Survey readiness

Executive Briefings: Most challenging standards are familiar and preventable

Maintaining a safe physical environment and taming infection control related to medical devices, equipment and supplies dominated the most challenging standards for hospitals surveyed by The Joint Commission (TJC) in the first half of 2016.

While seven out of 10 of the most challenging standards were oft-cited Environment of Care and Life Safety problems, a surprise Provision of Care standard rooted in when and how tests and medicines were ordered and by whom stood out as a concern at 46% of the hospitals surveyed.

(see Executive briefings, p. 5)

Life safety

Nov. 1 is here: 5 things to remember about the 2012 NFPA Life Safety codes

Barring a last-minute change by CMS or The Joint Commission (TJC), surveyors showing up at your hospital as of Nov. 1 will be looking for fire safety problems under the 2012 editions of the NFPA 101 Life Safety Code and NFPA 99 Health Care Facilities Code.

There were several exceptions to both codes in the final rule CMS published in May finally adopting the codes, but the changes largely are not new to hospital compliance leaders and

(see NFPA, p. 8)

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Cut it out: EHR’s copy/paste functions can lead to legal investigations

Think twice before allowing users to rely on your electronic health record’s (EHR) handy copy and paste tools. The features can put you in hot water, not only with surveyors, but legally as well.

While The Joint Commission (TJC) issued a Sentinel Event alert last year that included information about the dangers of copy-and-paste functions with EHRs, it did not specifically recommend prohibiting the practice and there is no standard against it (IJC 9/21/15). However, the integrity and accuracy of medical records continues to be among top challenges for hospitals (see article, p. 1).

The practice has drawn concern from many organizations, including the Plymouth Meeting, Pa.-based patient safety organization ECRI Institute, which recently created a “Toolkit on the safe use of copy and paste,” and CMS, which included a discussion of the practice in an overview of program integrity issues for EHR providers.

With such concerns, hospitals can be certain that surveyors will be on the lookout for problems. And now, hospitals can add possible legal woes to those worries.

The Department of Justice (DOJ) recently released information about a $21.5 million settlement the agency reached with the house call agency MD2U Holding Co. and its affiliates over allegations that the company violated the False Claims Act. Among other compliance problems, the DOJ alleged that the company used the copy-and-paste function of its EHRs to submit false Medicare bills to the government.

Unintentional errors widespread, too

While the government alleged that MD2U’s actions were intended to commit fraud, errors with the copy, cut and paste tools are widespread. When improperly or sloppily used, the tools can trip up even the most innocent provider. “It can misrepresent the services performed and create a false record,” explains attorney Robert Markette with Hall Render Killian Heath & Lyman in Indianapolis.

The problem is exacerbated when clinicians aren’t familiar with an EHR system, which means they’re more prone to making mistakes or using shortcuts while they get up to speed on the system.

One common problem is narratives that are general and similar in more than one record. “CMS will look at that. Services that don’t look unique for each patient provide no evidence that the services were actually performed,” warns attorney Mark Faccenda with Norton Rose Fulbright in Washington, D.C. He knows of audits where the similarity of records has been used by recovery auditors (RACs) or zone program integrity contractors (ZPICs) to deny claims on the ground that they were not a true reflection of the services performed.

Such similarities are also certain to draw the attention of surveyors, compliance consultants have said.
Watch for common copy/paste errors

Common copy-and-paste issues to look for include:

- **Boilerplate records that overlap,** either page after page, over time or from one patient to another. For instance, a patient's blood pressure should not be identical each time it's taken, Faccenda points out.

- **Gender confusion in records.** For example, if every patient is referred to as 'he' in chart notes, it might be because the doctor copied a part of a note from one record and used it as a template in all of his notes.

- **Repeated typographical and spacing errors.** That can indicate copying and pasting.

- **Inconsistencies in the record,** such as complaint of stomach ache with a detailed examination of the upper extremities.

- **Overall higher reimbursement with electronic records** when compared with paper records.

  Poor copy-and-paste habits can cause more than improper billing or compliance headaches. They can create malpractice allegations and HIPAA violations, says Markette. For example, if a provider copies and pastes overly long sections of a record, an important item, such as a lab test result, can be buried and missed.

  Pasting into the wrong patient's record not only corrupts that record and could impact patient care, but also it creates a potential breach of the other patient's privacy.

  “EHRs have benefits. They provide efficiencies, can work in real time and help in auditing with time stamps. But they are not magical. You need to police [their use],” warns Markette. — *Marla Durben Hirsch (ijc_editors@decisionhealth.com)*

Compliance

**Review policies with staff in wake of EEOC anti-retaliation focus**

Review hospital employment and disciplinary policies with staff, including supervisors, now that the Equal Employment Opportunity Commission (EEOC) has updated its guidance regarding retaliation against an employee's anti-discrimination activities.

The federal government prohibits discrimination based on race, national origin, color, sex, religion, disability, genetic information, including family medical history, or age (40 or older). The EEOC is the agency charged with enforcing the workplace anti-discrimination laws, such as Title VII of the Civil Rights Act, the Equal Pay Act, the Americans with Disabilities Act and the Age Discrimination in Employment Act.

Retaliation against an employee is the most frequently alleged basis of discrimination that the EEOC deals with and is found in about half of all discrimination rulings in recent years.

New guidance seeks to clarify

The new guidance, which updates the EEOC’s guidance from 1998 and is effective immediately, clarifies that employers cannot take a “material adverse action” against an employee who engages in “protected activity,” which includes:

- Communicating with a supervisor regarding employment discrimination.
- Resisting sexual advances or intervening to protect others.
- Requesting reasonable accommodations for disability or religion.
- Complaining to management about an EEOC-related compensation dispute.
- Talking to coworkers to gather information in support of an EEOC claim.
- Participating in the EEOC process, say by filing a claim or serving as a witness for someone who has filed a claim.

A material adverse action includes demotion, discipline or termination of employment and actions such as threatening to reassign an employee, workplace surveillance and making disparaging remarks about the employee or a family member of the employee in the media.

Resources

Steps to prevent problems

In light of the increased emphasis against discrimination in general and in the workplace as well as the issuance of the new guidance, employers should expect more awareness of the issue and that missteps on an employer's part will trigger retaliation claims.

The EEOC has provided practical advice to employers that it identifies as helpful to minimize the likelihood of retaliation violations. Suggested policy, training and organizational changes include:

- **Employers should maintain a written, plain-language anti-retaliation policy** and provide practical guidance on the employer's expectations, with user-friendly examples of what to do and not to do. The policies and procedures should have a reporting mechanism for employee concerns about retaliation, including access to a process for informal resolution, and a clear explanation that supervisors who retaliate against employees can be subject to discipline, up to and including termination.

- **Employers should train all managers, supervisors and employees** on the employer's written anti-retaliation policy, and send a message from top management that retaliation will not be tolerated. Offer explicit instruction on alternative, proactive, EEOC-compliant ways these situations should be handled. In particular, managers and supervisors may benefit from scenarios and advice for ensuring that discipline and performance evaluations of employees are motivated by legitimate, non-retaliatory reasons.

- **Managers and supervisors alleged to have engaged in discrimination** should receive guidance on how to handle personal feelings about the allegations when carrying out management duties or interacting in the workplace. Emphasize that those accused of EEOC violations, and in particular managers and supervisors, should not act on feelings of revenge or retribution, but also acknowledge that those emotions may occur.

- **Employers may wish to check in with employees, managers and witnesses** during a pending EEOC matter to inquire whether concerns regarding potential or perceived retaliation exist. That may help the employer spot issues before they fester and reassure employees and witnesses of the employer's commitment to protect them from retaliation.

- **Employers may require decision-makers to identify their reasons for taking consequential employment actions and ensure that necessary documentation supports the decision. Employers may examine performance assessments to ensure they have a sound factual basis and are free from unlawful motivations and emphasize consistency to managers. Have a third person, such as a human resources manager, review proposed employment actions of consequence to ensure they are based on legitimate non-discriminatory, non-retaliatory reasons.**

Where retaliation is discovered, identify and implement process changes. Review available data or other resources to determine whether particular organizational components have compliance deficiencies, then identify causes and implement responsive training, oversight or other changes to address the identified weaknesses.

Resources

- Questions and answers about the guidance: [https://www.eeoc.gov/laws/guidance/retaliation-qa.cfm](https://www.eeoc.gov/laws/guidance/retaliation-qa.cfm)

Ask the expert

It was here just a manual ago… missing a standard? Contact SIG

**Question:** Where did my standard go?

**Answer:** So you say you're updating your policies and documents as you get ready for survey, then you go to check The Joint Commission (TJC) standard and … it's not there?

Is the requirement gone? Or just somewhere else?

Don't worry — TJC can help, assured Michelle Johnson, associate director of the division of health care improvement under TJC's Standards Interpretations Group (SIG), during the Sept. 7 New York session of the commission's annual Executive Briefing.

The commission is deleting dozens of elements of performance (EPs) as it goes through each hospital standard chapter looking for requirements that are outdated or redundant to other standards, noted Michelle Johnson, associate director of the division of health care improvement under TJC’s Standards Interpretations Group (SIG).

But beware — while an EP may have been deleted, the requirement may still exist elsewhere in the manual.
So if you looking for a standard and can’t find it, contact the SIG, she advised. The group will let you know whether it was eliminated because it was duplicative of another standard or deleted all together, and why, she said.

For information on how to contact SIG, go to https://www.jointcommission.org/standards_information/jcfaq.aspx. — A.J. Plunkett (aplunkett@decisionhealth.com)

Executive briefings
(continued from p. 1)

Meanwhile, the Record of Care standard requiring complete and accurate medical records dropped to the bottom of the list, according to information released at the Sept. 7 Executive Briefings session held in New York.

While citations at hospitals ranged from problems with maintaining proper ventilation and humidity to crowded corridors and propped-open fire doors, hospitals also were scored for not following manufacturer’s instructions for sterilization and high-level disinfection (HLD) and improper storage of medical scopes.

The IC standard on medical devices and equipment was second on the top-challenges list, but two of the standard’s EPs stand as the main driver behind most determinations for immediate threat to life, noted Lisa Waldowski, TJC’s infection control specialist.

Recognize these challenges?

Review these problems behind the 10 most challenging standards to see whether you recognize similar concerns at your hospital:

1. Maintaining a safe and functional environment: Staying in the No. 1 spot, this EC standard confounds almost two-thirds of hospitals facing survey year to year. TJC’s Engineering Director George Mills called this the “wild card,” and it is generally acknowledged by consultants and other experts as a catch-all standard that a surveyor will cite for safety concerns not specifically addressed elsewhere.

Under EP 1, which requires hospitals to provide an interior space that meets the needs of the patients and that is safe and suitable to medical care, surveyors identified problems with unsecured oxygen cylinders, improperly segregated cylinders and areas that offer patients opportunity for self-harm.

Under EP 13 of this chapter, surveyors identified problems with the required ventilation or air pressures as well as temperature and humidity levels. Problems included patient complaints about areas being too hot or too cold, humidity that led to mold growth and doors being propped open, which causes improper ventilation and air pressure.

Problems such as those are best identified through regular environmental rounds, said Mills. “The biggest solution to this is walking around,” he advised.

Look for patients with too many blankets, he suggested. That may mean the temperature is askew. Examine windows for condensation. That would point to humidity and mold problems, which might be hidden behind wallpaper nearby, he noted.

2. Reducing the risks of infection connected to medical equipment, devices and supplies: In particular, hospitals are having difficulty keeping up with new instructions, procedures and new supplies related to HLD and sterilization, said Waldowski.

The problem continues to center on the cleaning of medical scopes, Waldowski noted, warning that IC will continue to be a hot topic with TJC and CMS.

Two areas of particular concern are how hospitals perform intermediate- and high-level disinfection of medical equipment devices, which is scored under EP 2, and improper storage of devices — primarily medical scopes — once they have been cleaned.

Problems are cited all along the cleaning process, she said. Among problems cited were:

• Not pre-cleaning devices properly at point of use in the procedure room.
• Not keeping the devices moist when transported from one place to another to keep bio remnants from hardening.
• Not following manufacturer’s instructions for the use of the cleaning products used during pre-cleaning and disinfection and sterilization.
• Not following manufacturer’s instructions for cleaning the devices themselves.
• Improper storage of devices while drying or packaged for storage.

Another problem often found was that the process and products used for cleaning and disinfection could vary from department to department, even if the devices used were the same.

3. Managing utility system risks: This EC standard on utility system risks moves between the second and third most challenging standards year to year, primarily...
because of the infection-control risk associated with improper ventilation and air exchanges. Mills advised hospitals to regularly monitor areas that were required to have positive or negative air pressure but to use the so-called “tissue test” only as a pre-screening tool to identify whether a problem might exist.

Mills warned that citations under EP 15, which requires proper ventilation and air-pressure relationships to control “airborne contaminants,” are considered condition-level deficiencies (CLDs) linked to a Medicare Condition of Participation. CLDs automatically draw the attention of CMS. However, Mills said that if a CLD is found during the Life Safety survey and the organization can repair not just that single problem but show that the entire process that led to non-compliance has been resolved, the surveyor may contact TJC’s central office and discuss reducing the finding down to a standard-level deficiency (SLD).

The fix has to include showing surveyors that the equipment involved has been repaired or adjusted so that the air pressure zone in question is balanced properly and that an ongoing process will make sure it stays in balance, Mills noted.

While the CLD may be reduced, the finding will remain, Mills reminded compliance executives. As a SLD, though, the hospital would have to show only the normal evidence of standard compliance (ESC) in the follow-up survey.

4. Maintaining the means of egress: Most problems identified under the means of egress standard found by surveyors are under EP 13, sometimes referred to as the requirement on “corridor clutter.” This Life Safety requirement has been updated to reflect the adoption of the 2012 version of the NFPA 101 Life Safety Code, including allowing for certain wheeled equipment and fixed furniture in hallways under certain circumstances. The changes have been allowed for hospitals for several years as categorical waivers.

Surveyors called out hospitals for the use of improper locks — including one instance of exit doors found chained — and linen or cleaning carts or wheeled computer stations left too long unused in a corridor.

Mills advised finding ways to make staff understand that the need to keep corridors clear was not just an annoying rule. He recommending pointing out that cluttered corridors also made their jobs harder and even painful if they had to navigate through while pushing a cart or carrying something and kept running into things.

5. Provides and maintains fire extinguishing systems: While Mills did not expound on specific problems found by surveyors during the New York briefing session, problems discussed at follow-up sessions included issues found with automatic sprinkler systems: missing ceiling tiles and blocked fire extinguishers. Those problems, as expected, are the same ones cited year after year. Ensure that sprinkler escutcheon plates are repaired or replaced as needed and continue to remind staff and contractors that piping for the automatic sprinkler systems is not designed to hold extra weight.

6. Providing care and treatment as ordered and prescribed, according to law and regulation: While this Provision of Care standard ranked fifth on the list of top 10 clinical standards for which hospitals sought clarification from TJC’s Standards Interpretation Group (SIG), it clearly confounds compliance officials more than they think. Although sixth on the overall list of most-challenging standards, it is second among clinical standards, behind only infection control, according to TJC officials.

Hospitals were most often cited under EP 1, which requires verbal or written orders from a licensed independent practitioner or other practitioner before providing care, treatment or services to a patient; under EP 7, which requires use of the most recent orders when providing care; and EP 20, which requires verbal orders or test results to be read back to verify information.

Surveyors cited hospitals for incidents in which no order was present before medications were administered, standing orders or protocols were implemented, verbal orders were not read back and active orders were not followed.

Found through patient tracers, the underlying problems were often tracked back to a nurse who knew a particular doctor would always request a certain set of tests or had gotten orders over the phone that were never verified by the physician, said Michelle Johnson, TJC’s associate SIG director.

TJC is seeing an increase in verbal orders that are not entered into the paper or electronic health record (EHR), Johnson observed.

If a physician doesn’t like to use an EHR or has difficulty using it, “get them help,” Johnson said.

7. Sustaining building features that protect from the hazards of fire and smoke: Doors were the primary problem under this LS chapter. Under EP 2 outlining requirements to contain smoke and fire in hazardous areas, a common problem were doors that were to remain
closed and locked found with their latches taped open or otherwise held open or unlocked for easier staff access.

Rather than look for infractions, Mills advised looking at the symptom rather than the staff cure or workaround. For instance, if the dirty utility area is often found to be the problem, talk to staff and find out why. Likely it’s going to be “when I’m carrying stuff it’s hard to get in,” noted Mills. Work out a time window when the door can be held open, such as when bed linens are being changed, he said.

8. Maintaining building features to minimize heat, smoke and fire: Under EP 5 of this LS standard, fire-rated doors must have positive latching hardware and be automatic or self-closing. And that concept is defeated by doors that are propped open.

Again, Mills recommended talking to staff about why the door was kept open and finding a solution. Often these doors are found with a mop-handle lodged between the door and door jamb, which can permanently damage the seal against smoke and fire, or a rubber under-door wedge brought in by housekeeping staff as they are cleaning or restocking a particular area.

Explore establishing a policy that allows door wedges under certain circumstances for short periods of time, Mills suggested. Give teeth to that policy, adding consequences for violations and including who would be in charge of enforcing the policy.

Then police it by making the wedges an official hospital tool, he continued. Put a serial number on each one, assign it to a staff member and hold that person responsible if it’s found left behind or inappropriately used, he said.

9. Hazardous materials and waste management:
Common problems cited year after year under this EC standard concern lead aprons that are improperly labeled or stored and eye-wash stations that are not maintained. While TJC does not require eye-wash stations, OSHA may require them in certain areas. And if a hospital does have eye-wash stations, TJC requires them to be maintained according to whatever evidence-based policy the hospital has established to maintain and test the stations regularly.

10. Complete and accurate medical records kept for each patient: Once at the top of the most-challenging standards list, TJC officials have said that problems with this standard have continued to fall as EHR systems have become more prevalent in hospitals and physicians have become more consistent in using them. However, the most common problems scored are under EP 19, which requires that all entries in the medical record be timed, and EP 11, that entries are dated. In addition, entries are found that are incomplete or illegible, which interferes with continuity of care and can be cited under EP 8, say TJC officials.

Johnson encouraged leaders to engrain in physicians during the onboarding educational process that timing and dating of entries into the medical record is not just a TJC standard, but is also a CMS COP requirement. Both will score it, she warned. She suggested that during education, bring something realistic into it. For instance, discuss what would happen if a chart was pulled into a legal proceeding, and ask “how can you support when this action was taken if it’s not dated and timed?”
As for legibility of an entry, it may not be cited immediately, Johnson said. But if another member of the survey team also cannot read it, it will be scored then.
— A.J. Plunkett (aplunkett@decisionhealth.com)

NFPA

(facilities managers. For a few years now, CMS and TJC have accepted categorical waivers for most of the key changes in the codes to give hospitals time to adapt.

Here are five things to remember when surveyors show up at your door:

• **Surveyors are going to cite only the things they see.** With the new codes and CMS’ insistence on ensuring that fixes are made within the 60 days required by federal regulations, gone are the days when TJC’s process of having a hospital self-identify deficiencies in a Statement of Conditions (SOC) made surveyors lives a little easier. Now it’s strictly, “see it, cite it,” say TJC officials.

But also gone is the automatic six-month extension for repairs outlined in the Plan for Improvement (PFI) that gave your hospital a little shade from quick but expensive fixes. Have a plan for fixes already in motion, including a plan for paying for those fixes if you are denied a time-limited waiver (TLW) based on hardship to make repairs or changes within 60 days.

• **Get your dampers in order.** If you can’t test your facility’s fire dampers now because they are inaccessible, part of your plan needs to include finding a way to access them and ensure they’re able to pass tests if you want to avoid being cited. The elimination of the SOC and PFI process could become a problem for many older hospitals that must be tested every six years. However, TJC has often allowed hospitals to rollover testing of inaccessible dampers survey to survey. No more.

If your hospital’s dampers are inaccessible because of infrastructure changes, you can do a Fire Safety Evaluation System (FSES) assessment and seek an equivalency from the CMS regional office, according to TJC’s Engineering Director George Mills. However, CMS approval of an equivalency is not guaranteed. Mills warns hospitals to “figure out how to get access” moving forward.

• **Have the risk assessment of your wet procedure locations ready.** The NFPA 99 Health Care Facilities Code requires special electrical precautions in operating rooms where wet procedures — think of procedures, such as joint replacements, that require a lot of irrigation — are done. Before now, the NFPA left it up to hospitals to decide which rooms or areas to designate as wet procedure locations.

Under the 2012 edition, all operating rooms are defined as wet procedure locations unless the facility has done a risk assessment to show otherwise, notes Jonathan Hart, senior fire protection engineer with the NFPA.

If you have not done a risk assessment, the special — and often expensive — electrical precautions required to keep patients and staff safe must be in place or the operating rooms will be shut down. The cheapest option is the risk assessment, say experts. The best risk assessment involves a multidisciplinary team.

• **Be ready to provide documents at the start of survey.** TJC has a list of required Environment of Care and Life Safety documentation. Review it and get those documents ready because you won’t have a second chance. Noting that the NFPA requires hospitals to have documentation ready to show inspectors at any given time, Mills said during the recent Executive Briefings that hospitals will not be allowed to provide required documents after the start of survey.

• **Other codes may be involved.** Remember that it’s not just the two fire codes named in the final rule that are now in effect. It’s also all the codes or standards those 2012 editions also reference, notes Dean Samet, regulatory compliance officer for TSIG Consulting in Springfield, Mo. Chapter 2 of the 2012 LSC is now “Referenced Publications” but was previously called “Mandatory References” in the 2000 version, Samet notes. “You should still think of them as mandatory,” he advises. And there’s also the possibility that your local authority having jurisdiction uses different codes all together. Check with your facilities’ manager on what’s current.
— A.J. Plunkett (aplunkett@decisionhealth.com)

Resources:

- CMS final rule on life safety requirements: [www.tinyurl.com/CMS-finalrule-2016-fire-safety](http://www.tinyurl.com/CMS-finalrule-2016-fire-safety)
- TJC list of required EC and LS documentation: [www.jointcommission.org/assets/1/6/LS_EC_Tool_3-25-16.pdf](http://www.jointcommission.org/assets/1/6/LS_EC_Tool_3-25-16.pdf)
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