A Simple Start to the New Year: Clear-cut Clinical Policies

Thursday, January 4, 2024

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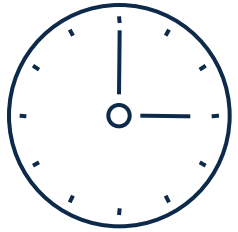

The webinar will start at the top of the hour.

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MONTHLY CLINICAL QUALITY INSIGHTS

Webinar Schedule & Topics

THE 3RD THURSDAY OF EVERY MONTH:

10AM Pacific, 1PM Eastern

TODAY

A Simple Start to the New Year: Clear-cut Clinical Policies

FEBRUARY

Hidden Obstacles and Sticky Wickets: Environment of Care, Life Safety, and Emergency Management

Past Webinars Available for Streaming

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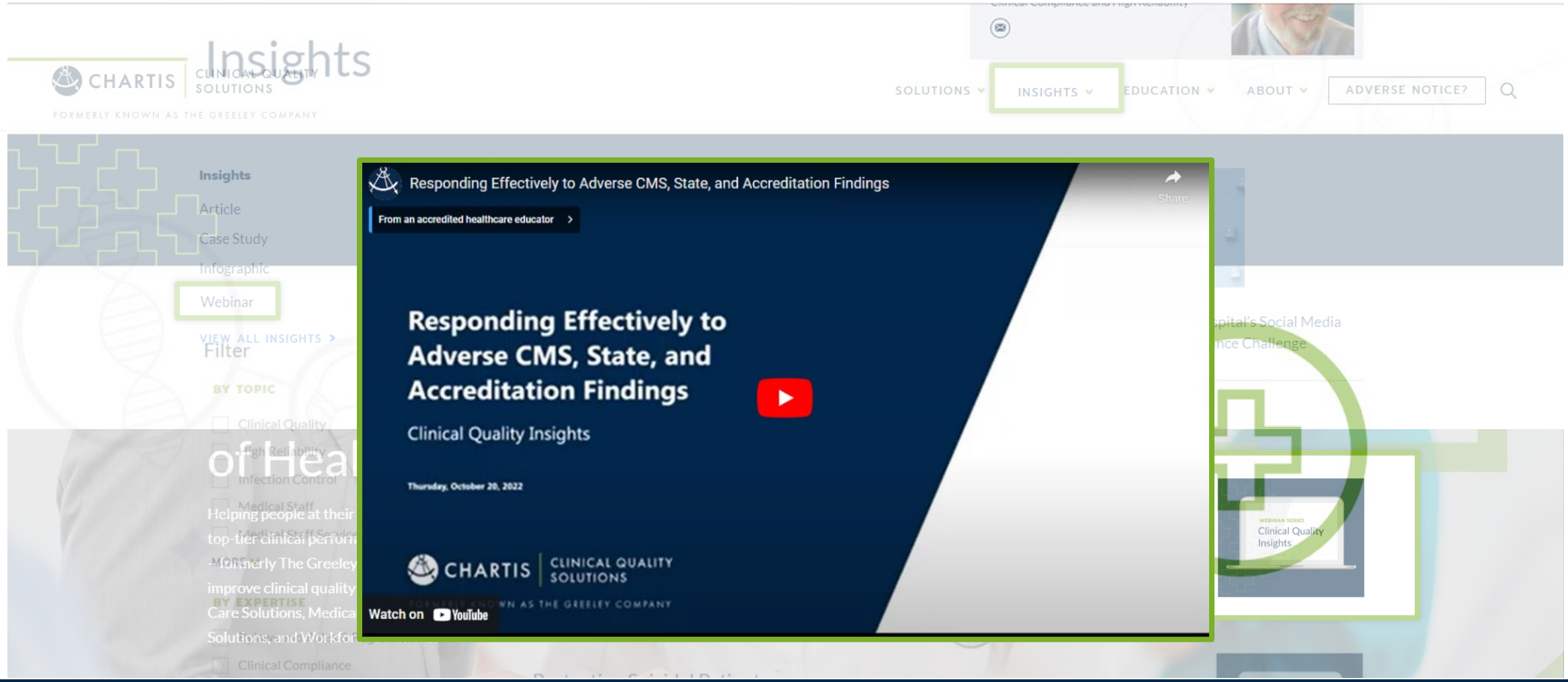

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AVAILABLE FOR STREAMING

- Practical Approaches to Ace Regulatory and Accreditation Surveys
- EMTALA Made Simple
- Protecting Suicidal Patients
- Responding Effectively to CMS, State, and Accreditation Findings
- Avoiding Infection Prevention Survey Catastrophes
- Survey Smarts: Looking Forward to 2023
- Increasing Nurse Efficiency: Documentation Simplification
- Better Meetings Better Results
- Overcoming Persistent Challenges in the Physical Environment
- TJC's Emerging Model for New Standards
- New CMS Interpretive Guidelines for QAPI
- Putting Your Best Foot Forward During Survey
- Connecting Hospital Rankings to Outcomes
- Compliance and Safety Challenges for Psychiatric Hospitals and Units
- CMS and QAPI: A Deeper Dive
- Mid-Point Update … Focusing on Regulatory Changes
- Reducing Burden: What Clinical Documentation Is Required vs. Self-Imposed
- **A Simple Start to the New Year: Clear-cut Clinical Policies**

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- Emergency Department/EMTALA
- Behavioral Health
- Infection Prevention
- Patient Safety
- Process/Policy Simplification
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SIMPLIFY & COMPLY

What is your role?

- Chief Quality Officer
- Other Executive Leader
- Quality Manager
- Patient Safety Officer
- Risk Manager
- Accreditation/Regulatory Compliance
- Consultant
- Other

TODAY'S DISCUSSION

Updating our community on new issues and trends related to CMS and Accrediting Organizations.

Lisa Eddy MSN, MHA, RN, CPHQ

Vice President,
Clinical Compliance and High Reliability

Cherilyn Ashlock DNP, RN, NE-BC

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Clinical Compliance and High Reliability

Bud Pate

Vice President - Content/Development,
Clinical Compliance and High Reliability

"

Keeping up with Change

Planning for Tomorrow

"

Who is your primary accreditor?

- The Joint Commission
- The Accreditation Commission for Health Care (ACHC)
- Det Norske Veritas (DNV)
- Center for Improvement in Healthcare Quality (CIHQ)
- Non-Accredited
- Other

Objectives

- **Identify overly complex, burdensome policies as a vulnerability for non-compliance.**
- **Consider changes to guidance documents that satisfy applicable requirements, evidence-based practice, and operational efficiency.**
- **Establish processes to create simple, concise, compliant, and safety-focused guidance documents that remove impractical and unnecessary expectations while satisfying all regulatory and accreditation requirements.**

Handouts will be linked to the Chartis Website for post-webinar streamers.

TODAY'S

Agenda

01 **Identify Common Policy Struggles**

02 **Understanding Different Document Types and their Impact**

03 **Policy Scenarios = Best to Worst**

04 **Policy Writing – Tips and Tricks to Simple Policies**

05 **A Look at Some Sample Policy Missteps**

Questions should be posted in the webinar interface throughout the presentation.

We will respond to any unanswered questions in writing following the webinar.

COMMON STRUGGLES

Common Struggles Leading to Increased Burden

Identifying policy development issues with big impacts

1. **Policy Design:** Doesn't align with staff's natural workflow. Hospitals don't really understand the path between expectation and operational reality.

2. **Regulation Myth:** Pervasive misunderstanding…"The last surveyor said, so it **must** be true". Incorrect or overinterpretation of requirements.

3. **Requirements:** Hospitals do not clearly understand regulatory requirements (CMS, TJC, DNV, etc.) with loss of regulation "intent" during policy development.

4. **The Kitchen Sink Methodology:** "While we're at it, let's require **this** in the policy" leads to excessive and unnecessary policy burden.

5. **If Policy Requires It…:** Building policies to force practice instead of building workflows that make sense. Believing BIGGER policies = BETTER policies and believing if we REQUIRE it in policy, it will happen.

6. **Operational Issues:** Not aligning policy to practice, and not considering how policy requirements are reflected in the EMR (extremely common).

Not All Documents are Policies

Understanding the Difference…

Impact more than one Department and/or Discipline

Only impacts one Department and/or Discipline

Multidisciplinary Policies	Ex: Restraint, Suicide, Sedation
Organizational Plans	Ex: UM Plan, QAPI, Emergency Management
Administrative Manuals	Ex: Compliance, Human Resources
Protocols	Can go either way depending on content
Departmental Guidelines	Clinical and Non-Clinical
Standards of Care	Ex: Surgery Recovery Standards of Care, ICU Standards of Care
Procedures Depending on content, can go either direction	Ex: QC Prior to Running Lab Chemical Test, Calibrating Equipment
Competencies	Unit/Department based competencies specific to a discipline

Policy Oversight Committee

Requires approval from appropriate stakeholder (Executive VP, CNO, Chairperson, etc.) then oversight committee

Departmental Approval

Only needs approval at the Department Level (Director of Department, Executive VP, etc.)

Polices Scenarios (Best to Worst)

POLICY = Requirement = Practice

POLICY ≠ Requirement = Practice

POLICY = Requirement ≠ Practice

POLICY ≠ Requirement ≠ Practice

This is where you want to be…

Policy = Requirement = Practice

Polices Scenarios (Best to Worst)

Policy ≠ Requirement = Practice

- Can often talk your way out of this
  - Likely providing safe care
- Fix = Correct the policy to match regulations
- Will generally not contribute to adverse events but doesn't align with regulations
- Can lead to a citation

Polices Scenarios (Best to Worst)

Policy = Requirement ≠ Practice

Policy ≠ Requirement ≠ Practice

- You can't defend this even if policy meets the regulation
- Liability
- Will almost always result in a citation
- Lack of Credibility
  - Policy Implementation Issues
  - Lack of policy monitoring
  - Lack of policy enforcement

Policy Development Tips

A Guide To Simplified Policy Writing

Ask Questions!

Is this policy worthy?

- Should this just be education?
- Is this a competency?
- Is this more appropriate as a guideline or training material?

Does this meet the intent of the regulation?

- Is "this" **safe**?
- Is this even required?
- What do the regulations really require (i.e., what is the regulation **intent**)?
- Are we putting cherries on top?

Ask Questions!

Who is my audience?

- Will my audience understand this?
- Does it make sense to their workflow?
- Is it something they can operationalize?
- Does policy match practice?
- Have I asked my audience for input?

How do I keep policy statements (purpose) slim?

- What's my intent? What are you trying to say in ONE sentence, maybe two?
- Are you focusing on your audience? Your policy statement should speak to your audience to provide clear intent.
- What am I trying to accomplish with this policy?

Ask Questions!

Am I setting people up for failure?

- Are you asking them to do something that:
  - Can't possibly be sustained?
  - Contradicts their natural workflow?
  - Adds additional requirements for "best practice"
  - Requires unnecessary documentation

Does this policy already exist?

- Have you searched current policies to ensure you aren't duplicating an existing policy?

Don't Do It!

Don't develop unrealistic expectations

- These are never sustainable
- Think of the newest clinicians on their busiest day

Don't ask people to document just to "prove" they did it

- Think outside the box. How else can we determine compliance?

Don't develop policies that conflict with other existing policies.

- Inventory policies

Don't Do It!

Don't make policy changes:

- For surveyor "preference" – they may "want" you to do something, but is it really a requirement or just a pet rock?
- In the name of best practice – teach best practice and put actual regulatory requirements in policy.
- For legal concerns – a policy will not save you in court when care was substandard – we failed the patient, period.
- Because you think policy dictates practice…you will never succeed in forcing compliance through policy/documentation. You must understand the process.

Don't Do It!

Don't turn your policy into a book:

- You rarely need a laundry list of definitions.
- It's fine to say staff will be educated but you don't need to say *how, when, where*, etc. they will be educated. This adds unnecessary burden to your policy.
- Don't embed pictures, algorithms, charts, graphs, etc. – these are addendums, attachments or guidelines.
- Don't copy/paste the Conditions of Participation/Joint Commission Standards and drop them in your policy.
- Don't add language that people trying to implement the policy won't understand.

Let’s Look at Some Examples

Policy Summary/Purpose Statements….You Don't Need Them!

(Current) PURPOSE: Dress and grooming are not only an indication of each Team member's personal pride, but also an expression of XXXX Hospital's overall high standards. It is important that each team member presents a personal appearance in which both the patients and public alike can place their confidence.

(Current) Policy Summary: It is the policy of XXXX Hospital to require personal hygiene, grooming, dress, and appearance of staff, to meet appropriate dress code standards while on duty. As such, XXXX team members should avoid extremes in dress, grooming, and personal appearance. Considering that appropriate dress is based, in large part, on an individual's perception, XXX management reserves the right to make the final decision on appropriate attire. Infection Control Standards or Department Policy, such as required uniforms, may supersede this policy's general dress standards. XXXX Hospital requires certain team members to wear scrubs or other attire for infection control purposes. These team members are the only group of team members that are approved to wear hospital-supplied scrubs.

Questions:

- What's my intent? What are you trying to say in ONE sentence?
- Who is your audience?
- Did we achieve WHAT not HOW?

(New) Policy Statement: All XXX employees will abide by dress code standards.

Who Is the Audience?

Headers

Policies:

1. **Patient Rights**
   a. All patients are informed of their rights, including their right to considerate, respectful care and the right to be actively involved in their care.
   b. These rights include pain management, the right to receive or refuse treatment for acute and/or chronic pain and the right to participate in determining the goal of pain management.
   c. The patient's right to receive care that supports their cultural and spiritual values, are also considered in pain management decisions.

- Who is this information meant for? Audience?
- All of this is included in Patient Rights handouts, posters, etc.
- If for nursing staff, this is just education they should get in CBL/Online Learning.

Is This Really Policy?

Or Education?

POLICY:

A. Patients have the right to appropriate assessment and management of pain that achieves the highest level of relief that can be realistically and safely provided.

B. The patient's report of pain, as measured on a standardized scale, is considered an effective assessment tool in the management of their pain due to the subjective nature of pain.

C. The patient and family members are encouraged to be involved in the patient's pain management when appropriate to work with the provider to establish realistic expectations and goals, discuss treatment progress such as relief of pain and improved physical and psychosocial function, and to guide patients in a manner that increases likelihood of treatment adherence.

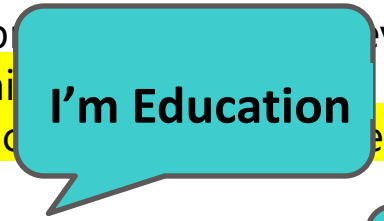
D. Education:

1. The hospital provides education for staff and licensed independent practitioners, including:
    1. Pain assessment and management
    2. Safe use of opioid medications
    3. Available services for consultation and referral of patients with complex pain management needs
    4. Opioid treatment programs that can be used for patient referral.
2. The hospital provides education for patients and families, including:
    1. Pain management
    2. Treatment options
    3. Safe use of opioid and non-opioid medications when prescribed.
    4. Discharge plan of care, side effects of pain management treatment, and safe use, storage and disposal of opioids when prescribed.

Don’t Paint Yourself into a Corner with Prescriptive Language

PRINCIPLES OF ANALGESIC MANAGEMENT OF PAIN

XXXXXXX Pain Management policy is based upon evidence and clinical p everal principles of analgesic management to meet the objective of preventing moderate to severe pai
When continuous pain is anticipated, a fixed-dose schedule (around the c ed.



A PRN order of a rapid onset analgesic may be necessary to control activity-related (breakth

To ensure opioids are safely administered, begin wit rate to comfort.

Modification in analgesic administration is based upon assessment of the effect of t ncluding change in pain intensity, relief, and side effects experienced.

Patients respond differently to various opioid and non-opioid e, if one drug is not providing adequate pain relief, another in the same class may result in better pain contr

Assessment of effect should be based upon the onset of action of the drug administered.

Be Careful with Word Choices….

1. **Initial Comprehensive Pain Assessment**

a. The patient's initial assessment upon admission and with each new onset of pain will include a comprehensive evaluation for pain using multidimensional tools assessing physiologic signs (i.e., elevations in blood pressure or heart rate), verbal and nonverbal cues (i.e., grimacing, crying, restlessness, posturing, furrowing of brows, moaning, withdrawal, or guarding), or one-dimensional tools (0-10). This assessment includes:

- Intensity (pain score), description, location, type, onset, and frequency
- aggravating and relieving factors (both pharmacologic and non-pharmacologic)
- patient's pain goal
- pain interventions

You don't want to corner yourself by stating that the initial assessment upon admission should include a "comprehensive pain assessment". **TJC no longer uses this language**. Additionally, a physician may perform a thorough pain assessment in the ED or in an H&P and this is sufficient. When admitted, nursing would re-evaluate pain. You also want to steer clear of words like "The assessment includes" and instead state, "**The assessment may include, but is not limited to……"**

Be Careful with Word Choices….

a. Patients potentially at increased risk for opioid related respiratory depression are identified in Appendix C
b. The pain scale will be selected according to the developmental stage of the patient, patient's ability to self report, motor function, and in consultation with the patient/patient's family.
c. The same scale will be used consistently throughout the inpatient hospital stay unless otherwise indicated.
d. In outpatient/clinic settings a p[illegible]assessment will be completed upon the initiation of care and as related to the reason for the visit.

An age, condition and ability-appropriate pain assessment should be conducted for any patient reporting or suspected of having pain.

Be Careful with Word Choices….

a. Patients potentially at increased risk for opioid related respiratory depression are identified in Appendix C: Patient at Increased Risk for Opioid Related Respiratory Depression.
b. The pain scale will be selected according to the developmental stage of the patient, patient's ability to self report, motor function, and in consultation with the patient/patient's family.
c. The same scale will be used consistently throughout the inpatient hospital stay unless otherwise indicated.
d. In outpatient/clinic settings a pain assessment will be completed upon the initiation of care and as related to the reason for the visit.

Are you compliant with this?
Does this statement provide a path from expectation to operational reality?
Do we expect staff to document WHY they are using a different tool when there should already be evidence of this in the record?

Be Careful with Word Choices….

a. Patients potentially at increased risk for opioid related respiratory depression are identified in Appendix C: Patient at Increased Risk for Opioid Related Respiratory Depression.
b. The pain scale will be selected according to the developmental stage of the patient, patient's ability to self report, motor function, and in consultation with the patient/patient's family.
c. The same scale will be used consistently throughout the inpatient hospital stay unless otherwise indicated.
d. In outpatient/clinic settings a pain assessment will be completed upon the initiation of care and as related to the reason for the visit.

Other ambulatory patients need not be assessed for the presence of pain unless:

- Pain is commonly associated with the condition for which they are seeking care or
- Pain may be induced by subsequent treatments or interactions (for example, patients undergoing an outpatient invasive procedure or potentially painful therapy).

Understand the Requirements

Pain Reassessment

a. For inpatients, reassess for the presence of pain daily while awake.
b. If the patient is experiencing pain, pain is reassessed every 4 hours.
c. If a pain management intervention is provided, reassessment should occur once a sufficient time has elapsed for the treatment to reach peak effect:
    - Within 30 minutes for parenteral medications
    - Within one hour after oral or rectal medication or non-pharmacologic intervention.
    - Every four hours for pain controlled with a transdermal opioid patch
    - As required for specific therapies (Appendix A: Adult Patient or Appendix B: Pediatric Patient
d. At time of discharge, pain is reassessed. To prevent a delay in the discharge process, the timing following intervention should be based on the clinical judgment of the physician and/or nurse.
e. Reassessment includes:
    - one-dimensional tool used, intensity (pain score), description, location and intervention(s) or
    - complete multidimensional tool, intensity (pain score), intervention(s)

Does policy match practice? What if the patient is sleeping?
Is this a clear path from expectation to execution?

Avoid Conflicting Instructions

Initial dose (First dose):

1) Assess the patient before administering the ordered medication.

Unexpected intense pain, particularly if sudden or associated with altered vital signs, such as hypertension, hypotension, tachycardia or fever, is to be evaluated and reported to the physician. Character and location

The assessment/reassessment process includes considering the psychosocial, spiritual, cultural, and

Consider the patient's pain assessment and previous response to analgesic therapy.

In the Emergency Department and other outpatient areas, i.e., outpatient surgery, Radiology, etc., pain is

Assess the patient before administering the ordered medication, paying special attention to the clinical need as well as monitoring for potential adverse effects both before and after the next dose

Reassessment: If symptoms are not relieved in the expected period of time for the ordered analgesic and/or route, additional doses may be given for a total amount not to exceed the maximum prescribed dose in the range order with the ordered frequency. If the remainder of the prescribed dose is administered, the start of the next dosing interval begins with the time at which the remainder of the dose was given.

To Reference or Not

References:

Comfort Measures Only Treatment Guideline
Clinical Practice Guidelines: Ketamine as an Adjunct to Pain Management
Clinical Practice Guidelines: Ketamine as an Adjunct to Pediatric Pain Management
Clinical Practice Guidelines: Ketamine in Pediatric Palliative Care Cancer Patients
Clinical Practice Guidelines: Ketamine for Facilitation of Rapid Sequence Endotracheal Intubation by Continuous Infusion in Adult ICU
Clinical Practice Guidelines: Ketamine in Palliative Care Cancer Patients
General Medicine Palliative Care Comfort Measures Only Order Set
Institute for Safe Medication Practices
Joint Commission on Accreditation of Healthcare Organizations
Policy Administration of Epidural/Intrathecal Analgesia
Policy Intrapleural Analgesia
Policy Naloxone Administration to reverse Effects of Suspected Opioid Induced Central Nervous System and Respiratory Depression
Policy Patient Controlled Analgesia (PCA) or Intravenous Opioid Analgesia Continuous
Policy Peripheral Nerve Catheter for Analgesia

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19 years

17 years

15 years

25 years

17 years

16 years

20 years

27 years

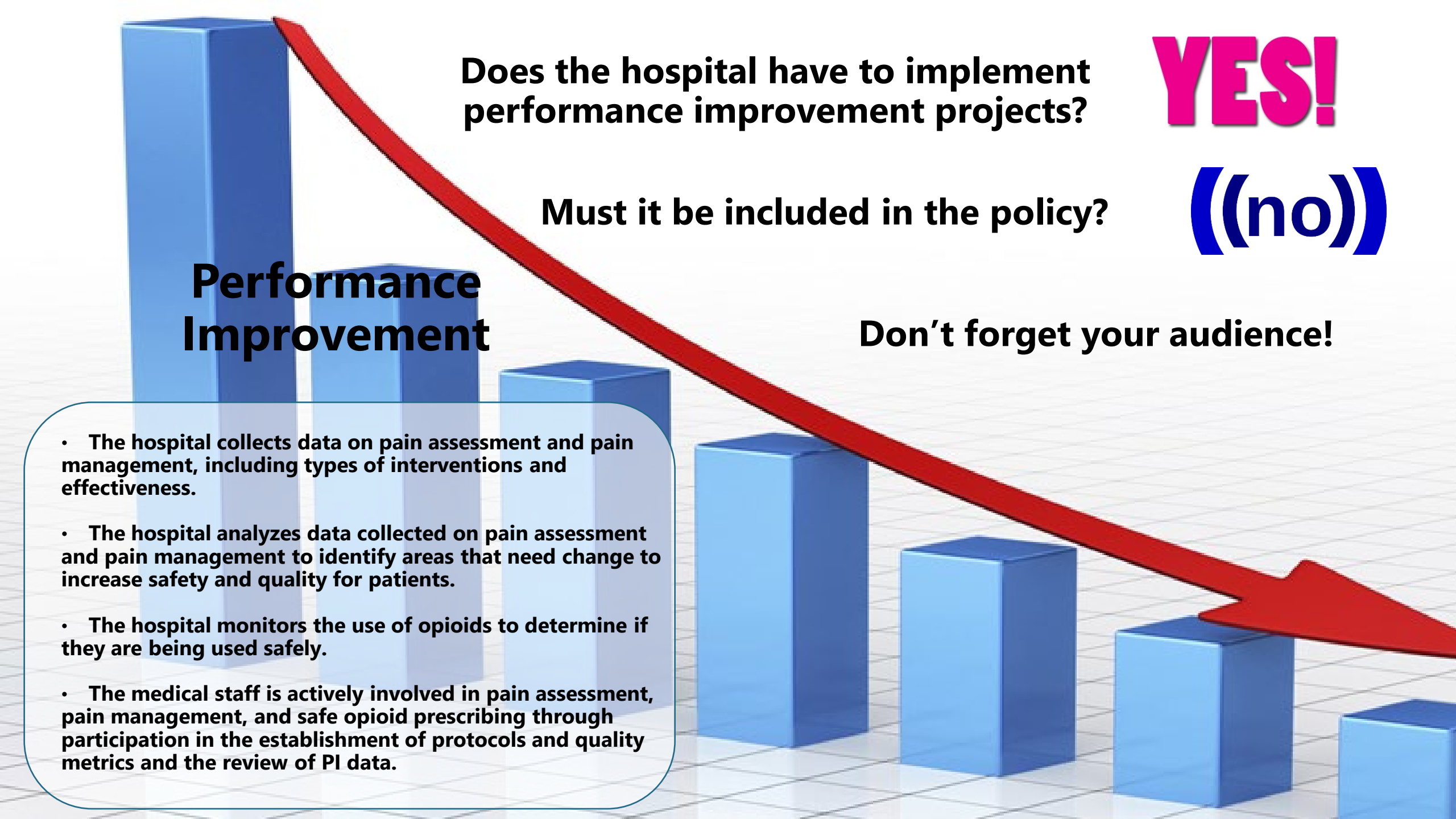
No reference

18 years

15 years

WHAT ABOUT QUALITY MONITORING?

What to include in policy



Performance Improvement

Does the hospital have to implement performance improvement projects?

YES!

Must it be included in the policy?

((no))

Don't forget your audience!

- **The hospital collects data on pain assessment and pain management, including types of interventions and effectiveness.**
- **The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.**
- **The hospital monitors the use of opioids to determine if they are being used safely.**
- **The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through participation in the establishment of protocols and quality metrics and the review of PI data.**

What We Covered Today. Thanks for Joining!

01 Identify Common Policy Struggles

02 Understanding Different Document Types and their Impact

03 Policy Scenarios = Best to Worst

04 Policy Writing – Tips and Tricks to Simple Policies

05 A Look at Some Sample Policy Missteps

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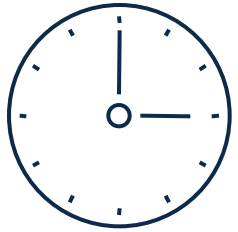

Thank you for participating in today's webinar.