Proposed 2009 NPSGs
look at infection control, med rec

Continuing Education | Learning Objectives

After reading this article, you will be able to:
1. Identify proposed additions to the 2009 National Patient Safety Goals
2. Identify healthcare-acquired infections targeted by the 2009 proposed goals
3. Discuss which Universal Protocol requirements have been identified for revision under the proposed 2009 goals

The Joint Commission just closed the field review period for its proposed 2009 National Patient Safety Goal (NPSG) requirements and implementation expectations (IE). The organization announced the proposed goals January 16 and accepted comments from the field until the end of February.

These proposed NPSGs affect hospitals and critical access hospitals, ambulatory care and office-based surgery, behavioral healthcare, disease-specific care, home care, laboratories, and long-term care.

The proposed goals for 2009 focus on the following areas:
- Goal #1, patient identification
- Goal #3, safe use of medications (laboratory only)
- Goal #7, healthcare-acquired infections (HAI), focusing on methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile–associated disease (CDAD), catheter-associated bloodstream infections, and surgical site infections (SSI) in acute care hospitals
- Goal #8, medication reconciliation
- Goal #13, patient involvement in their own care
- Universal Protocol

Last year, after the NPSGs were finalized, healthcare organizations faced two new NPSGs in preparation for 2008, one requiring clinicians to respond rapidly to changes in a patient’s condition, and the other relating to anticoagulant therapy.

“There are some components that are straightforward and can easily be assimilated into regular quality improvement processes within healthcare organizations,” says Elizabeth Zhani, spokesperson for The Joint Commission (formerly JCAHO). “There are other components that will create reaction from the field due to the complexity of how to best manage healthcare-associated infections.”

“I think the [most] important things are the changes to Universal Protocol. The message is that you need to implement these changes now in your policies and procedures, and maybe form a committee to get the process started.”

—Sue Dill Calloway, RN, MSN, JD

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Goals < continued from p. 1

In a change from previous years, the 2008 goals will be phased in throughout the year, with full implementation required by January 2009. At prestime, the proposed 2009 NPSGs had not been finalized, nor has an announcement been made about whether there are plans to stagger implementation.

"Depending on the feedback from the field, our external advisory committee and the Board of Commissioners will determine the timing for implementation of these requirements," says Zhani. "This is a set of issues that need to be managed as quickly as possible."

Goal #1

Under the proposed revisions, Requirement 1A would be expanded to include an IE requiring that the patient be actively involved in the identification process, when possible, before any venipuncture, arterial puncture, or capillary blood collection procedure. Proposed Requirement 1C aims to eliminate transfusion errors related to patient misidentification.

"Considering that blood transfusions, and hanging the wrong blood, is one of the eight conditions CMS will not reimburse Medicare payments for, its inclusion is not surprising," says Sue Dill Calloway, RN, MSN, JD, director of hospital risk management for OHIC Insurance Company, The Doctor’s Company, in Columbus, OH.

The proposed goals focus on infection control because “HAI presents an important set of healthcare issues that have gradually become recognized for their complexity, and healthcare organizations play a critical role in managing the cycle of HAI problems,” says Zhani.

It is not, however, related to recent developments by the federal government to crack down on HAI.

“This initiative reflects what is considered a critical issue for improving the safety of patient care, and The Joint Commission has been focused on HAI problems for some time now,” says Zhani.

Goal #7

Perhaps most newsworthy is the inclusion of a new proposed requirement aimed at stopping drug-resistant organism infections in hospitals. Specifically, proposed Requirement 7C targets MRSA and CDAD. Among its 16 IEs, 7C requires education for healthcare workers, patients, and their families, as well as the measurement and monitoring of infection rates. It also requires lab-based alert systems when MRSA patients are detected and a surveillance system for CDAD.

Requirement 7D proposes 13 IEs, including IEs for before and after insertion of the catheter. Requirement 7E
has both general and specific IEs, seven in total, for the prevention of SSIs.

Bud Pate, REHS, practice director of clinical operations improvement for The Greeley Company, a division of HCPro, Inc. in Marblehead, MA, calls the hand hygiene standard, 7A, a great standard.

“They said, ‘You will follow [Centers for Disease Control and Prevention] guidelines.’ Everybody can pull out CDC guidelines and know what to do. No problem,” he says.

Goal #8

Proposed revisions to Goal #8 are composed of new and revised requirements and IEs intended for clarification, not alteration, of previous requirements. Revisions have been made to Requirements 8A, 8B, and 8C for the reconciliation of patient medication across the continuum of care. Requirement 8D has been added, requiring modified medication reconciliation processes in settings where medications are not used, used minimally, or prescribed for short durations, such as outpatient radiology, ambulatory care, and behavioral healthcare.

“They’ve incorporated many of the things included on the 17-page implementation expectation and FAQ into the medication reconciliation goal,” says Dill Calloway. Pate sees challenges in the future if the proposed changes to medication reconciliation goals are put into place.

“What they’ve done is, instead of making things clearer, they’ve made a lot more documentation requirements that seem to be aimed at satisfying the surveyor instead of protecting the patient,” he says.

Goal #13

Two IEs have been proposed for Goal #13, which targets increasing involvement of patients in their own care. The first new IE would require facilities to provide patients with information regarding infection control (e.g., hand hygiene or respiratory hygiene practices), and the latter would require facilities to provide surgical patients with information about preventing adverse events during surgery (such as patient identification or surgical site marking processes).

“I think the patient family education [addition] is excellent, and some organizations already have implemented hand hygiene and respiratory hygiene handouts for patients and their families,” says Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, a healthcare consultant in Trabuco Canyon, CA.

Universal Protocol

The proposed changes to the Universal Protocol, like those made to Goal #8, are not meant to change the overall concept of the goal but rather to clarify existing requirements. According to the draft 2009 NPSGs, the Universal Protocol contains the same concepts it has in previous iterations.

Extensive clarifications have been proposed for Requirements 1A, 1B, and 1C, including four rewritten IEs under 1B (surgical site marking), and six rewritten IEs under 1C (time-out verifications).

“I think the [most] important things are the changes to Universal Protocol,” says Dill Calloway. “The message is that you need to implement these changes now in your policies and procedures, and maybe form a committee to get the process started.” That said, she continues, these changes affect the current interpretation of what facilities should be doing to prevent wrong-site surgery, specifically regarding the surgeon or licensed independent practitioner who must be in the room during surgical site marking.

Although the review period has closed, the proposed revisions are available on The Joint Commission’s Web site at www.jointcommission.org/Standards/FieldReviews/09_npsg_fr.htm.

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Q&A with Kurt Patton

Universal Protocol: Clarifying the physician’s role

According to the Universal Protocol for preventing wrong-site surgery, who is required to do the site marking? We are hearing that The Joint Commission states it must be the surgeon.

In the Universal Protocol, Requirement 1B, EP 6, it states that the person performing the procedure “should” do the site marking. A subtle shift in defining the word “should” was noted in 2007 in reviewing hospital requirements for improvement and clarification responses.

As of early February, The Joint Commission (formerly JCAHO) had not yet published its 2008 National Patient Safety Goal FAQs, but the rumors from this year’s surveyor conference indicate that the term “should” has been somewhat redefined. What I hear is that the term means that the person performing the procedure should do the marking, unless there is some reason why he or she cannot. Many hospitals have interpreted the word using a Webster’s-like definition in the belief that it gave them a choice as to whether the person performing the procedure had to be involved in site marking. These hospitals then established internal procedures, for the most part assigning site marking to nursing staff members.

It appears that, absent some reason for the specific case, this routine assignment of responsibility is no longer acceptable. I have begun to see this RFI appear with some frequency in 2008, and it appears that the surveyors were instructed at their annual training program to apply this new definition.

Some surveyors, knowing that customers have not yet seen this mandate in writing, are suggesting that hospitals seek to clarify the RFI, but at this time, I don’t know whether these clarifications will be accepted. Hopefully, we will all soon see official confirmation from The Joint Commission about this issue. In the meantime, hospitals would be wise to consider the term “should” as a directive. The person performing the procedure should do the site marking—as opposed to assigning it to another staff member.

While we are talking about the Universal Protocol, we should also remember that this applies to all invasive procedures, wherever they are performed in our hospitals. Too often we see this requirement fully implemented in the main OR, but forgotten about in bedside procedures or ambulatory invasive procedures. The Joint Commission is looking for this protocol to be applied for bedside procedures, such as chest tube insertion, peripherally inserted central catheter line placement, mole excision, and other invasive—but often considered minor—procedures.

Editor’s note: Patton is the former Joint Commission executive director of accreditation services and principal of Patton Healthcare Consulting, LLC, in Glendale, AZ. To ask him a question, e-mail Matt Phillion at mphillion@hcpro.com and look for the answer in an upcoming issue.
Simple advance directive identifier limits confusion

Continuing Education | Learning Objectives

After reading this article, you will be able to:
1. Identify where The Joint Commission addresses advance directives in its standards
2. Discuss specific challenges when advance directive information is difficult to find on patient charts

It's amazing how far a piece of red plastic can go toward improving how a facility tracks patient information.

Attached to every patient chart at Garrett County Memorial Hospital in Oakland, MD, you will find a red plastic sheet. The sheet is easy to locate quickly in the documentation and handy for verifying information during an emergency situation—which is important, since the plastic sheet contains the patient's advance directive information.

It seems like a simple fix: electing to use a brightly colored plastic cover for legal paperwork in the patient's record. But given how sensitive the issue of advance directives is, and how it can require split-second decisions to be made about the treatment a patient in distress will receive, a simple but effective method of communicating advance directive information is pivotal.

Q: Does The Joint Commission (formerly JCAHO) directly address advance directive policies?
A: Advance directives are addressed in the Comprehensive Accreditation Manual for Hospitals in the chapter “Ethics, Rights and Responsibilities” (RI) under standard RI.2.80.

“We knew we needed a better solution,” says Charlene Bennett, RNC, BSN, MSHA, Joint Commission coordinator and nurse manager of the obstetrics department for Garrett County Memorial Hospital. “We had problems quickly finding the power of attorney paperwork or advance directives. So staff members began engaging in a tracking mechanism to track how difficult it was to get to this information in certain situations.”

Frequently, charts will have a specific spot for advance directive paperwork, but finding it quickly can be difficult, particularly if the chart has been shuffled and papers replaced in the wrong order.

The staff of Garrett County Memorial Hospital—a small facility with 30 beds—started tracking how many man-hours were burned up looking for advance directive information. A team was formed between social work services and the nursing staff to devise a plan for preventing paperwork issues at the facility.

“The idea was brought up that if we can keep [the information] here at the hospital, we don’t have to worry about it coming back” with the patient’s next visit, says Bennett.

The red slide containing this information is slightly larger than the sheet itself, so in a code situation, there's no flipping through the chart to find it. The paperwork remains with the patient’s record after discharge.

“Whether it’s an old chart or active chart, it’s always in place,” says Bennett.

The staff then verifies advance directive information should the patient be readmitted at any point.

This also goes for power of attorney documentation, which can frequently be an area of conflict for families, and which can involve staff members.

“Large families can have disagreements, so this is really a protective method for us,” says Bennett. “We’re doing what the patient wants. We have the name of the person she or he has designated [with power of attorney].”

Every facility has seen its share of fights over power of attorney or deciding what a patient—no longer able to communicate for him- or herself—wants in terms of life-saving measures or medical care.

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Advance directive
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“Someone may say they have power of attorney, and we can update the patient’s record to reflect that when they bring in the paperwork,” says Bennett. “This protects us.”

Having the patient’s advance directive readily available at the facility also protects the family.

“It takes the burden off of the family,” says Bennett. Patients want their wishes complied with, even when deteriorating health prevents them from communicating those desires themselves. “It’s difficult for families to watch what their parent wants done,” she says, “but they never have to live with making the wrong decision” if the patient has made it clear in his or her advance directive what that decision should be.

From the beginning

When patients are admitted to Garrett County Memorial Hospital, their previous chart is sent for in medical records. If they have filled out an advance directive, the red plastic sheet will be in the record and transferred to the new chart.

“We have an area where we discuss the advance directive with the patient, ask them if there has been any changes,” says Bennett. “If there have [been changes], we have a social worker work with them to make sure the information is up to date.”

The same goes for power of attorney—addressed on the face sheet—and other legal paperwork.

“Once we have the go-ahead, that stays on the chart,” says Bennett. “It’s so hard to get people to bring [legal paperwork] in. If the advance directives are not here on admission, you spend a lot of time getting the paperwork.

You’re expected to follow [the legal documents], but without the paper in hand, it’s a vicious cycle. Going just on what someone says can place you in a liability situation.”

Staff reaction

The policy has been in place for several years now.

“We sail through the process now,” says Bennett. “It decreased the time spent trying to track down information and allowed us to devote more time to patient care.”

The staff members found the process a relief, removing significant stress and concerns that they could be following instructions that did not comply with patient wishes.

“There was always the worry [if] you were doing what you were supposed to,” says Bennett. “Particularly if you were waiting on a piece of information and a patient event happened—you have to do everything you can until you have this information in hand. You worry that you’re doing more, or not enough, for what the person wants.”

Treating the issue of advance directives as a multidisciplinary problem helped Garrett County Memorial Hospital by bringing not only the nursing perspective to the problem but social work and medical records as well. Consider the following additional tips for developing a sturdy plan of action:

➤ See physician input
➤ Benchmark with similar facilities
➤ Look to the future—a paperless facility will have different needs than one still working with paper documents
➤ Many advance directive rules and requirements are state-specific—make sure to consult state mandates and recommendations

“This was a very easy transition,” says Bennett. “I think it took a lot of work away, and it makes you feel more confident that you’re abiding by your patient’s wishes.”
Although the restraint and seclusion standards have been in place for quite some time, a large percentage of hospitals continue to receive RFIs related to one or more of the EPs. With the 2007 revisions to the CMS Conditions of Participation (CoP) for patients’ rights, there is no longer alignment between The Joint Commission and CMS.

Both requirements are fairly clear in that they outline the rights of all patients. All patients have a right to be free from physical or mental abuse and corporal punishment and free from restraint or seclusion in any form when they are imposed as a means of coercion, discipline, convenience, or retaliation by staff members. The focus of restraints or seclusions should be on the safety of the patient, staff members, and others. Restraint reduction is a topic that likely has been discussed in all hospitals, but perhaps the focus should be on the appropriate utilization of restraints.

One of the primary differences between the Joint Commission (formerly JCAHO) standards and CMS’ CoPs is the modification of the definition of restraint. CMS no longer categorizes restraints into behavioral and medical-surgical. Instead, it has eliminated the two categories and defined requirements for caring for the “violent or self-destructive behavior” standard.

In addition, there is a significant focus on the education of staff members in the techniques and strategies related to de-escalation techniques and alternatives to restraints.

Physicians need to be educated as well; however, this can be accomplished through communication. The narrative published at the time of the revised rule basically stated that physicians must have a working knowledge of the hospital’s policy.

The trick is not in getting that message out the first time but in creating a process to ensure that the physicians are routinely reminded of the policy requirements and that newly appointed physicians get the message during orientation.

What information must be reported?

Information as outlined on the Restraint/Seclusion Death Report Worksheet must be submitted to the appropriate CMS regional office within one day. Regional office contact information can be obtained at www.cms.hhs.gov/RegionalOffices.

What changes, if any, are being planned for the restraint standards to bring them into agreement with the 2007 revised CMS CoPs?

According to a member of The Joint Commission’s Hospital Professional and Technical Advisory Committee, the restraint and seclusion standards are currently under review for revisions to increase clarity and improve flow in the “Provision of Care” chapter. These revisions were scheduled to be posted for the field to review in February.

The Joint Commission is also evaluating the revisions to the CMS requirements for restraint and seclusion. Any changes to the content of the standards are outside the scope of the Standards Improvement Initiative and will be accomplished through the regular process for standards development.
### Restraint/Seclusion Death Report Worksheet

**Contact Information**
- RO contact’s name: 
- Date of RO contact: ___________ RO Contact’s phone number: 
- Facility contact: 
- Facility contact’s phone number: 

**Provider Information**
- Hospital Name: 
- Provider Number: 
- Address: 
- Zip Code: ______

**Patient Information**
- Name: 
- Date of Birth/Age: 
- Medicare/Medicaid Number: 
- Admitting Diagnoses: 
- Date of Admission: 
- Date/time of Death: 
- Cause of Death: 
- Did the facility conduct a root cause analysis? Yes _____ No _____ 

**NOTE:** Hospitals may provide the following information over the telephone, or to the SA during its investigation.

- Length of Time in Restraints/seclusion: 
- Circumstances surrounding the death: 

**Results of any facility investigation:** 

**Restraint/Seclusion Information**
- Type: Physical Restraint _____ Seclusion _____ Drug Used as a Restraint _____ 
- Restraint Standard: Acute Medical/Surgical Care _____ Behavioral Management _____ 
- Reason(s) for seclusion/restraint use: 
- Less restrictive methods of behavior management considered: 

- Restraint/seclusion order date/time: 

- Quote actual restraint/seclusion order(s): 

**Source:** CMS, www.cms.hhs.gov.
Often, simple steps help hospitals perform better on Joint Commission surveys. For Valley General Hospital in Monroe, WA, it was a matter of color coding pharmacy medications, eliminating unapproved abbreviations at the source, and distributing educational newsletters to staff members.

In October 2007, the then 72-bed hospital underwent its Joint Commission (formerly JCAHO) survey. The survey lasted the usual four days and involved two surveyors (an RN and a social worker) for Valley General’s chemical dependency unit. According to Quinn Hatala, RN, BSN, manager of clinical quality and patient safety at Valley General, the survey was “uneventful.”

Valley General’s Joint Commission surveyors focused on the National Patient Safety Goals (NPSG) and used patient tracers as a main tool to assess compliance, common practice for the accrediting body. They found a few habits that could be refined, but in general, found many of Valley General’s practices and policies in compliance. Hatala says the surveyors could find no unapproved abbreviations in her entire facility. Valley General’s policy requires any unapproved abbreviations to be addressed at the pharmacy. If one is found—usually written by a physician new to the hospital—the pharmacy calls the physician to discuss and correct the order, says Hatala.

“[The pharmacy] calls the doctors specifically to talk to them about the order, and right then and there get a patient order . . . If [unapproved abbreviations] come up, they’re immediately corrected, and the physician gets immediate education on the abbreviation,” says Hatala. “That is our policy, and it’s quite effective.”

Look-alike/soundalike

Another pharmacy practice, created after the Joint Commission surveyor alerted the hospital to a possible look-alike/soundalike danger, also helps the hospital crack down on medication compliance. Although frontline staff members use a laminated sheet that lists both unapproved abbreviations and look-alike/soundalike drugs on the front of every chart, possible problems elsewhere in the hospital concerned the surveyor.

“Where we fell down was in our pharmacy,” says Brenda Rogers, RN, BS, associate administrator of clinical services and chief nursing executive of Valley General. “We did not have a really clear visual definition [of the medications], so we changed the way we labeled the medication in the pharmacy and did some color coding to correct that.”

Now, Valley General’s pharmacy labels look-alike/soundalike medications with bright yellow labels and larger fonts and high-alert medications with red labels to ensure that pharmacists are especially careful when reading these medications.

Like at many other hospitals, time-outs were also a concern. Although Valley General documented and performed time-outs methodically, its documentation didn’t indicate when the time-outs occurred.

“[The surveyor] said some hospitals conduct multiple time-outs and she doesn’t care if you’re doing one or three,” says Hatala. “[The Joint Commission] wants to see that one is done immediately prior to the first incision.”

Valley General staff members are now aware that they need to write the time on surgery documentation.

Changes in policies and procedures are only part of a survey process, says Hatala. Staff education can be just as important, especially when surveyors perform patient tracers.

“The staff received a weekly newsletter throughout what we anticipated to be our survey year, and that raised the level of awareness and reinforced their existing knowledge,” says Hatala. “It really paid off well because during the survey, staff knew what to expect from the surveyor and could articulate our processes very well to the surveyors.”
The Joint Commission has created a task force and charged it with exploring issues surrounding implementation of revisions to standard MS.1.20.

The task force is expected to present its findings at the Board of Commissioners meeting, which takes place at the end of February.

It was unclear at presstime whether immediate action would take place following the task force’s report.

“We have no idea what we’re going to be seeing,” says Ann O’Connell, partner at Sacramento, CA–based Nos-saman Guthner Knox & Elliott, LLP, and a member of The Joint Commission’s (formerly JCAHO) task force. “I can say the discussions were productive, lively, and everyone had an opportunity to present their positions and opinions. There was also a fair amount of listening that went on.”

The standard, which has undergone several revisions and iterations in the past few years, was approved with these latest revisions by the Board of Commissioners in June 2007 for implementation in July 2009. According to an official statement by The Joint Commission at the time, the revisions were meant to foster a strong working relationship between the medical staff and the governing body, “while minimizing disruptions to the hospital, including the medical staff.”

The task force was assigned the role of addressing concerns regarding the potential effect of implementing the revised standard, and will offer suggestions to remedy these issues while supporting the objectives of the revisions.

“The problem with the standard is that on the one hand, you’ve got receptiveness to address the concerns being raised [about the most recent changes], and on the other hand, there is an inclination on the part of [The Joint Commission] that they want to address it through means other than modifying the standard and elements,” says O’Connell.

The current approach discussed with the task force is to use interpretation or enforcement—or lack thereof—to address the MS.1.20 changes, says O’Connell.

“For those who like it as it is, that’s an acceptable resolution, but for those who don’t, I think it’s unsettling that there has to be a kind of behind-the-scenes approach to fixing it,” she says.

As the standard currently reads—prior to any changes that might follow the task force’s feedback—the most significant changes to MS.1.20 include:

- A revised introduction discussing the relationship between the organized medical staff and the medical staff executive committee, as well as defining “process” and “procedural detail.”
- A note directing readers to Standard LD.2.40 for guidance on matters regarding managing conflict.
concerning the medical staff bylaws, rules and regulations, and policies.

➤ An explanation of the revised structure of the standard.

➤ New clarifying language before groups of EPs to define what must be in the medical staff bylaws, versus what must be either in the bylaws or in the rules and regulations or policies.

➤ Two new EPs aligning the standard with the CMS requirements for medical staff bylaws.

➤ Another new EP, which explains the medical staff’s ability to directly propose medical staff bylaws, rules and regulations, and policies to the governing body.

➤ A new requirement that states that the authority delegated by the organized medical staff to the medical staff executive committee to act on its behalf must be included in the bylaws. This requirement also states that the bylaws should also include an explanation for how that authority is delegated and removed.

Prior to last year’s announced revisions, it had become common practice to put organizational aspects—aspects of the medical staff that do not change very often—into the bylaws, while keeping components that require more frequent updating and alteration in policies and procedures. The thought behind this trend was to simplify and speed up the revision process by removing the need to call for a vote of the entire medical staff on the lesser changes that would be included in the policies and procedures.

Last year’s iteration was the first draft to address delegation, allowing the executive committee to act on behalf of the medical staff if such power has been delegated by the bylaws—something many executive committees were already doing.

“Can a medical staff decide for themselves how to amend separate parts of the bylaws?” says Joseph Cooper, MD, a consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. “If they say okay, all this stuff has to be in the bylaws, and yet the medical staff and board decide that a section can be amended by the medical executive committee, can they still do that? That’s where the confusion lies. If they’re going to say yes, as long as everyone agrees we can do that, we’ll call it all bylaws, but it’s the amendment process that is the real key . . . The concern is how can it be that prescriptive?”

“Am I optimistic?” says O’Connell. “I’d say I’m on the low side of the halfway mark, but I believe our best chance of getting improvements is continuing to work cooperatively and to share information and suggestions. There are ways to address concerns without upsetting the whole applecart; but I still think some fundamental changes are necessary if we’re to be able to accomplish the stated goals of improving hospital/medical staff relations.”

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Managing Editor

BOJ
CMS CORNER

CMS revises interpretive guidelines in infection control

Editor’s note: Sue Dill Calloway, RN, MSN, JD, director of hospital risk management for OHIC Insurance Company, The Doctor’s Company, in Columbus, OH, is the CMS Corner lead contributor. Submit a topic idea to her by contacting BOJ Managing Editor Matt Phillion at mphillion@hcpro.com.

Any hospital that accepts Medicare and Medicaid patients must follow the hospital Conditions of Participation (CoP) that are promulgated by CMS. These regulations must be followed for all patients, not just Medicare patients. New infection control interpretive guidelines recently revised by CMS have been designated as A standards, so they do not apply to critical access hospitals unless the facility has a separate rehab or behavioral health unit.

Infection control is a very important area in today’s healthcare environment. Hospitals should ensure that they have a qualified and competent infection control nurse, infection control coordinator, infection control professional, or hospital epidemiologist. The board and senior leadership should make sure there is adequate staffing and resources to get the job done.

According to estimates from the Centers for Disease Control and Prevention, healthcare-associated infections account for about 1.7 million infections and 99,000 deaths each year in American hospitals.

CMS issued a memo to its state survey agency directors late last year to advise them that there have been some revisions to the hospital CoPs for infection control. This was done to reflect new changes in the area of infection control and communicable diseases, as well as to reflect current terminology, current knowledge, and best practices.

There is a process to get to the final pages of the state operations manual. First, the section is published in the Federal Register. Infection control is contained in section 482.42. Then, CMS takes the federal rule and adds a layer of interpretation for hospitals to follow—this part is called the interpretive guidelines—to assist the surveyors in using the regulation to survey the hospital.

Surveyors are advised to be cautious in using the interpretive guidelines, because they do not replace or supersede the law. They should not be used as a basis for citation. However, they do contain authoritative interpretations and clarifications and can assist the surveyor in making determinations of compliance.

This recent memo about infection control, issued by Thomas E. Hamilton, director of the Survey and Certification Group, states that the new interpretive guidelines include a new survey procedure for use in determining compliance. These also contain discussion and examples of practices that hospitals are encouraged to adopt, but which are not necessarily required by the regulation. Hamilton said that the revised guidelines are effective immediately and surveyors should be trained to start using them within 30 days of the announcement.

It is interesting to note that CMS does not have a mechanism to inform hospitals of these changes. It does not seem to work with the American Hospital Association or state hospital associations, which could help get this information into the hands of hospitals so that it could be reviewed and acted upon.

Source
CMS, Memo 08-04, dated November 21, 2007 (http://tinyurl.com/2ek9q4).