HOSPITAL HAPPENINGS

NORTH DAKOTA DEPARTMENT of HEALTH

Fall 2017

Welcome to this edition of ***Hospital Happenings,*** a newsletter published by the North Dakota Department of Health, Division of Health Facilities. ***Hospital Happenings*** is designed to help hospitals stay up-to-date on various issues. Please share with your staff.

Inside this issue

Implementing the New Emergency Preparedness Requirements

The Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers became effective Nov. 15, 2016, with an implementation date of Nov. 15, 2017. This rule applies to all 17 provider and supplier types and compliance is required for participation in Medicare.

This rule includes four provisions: 1) risk assessment and planning; 2) policies and procedures; 3) communication; and 4) training and testing. Action items include:

1. Perform a risk assessment and, using an all hazards approach, develop an emergency plan. The plan may include floods, tornados, power outages, equipment failure, bomb threats, etc. The plan should also include a process for transferring patients out of the facility, if necessary. The emergency plan must be updated and reviewed at least annually.
2. Develop policies and procedures based on the risk assessment and plan. The policies and procedures must also be reviewed annually.
3. Implement a communication plan to coordinate patient care within the facility, across health care providers, state and local public health departments, and management systems. The plan focuses on communication during a disaster and is required to be reviewed and updated annually.
4. Provide training and testing by Nov. 15, 2017. Once the emergency plan is developed and the communication plan and policies and procedures are in place, the facility must provide training and testing. The rule requires facilities to participate in a full-scale exercise that is community-based or, when not available or accessible, the facility must conduct an individual-based facility exercise. Between Nov. 15, 2016 and Nov. 15, 2017, the facility must complete two exercises/drills, which may include, but are not limited to, a full-scale exercise and a tabletop exercise. Annual training and testing is required and is considered annual if it is within 12 months of the last emergency drill.

If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, it is exempt from participating in a community -based or individual facility-based full-scale exercise for one year following the onset of the actual event.

For more specifics, please refer to CFR Part 482 for Hospitals and Part 485 for Critical Access Hospitals.

New rules in the North Dakota Administrative Code Chapter 33-07-01.1, Section 33-07-01.1-34.1 Outpatient Birth Services in Hospitals and revisions to Section 33-07-01.1-01, General Provisions – Definitions were effective July 1, 2017. The Licensing Rules for Hospitals in North Dakota can be accessed at http://www.legis.nd.gov/information/acdata/pdf/33-07-01.1.pdf.

New Survey and Certification Letters

The Centers for Medicare and Medicaid Services (CMS) transmits memoranda, guidance, clarifications and instructions to state survey agencies and CMS regional offices through use of survey and certification (S&C) letters. Below is a list of the new S&C letters affecting hospitals since Jan. 2017. The S&C letters are available at: www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage.

S&C 17-17 Recommendations to Providers Regarding Cyber Security. 01/13/2017.

S&C 17-21 Information to Assist Providers and Suppliers in Meeting the New Training and Testing Requirements of the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule 03/24/2017.

S&C 17-22 Medicare Learning Network Conference Call National Provider Call for Emergency Preparedness Requirements for Medicare/Medicaid Participating Providers and Suppliers Final Rule. 03/24/2017.

S&C 17-24 Notice of Proposed Regulation Changes for Accrediting Organizations Transparency and Termination Notices. 04/14/2017.

S&C 17-29 Advanced Copy – Appendix Z, Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures. 06/02/2017.

S&C 17-30 Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease. 06/02/2017. Revised 06/09/2017.

S&C 17-34 New Guidance for the Formatting of the Plans of Correction. 06/16/2017.

S&C 17-35 Reasonable Assurance Will Apply to Providers and Suppliers Who Voluntarily Terminate and Seek New Certification If a Termination Action by the State Agency Had Been Initiated. 06/16/2017.

S&C 17-38 Fire and Smoke Door Annual Testing Requirements in Health Care Occupancies. 7/28/2017.

S&C 17-40 FY 2016 Report to Congress: Review of Medicare's Program Oversight of Accrediting Organizations and the Clinical Laboratory Improvement Amendments of 1988 Validation Program. 07/28/2017.

S&C 17-42 Termination Notices Available via the Survey & Certification Website. 08/18/2017.

S&C 17-43 Quality and Certification Oversight Reports Website Launch. 08/22/2017.

S&C 17-44 Advanced Copy – Revisions to State Operations Manual Hospital Appendix A. 09/06/2017.

Nurse Aide Registry Reminders *By Cindy Kupfer*

- Please review all Initial Nurse Aide Applications to make sure the entire application is readable and complete.
- In an effort to streamline the Nurse Aide Registry services, as of May 1, 2017, we are following NDAC rules 33-43-01 and will not be refunding submitted registry fees. For example, when one check is submitted to pay for ten applicants and one applicant cannot be processed, all fees will be kept and nine applicants will be processed. A notice will be sent to the one applicant that was not processed. When the applicant resubmits their corrected application the fee will need to accompany the application.
- Reminder: For any registrants that have received their reminder renewal cards for Sept. 30, 2017, you still have time to renew online.

Reporting of Death Associated with Restraint or Seclusion

Pursuant to 42 CFR §482.13(g) and CMS S&C Memo 14-27 (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-27.pdf), short term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, long term care hospitals, and critical access hospitals with rehabilitation or psychiatric distinct part units must use Form **CMS-10455** (11/13) to submit required reports **via fax at 443-380-8868.** Current OMB approved CMS-10455 form is found at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10455.pdf**.

In 2012, CMS replaced the requirement that hospitals must report deaths that occur while a patient is **only** in soft, 2-point wrist restraints with a requirement that hospitals must maintain a log (or other system) of all such deaths. Therefore, there is no need for hospitals to forward the report for 2-point wrist restraints only. This log must be made available to CMS immediately upon request if needed. CMS has indicated the log is internal to the hospital and the name of the practitioner responsible for the care of the patient may be used in the log in lieu of the name of the attending physician if the patient was under the care of a non-physician practitioner and not a physician. When reporting the use of mittens as restraint, please add "mittens" in section C.

The timeframe for reporting deaths to the CMS Regional Office is no later than the close of business on the next business day following knowledge of the patient's death.

*Hospitals **should not call** CMS to report a death*. Do not include any additional information or attachments to the required CMS form (Form **CMS-10455** (11/13) when faxing the report to the fax number above. Since restraint death reports contain personal health information, do not send restraint death worksheets to a personal email address, as it is a HIPAA violation.

Legionnaires' Disease (LD) *By Joanne O'Hare*

"**Legionella Infections:** The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care (LTC) facilities. Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs, and decorative fountains. **Facility Requirements to Prevent Legionella Infections:** Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of legionella and other opportunistic pathogens in water." (Reference: S&C 17-30)

Outbreaks are usually due to environmental reservoirs in large water systems. The bacterium is transferred to humans by aerosol from showerheads, cooling towers, hot tubs, and decorative fountains. In the United States, between 2000 and 2014, 15% of LD outbreaks were associated with hospitals. Approximately 9% of reported legionellosis cases are fatal.

Regulations include:

-42 CFR 482.42 for hospitals

-42 CFR 485.635(a)(3)(vi) for critical access hospitals

Surveyors and accrediting organizations will review policies, procedures, and reports documenting water management implementation results to verify:

- Facilities conduct a risk assessment for waterborne pathogens.
- Implementation of a water management program that includes control measures.
- Facilities specify testing protocols and acceptable ranges for control measures.

"Healthcare facilities are expected to comply with CMS requirements to protect the health and safety of its patients."

Compliance with Federal Hospital/CAH Requirements and the Use of Emergency Medical Services Professionals in a Hospital Setting

On Aug.1, 2017, changes to North Dakota Century Code (NDCC) 23-27-04.4 went into effect regarding the supervision of emergency medical services (EMS) professionals employed by a hospital. NDCC 23-27-04.4 now states, "Emergency medical services professionals who are employed by a hospital may provide patient care within a scope of practice established by the department. Under this section, these emergency medical services professionals must be supervised by a hospital designated physician, physician assistant, advanced practice registered nurse, or registered nurse."

Hospitals/CAHs must remain in compliance with both federal and state regulations if implementing any changes under this new NDCC language. CMS has indicated "the oversight and supervision of EMS professionals is a scope of practice issue for practitioners and other healthcare professions that would be asked or expected to provide that oversight and supervision. Providers would need to adopt policies, procedures, and job descriptions that would be in agreement with the State Boards determination of the scope of practice for the various disciplines involved." Given this guidance, EMS professionals working in a hospital setting may provide patient care within the scope of practice established by the North Dakota Department of Health, Division of Emergency Medical Systems. It is the responsibility of the hospital/CAH to define the specific role of EMS professionals within their hospital/CAH including the organizational structure for oversight and supervision.

CMS has specifically stated, a hospital/CAH ". . . would not be permitted to schedule an individual to function in 2 (or more) roles simultaneously. For instance, an individual could not be on the nursing staff schedule and then permitted to take an EMS call where they could be away from the CAH for an unknown period of time. However, an individual could be on the nursing staff schedule for one period of time (ie 7am-12pm) and the EMT staff schedule for another period of time (ie 12:30-6pm)."

Federal hospital and CAH requirements indicate the hospital/CAH must ensure staff are qualified which is ultimately the responsibility of the governing body. The governing body must ensure staff are competent and meet all licensure and certification requirements, minimum qualifications, training and education requirements, and are practicing within their scope of practice. The hospital/CAH is responsible to provide emergency care necessary to meet the needs of its inpatients and outpatients. The hospital/CAH must determine the categories and numbers of physicians, specialists, registered nurses (RNs), EMS professionals, and support staff needed to meet anticipated emergency needs. There must be sufficient medical and nursing personnel to respond to the emergency medical needs and care for the patients. The nursing services regulations for hospitals/CAHs require that a RN provide or assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. An RN must make all patient care assignments and supervise and evaluate the nursing care for each patient.

In summary, a hospital/CAH employing EMS professionals in a hospital setting must define the specific role of EMS professionals within the facility and the oversight and supervision of these individuals. The hospital/CAH is responsible to ensure appropriate staff to meet the medical and nursing needs of patients consistent with federal and state regulations.

For specific questions related to hospital/CAH compliance with 42 CFR 482 or 42 CFR 485, please contact the North Dakota Department of Health, Division of Health Facilities at 701.328.2352. Questions regarding scope of practice should be directed to the appropriate regulatory entity for that profession.

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