Compliance

Set a clear policy and reinforce training with staff on expectations for visitors

Balancing the rights of patients to have visitors with the ability of the staff to do their jobs can be tricky. So having a clear policy on what a visitor can and cannot do is crucial.

Ensure your visitor's policy also includes how staff will be trained to implement these policies, reminds Kurt Patton, founder of Patton Healthcare Consulting and a technical adviser to Inside the Joint Commission.

(see Visitor expectations, p. 6)

Emergency management

Don’t forget the children when planning how your hospital will respond in a disaster

Appoint a pediatrics representative to participate in disaster planning and include children's gathering places in community health needs assessments to ensure your facility's Emergency Operations Plan properly addresses its youngest potential patients.

In addition to their dependence on adults, children are particularly vulnerable in disaster situations because of special physiological circumstances such as highly permeable skin, faster respiration and a closer proximity to the ground, according to a 2015 policy statement from the American Academy of Pediatrics.

(see Children, p. 7)

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Emergency management

Assess how your EOP meets children’s needs against key AAP recommendations

Does your Emergency Operations Plan (EOP) include being prepared to handle children who arrive at your hospital either as patients or with adults who are patients?

The Joint Commission’s Emergency Management standard EM.02.02.11 requires hospitals as part of its EOP to prepare for how it will manage patients during emergencies. Under EP 4, the requirement includes managing a potential increase for “clinical services for vulnerable populations,” including pediatric, geriatric and disabled patients.

Assess your EOP against this checklist, taken from key recommendations by the American Academy of Pediatrics’ report, “Ensuring the Health of Children in Disasters,” published in November 2015. (For story, see p. 1.)

Does your EOP:

☐ Address the unique physical, mental, behavioral, developmental, communication, therapeutic and social needs of all children?

☐ Do pediatricians or other representatives with expertise in pediatric health care and planning participate in your disaster planning, response, and recovery efforts as subject matter experts?

☐ Does your EOP including inpatient, outpatient, and emergency services facilities in operational preparedness and resiliency planning, in order to continue providing care for children during and after disasters?

☐ Does your EOP identify the equipment, medications and supplies children will need during a disaster? And is it on parity with similar adult needs?

☐ Do your disaster exercises and drills include children as both victims and responders “as appropriate to their age, development, and capability.”

☐ Does your mass casualty triage plan effectively address children’s unique physiology and development?

☐ Does your EOP encourage pediatricians (and presumably others) “to recognize and attend to their own needs in disasters and take steps to avoid burnout and compassion fatigue?”

In recommending that children be included as mock victims in disaster drills or exercises, the report’s authors note that families with children or adolescents who have special health care needs or limited English proficiency or communication skills can enhance preparedness. They also recommend reaching out to local initiatives such as Teen Community Emergency Response Teams (Teen CERT) and FEMA Youth Preparedness Councils to find youths who can also participate in exercises, as either mock victims or responders themselves.
The authors also note that critical to the care of children with special needs will be information about the children and their unique requirements. The academy has developed an “Emergency Information Form” designed to gather the most critical information. A blank form can be found at www2.aap.org/advocacy/blankform.pdf.

To read all the recommendations as well as the AAP’s full report, go to http://pediatrics.aappublications.org/content/pediatrics/early/2015/10/13/peds.2015-3112.full.pdf. — A.J. Plunkett (aplunkett@decisionhealth.com)

Cybersecurity

Can ransomware affect hospital accreditation? Yes, check this standard

The recent high-profile computer hacker intrusions into hospital computer systems may also mean increased scrutiny from The Joint Commission (TJC).

Hospitals encounter a host of problems if they become a target of a ransomware attack, when hackers shut down all or part of a medical or patient record system and demand payment before returning control to the facility. Such attacks also will likely put a particular hospital on TJC’s radar, especially since these incidents sometimes receive extensive media attention (IJC 2/22/16).

“In some sense, nothing is new. The Joint Commission has had a standard that requires hospitals to maintain the security and integrity of health information for several years. But as always as an actual real-life issue arises in the public domain, it brings new attention to the topic,” says John Rosing, executive vice president at Patton Healthcare Consulting, based in Glendale, Ariz.

The TJC standards applicable to ransomware involve not only emergency management but also the electronic or paper medical record including Information Management standards Im 02.01.03 (protecting health information privacy) and Im 01.01.03 (planning for the continuity of IM processes), says Rosing. “Additionally computer systems are part of your utility program,” he points out.

To address these standards, hospitals should:

- **Identify and inventory systems.** This includes not only your electronic health record system and other devices or equipment that contain patient information, but other systems, such as the computer that runs your HVAC system. Ransomware can infect any type of computer.
- **Evaluate the security of these systems.** Conduct a risk assessment. If risks are identified, put in plans to prevent or mitigate a computer disruption or failure.
- **Prioritize the systems.** Determine which ones if they failed would bring the hospital to its knees versus being a minor inconvenience, says Rosing.
- **Ensure that there is proper security and redundancies, starting with the priority systems.** This includes security of the building where the systems are located.
- **Make sure the hospital has a backup plan if the systems are hit by ransomware.** For instance, what would the downtime procedures be, how would the hospital revert to paper records, and when would patients need to be transferred or evacuated because services can no longer be provided safely. — Marla Durben Hirsch (ecl_editors@decisionhealth.com)

Compliance

**EC, LS standards remain most challenging, but other EPs are history**

In keeping with a promise made during last fall’s Executive Briefing by The Joint Commission (TJC), the accrediting body has started to delete elements of performance to rid the hospital manual of repetitive or outdated requirements.

The first batch included 131 EPs. Note, however, that while the EPs may be gone, the requirement may remain. The rationale behind many of the deletions was that the requirement existed in another EP or standard and therefore was unnecessary. The deletions become effective July 1, 2016.

The commission prepublished the list on its website: http://www.jointcommission.org/assets/1/18/Prepub_HAP_EP_Review_v2.pdf.

TJC also announced its top 10 most challenging standards for hospitals surveyed in 2015 and, as might have been predicted, Environment of Care and Life Safety standards dominated the list.

The standards were outlined in TJC’s April issue of Perspectives magazine:

- **EC.02.06.01** (Establish and maintain a safe and functional environment.)

(continued on p. 6)
Work tool

Chart for reviewing hospital training and education requirements, part 3

Use these charts on primary CMS and OSHA training and education requirements to review your hospital’s needs, and make that review ongoing to ensure both clinical and facilities employees are being provided the information they need to keep patients — and themselves — safe.

The number of training and education requirements set by The Joint Commission (TJC), CMS, OSHA and other agencies can be daunting.

Each aspect of training should have a “business owner” from the group most affected by the specific requirement, advises Kurt Patton, a former TJC executive director of accreditation services and founder of Patton Healthcare Consulting, the Glendale, Ariz.-based firm that serves as technical adviser to IJC.

At the same time, the quality department should stand as the content expert that periodically asks “clinical departments and HR [human resources] to enhance training or change documentation,” says Patton. “Someone needs to know that different departments are meeting training requirements. It’s not just meeting deadlines either. Someone has to take a critical view of the content.”

While ideally that is the user department, beware that sometimes those closer to the training can design the easiest and most meaningless training, Patton warns. Having someone outside the department in addition to the “business owner” can counter that tendency.

These charts are the latest generation of lists shared over the years between facilities as well as Inside the Joint Commission, and have been updated against similar information from compliance consultants. (For TJC requirements, see IJC 4/4/16, 3/7/16.) Soon all the charts will be compiled into a single document and posted online, with the link provided for IJC readers.

— A.J. Plunkett (aplunkett@decisionhealth.com)

<table>
<thead>
<tr>
<th>Reference</th>
<th>Standard</th>
<th>Frequency of Training</th>
<th>Employees Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>482.45(a)(5)</td>
<td>(See also TJC requirements: TS.01.01.01) Organ and tissue donation</td>
<td>Initial Yes</td>
<td>All appropriate employees, including all patient care staff.</td>
</tr>
<tr>
<td>482.13(f) / 482.13(e)(11)</td>
<td>Restraint and seclusion</td>
<td>Annual Yes (must demonstrate competency)</td>
<td>All appropriate staff. Physicians must have education on the hospital policy.</td>
</tr>
<tr>
<td>482.13(c)(3)</td>
<td>(See also TJC, PC.01.02.09. EP3) Abuse and neglect</td>
<td>As Needed Yes</td>
<td>All employees.</td>
</tr>
<tr>
<td>482.23(c)(1)</td>
<td>Administration of drugs and biologicals</td>
<td>Initial Yes</td>
<td>Nursing or other personnel authorized to administer drugs/biologicals.</td>
</tr>
<tr>
<td>482.23(c)(3)</td>
<td>Blood transfusion / IV blood administration</td>
<td>Annual Yes</td>
<td>Employees (non-LIP’s) who may administer IV blood transfusions.</td>
</tr>
<tr>
<td>482.28(a)(1)</td>
<td>Food service</td>
<td>Initial Yes</td>
<td>Dietary staff.</td>
</tr>
<tr>
<td>482.13(b)(3)</td>
<td>Advance directives</td>
<td>As Needed Yes</td>
<td>All employees.</td>
</tr>
<tr>
<td>482.42(a)(1)</td>
<td>Infection prevention and control</td>
<td>Initial Yes As Needed Yes</td>
<td>All employees.</td>
</tr>
<tr>
<td>482.13(h)</td>
<td>Patient visitation rights and cultural competency</td>
<td>Initial Yes</td>
<td>Employees who control visitation.</td>
</tr>
<tr>
<td>482.23(b)(5)</td>
<td>(Item 4.A.2 on CMS survey infection control worksheet) Urinary catheter insertion/ maintenance</td>
<td>Initial Yes Annual Yes</td>
<td>Employees responsible for inserting and maintaining urinary catheters.</td>
</tr>
<tr>
<td>482.42</td>
<td>(Item 4.B.1 on CMS IC worksheet) Central venous catheter insertion</td>
<td>Initial Yes Annual Yes</td>
<td>Employees responsible for inserting central venous lines.</td>
</tr>
<tr>
<td>482.42</td>
<td>(Item 4.B.8 on CMS IC worksheet) Central venous catheter access and maintenance</td>
<td>Initial Yes Annual Yes</td>
<td>Employees responsible for accessing and maintaining central venous lines.</td>
</tr>
</tbody>
</table>
## OSHA REGULATORY TRAINING REQUIREMENTS

<table>
<thead>
<tr>
<th>Reference</th>
<th>Standard</th>
<th>Frequency of Training</th>
<th>Employees Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1910.38(a)(5)(i), (ii)(a) through (c) and (iii); (b)(4)(i) and (ii)</td>
<td>Employee emergency plans and fire prevention plans</td>
<td>Initial: YES</td>
<td>All employees.</td>
</tr>
<tr>
<td>1910.95(i)(4); (k)(1) through (3)(i) through (iii)</td>
<td>Hearing protection</td>
<td>Annual: YES</td>
<td>All employees exposed to 8-hr TWA / 85dB(A) or above.</td>
</tr>
<tr>
<td>1910.132(f)(1)(i) through (v); (2)(3)(i) through (iii) and (4)</td>
<td>Personal protective equipment</td>
<td>As Needed: YES</td>
<td>All employees required to wear PPE.</td>
</tr>
<tr>
<td>1910.134(k)(1)(i) through (viii); (2), (3), and (5)(i) through (iii)</td>
<td>Respiratory protection</td>
<td>Initial: YES</td>
<td>All employees required to wear a respirator.</td>
</tr>
<tr>
<td>1910.139(a)(3), (b)(3); (e)(2) through (4) and (5)(i)</td>
<td>Respiratory protection for tuberculosis</td>
<td>Annual: YES</td>
<td>Employees required to wear respiratory protection from TB.</td>
</tr>
<tr>
<td>1910.145©(1)(ii), (2)(ii) and (3)</td>
<td>Accident prevention signs and tags</td>
<td>Initial: YES</td>
<td>All employees.</td>
</tr>
<tr>
<td>29 CFR 1910.146(g)(1) and (2)(i) through (iv)(3) and (4) and (k)(1)(i) through (iv)</td>
<td>Confined spaces</td>
<td>Annual: YES</td>
<td>All employees exposed to permit-required confined spaces.</td>
</tr>
<tr>
<td>1910.147(a)(3)(ii); (4)(i)(d); (7)(i)(a) through (c); (ii)(a) through (f); (iii)(a) through (c)(iv) and (8); (e)(3) / LRHS 112-20-33 Lockout/Tagout Training</td>
<td>Lockout/tagout</td>
<td>Initial: YES</td>
<td>User level: Required to lockout/tagout/awareness level.</td>
</tr>
<tr>
<td>1910.157(g)(1), (2), and (4); 1910.158(e)(2)(ii). 1910.155(c)(41)</td>
<td>Portable fire extinguishers</td>
<td>Annual: YES</td>
<td>All employees.</td>
</tr>
<tr>
<td>1910.160(b)(10)</td>
<td>Fixed extinguishing systems</td>
<td>Initial: YES</td>
<td>All employees working on fixed extinguishing systems.</td>
</tr>
<tr>
<td>1910.164(c)(4)</td>
<td>Fire detection systems</td>
<td>Annual: YES</td>
<td>All employees working on fire detection systems.</td>
</tr>
<tr>
<td>29 CFR 1910.165(d)(5)</td>
<td>Alarm systems</td>
<td>Initial: YES</td>
<td>All employees who will be servicing alarm systems.</td>
</tr>
<tr>
<td>1910.178(1)</td>
<td>Powered industrial trucks, lifts</td>
<td>Annual: YES</td>
<td>All employees operating powered industrial trucks, lifts.</td>
</tr>
<tr>
<td>1910.264(d)(1)(v)</td>
<td>Laundry machinery and operation</td>
<td>Annual: YES</td>
<td>All employees involved in laundry operations.</td>
</tr>
<tr>
<td>1910.1048(n)(1) through (3)(i) and (ii) and (b)(iii) through (viii)</td>
<td>Formaldehyde</td>
<td>Initial: YES</td>
<td>All employees exposed to formaldehyde.</td>
</tr>
<tr>
<td>1910.1030(g)(2)(i); (i)(a) through (b)(iv) through (vi)(vii)(a) through (n);(viii) through (x);(x)(a) through (c).</td>
<td>Bloodborne pathogens</td>
<td>Initial: YES</td>
<td>All employees exposed to bloodborne pathogens.</td>
</tr>
<tr>
<td>1910.1096(f)(3)(viii); (i), (f)(2) through (3)</td>
<td>Ionizing radiation</td>
<td>Initial: YES</td>
<td>All employees working in any part of a radiation area.</td>
</tr>
<tr>
<td>1910.1200(b)(4)(iii); (h)(1), (2)(i) through (iii) and (3)(i) through (iv)</td>
<td>Hazard communication</td>
<td>Initial: YES</td>
<td>All employees.</td>
</tr>
<tr>
<td>1910.1450(f)(1)(2) and (f)(4)(i)(a) through (c) and (iii)</td>
<td>Hazardous chemicals in laboratories</td>
<td>Initial: YES</td>
<td>All laboratory employees.</td>
</tr>
<tr>
<td>OSHA 3148-01R, General Duty Clause</td>
<td>Workplace violence</td>
<td>Initial: YES</td>
<td>All employees.</td>
</tr>
<tr>
<td>29 CFR 1910.1200, OSHA Technical Manual: Sec VI; Chap 2: Occ Exposure to Haz Drugs.</td>
<td>Cytotoxic drugs (antineoplastic drugs)</td>
<td>Initial: YES</td>
<td>All employees with cytotoxic drugs used in their work areas.</td>
</tr>
<tr>
<td>General Duty Clause, OSHA Publication: Safe Use of Glut in Healthcare Facilities; OSHA 3258-08N, 2006</td>
<td>Glutaraldehyde</td>
<td>Initial: YES</td>
<td>All employees exposed to glutaraldehyde.</td>
</tr>
</tbody>
</table>
(continued from p. 3)

- IC.02.02.01 (Reduce the risk of infections with medical equipment, devices and supplies.)
- EC.02.05.01 (Manages utility system risks.)
- LS.02.01.20 (Maintain means of egress.)
- LS.02.01.30 (Provide and maintain building features to protect from fire and smoke.)
- RC.01.01.01 (Complete and accurate medical records.)
- LS.02.01.35 (Provide and maintain fire extinguishing systems.)
- LS.02.01.10 (Building/fire protection features designed and maintained to minimize fire, smoke, and heat.)
- PC.02.01.03 (Care, treatment, and services are ordered or prescribed in accordance with law and regulation.)
- EC.02.02.01 (Management of hazardous materials and waste.) — A.J. Plunkett (aplunkett@decisionhealth.com)

Visitor expectations

(continued from p. 1)

For hospitals that use The Joint Commission (TJC) for deemed status with Medicare and have swing beds, a patient’s rights for having visitors are outlined in Rights and Responsibilities of the Individual RI.01.07.05, while a patient’s responsibilities are under RI.02.01.01.

Expectations in the Conditions of Participation are under §482.13(h): Patient visitation rights. “A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation.”

Find specifics at www.tinyurl.com/CMS-soma. — A.J. Plunkett (aplunkett@decisionhealth.com)

Compliance

Sample policy: Hospital uses COPs to set expectations for visitors

Below is a policy shared by Lisa Betterson, MS, CSHA, director of regulatory & accreditation affairs, with Parkland Health & Hospital System in Dallas, and outlines expectations for visitors as the hospital determined from the COPs.

Visitor conduct

- Tobacco use is not permitted in the hospital or on hospital grounds.
- All weapons are forbidden in the hospital except for on-duty law enforcement personnel.
- Visitors are expected to adhere to visiting hours and restrictions.
- Visitors should be free from recent exposure to communicable disease without fever or visible signs of illness. During times of infectious outbreak in the community (ex. Influenza, measles, mumps, chicken pox, etc.), the hospital has the right to restrict visitation.
- Visitors are required to dress appropriately (ex. shoes must be worn in the hospital at all times).
- Visitors not responding to requests or displaying inappropriate behavior will be referred to the appropriate nursing administrator or local police.

Restriction of visitation hours

Visitation hours can be restricted or limited when visitation interferes with the care of the patient and/or the care of other patients. Health care professionals may exercise their best clinical judgment when determining when visitation is, and is not, appropriate. Best clinical judgment takes into account all aspects of patient health and safety, including the benefits of visitation on a patient’s care as well as potential negative impacts that visitors may have on other patients.

Examples of restriction circumstances:

- There may be infection control issues.
- Interferes with the care of other patients.
- Visitors engaging in disruptive, threatening or violent behavior of any kind.
- Patient roommate needs privacy or rest.
- Patient undergoing care interventions.
- Limitations on the number of visitations for clinical reasons during a specific period of time.
- Minimum age requirements for child visitors; and,
- Prohibit all forms of abuse, neglect and harassment whether from staff, other patients or visitors.

Visitors in isolation are subject to isolation guidelines and the patient’s nurse can provide those specifics.

All visitors under the age of 14 must be accompanied by an adult other than the patient and will not be permitted to stay overnight.
Children

(continued from p. 1)

Even so, the 2013 National Pediatric Readiness Assessment found that only 47% of all U.S. hospitals had written disaster policies that addressed issues specific to the care of children. (Assess your plan against this checklist, p. 2.)

“Hospitals have been doing much better with pediatric readiness overall, but with disaster planning, we seem to be going in the opposite direction,” observes Dr. Joseph Wright, MPH, co-author of the AAP policy statement and the professor and chair of the Howard University College of Medicine Department of Pediatrics and Child Health in Washington, D.C.

This can cause all sorts of soft points in disaster preparation. As one example, Wright points to the decontamination facilities that can be vital in disaster response. Most are created with a single-file setup for those needing to be treated, but chaos can ensue if children must enter the lines alone without their parents. Thus, Wright notes, creating a “double-wide” decontamination unit is optimal for children and adults.

Pediatrics coordinators play vital role

This is just one example of the many issues, large and small, that can arise when children, who comprise approximately 25% of the U.S. population, aren’t specifically considered as part of a hospital’s disaster plan. And it’s why Wright recommends appointing a pediatrics expert to participate in planning.

“Identify a pediatric coordinator,” Wright advises. “Unless a pediatrics expert is explicitly at the table, we can’t implicitly expect children’s needs to be included.”

A pediatric coordinator should be “someone who wants the role,” Wright says. Ideally, this coordinator would report to a chief medical officer, chief operating officer or another member of the C-suite and take part in designing disaster responses and drills and weigh in on the potential child-friendliness of new construction projects or renovations.

“Most hospital emergency departments will have someone on staff who is responsible clinically for children,” Wright notes. “That person or someone like them really needs to also be engaged at the administrative level. It could be a nurse, or it could be a physician.”

Assess children and health needs

An assessment of community needs, experts contend, can inform disaster planning in general and children’s needs specifically.

Under the Affordable Care Act, nonprofit hospitals must conduct community health needs assessments at least once every three years to maintain their tax-exempt status. Although the assessments are large and complex undertakings, it is relatively easy to incorporate children’s needs into that process.
As part of such an assessment, get a sense of your needs as they relate to children by determining how many children live in a given hospital’s catchment area, where they congregate during the day (be it schools, day care centers or other facilities) and community assets like pediatrician’s offices that could help augment disaster response activities.

“It’s an inventory of what the lay of the land around your facility is, including areas where children gather during the day. It falls in the domain of community benefits,” Wright explains. “Get a better grip on what the capabilities are in the local catchment area.”

Public school data can be one way of obtaining this information (contact your local department of education to get started). Include other areas specific to children in an inventory of community assets, which typically lists nonprofit organizations, faith communities, parks and similar entities.

Include local pediatricians in your plan

Pediatrician offices are, of course, a key part of the support network for children and hospitals. Reach out to the private-practice pediatricians who interact with your hospital to ensure they have appropriate disaster-response capabilities of their own and as such can support and work alongside hospitals if tragedy strikes.

“I engage my volunteer faculty with regard to hospital-based preparation by making sure they have readiness in their own offices,” Wright says. “The hospital can’t be the be-all and end-all. Offices will be resources as people shelter in place. They should have the capability to stabilize and transfer if they need to.”

Other recommendations on pediatrics disaster response, according to the AAP policy statement, include:

- **Collaborate on disaster planning or community assessments with local groups dedicated to children.** This includes educators and school personnel, child-care programs, foster care agencies and the juvenile justice system.
- **Make equipment, medications and supplies for children available during a disaster** in parity with similar adult needs. Take timely steps to increase stockpiles if necessary.
- **Try to include children in disaster exercises and drills.**
- **Address children’s unique physiology and development in mass casualty triage** and related educational efforts.
- **Encourage pediatricians to pursue ongoing postgraduate education on disaster issues** and/or sign up for or engage with disaster response systems such as the Health Alert Network. — Scott Harris (ecl_editors@decisionhealth.com)

**Resource:**

- Ensuring the Health of Children in Disasters: [http://pediatrics.aappublications.org/content/early/2015/10/13/peds.2015-3112](http://pediatrics.aappublications.org/content/early/2015/10/13/peds.2015-3112)

**Equipment management**

**CMS clarifies requirement on meeting NEMA standard with CT equipment**

CMS has clarified what organizations will be verifying whether hospital computed tomography equipment meets the National Electrical Manufacturers Association (NEMA) Standard required to qualify for full Medicare payment for diagnostic imaging in outpatient settings.

As of the start of 2016, hospitals that did not meet NEMA standard XR-29-2013, “Standard Attributes on CT Equipment Related to Dose Optimization and Management” faced a 5% penalty when billing for those services. That penalty goes up to 15% in 2017 if the equipment remains out of compliance (IJC 3/7/16.)

In issuing a revision April 15 to survey-and-certification letter S&C: 16-19-ALL, CMS clarified that accrediting organizations may check compliance but CMS state and regional survey staff will not. “Surveyors will not be expected to determine compliance with advanced diagnostic imaging (ADI) suppliers or hospital outpatient department requirements. Accrediting organizations (AOS) will be evaluating compliance on a periodic basis. State agency and regional office staffs have no role to play in this process,” according to CMS. — A.J. Plunkett (aplunkett@decisionhealth.com)

**Resource:**
