Steven Hirsch and Associates

Accreditation News

Spring 2011 Volume 3, Issue 2

Able to Support DNV Accredited Healthcare Facilities

Steven Hirsch, MPA, FACHE, President of Steven Hirsch & Associates recently completed a two week training program that qualifies him to participate in DNV accreditation surveys, at the same level as a surveyor. Training included detailed review of the National Integrated Accreditation for Healthcare Organizations Standards (NIAHO), followed by a full week of training as a "Lead Auditor" in the ISO 9001 standards that are utilized as part of the DNV accreditation process.

The initial accreditation review (Year 0) conducted by DNV focuses on the NIAHO standards alone. The second annual review (Year 1) is a "gap analysis" to determine compliance of the organization seeking DNV accreditation with the ISO 9001 standards, in addition to any follow up of standards previously identified as being "Noncompliant-1" findings. The following year (Year 2), DNV conducts a "dry run" accreditation survey to determine the hospital's compliance with ISO 9001 standards and again, follow-up to any Noncompliant-1 standards. The next year (Year 3) is a full NIAHO survey at which time the accredited organization is also expected to be ISO compliant. In the event that the hospital is not "ISO" compliant, the organization may be assigned "Jeopardy Status," which places its continued DNV Accreditation at risk.

Steven Hirsch & Associates is now equipped to assist hospitals seeking DNV Accreditation, as well as implementing ISO standards within the organization, and conducting periodic audits as required under the ISO standards. For additional information, please contact the offices of Steven Hirsch & Associates at (800) 624-3750.

Written by Steven R. Hirsch, MPA, FACHE

Steven Hirsch and Associates

18837 Brookhurst Street
Suite 209
Fountain Valley, CA 92708

Toll Free: (800) 624-3750
Phone: (714) 965-2800
Fax: (714) 962-3800

WE'RE ON THE WEB!

WWW.SHASSOCIATES.COM

Patient Safety Licensing Survey (PSLS)

Survey Purpose

The Patient Safety Licensing Survey (PSLS) is designed to evaluate compliance with statutory mandates for licensing of general acute care and acute psychiatric hospitals. The primary focus is to monitor the implementation of statues that have been in effect since 2006. The survey process includes an assessment of the hospital's implementation of eight specific categories:

1. End of Life Care
2. Brain Death
3. Hospital Services

Continued on the Next Page...

Patient Safety Licensing Survey (PSLS) Continued…

4. Patient Safety & Infection Control
5. Discharge Planning
6. Dietary
7. Immunizations
8. Fair Pricing

Statue Requirements

Senate Bill 158 Chapter 294 Statutes of the 2008 Health and Safety Code (HSC) Section 1288.95 contain detailed training requirements for hospital infection control committee chairs and all licensed and non licensed hospital staff including temporary and environmental services staff. These requirements became effective in January 2010:

- "A physician designated as a hospital epidemiologist or infection surveillance, prevention, and control committee chairperson shall participate in a continuing medical education (CME) training program offered by the federal Center for Disease Control and Prevention (CDC) and the Society for Healthcare Epidemiologists of America, or other recognized professional organization. The CME program shall be specific to infection surveillance, prevention, and control. Documentation of attendance shall be placed in the physician's credentialing file.
- All staff and contract physicians and all other licensed independent contractors, including but not limited to, nurse practitioners and physician assistants, shall be trained in methods to prevent transmission of HAI, including but not limited to MRSA and *Clostridium difficile* infection.
- All permanent and temporary hospital staff employees and contractual staff, including students, shall be trained in hospital specific infection prevention and control policies, including but not limited to, hand hygiene, facility-specific isolation procedures, patient hygiene, and environmental sanitation procedures. The training shall be given annually and when new policies have been adopted by the infection surveillance, prevention and control committee.
- Environmental services staff shall be trained by the hospital and shall be observed for compliance with hospital sanitation measures. The training shall be given at the start of employment, when new prevention measures have been adopted, and annually thereafter. Cultures of the environment may be obtained by the hospital to determine compliance with hospital sanitation procedures."

Survey Readiness

Each hospital must, by now, have a physician who has completed the required training offered by a recognized professional organization, as described in the Code. NOTE: This includes physician-chairman who are board-certified Infectious Disease Physicians!

Hospitals must be able to demonstrate that ***all*** employees, contract workers and students have completed infection prevention and control training. There must be documented evidence of attendance or participation in the training both at orientation and annually. In addition, there must be documented evidence that each environmental services staff received training on hospital sanitation measures on hire and annually, thereafter.

The training programs must be provided by an individual who is knowledgeable in infection prevention and control, particularly the hospital's specific IC policies. A blast fax or email notification does not constitute an acceptable method of training. Training should be face to face. If video or other media is utilized, the employee should be given a method to contact someone who can address any questions or concerns related to the material presented. Records of these trainings must be accessible on the day of the survey.

Written by Idamae Rolle-Kennedy, RN, BSN, MPH, CLE, CIC

Ortho-Phthalaldehyde (OPA) High-Level Disinfectant

Earle H. Spaulding devised a rational approach to disinfection and sterilization of patient-care items and equipment. The system classifies instruments and items for patient care as to their risk of an infection based on their use. Critical items, including laparoscopes and arthroscopes, are those that enter places that are considered sterile (the blood stream, internal organs). Instruments, including respiratory therapy equipment, and GI scopes, that normally come in contact with the mucous membranes or non-intact skin are considered to be semicritical.

Given the increasing incidence of improperly disinfected items causing outbreaks of infection, and the re-use of "single use" devices without proper sterilization, regulatory agencies are paying particular attention to the sterilization/disinfection processes in hospitals. Of particular concern are those areas that may not be under the close observation of the sterile processing department and/or infection control (clinics, small departments, radiology, physical medicine (wound care)).

Every hospital must conduct training and competency assessment for all users, including color acuity testing. This must be done annually, as any failure in the process can have a significant adverse outcome.

The user must develop, implement, and monitor the quality control system as defined by the product manufacturer. The Infection Control professional must also review the process and the quality control on an unannounced, but regular basis. Results of monitoring must be reported through the infection control or quality reporting structure.

It is our recommendation, and a requirement of our ICPs, that the OPA process be tested with each cycle of use, and, with many OPA products, that appropriate control of the test strips be performed and documented. All test strips, in addition to the actual product have both shelf-life consideration and storage requirements. Monitoring of these requirements should be included in the overall quality process. Based on data in the MSDS, the product must be used in a well ventilated area and with appropriate exhaust ventilation; for example, a minimum of 10 air exchanges per hour, or as defined by state and local regulations.

Safe handling advice:
Wear appropriate personal protection. Avoid contact with skin, eyes and clothing. Remove contaminated clothing and launder before reuse.

High level disinfection, which is defined as a sterilant used for a shorter contact time to achieve a 6-log kill of an appropriate *Mycobacterium* species, can be accomplished with a number of different products, including gluteraldehyde, hydrogen peroxide, or peracetic acid. Any product that is chosen must have an FDA indication for its intended use! Additionally, the process is defined by physical criteria, which include the precleaning of the item, the contact time, and the temperature of the product ("room temperature" must be monitored as some products have different contact times at different temperatures, and some rooms have different temperatures).

Yet another consideration is the device manufacturer's recommendation for sterilization or disinfection. It is essential to validate the intended process with the manufacturer's recommendation. Some chemical treatments may void warranties, or limit the use.

When performing quality assurance and quality control, it is important to not co-mingle the various control products from different manufacturers. Surveyors are aware of the various manufacturer's recommendations, and will validate your processes.

Written by David Woodard, M.Sc., CLS, CIC, CPHQ

CMS Issues Clarification on Occupancy Classification Under the Life Safety Code

In December 2010, CMS issued a memorandum which effectively requires hospitals to reclassify its "Business Occupancies" as "Ambulatory Healthcare Occupancies," regardless of the number of patients receiving care or treatment who are incapable of self preservation. The guidelines were revised in February 2011, and as a result, hospitals may have a bit more flexibility in how its Ambulatory Care sites are classified, under the Life Safety Code, NFPA 101, 2000 Edition.

The CMS memo addresses mixed occupancy classifications, indicating clearly that hospitals or "Healthcare Occupancies" must be adequately separated from other building components, if classified as a different category of occupancy, as defined under the Life Safety Code. The hospital component however, continues to be considered a "Healthcare Occupancy" under Chapters 18 (New Healthcare Occupancies,) or Chapter 19 (Existing Healthcare Occupancies,) of the Life Safety Code, 2000 Edition.

According to Chapter 20 (New Ambulatory Healthcare Occupancies,) and Chapter 21 (Existing Ambulatory Healthcare Occupancies) in the Life Safety Code, "Ambulatory Healthcare Occupancies" is defined as "a building or portion thereof used to provide healthcare services on an outpatient basis simultaneously for four or more patients that (1) provide treatment for patients that renders the patients incapable of taking action for self preservation under emergency conditions without the assistance of others; or (2) provides, on an outpatient basis, anesthesia that renders the patients incapable of taking action for self preservation under emergency conditions without the assistance of others." CMS does not consider the number of patients treated when determining "Ambulatory Healthcare Occupancy" classification or whether or not the patient has been "rendered" incapable of taking action for self preservation by the facility. The only consideration recognized by CMS is whether the patient is capable or incapable of self preservation and therefore, the organization needs to determine its occupancy classification, regardless of the number of patients being served.

For those buildings that are regarded by hospitals as a "Business Occupancy," as defined in Chapters 38 (New Business Occupancies,) and Chapter 39 (Existing Business Occupancies) under the Life Safety Code, patients treated therein are expected to be capable of judgment and taking appropriate physical action for self preservation in an emergency. CMS Interpretive Guidelines consider a patient to be incapable of self preservation due to numerous factors, including but not limited to, age, physical or mental disability, medical or therapeutic interventions, medication reactions, etc. CMS further expects that there be consideration given to both the characteristics of current patients and the characteristics of patients the facility is likely to provide medical treatment for, or services to in the future, as evidenced through representation to the public of its scope of services and potential patient population.

Despite the clarification issued by CMS on determining Occupancy Classification, as indicated in our previous article on this topic, it is imperative that each healthcare organization that offers Ambulatory Care Services in what they believe to be a "Business Occupancy" under the Life Safety Code, carefully evaluates that patient care and treatment setting are in accordance with the revised Interpretive Guidelines, as these settings may need to be reclassified as "Ambulatory Healthcare Occupancy." The results of this assessment and potential reclassification of Business Occupancies to Ambulatory Healthcare Occupancies will, as applicable, need to be also addressed in the hospital's "Statement of Conditions" or equivalent, depending on which accrediting organization is involved (Joint Commission, HFAP, or DNV). A reclassification of a "Business Occupancy" to a "Ambulatory Healthcare Occupancy" may also require significant capital investment in the structural features of fire protection, fire alarm systems, etc. Should you require assistance in this regard, please do not hesitate to contact our office.

Written by Steven R. Hirsch, MPA, FACHE