CMS releases proposed Conditions of Participation

In a just-released proposed rule drafted by CMS with changes to the Hospital and Critical Access Hospital Conditions of Participation (CoPs), you will see increased flexibility, improved clarity of regulations and reduced burden of health care regulations from CoPs.

Changes have been proposed to areas such as the governing body, patient’s rights, medical staff, nursing services, medical record services, infection control, outpatient services and transplant center process requirements. CMS’s other alterations seek clarification on organ recovery and receipt, definitions and provisions of services, pharmaceutical services and infection control, personnel qualifications and surgical services.

Here are eight areas with proposed changes:

Governing body. Hospital systems will be allowed to have one governing board across all the hospitals within the system.

(see CoPs, pg. 5)

Follow these tips to create a simple, effective emergency management plan

Emergency management plans are necessary documents for every hospital to have. Planning for the difficult situations makes it that much easier when an emergency comes up. Many emergency management plans are too broad and don’t go into the details of responding to emergency situations, while others cover the necessities but leave out additional elements that make a plan simple and easy to use.

(see EOP, pg. 5)

Take part in our annual salary survey. Fill out the insert in this issue of JJC and fax it back to Editor Rachael DeNale at 1-301-287-2985. Or you can fill out the survey online at: www.zoomerang.com/Survey/WEB22DMX0WTPW5.
Cardio med errors: Take low-cost steps now

Take inexpensive steps right now, such as properly measuring patient weight, age and creatinine levels, to reduce acute cardiovascular medication errors and meet Joint Commission standards at your hospital. Other steps recommended by a recent report, such as purchasing CPOE, bar-code verification systems and smart pumps, may strain your budget. Do the ones your hospital can afford now and plan for the others later.

Aspirin, fibrinolytic agents, ß-blockers, heparin and other medications are the leading drugs involved in medication errors affecting patients with acute coronary syndrome and related heart problems, says the American Heart Association (AHA) in its statement, “Medication Errors in Acute Cardiovascular and Stroke Patients,” published last year. Joint Commission standards that affect cardiovascular medication errors include MM.01.01.03 (the hospital safely manages high-alert and hazardous medications) and the anticoagulation therapy National Patient Safety Goal NPSG.03.05.01 (reduce the likelihood of patient harm associated with the use of anticoagulant therapy).

“The recommendations are all reasonable and appropriate,” says Albany (N.Y.) Medical Center (631 beds) Director of Clinical Pharmacy Services Tim Lesar, but adds that while some are easy to implement, others depend on institutional budgets and resources. His hospital, like UT Southwestern Medical Center (271 beds) in Dallas, has made progress with many of the steps recommended, but is moving forward more slowly on the more expensive ones.

Following are the eight recommendations from the American Heart Association, along with where Albany Medical Center and UT Southwestern are in implementing them:

1. **Obtain accurate patient weight on admission.** One of the easiest and least expensive steps to take, yet one that often is not taken. “The pharmacist can see this when ‘hovering’ (with the computer cursor) over the patient information bar in our electronic medical records system that identifies the date and time the data was updated,” says Susan Sham, director of health system medication safety at UT Southwestern.

2. **Calculate estimated creatinine clearance with the Cockcroft-Gault formula on patient admission.** This should also be performed as changes in creatinine occur, the AHA states. Both Albany Medical Center and UT Southwestern do this.

3. **Take age into account when making medication dosage adjustments.** Increase surveillance for ADEs for higher-age patients, recommends the AHA. Albany Medical Center has “drug-based monitoring of the elderly,” says Lesar, mentioning antibiotics and anticoagulants as examples. While this appears to be a low-cost step, Lesar notes that comprehensive proactive adverse drug response monitoring for elderly patients would require an additional pharmacist, who would integrate with the cardiac care unit team.
4. **Standardize order forms and protocols for anticoagulation therapy.** UT Southwestern, which won plaudits from Joint Commission surveyors for its anticoagulation therapy notebook, has four standardized forms: a standard heparin infusion order, an acute coronary syndrome and congestive heart failure heparin infusion order, a neurology/stroke heparin infusion order, and a neurology heparin infusion order.

5. **Integrate pharmacists and nurses within the cardiovascular care teams in the ED, ICU and inpatient wards.** This will enhance communication and medication safety, the AHA says. But finding the staff is a management resource issue, which would mean either reassigning staff from other responsibilities, or finding money in your budget to hire new staff. “We do have a decentralized pharmacist, but (he) covers four ICUs, so they are not really well ‘integrated,’ with the CCU team...,” says Lesar. UT Southwestern pharmacists are permanently stationed in the cardiovascular ICU and on pulmonary hypertension patients, although not in the ED, says Sham. In addition, pharmacists can be called to nursing stations on nursing units as needed.

6. **Implement CPOE, medication bar-coding verification and smart infusion pumps in all inpatient wards and the ED.** Probably the most expensive recommendation on the AHA list, and clearly not one that all hospitals can afford, especially for all three technologies. Neither Albany Medical Center nor UT Southwestern has all three in place.

7. **Educate staff on high-alert medications, including anticoagulants, safe administration, medication reconciliation, look-alike/sound-alike drugs, and automated dispensing cabinets.** Not necessarily expensive, depending on the education system you use. On-line education modules are used at UT Southwestern to train staff on anticoagulant risk reduction, says Sham. In addition, nurses were recently trained to deal with strokes.

8. **Encourage a hospital-wide culture of safety that promotes a no-fault internal and external medication error reporting and interdisciplinary quality improvement review processes.** This is not so much a budget issue as it is a time issue. “We are continuing to work on this,” says Sham. “At our medication-safety nursing pharmacy outcomes group meeting, we have discussed the issues and barriers to reporting...” Lesar passed the ball to management, risk management and quality management, saying that if these departments “handle errors appropriately, then this develops. It took years, and we are pretty good in terms of handling errors on a no-fault ‘just’ basis.” – Bob Sperber (bsperber@decisionhealth.com)

**Use 5-why’s communication process to uncover causes of error**

Communication skills are essential when investigating – either through root cause analyses or more informal procedures – errors, near-misses and potential errors spotted by staff. The “5 why’s,” when used as part of a larger question-and-answer strategy, are a valuable arrow in your investigational quiver.

**Questions for a root cause analysis**

Root cause analyses are required by the Joint Commission when a sentinel event, such as an ADE, occurs. Steve Harden, president of LifeWings, the Nashville-based health care and aviation communications consultants, suggests the following questions be asked in addition to the “5 why’s:"

1. **What happened?** “An RCA is only as good as the level of accuracy of the understanding of the factual, actual events as they occur chronologically,” he says. “Everyone involved should be asked ‘what happened?’ As much time and effort should be spent on this as on any other step of the methodology.”

2. **What were you thinking as this happened?** “Here we are trying to probe the ‘why’, e.g., ‘Why did you do what you did?’ Every event comes down to a moment of truth, or several linked moments of truth,” Harden says, “where a decision is made and acted upon. Why was that decision made? Here you can utilize the ‘5 why’s’ and dig deeper. Knowing the ‘why’ will almost always tell you what needs to be changed.”

3. **What would you do differently next time to have a different outcome?** “Here we are trying to probe the ‘why’, e.g., ‘Why did you do what you did?’ Every event comes down to a moment of truth, or several linked moments of truth,” Harden says, “where a decision is made and acted upon. Why was that decision made? Here you can utilize the ‘5 why’s’ and dig deeper. Knowing the ‘why’ will almost always tell you what needs to be changed.”

4. **What should we do differently as an organization to have a different outcome next time?** “Here we are trying to probe the ‘why’, e.g., ‘Why did you do what you did?’ Every event comes down to a moment of truth, or several linked moments of truth,” Harden says, “where a decision is made and acted upon. Why was that decision made? Here you can utilize the ‘5 why’s’ and dig deeper. Knowing the ‘why’ will almost always tell you what needs to be changed.”
Here’s how it works: Ask the question “why” five times, suggests Paula Griswold, executive director of the Massachusetts Coalition for the Prevention of Medical Errors. The result is a drilling-down process that takes you to a level of specificity where the error or potential error can be addressed.

Example: A pharmacy tech says that he saw a look-alike drug in the wrong bin.

1st why: “Why were there two different drugs in the same bin?” Answer: “They looked alike.”

2nd why: “If they looked alike, why did someone not check the labels further?” Answer: “The labels have similar colors and lettering and generally look the same, so it was not realized that they were different.”

3rd why: “Why do we have drugs with similar labels near each other?” Answer: “Alphabetically, they fall next to each other, and the bins are arranged alphabetically.”

4th why: “Why are the bins arranged alphabetically?” Answer: “To make it easy to find specific drugs.”

5th why: “Why do we continue to use a drug bin system where these kinds of errors can occur?” At this point, the answer of redesigning the bin system, perhaps by ‘vertically segregating’ any look-alike / sound-alike drug pairs, could be discussed.

But there must be more to the process. The “5 why’s” are useful but insufficient by themselves,” says Harden. “You can’t just jump to the ‘why’s’ without some preliminary steps.”

The aviation model

In aviation accidents and incidents, Harden uses a model that has “good airplane” on one side and “mangled metal” on the other. In between are five elements: hardware, human factors, policies, procedures, and technical knowledge/skill.

“Think of this as an 'error chain' with each (element) as a link in the chain,” he says. “For each link you would have to ask something like, ‘Were there any hardware issues that contributed to this event? If so, what were they? Why did they happen?’ Then you could get into the ‘5 why’s.”

Questions should be asked to the subject matter expert, Harden says. For instance, for hardware issues, you would speak with the hardware expert in your hospital, most likely the IT manager or someone working in that department.

Effectively training your staff to prevent medication errors addresses Joint Commission standard MM.08.01.01 (the hospital evaluates the effectiveness of its medication management program) in particular, EPs 6, 7 and 8. Doing root cause analyses address Joint Commission standard LD.04.04.05 (the hospital has an organization-wide, integrated patient safety program within its performance improvement activities) EP 8, which says, “the hospital conducts thorough and credible root cause analyses in response to sentinel events…” – Bob Sperber (bsperber@decisionhealth.com)

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CoPs

(continued from pg. 1)

This will allow more uniformity and cohesive decision-making across the entire system.

Patient’s rights. CMS has found no direct correlation between the use of soft, two-point wrist restraints and patient deaths, and has thus proposed to ease the reporting requirements when a patient dies while wearing two-point wrist restraints but not while in seclusion.

Medical staff. CMS proposes to allow practice privileges to physicians and non-physicians whether or not they are part of the hospital’s official medical staff.

Nursing services. CMS hopes to streamline health care delivery to patients by allowing qualified practitioners (allowed by their state scope of practice) to order the preparation and administration of drugs and biologicals. The proposed changes expand the use of standing orders in order to increase the timeliness of necessary care.

Medical record services. Hospitals will be allowed to defer to hospital policy and state law for designating specific timeframes for authenticating verbal orders.

Infection control. CMS proposes removing the infection control log to allow hospitals to have the flexibility to track and monitor infections.

Outpatient services. This proposed CoP will allow hospitals to develop individualized management structures for outpatient services areas and, if applicable, assign more than one person to manage this service area.

Transplant center requirements. CMS has also found there is the potential for redundancies when verifying blood type. This proposed rule will remove certain blood type verification requirements for transplant centers. – Rachael DeNale (rdenale@decisionhealth.com)

EOP

(continued from pg. 1)

Anjanette Hebert, director of security, safety and emergency preparedness at Lafayette General Medical Center, gave a presentation at the 15th Annual EC Summit in Las Vegas in October on what to include in a top-notch emergency operations plan. In her presentation, she focused on the elements to include in a successful plan.

“The success of the plan is in the planning,” Hebert says.

The key elements in a simple and effective plan are:

• relationships – among staff, among other hospitals and with the community,
• simple tools that are easily accessible by the staff during an emergency,
• access to resources in an emergency and
• training to test your staff’s limits.

Follow these tips from Hebert to make your emergency operations plan as simple and effective as possible.

Be specific

Create an all-hazards plan with appendices. Staff should be able to use your plan in any emergency, with directions on how to handle specific events, such as a hurricane, in the appendices.

Personnel to include when creating your emergency operations plan

<table>
<thead>
<tr>
<th>Internal stakeholders. By reaching out to all members of your immediate structure, you may find resources that you haven’t already included in your plan or your resource list.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include these departments and members of your hospital community when developing the plan:</td>
</tr>
<tr>
<td>• physicians, • counselors, • nursing and support areas, • social workers, • pharmacy, • respiratory, • chaplains,</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External stakeholders. Work with members of the community at large. Reach out to members such as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• the local police, • emergency medical services and offices of emergency preparedness, • fire departments, • other hospitals,</td>
</tr>
</tbody>
</table>

That might help you determine weaknesses in your emergency management plan for wide-scale emergencies. You’ll also strengthen your relationships, which will help you coordinate your emergency responses. – Rachael DeNale (rdenale@decisionhealth.com)
November 21, 2011

Inside the Joint Commission


Whichever specific appendices you include must be customized to your hospital’s environment. Conduct a hazard vulnerability analysis to determine which events are most likely in your area and warrant specific plans.

Avoid vague and general statements. Those are often used in an all-hazards plan so actions can be applied to many situations. But if your statements are too vague, your staff may not understand what tasks they actually need to complete in an emergency or how to do them.

For example, instead of saying that a general staff member must do a particular task, state specifically whose responsibility that is.

Include a chain of who is responsible for the tasks in case the original person cannot follow through.

Include institution-, system- and community-specific information to make instructions in your emergency operations plan easy to understand and simple to carry out.

For example, list the specific area in the community that you know could be set up as a triage center if your hospital cannot handle the patient load from an emergency.

TIP: Set up agreements with other facilities and vendors before an emergency occurs so you will be better prepared when the time for action actually comes.

TIP: Involve other hospitals in and out of your system when planning for area-wide emergencies.

TIP: Involve your local police force and fire department when setting up your plan so everyone understands the goals and actions of each group during an emergency.

Provide quick lists, checklists and cheat sheets. During an emergency, you probably won’t have time to read your entire emergency operations plan. Shorten information into quick lists with brief instructions and reminders of what to do, easy-to-follow checklists and cheat sheets. That will save time and improve the response to the emergency.

TIP: Include tools such as stickers with important phone and fax numbers, checklists in easily accessible places and badge companions – cards that attach to the staff badge at your facility with quick guides to codes, alerts or steps to take in an emergency.

Determine alternatives

Identify your surge capability. Emergencies cause a greater influx of patients to hospitals. You need to identify what level of patient surge your hospital can handle while providing appropriate care. Recognize what that capacity is before you need to turn to alternative processes, and include that information in your emergency operations plan.

Establish alternative processes. When a large-scale emergency occurs, your hospital may be stretched beyond its capacity. For instance, you may be faced with a situation where your emergency plan is no longer an option. You must have an alternative to turn to, so you can still carry out operations.

Identify what triggers alternative plans. If one step cannot be carried out the way you mapped out in your emergency operation plan, determine another method to continue the response. Also, identify potential scenarios that will cause you to switch to the alternative methods

Understand the importance of documentation

Documentation is an important element in your preparation. The Joint Commission may review your emergency operations plan or check that you’ve documented your preparations.

Document your drills. Capture your facility’s activity during drills by using incident command system forms. FEMA provides a comprehensive list of ICS forms covering many topics. This will satisfy many of the emergency management documentation requirements listed by the Joint Commission.

Critique your work. Develop critique forms for your drills that follow the Joint Commission’s six areas of emergency management: communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities.

Review your critiques and improve your emergency management plan and drills based on any deficiencies you find in the review through additional training and adjustments to the plan.

TIP: Keep your documents from your drills and your critiques in clearly labeled and easy to find locations in your hospital. That way, if you’re asked to show documentation during a survey, you’ll know precisely where it is. – Rachael DeNale (rdenale@decisionhealth.com)
you've created. Include those triggers in your plan, so they are easily identifiable in an emergency.

Establish resource arrangements. Compile a list of resources – what you will need in an emergency and resources your facility can provide – before that type of situation comes up. Determine how to obtain those resources when an emergency occurs, including working with other institutions and departments (see box, pg. 5).

Don't limit your plan

Allow flexible response. Your plan must be flexible enough to accommodate for the scale of the event. For instance, an emergency that affects only the hospital will require a different response than a region-wide emergency, such as a natural disaster.

Plan for several types of events. You don’t need to plan for every possible emergency, but you need to determine what’s likely in your area and plan accordingly. Have plans to respond to, at a minimum, the top three most likely events identified by your hazard vulnerability assessment. But you may want to go beyond these top three in order to be prepared for a less likely occurrence.

Challenge your staff. Throw surprises and unexpected scenarios at your staff when going through regular drills.

For example, in an evacuation of your hospital, you may not have access to all emergency exits because of debris or obstacles blocking the evacuation routes. During your drills, add unexpected hindrances to prepare for that type of situation.

Develop back-ups in your plan

Develop manual responses. Develop manual or other alternative responses in case the power is out at your facility, including creating power outage kits for emergencies that include flashlights and other tools.

Establish a paper process. If your electricity is out, you won’t be able to keep up with electronic medical records. Develop a process to keep up with patient updates and information through paper documentation to replace the electronic data collection and information management systems you usually have in place.

Develop a back-up communications procedure. In the event of an emergency, you’ll need to communicate with your staff, with the community and with other leaders. Determine what that method of communication will be. In your plan, describe how and when to use it.

Consider how you will power the back-up method of communication, how long this new method will last and how your facility will communicate with your staff if you must relocate.

Practice. Be sure to practice the manual procedures during your drills. And use the back-up communication method you’ve developed and the equipment you’ll need in an emergency in your regular drills. That will familiarize your staff with how to use it. – Rachael DeNale (rdenale@decisionhealth.com)
Providing an optimal healing environment checklist

Adapt this checklist for providing an optimal healing environment, courtesy of Tom Murray, director of environmental safety at Sanford USD Medical Center, for your facility.

Checklist for Providing an Optimal Healing Environment

Based on the published research and the experience of many organizations, we recommend that any health care organization use the following checklist to assess whether they are providing a physical environment that promotes optimal healing.

Table 3. Checklist of Physical Design Elements to Promote an Optimal Healing Environment

<table>
<thead>
<tr>
<th>Environmental Design Element</th>
<th>Implemented</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Build private patient rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Provide adequate space for families to stay overnight in patient rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Install alcohol-based hand gel dispensers:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>In patient rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In patient care areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Meet World Health Organization recommended noise level standards:†</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Perform noise audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop noise reduction plan (e.g., eliminate audible paging)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Implement noise reduction plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Optimize lighting in medication prep areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Minimize unnecessary patient transfers (e.g., acuity-adaptable rooms)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Provide wider doors in patient bathrooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Install optimal air filtration systems (i.e., protect immunosuppressed patients)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9. Install ceiling-mounted patient lifts to reduce staff injuries:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>In patient rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In patient care areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Install clear, effective wayfinding systems</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Environmental Design Element</th>
<th>Implemented</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Install “positive distractions” (to reduce patient anxiety): Music</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Art and interactive art</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Architectural features</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Provide choices for patients: Control lighting</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Control privacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control music and visual images</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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