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TJC PERSPECTIVES

Language Updates:
The March issue of *Perspectives* provides a link to the TJC Prepublication webpage for another round of tweaks to the standards to align TJC language with the appropriate CMS references and language. In general, you have already been evaluated on these requirements as they are existing standards, however when refinements occur it is always a good practice to double check your policies, practices, and the actual CMS regulatory language to verify you are fully compliant with any nuances in their terminology.

"Corporal Punishment"
For example, one of the restraint and seclusion prohibitions has been redefined to include a prohibition on using restraint as a means of "corporal punishment." Previously the EP required a prohibition on use of restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation. Some might view the term discipline and corporal punishment as similar, but in fact they are different in that corporal punishment inflicts some degree of suffering, whereas discipline can be more of a teaching tool. It is quite likely that your policies may not have ever considered or included the term "corporal punishment," and it would be wise to include that terminology.

"Support Person"
There are also refinements to the standards for visitation rights to include the term "support person" as well as guidance to not discriminate by limiting, restricting, or otherwise denying visitation rights. There is a new note added to RI.01.05.01, EP 1 relative to advance directives, which must be in accordance with 3 sections of 42 CFR.489. If you look in your CMS State

Operations Manual (SOM) for hospitals, you will find the content requirements under tag A-0132.

So, look and verify you have the right language in your policy, but this should not require any significant new programs or services to be developed. The standard changes become effective on July 1, 2024.

History & Physicals:
This month the *Consistent Interpretation* column discusses PC.01.02.03, EPs 4 and 5 relative to medical histories and physicals. EP 4 requires the H+P be performed 30 days prior to, or within 24 of an inpatient admission, whereas EP 5 requires an update if the H+P was performed within 30 days prior to admission or an outpatient surgical or procedural service.

The noncompliance rates for these two elements of performance are 10% and 6% respectively in 2022.

Those rates are slightly lower than we might have anticipated because we often see gaps in completion within the 24-hour period and confusion about the update requirement, where some staff mistakenly believe an H+P performed on an outpatient within the 24 hours of their outpatient surgery does not require an update. In actuality, the update is still required after the patient arrives at the hospital on the day of their planned procedure, regardless that the H+P was performed less than 24 hours ago in the physician's office.

The Guidance/Interpretation section has information on nuances of scoring H+P-related deficiencies against other standards but there are two "keepers" or nuggets that we often receive questions about that you may want to keep on file.

The first issue deals with using the prenatal record as an acceptable H+P which can be done and TJC links you to one of their standards FAQs on how to do that, providing you update the prenatal record with the patient's condition at the time of admission. This FAQ is in the Provision of Care Chapter of the FAQ online library, but use the link in Perspectives to make it easier to find.

The second "keeper" is under the Guidance for EP 5, and it describes that another H+P is not needed for an inpatient who has a surgical procedure several days after admission as an inpatient, providing there was an H+P done within 24 hours of admission; the daily progress notes then serve as the required updates.

TJC EC NEWS

Preventative Maintenance Inspections:
This month's edition of *EC News* has a great article on level-loading preventative maintenance inspections by rebalancing the schedule. The article points out that without planning and rebalancing you will have some months with relatively few preventative maintenance (PM) inspections due and other months with an impossible number of inspections due.

In addition, you may have more limited staffing in summer months due to vacations, so ideally the number of PM inspections due should be less in those months. With planning and rebalancing you can reduce the number of PM inspections due during those summer months to arrive at a more achievable workload. While you can't delay inspections to help rebalance, to some extent you can advance dates to help rebalance workload.

The author also points out that if you look for equipment that every department has at the same time, your biomed staff will be returning to the same units over and over all year long. As an alternative they suggest looking at all the medical equipment stored on unit X at one

time, so you don't have to keep going back. As the requirement is to achieve 100% of PM inspections due on time, rebalancing can potentially help you to achieve that goal. Conversely not rebalancing may be planning to fail if the workload is not achievable.

Readers will want to share this article with your biomedical department.

ICRA, PCRA, Life Safety Inspections and ILSM:
This month's *EC News* has great refresher on the risk assessments that must be done prior to renovations or construction. Large medical centers that do lots of construction are more familiar with these acronyms for required risk assessments, but we commonly see newer and smaller organizations being surprised by the failure to do one or more of these mandatory planning activities prior to construction or renovations.

The infection control risk assessment or ICRA helps to identify the potential contamination that might take place during the project due to dust, debris, ventilation, or a lack of control of the worksite. Additionally, the ICRA should include preventative actions, for example negative air pressure in the job site or protective barriers, that are intended to reduce the risk of contamination, as well as periodic inspections of the job site.

The American Society for Healthcare Engineering (ASHE) has one of the most widely used ICRA tools available for free download: ASHE ICRA 2.0™ Tool and Permit.

The life safety risk assessment helps to identify potential fire hazards that may arise due to the construction and changes to evacuation routing that might be needed to go around the construction site. As potential fire safety hazards are identified, there comes a need for yet one more evaluation tool called interim life safety measures, also known as ILSM.

ILSM activities are designed to mitigate fire safety hazards that might develop due to construction. Standard LS.01.02.01, EPs 1 and 2 outline when interim life safety code measures need to be implemented and basically this is:

1. Whenever you are going to do construction or renovation that could affect fire safety.
2. Whenever you self-identify a defect in the building that cannot be immediately corrected.

We see this second rationale for implementing ILSM coming up very frequently on survey, when surveyors identify life safety code defects that must be fixed, such as penetrations that were not fire-stopped appropriately. Surveyors will require you to come up with an immediate ILSM plan to mitigate the fire hazard from that defect until such time as the defect can be corrected.

EPs 3-15 of LS.01.02.01 then describes measures you can implement that might help mitigate the fire safety hazard. Some of these can be quite simple such as providing additional firefighting equipment in the area (EP 6), or additional firefighting training (EP 10). These elements of performance basically provide a road map of potential mitigation activities.

The number one problem we have seen for many years is just the failure to even consider implementing any ILSM activities from construction, renovation, or self-identified life safety code defects. The corresponding number one reason for not implementing any ILSM activities is often verbalized as "we thought the defect or renovation project was so minor we assumed we did not have to do anything." In reality, every renovation and

every life safety code defect must be analyzed no matter how minor, and only after the analysis can you reach a conclusion about the need for ILSM.

The next type of pre-construction risk assessment discussed in the EC News article is a pre-construction risk assessment or PCRA. Conceptually it is similar to an ICRA, but more expansive in that it examines more than just infection hazards. For example, if the project is going to require any jack hammering or the use of odorous chemicals, if yes, the noise, vibration and smell would be very distracting to both staff and patients in any adjacent clinical areas, then a mitigation plan must be implemented. Here you might want to search the web to see some of the tools that others have developed.

Some experts embed infection prevention issues inside of a larger PCRA and others use the ICRA as the key tool and embed PCRA related issues in the ICRA. The ASHE ICRA tool already does address noise and vibration. One reason in favor of using two tools is just to avoid a survey nervousness-induced mistake as the surveyor asks to see your ICRA and PCRA for a specific project. Sometimes people will get nervous and not realize you have incorporated PCRA criteria into a larger ICRA and instead inform the surveyor "we only have the ICRA, we don't have a PCRA."

Keeping things simple by using two forms with two different titles can sometimes prevent inadvertent admissions of guilt. As you know surveyors commonly reference the admission of guilt in the body of their finding with a statement such as: "the lack of a PCRA was confirmed by the Director/Administrator."

We encourage readers to share this *EC News* article with their facilities team and to verify you have up to date policies for ICRA, PCRA and ILSM as well as forms and documentation for each project that validate the assessments were performed and the verification of compliance with planned mitigation strategies has been affirmed.

One practice we see some organizations do is to post their ICRA/PCRA at the jobsite. Then administrators on rounds, adjacent clinicians or others can easily see that the evaluations were performed and validate that the mitigation strategies are in place and effective. If you see dust coming into the nearby hallway or a plastic barrier that is billowing into the hallway instead of being drawn into the construction site, those on rounds can more effectively critique implementation of the measure and question who has been inspecting this project and why is it not in control at this time.

TJC EM LEADER

New Publication:
In February, TJC separated off their emergency management content out of *EC News* into a new publication called *Emergency Management Leader*. A copy of the first issue was sent to all current subscribers of *EC News*. There definitely is some very good content in the newsletter that can help to make your emergency management program better. At present, emergency management seems to have a limited focus and limited impact on the overall accreditation survey, but the subject however is important so everyone will likely want to subscribe to the new publication for at least your EM lead organizer.

Success After a Flood:
There is a case study in the February edition on a disaster that occurred at the Grady Hospital in Atlanta when a 24-inch water pipe broke above the 6th floor of

the hospital, allowing 100,000 gallons of water to cascade through the building before the water pipe could be completely shut off. Basically 6 floors of the hospital were destroyed requiring relocation of 185 patients.

From the perspective of EM planning, the case study shows how one scenario can branch out into additional disasters and extended duration. In this case the water leak led to a prolonged power outage in addition to the water damage. Then Covid-19 began, and the hospital had lost a significant portion of its inpatient capacity. Then their city was hit by two major episodes of civil unrest and two nearby hospitals closed, taking away another 700 inpatient beds.

If you were designing a drill scenario it would take quite an imagination to even come close to this case study, but it certainly points out the value of planning for such disasters.

EM Survey Session Preparation:
There is also a survey preparation article to help readers prepare for an accreditation survey EM session, providing a checklist of materials, documents, and session content issues to be ready to discuss that your EM program lead will find valuable. One tip they advise is to review your documents and make sure the current dates and content are correct. We would add due to the ability to "borrow" such documents posted to the internet, also be sure to review the name of the organization and departments mentioned in the document are correct to your organization.

Cybersecurity:
Lastly, the first issue contains a very timely drill scenario for a cyberattack exercise. As these are becoming an increasingly frequent problem it might be worthwhile to make this one of your 2024 exercises.

ACHC

Informed Consent:
The Accreditation Commission for Health Care (ACHC) has a blog and we noticed that back in August 2023 they did a post on *Unraveling the Mysteries of Informed Consent*. This is an issue that we see CMS scoring with significant frequency and one which we have been having internal discussions with our own consultants to ensure a thorough approach. The format ACHC took to develop their guidance is question and answer.

For example, when is consent needed, who can obtain consent, where should the discussion take place, what must be on the form, what should be in the hospital policy, and who is legally permitted to sign the consent.

CIHQ

Competency Expectations:

In February, the Center for Improvement in Healthcare Quality (CIHQ) posted a blog on the competency expectations from the new USP Chapter 797. While there are many things that are new as a result of the new USP Chapter, the competency session has multiple and substantial changes to the competency requirements as compared to the earlier edition of Chapter 797 that is worth taking a look at. To read the blog, go to the CIHQ Blog Archive page, scroll down to the Medication Management section, and click on "USP-797 Revisions Focusing on Staff Competency."

CMS

Texting Orders:

There was one new QSO memo published in the prior month, QSO-24-05, dated February 8, 2024. This memo addressed the issue of texting of orders, which had previously been prohibited.

CMS states that Computerized Provider Order Entry (CPOE) is still the preferred method of entering patient orders, but in recognition of the improvements in encryption and interface capabilities of texting platforms to transfer data into the EMR, texting orders is permitted, "If accomplished through a HIPAA compliant, secure texting platform and is in compliance with the conditions of participation."

We noticed that Joint Commission has posted an FAQ to its website, basically stating they are reviewing this change to determine if their process should also change. So, if you are Joint Commission accredited, don't jump on this too soon.

Federal Register Proposed Rules:

On February 15th, CMS posted proposed rule changes for accrediting organizations, *Medicare Program; Strengthening Oversight of Accrediting Organizations (AOs) and Preventing AO Conflict of Interest, and Related Provisions*. Many of the proposed changes were also proposed and withdrawn several years ago.

As proposed rules, you will probably want to do a close read on the suggested changes and work with your State Hospital Association or AHA in submitting comments to

CMS during the 60-day comment period. Some of the proposed changes include:

- Limitations on fee-based consulting provided by an accreditor if the reason for consulting is based on a complaint about care
- Separation of staff between consulting and accreditation teams
- Incorporating the precise CMS COP language into standards rather than similar explanatory language
- Limitations on daily briefings provided by surveyors which may detract from survey time
- No time limits on complaint-based surveys as most complaint surveys at present are one surveyor for one day
- More surveyor time on site and visiting off campus locations
- Public reporting of survey findings
- All accrediting organizations need to obtain psychiatric hospital deemed status

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