Steven Hirsch and Associates

Accreditation News

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Carbapenem-Resistant Enterobacteriaceae (CRE)

Now that we have become familiar with MRSA, VRE, and *C.difficile*, we are made aware of an emerging group of multi-drug resistant organisms called carbapenem-resistant or carbapenemase-producing *Enterobacteriaceae (*CRE). In the past, infections caused by *Enterobacteriaceae* have been successfully treated by β-lactam antibiotics (derivatives of penicillin). These include the antibiotics Doripenem, Ertapenem, Imipenem, and Meropenem. Resistance to β-lactam class, carbapenems was identified several years ago and continues to rise with their use. The most commonly identified species among CRE organisms are carbapenem-resistant *Klebsiella pneumoniae* (CRKP), which are resistant to almost all available antimicrobial agents. CRKP have been associated with a high rate of morbidity and mortality, particularly among patients with prolonged hospitalization, ICU patients and patients exposed to invasive devices such as central lines and ventilators.

Currently, the prevalence of CRE is low in the majority of hospitals in the United States. The challenge before us is to limit their impact while the prevalence is low, and before CRE becomes established in our hospitals. In response to this challenge, in March of 2009, the CDC published **Guidance for Control of Infections with Carbapenem-Resistant or Carbapenemase-Producing *Enterobacteriaceae* in Acute Care Facilities** (*MMWR. 2009; 58:256 -260).* The CDC recommends that all acute care hospitals establish aggressive infection prevention and control strategies which include the use of isolation of identified cases using Contact Precautions, surveillance studies to determine the prevalence of the bacteria in the hospital, and implementation of the Clinical and Laboratory Standards Institute (CLSI) guidelines for the detection of carbapenamase production in isolates submitted to the laboratory. The CDC also recommends that all acute care facilities review microbiology reports for the previous 6-12 months to ensure that unrecognized CRE cases have not occurred. If cases are identified, it is recommended that facilities conduct a point prevalence study (a single round of active surveillance) by obtaining rectal or perirectal swabs in units with high risk patients. The goal of this surveillance is to identify undetected carriers of CRE and to enforce vigorous infection prevention measures. As you face your own challenges in preventing the emergence, and/or control of CRE, we would like you to know that Steven Hirsch and Associates is available to review your current laboratory and infection prevention practices, and to assist you in limiting the impact of these resistant organisms on your organization.

Written by Susan Viker, RN, CIC of Steven Hirsch & Associates

Revised 2009 Accreditation Requirements

As part of The Joint Commission's (TJC) efforts to retain its CMS deemed status, a document titled "Revised 2009 Accreditation Requirements as of March 20, 2009 in Response to CMS Deeming Application". In preparation for organizations to meet these new requirements, we are recommending a review of existing documents, policies, etc to assure compliance. Surveyors are requesting documents to get a feel for organization readiness in their ability to produce them. Here is a preliminary listing that will provide all of you a "heads up" in preparation for survey under the new and revised standards. This list is reflective of actual documents that are being requested by surveyors:

Tertiary Requests (meaning these are CMS requirements – scored but do not count toward accreditation decisions.)

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Revised 2009 Accreditation Requirements Continued

1. Organization budget information regarding:
   a. Income and expenses
   b. Capital expenditure plan for 3 years, including anticipated source of financing for the capital expenditures (Note: this links to the SOC and Plans for Improvement)
   c. Evidence that capital budget was sent to a governing body for review and approval
   d. Evidence that the budget was prepared by an interdisciplinary committee (we showed this by producing the calendar of the individual budget meetings the CEO and CFO had with the department heads – they want to see more than the CFO involved in the budget process)
2. Organizational chart related to clinical responsibilities of the following (as applicable):
   a. Anesthesia services
   b. Emergency services
   c. Nursing services
   d. Outpatient services
   e. Respiratory services
3. List of all contract services, including the scope and nature of the services provided.
4. Does the organization participate in a QIO cooperative project? If so, briefly describe.
5. Please list all voting members of the Medical Executive Committee with their professional designation (MD, DO, etc.).
6. Are emergency services provided at the organization? IF NOT, please provide the written policies and procedures developed by the medical staff for the appraisal of emergencies, initial treatment and stabilization of patients, and referral of patients when needed.
7. Any off campus departments? Do they provide emergency service? IF NOT, please provide the medical staff policies for appraisal of emergencies, initial treatment and referral of patients for emergency care from the off campus locations.
8. Are there any dentists, podiatrists, optometrists, chiropractors or clinical psychologists who admit patients? If so, please list them.
9. Provide the policy concerning autopsies that covers
   a. When are they to be requested;
   b. How permission is obtained and documented;
   c. What is the system for notifying the attending physician that an autopsy is to be performed, when, and at what location.
10. Provide medical staff policies on blood transfusion and intravenous medications.
11. Provide laboratory policies on tissue specimens:
   a. Include documentation that they were approved by the medical staff;
   b. Include any specification about which specimens require macroscopic exams only, and which require macro and micro examination.
   c. Include procedures for collecting, preserving, transporting, receiving and reporting exam results for tissue specimens.
12. Policies on BEHAVIORAL restraint and seclusion that include the following:
   a. Definition of restraint;
   b. Definition of seclusion;
   c. Physician and other authorized LIP training requirements;
   d. Staff training requirements;
   e. Who has the authority to order Restraint & Seclusion;
   f. Who can initiate Restraint & Seclusion;
   g. Circumstances under which Restraint & Seclusion are discontinued.
13. Is there a policy, procedure, process that covers reporting the following to CMS:
   a. Deaths while in restraint or seclusion.
   b. Deaths 24 hours after restraint or seclusion;
   c. Deaths up to one week later, when reasonable to assume that restraint or seclusion contributed to the deaths.
14. Policies and procedures regarding discharge planning.
15. Policies and procedures concerning NON-behavioral restraint.
   a. Documentation that these were approved by the medical staff and nursing leadership.
16. Policies and procedures concerning the grievance process.
17. Copy of the grievance log for the past 6 months.
   a. Documentation that the governing body or a grievance committee reviews and addresses complaints/grievances.
   b. Documentation that the governing body approved the process.

Written by Linda Lawrence, RN, BSN, MBA of Steven Hirsch & Associates