Steven Hirsch and Associates

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Steven Hirsch and Associates

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OUR MISSION

Our mission is to provide dynamic integrated expertise that supports health care organizations in meeting and exceeding patient care standards as mandated by the regulatory environment.

OUR VISION

To provide a positive and supportive environment that fosters professionalism while providing the highest quality client centric consulting expertise in the health care industry.

OUR VALUES

CREDIBLE • ETHICAL
EXPERT • INTEGRITY
PROFESSIONAL
RESPONSIVE

Educate for C-LEAN-ing

Let's write a policy for that! Any talk about compliance and cleaning will include that suggestion. Here are pointers on what type of cleaning policy to make for your setting. It is assumed everyone knows the proper steps to use with cleaning items; we all use the dishcloth, soap, and water to clean our dishes, clothing and floors. (Hopefully we do not use the same cloth for all). What could be so different about the hospital or health care setting?

The difference in 2016 is the number and types of organisms, the amount of soil or bioburden (definition coming up) in a location, and the individuals performing the cleaning. Usually a facility will have a standard type of cleaning solution, wipes and methods defined-but not always followed by the staff.

True story: an associate stated "I have people who do that for me at home" when being instructed to clean IV fluid waste from an IV pump with a wipe. Puzzled, I asked whether there were people in the hospital who were responsible for cleaning and the answer was "Housekeeping." In no way was this individual going to don gloves and wipe anything. This person was waiting for the cleaning people (and me) to remove the visible soil. Sometimes our colleagues may believe there are magic elves that come out at night like Rumpelstiltskin and clean the hospital beds, IV equipment and more.

Consider this second dilemma of infection preventionists: What do we do about a made bed, left in an isolation room? Can it be marked as "used," or as "do not use?" Do we remove the bedsheets so it is a bare mattress? I would hate to look at that all day if I were a patient. Often our patients must share rooms. In one of our most excellent hospitals, the staff moves the bed out of the room and places it into allowable storage, so it doesn't obstruct the corridor. Additionally we could always count on hospital staff to have cleaned the bed before making it up for the next person. Teach that practice to control *C. difficile*, MRSA and VRE.

Make a note to train for cleaning, disinfection and sterility to remember: E-D-U-C-A-T-E:

E- Every health care worker in each department must know how to decontaminate, clean, maintain, handle and store equipment in an aseptic manner.

D- Disinfection must occur after cleaning the items that are to be used by one patient or person prior to the next. Disinfect items properly according to

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Educate for C-CLEAN-ing Continued...

the disinfectant product manufacturer's instructions. Learn the proper methods of sterility assurance.

U- Uncleaned items need to be separated from cleaned items. Decontamination space can be limited to the soiled utility area, as long as items are removed for reprocessing.

C- Care enough to cover items that have visible soil or stains. Bioburdens: That is visible urine, feces, and spills make a ring on any item. Bioburden can be invisible too, inside of improperly cleaned and disinfected items. On a reusable air mattress, it can appear as if it was never cleaned. Hint: Do not leave a non-porous turn mattress pad under anyone as a lifting mechanism. It is non-breathable and not permitted.

A- Air dry when able, instead of wiping items dry with a cloth (the cloth can accumulate organisms). Absolutely do not allow anyone to remove partially dried surgical instruments for use if not completely aerated after sterilizing: They will compress bacteria into the moist pack.

T- Teamwork makes the cleaning job go quickly. T- Time is the enemy of proper cleaning and if time is not allotted for cleaning, cleaning never occurs until that last minute rush. Getting ready for company is one thing: Cleaning for the patients and inspector is quite another. They always know it can be soiled underneath. A recent study done by Association for Healthcare Environment mentioned it can take 90 minutes to properly clean a *C.difficile* room with bleach wipes. Are walls wiped? Is the curtain changed? That is the standard.

E-Enjoyable cleaning involves mindfulness. It is pleasant to make a piece of equipment glow; to repurpose instruments properly; it is beneficial to see the correct time, pressure and temperature on a sterilizer indicator. Make it unpleasant for individuals who do not cooperate, since it is equally unpleasant to put up with staff who dislike cleaning and place soiled items aside for someone else. Designate a cleaning person for utility areas, common areas, and frequently used items. Call to mind the mission of the particular facility, or use the current LEAN process to improve performance of cleaning.

In "LEANing up the cleaning process" (on line at http://www.cmmonline.com/articles/leaning-up-the-cleaning-process-3) the author recommends bringing everything to a "new-like" condition and eliminating items not being used, as well as obtaining buy-in from the front line workers.

Written by Denise Bleak MSN, PHN, CIC of Associates

ECRI In Case You Missed It

Information, in great volume, flows rapidly in today's health care arena. The following is some recent information that may be of interest to you in your workplace.

ECRI Institute

ECRI has published its third annual list of the top ten patient safety concerns for 2016. During our survey activities at Steven Hirsch & Associates, our team has encountered many of the same scenarios.

1. "Information technology configurations and organizational work flow do not support each other." This may be seen in lack of flow of information and documentation completed in surgery that is to be communicated to other areas of the clinical setting. In some areas, the nurse is not able to retrieve documentation of the pre-procedural verification and other documentation collected in surgery.
2. "Patient identification errors." Our team has direct observations of lack of use of two patient identifiers, such as during medication administration when the nurse already "knows" the patient.
3. "Inadequate handling of behavioral health issues in non-behavioral health settings." With boarding of patients requiring psychiatric care in the Emergency Department until a psychiatric bed be-

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ECRI In Case You Missed It Continued...

comes available, are the clinical staff members well able to provide appropriate interventions to the patient?

4. "Inadequate cleaning and handling of flexible endoscopes." We find that many hospitals are not conducting annual competency, including direct observation, for staff whose role it is to clean and disinfect scopes.
5. "Inadequate test result reporting and follow-up." In most cases, this is a documentation issue in which it was discovered that the reporting of the results to the provider was accomplished, but documentation of the reporting was lacking.
6. "Inadequate monitoring for respiratory depression in patients receiving opioids." Serial assessment of a patient's respiratory status may contribute to the reduction of opioid induced respiratory depression. Organizations are encouraged to develop and implement institutional policies and procedures that are aligned with current evidence-based guidelines.
7. "Medication errors related to pounds and kilograms." Yes, this continues to occur! We recently were conducting a survey in a hospital in which weights were obtained in pounds and then converted to kilograms by the nurse because the scales used only displayed weight in pounds. At another location, the electronic health record converted the pounds entered into kilograms, but the program was incorrect as were the resulting weights in kilograms.
8. "Unintentionally retained objects despite correct count." Thankfully, we have not experienced this situation in a survey; nevertheless this situation does occur.
9. "Inadequate antimicrobial stewardship." It takes a dedicated team, and leader, to successfully implement a meaningful antimicrobial stewardship program. In some cases, formation of this team with clearly identified role expectations, is challenging.
10. "Failure to embrace a culture of safety." Certainly, no one ever wants patient care to be anything but the best. However, creation of a culture of safety that is pervasive throughout an organization requires leadership, willingness to devote resources necessary, and involvement of staff at all levels of the organization. Sometimes this focus may unfortunately get blurred in the day to day challenges of healthcare.

Information in this article was derived from the April 2016 edition of the ECRI Institute's Risk Management eSource.

Written by Linda Paternie, RN, BS, MHA, CJCP of Associates

About Steven Hirsch & Associates

Steven Hirsch & Associates has been providing healthcare management consulting services including accreditation preparation services to hospitals and other healthcare related organizations throughout the United States since 1987. Beyond accreditation and licensure survey preparedness, our healthcare consulting team can provide assistance in a number of areas including Medicare certification, performance improvement, nursing management, infection prevention and control, Life Safety Code compliance, medical staff services (including credentialing and independent peer review), clinical lab management and compliance with HIPAA. For more information on how Steven Hirsch & Associates can assist you with accreditation and licensure preparedness, Medicare certification and other management challenges, please contact us at (800) 624-3750 or visit www.shassociates.com.

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- Pre-accreditation, Medicare certification, and Licensing surveys
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- Performance improvement (CQI) and Patient Safety consultation
- Management of the Environment of Care (including Life Safety Assessment)
- Joint Commission Survey Interview Training
- PPR Preparation

"There is Nothing Permanent Except Change." Heraclitus

The Joint Commission (TJC) has announced that the evaluation of standards and elements of performance conducted over the past several months has resulted in changes to the Comprehensive Accreditation Manual for Hospitals (CAMH).

Effective July 2016, 131 elements of performance (EPs) have been eliminated from the CAMH. It is important to realize that the intents of these elements of performance are still in effect. Compliance has not gone away, rather, compliance will be evaluated under other existing standards. TJC is attempting to streamline the survey process while remaining true to upholding quality and safety. Patient care processes are not expected to be changed, but are to be maintained and reinforced. The prime focus remains that of quality and safety.

The Joint Commission deleted EPs because they were addressed under other existing EPs. These EPs include four Environment of Care EPs, four Human Resources EPs related to education and training, four Infection Prevention and Control EPs related to communication and to influx of potentially infectious patients, seven Information Management EPs, four Leadership EPs, one Medication Management EP related to medications brought in from home, two Nursing EPs related to education/experience and to writing of standards, and fifteen Provision of Care EPs.

The entire standard of PI.04.01.01, Staffing Effectiveness, which has not been in effect for some time, has been removed. Six Record of Care EPs were deleted, as were three Rights and Responsibilities EPs, two Transplant Safety EPs and four Waived Testing EPs.

Numerous EPs are no longer needed because they have become a routine part of current clinical practice and operations. They were removed. And the remaining EP's were found to be addressed by external requirements and thus eliminated from the CAMH. A complete list of standards, deletions and reasons for deletions can be found in the May 2016 edition of Perspectives, the official newsletter of The Joint Commission.

94 additional elements of performance will be deleted effective January 2017. These 94 EPs are related to the restraint and seclusion standards that were applicable to organizations not using accreditation for Medicare reimbursement. TJC has decided to apply the existing restraint and seclusion standards that address the Conditions of Participation for **all** organizations regardless of deemed status. Therefore PC.03.02.01 through PC.03.03.31 shall be deleted as of January 1, 2017.

It is important to stress that although all of these EPs are gone, they should not be forgotten! Their intent and implementation will be addressed during survey processes and can be cited under the appropriate standard and EP.

And remember to keep in mind that if nothing ever changed, there would be no butterflies!

Written by Linda Paternie, RN, BS, MHA, CJCP of Associates