



Patton Healthcare Consulting Newsletter February 2016

NEWS FROM TJC

High Level Disinfection and ILSM

The lead article in the February issue of Perspectives is about their new booster pack on high level disinfection and sterilization that was released in December. We discussed developing teams to analyze the different sections of this booster pack in our December newsletter and hopefully this has been started. There is nothing as complex, as difficult and as frequently scored as this issue, so being better prepared is highly recommended. There is also a great article entitled Plan B, which is a continuation of the TJC series called Clarifications and Expectations. This month they discuss interim life safety code measures as required by LS.01.02.01. This standard is particularly important because EP 3 by itself is associated with an adverse outcome, accreditation with follow up survey, (AFS) if there is a failure to have an ILSM policy and evaluate life safety code deficiencies using that policy.

In years past hospitals got stung by this standard when their ILSM policies and implementation only focused on construction and failed to consider other life safety code defects, such as those items being added to the Part IV, Plan for Improvement or PFI. The Joint Commission has helped to make this clearer in recent years through their many publications, educational programs and now even in the PFI itself where it asks the hospital to identify if the issue has been

evaluated for ILSM.

Another point of confusion we have seen in hospitals is a failure to implement any ILSMs unless the fire alarm was shut off for 4 hours or more, in which case the safety measure implemented was a fire watch. This article makes the distinction clear between fire watch (EP 1) and ILSM's (EP's 4-14). Fire watch is an absolute requirement if the alarm system or sprinkler system is going to be out of service for 4 hours or more. ILSM's, or other means of keeping people safe may be needed for other defects or construction and your policy should help shape what you do to keep people safe. A good way to think about this standard is EP's 4-14 are things we might do, in order to promote fire safety during the timeframe when one or more defects exist. Based on the nature of each temporary defect, your ILSM policy and facilities staff should determine which of the things described in EP's 4-14 are going to be done to enhance fire safety during this period.

We mentioned that in past years we used to see hospitals fail to evaluate for ILSM. This is seen less often today due to the reminders TJC has issued and the link in the PFI. However, we still often see a failure to document the implementation of the selected ILSM's. If your policy says you are going to do something, and your risk assessment or decision making process confirmed you were going to do it, then you have to do it and a log or some other suitable documentation should exist to prove that you did it. Sounds simple, but when a project goes on for months, it is too easy to forget the commitment

to conducting an extra fire drill (EP 11) or extra rounding to keep an area clean of combustible debris (EP 9).

One last risk point we want to mention for this standard is a failure to evaluate ILSM for Life Safety Code defects which cannot be immediately corrected, but do not trigger a PFI because you believe you can correct the defect within 45 days of discovery. While you can bypass adding the defect to the PFI, you can't bypass evaluating the defect for ILSM or implementing ILSM as deemed necessary.

This article from Perspectives should be shared with facilities leadership and discussed at their EC committee to verify compliance. The key questions to ask for this self-assessment are:

- Do we have the required policy, which includes construction, and all identified defects?
- Are we evaluating all defects that cannot be corrected immediately (i.e., today)?
- Does our evaluation tool include potential implementation of all enhanced safety measures described in EP's 4-14?
- Do we have documentation that we implemented ILSM for recent defects as described in our policy?

EC NEWS:

EC News has the same article on ILSM as Perspectives. The page one article is on PPE training through simulation and it is interesting as it describes testing staffs ability to safely don and doff PPE by using a chemiluminescent contaminant in mock blood and body fluids. The donning and doffing of PPE can seem overly simple to staff, but demonstrating how easily contamination can occur on personal clothing, shoes, etc. may make the simulation more interesting and educational. There is a very worthwhile article written by a facilities director entitled "Tips for Succeeding During a Life Safety Building Tour." The article provides 5 tips for success on survey, which are:

- Have your life safety code drawings available and up to date. Too often this breaks down at the very start of the building tour because the building no longer matches the drawings.
- Make sure the staff participating in the building tour have access to and knowledge of the standards. The author mentions discussion with a surveyor where the surveyor describes these staff not even having a copy of the standards. We see this too as consultants where the staff have no knowledge of how to use the E-edition and thus have no access to the standards. We also see staff having the "R" (high risk) EP's from the Focus Standards Assessment (FSA), but not all the standards and EP's.
- Conduct your own building tour by making more effective use of the EC rounds that must be conducted every 6 months.
- Encourage staff reporting of defects. We see this as a significant break point very often where staff perceive a lack of responsiveness, so they stop reporting. Then as consultants we see, or TJC sees stained ceiling tiles, fire-rated doors that don't latch, missing escutcheons, popped ceiling tiles or other defects which could have been corrected had they been reported.
- Maintain structures for safety. Here they discuss your regular above the ceiling inspection program and programs such as inspection after a vendor has been above your ceiling. If you are not looking above the ceiling, you are going to be unpleasantly surprised by what TJC finds when they look.

This article should also be shared with facilities staff for discussion and analysis to verify that you have all these processes in place and staff are regularly reporting defects. A good way to verify your readiness is to compare environmental findings on EC rounds and Quality rounds. If Quality staff are finding environmental defects, the first line of defense is not working.

CMS UPDATE:

Two Memos Related to Infection Prevention

CMS issued a new Survey and Certification (SC) memo for the Hospital industry, SC 16-05, dated December 23, 2015. The good news is that this SC memo only describes a plan for CMS to pilot test and refine a new tool for conducting evaluation of infection control practices. The plan is to have a contractor conduct 10 pilot surveys in federal fiscal year 2016, but no routine deficiency notices will be issued from these pilot surveys. However, if the contractor sees what they perceive to be an immediate jeopardy situation, they will make a referral of that issue to the appropriate CMS regional office for evaluation. There was a second SC memo, SC 16-06 issued on January 22, 2016 which discusses an online training program available to CMS surveyors on infection control, specifically hand hygiene, injection safety, and environmental cleaning. In recent years we have seen an enhanced focus on infection control related issues by both TJC and CMS surveyors, and you can anticipate enhanced knowledge and ability to evaluate compliance as these agencies conduct surveyor training.

Nursing Home CMS Memo

We wanted to briefly mention another SC memo issued last fall to the nursing home industry. This memo, SC 16-04, dated November 27, 2015 discussed focused dementia survey tools. Much like CMS did a few years ago with enhanced tools to evaluate infection control related issues; they have developed additional tracer tools for surveyors to evaluate dementia care in nursing homes. We mention this only because some of the same surveyors conduct SNF and acute hospital surveys. With some clients we have seen a focus during hospital surveys on treatment of patients with dementia and in particular pharmacologic treatment involving sedative medications with findings about non-approved indications and dosing. Time is always limited,

but if you have a busy ED serving a large number of nursing home transfer patients, many of whom are exhibiting behavioral symptoms, you may want to review these tools to better understand where your CMS surveyors are coming from.

OTHER PUBLICATIONS:

In the fall of 2015 there was a Joint Interim Guidance document issued by APIC, AAMI, AORN, ASHE, ASHRAE and FGI on HVAC (e.g., temperature, humidity, air exchanges, pressure gradients) requirements in the operating room and sterile processing areas. This is readily available on the websites of the participating agencies. The easiest way to find it is to Google the title and there are multiple links to the same document. The bottom line advice on this issue is to know your design requirements and pick your clinical practice guidelines (CPG) that your hospital adheres to. Joint Commission surveyors seem very knowledgeable about AAMI, but if your using AORN let them know and know the details of what AORN requires.

SGNA has two new clinical practice guidelines (CPG), one on reprocessing of flexible GI endoscopes and a second on infection prevention in the GI setting. These can be downloaded from SGNA using this link: <https://www.sgna.org/Education/Standards-Practice-Guidelines>

In the flexible scope document SGNA provides guidance on minimum cycle documentation including:

- Procedure date and time
- Patients name and MR #
- Endoscopists name
- Endoscope model and serial number or other identifier
- Names of individuals who reprocessed the endoscope.

This cycle documentation differs from what we have previously described from AAMI, so again,

pick your CPG, know what your CPG requires and be sure you have the basic requirements covered. The flexible scope document also recommends a Spill Containment Plan for the reprocessing staff. Many times there is a spill containment plan for the hospital and staff have some minimal knowledge of who to call, but may not be able to actually discuss any details, or specific actions they must take.

The flexible scope document recommends a “time out” or safety stop for a visual inspection of a cleaned scope prior to sending it for reprocessing. This is a step we seldom hear staff describe, as there is usually a presumption that pre-cleaning followed by cleaning worked effectively and it is thus safe to send for HLD. This SGNA document also cross references and

suggests use of AAMI guidance to include adequate lighting and magnification during this visual inspection process.

Whether you have selected SGNA as your CPG or not, you will want your endoscopy and infection control leadership to review these documents and decide if changes are needed in your practices. Knowing the minutiae in clinical practice guidelines and implementing all the minutiae in your selected CPG is essential. The seemingly minor differences in guidance can lead to “gotchas” during survey if you are not clear whose advice you adhere to.

If you are reading this newsletter because it was forwarded to you and you would like to be added to the

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