% requirement, or minimum exhaust gas temperature, then in addition you must perform an additional test of the generator at 50% of the nameplate rating for 30 minutes, followed by another 60 minutes at 75%.

This same article also describes the requirements for emergency lighting under EC.02.05.07. We had discussed this in the context of the most frequently scored standards in ASCs in our newsletter last month. Unfortunately, we had a typo in our newsletter that we need to correct. EP 1 requires a monthly functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum of 30 seconds. In addition, EP 2 requires a test every 12 months of battery powered lights for egress and exit signs for a minimum of 90 minutes, not the 90 seconds we had stated last month.

Medical Equipment Preventative Maintenance:
This month's EC News has another article discussing how to achieve the required 100% completion rate on preventative maintenance for medical equipment.

The authors describe two medical equipment examples of devices; ventilators and infusion pumps, that may be hard to access due to almost constant use, and hard to find due to the ease of transfer between units.

The author suggests proactive communication between the biomed department and the clinical units using the equipment to try and take it out of use the month prior to its PM due date. This certainly makes sense, but this remains a very challenging task just to find the device and take it out of service. This subject would probably be a good one for discussion at each organization, starting with identification of what your current PM completion rate is for ventilators and infusion pumps.

In addition, you might want to identify the ten (10) pieces of medical equipment with the lowest completion rates to determine if some other device is even more problematic than ventilators and infusion pumps at your organization.

Hospitals often agonize over what to select for their FMEA or intensive analysis every 18 months and this might be a good redesign project if your completion rates are below the CMS required 100% rate.

Interim Life Safety Code Measures:

Lastly, EC News has another article on the requirements for interim life safety code measures, (ILSM) along with one more of their sample policies on this issue.

ILSM basically is the additional things you will do to promote environmental and life safety whenever construction is taking place, or you have self-identified a life safety code defect. In addition, ILSM measures must also be implemented during your survey when TJC identifies a life safety code defect.

The ILSM requirements are detailed in 15 elements of performance for standard LS.01.02.01. The first EP establishes the policy requirement and you want to ensure that your policy covers both construction and any other identified life safety code defects identified by you or others. EPs 2-14 are then possible mitigation strategies you could implement to enhance building safety until the construction ends or the safety code defect is corrected.

You want to verify that at a minimum your policy includes the safety strategies discussed in EPs 2-14, and EP 15 then authorizes the organization to design and implement additional strategies not already described in the earlier EPs.

In addition to having a policy with the enhanced safety strategies discussed in EPs 2-14 and any other strategies you develop locally, there should also be an evaluation process at the organization to determine which strategies make the most sense to implement given the nature of your construction project or life safety code defect.

The draft policy attached to EC News is certainly robust and should be evaluated against your own policy to determine if you should make enhancements to the existing policy.

ASHP

Contrast Shortage:

Your organization has likely been faced with a shortage of IV contrast this past month. The American Society of Health-System Pharmacists has issued a guidance memo providing some insight into potential strategies to utilize the pharmacy's sterile compounding service to optimize use of each vial of contrast.

Contrast is a confusing product in that it is sold as a pharmacy bulk package, a radiology bulk package, and a single dose vial. The pharmacy and radiology bulk packages have FDA approved product labeling that requires use of the contents in 8 hours or less. This FDA product labeling must be adhered to.

The FDA approved product labeling for a single dose vial does not provide general beyond use time once transferred to a syringe but only provides guidance when used in an automated contrast injection system, limiting its use to a 4-hour period.

Since the FDA has not specified a beyond use time for syringe transfers, hospitals may defer to USP Chapter 797 guidance for repackaging into a syringe in a pharmacy hood and clean room, a medium risk compounding situation under 2008 USP 797 guidelines which would permit up to 30 hours at controlled room temperature and nine (9) days if stored in a refrigerator.

Implementation of this interpretation for beyond use dating may appear to pose regulatory compliance risk, however the Joint Commission has posted an FAQ stating that the ASHP position is essentially consistent with their standards.

The ASHP guidance document can be downloaded from: https://www.ashp.org/-/media/assets/drug-shortages/docs/considerations-imaging-contrast-shortage-mgmt.pdf

The ASHP statement provides very useful conservation strategies for the limited amount of contrast that hospitals can acquire. The American College of Radiology has also issued a memo, discussing alternative strategies to performing a procedure with IV contrast. This memo can be accessed from: https://www.acr.org/Advocacy-and-Economics/ACR-Position-Statements/Contrast-Media-Shortage

CMS

Covid Vaccination Medical Exemptions:
We heard updated information from Joint Commission this past month; that based on their continuing dialogue with CMS, that CMS does indeed expect organizations that may have approved medial exemptions for Covid vaccination prior to the publication of the interim final rule, to have all the required data elements present.

TJC has developed a new FAQ in the leadership chapter addressing this point. It is therefore possible that if you did not initially obtain all the required data elements when you first granted an individual a medical exemption, that you may have to reconnect with that worker.

Details about the documentation requirement were published by CMS in QSO 22-11, April 5, 2022. Different programs or provider types had different appendices and the hospital program was appendix D. This document stated the following relative to documentation of medical exemptions:

> *"Medical exemption documentation must specify which authorized or licensed COVID-19 vaccine is clinically contraindicated for the staff member and the recognized clinical reasons for the contraindication. The documentation must also include a statement recommending that the staff member be exempted from the hospital's COVID-19 vaccination requirements based on the medical contraindications.*
>
> *A staff member who requests a medical exemption from vaccination must provide documentation signed and dated by a licensed practitioner acting within their respective scope of practice and in accordance with all applicable State and local laws. The individual who signs the exemption documentation cannot be the same individual requesting the exemption."*

Emergency Management Exemptions:
CMS also updated its guidance on emergency management exemptions due to the public health emergency. This memo is QSO-20-41, originally posted 6/21/21 and now updated 5/26/22. Basically, if your organization has been operating, and continues to operate under your activated emergency management plan, then your organization is exempt from your next full-scale exercise.

This exemption would also apply if you deactivated your plan in 2021, but reactivated it due to a surge in Covid cases in 2022 and you were operating under your activated plan when your 2022 full scale exercise became due. This exemption does not apply to your exercise of choice.

The revised CMS memo has updated their rather complex timeline scenarios for inpatient and outpatient providers to try and provide guidance to the industry on who is eligible for this exemption based on your provider type and your own organization's timeline. We have to warn you though that these timelines may appear confusing, causing you to read and re-read the memo several times.

It may seem irreverent, but if you are in doubt, it may take less time to design, perform, and critique an emergency management exercise, than it would to labor over this revised memo trying to determine if you are eligible for an exemption.

If you are eligible for this exemption don't forget that both CMS and TJC would expect you to evaluate your activated plan and response to the actual public health emergency, just as you would if you had conducted an exercise.

Reporting Covid Statistics:

On May 27, 2022, CMS made what most of our readers will consider a minor change to its memo, QSO 21-03 originally published 10/6/2020 on reporting Covid statistics. If you work in a psychiatric or rehabilitation hospital you will consider this to be a much more significant update.

The daily statistics that hospitals complete relative to Covid cases and utilization of beds and services is being changed for psychiatric and rehabilitation hospitals to a once-a-year snapshot, reporting only statistics for one prior week. The existing daily reporting requirements for acute hospitals and CAHs has not changed.

CONSULTANT CORNER

Dear Readers,

Accreditation, Compliance, and Patient Safety. That is what we at Patton are here to help you achieve.

Whether you are Getting Ready, Staying Ready, or responding to an adverse event, we are here for you!

Please contact one of us below, reach out through our submission form, or call us at (888) PHC-INC1.

We look forward to helping you!

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