



Accreditation News

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Dialysis Service Meets Regulations

Dialysis services, whether provided under contract or in-house, are required to comply with multiple federal and state laws and regulations. For facilities with deemed status, there are additional accreditation standards to fulfill. The Joint Commission Accreditation Manual for Hospitals, within twelve of its chapters, contains essential elements dialysis services must meet and document. Compliance is of the utmost importance to assure patient safety, quality, satisfaction, and reimbursement.

Components for dialysis can be divided into seven parts: contractual agreement requirements, equipment care and bio-medical oversight, healthcare provider, patients' needs, environmental concerns, medical director responsibilities, and infection prevention activities.

Contracts must be communicated in writing to the Healthcare organization. The dialysis vendor contract must clearly define the expectations of performance in quantifiable terms. These expectations need to be evaluated on an annual basis and the results presented to the Healthcare organization. In circumstances where performance expectations are not met, there needs to be an action plan identified to improve the services. Contracts need to be reviewed on a periodic basis and revised as needed. The Contracts must be available on site for surveyors to review.

The facility is advised to maintain a list of all contract services and ensure that all are current. Contracts must have input from the medical staff, both for the initial vendor selection and for renewal. Quality Indicators need to be reported through the Quality Committee, preferably by a member of the Dialysis team. Finally, policies and procedures from the Dialysis provider require hospital/medical staff review and approval prior to implementation. These need to follow the same path as all other hospital policies and procedures. The contract must clearly reflect an expectation for the vendor to comply with applicable accreditation standards, laws, and regulations. Additionally, the contract should contain a statement that the hospital retains administrative and professional responsibility for the services provided.

Equipment care is the next component that must be in compliance for a successful survey. Dialysis machines must be checked by bio-medical engineering on-site, prior to use, as they enter the facility. Records of preventative maintenance should also accompany the machine. The machines are to be serviced per the manufacturer's guidelines and all maintenance activities must be documented. Cultures of the machines should be performed on a routine monthly basis and results reported to the Infection Prevention Committee. Corrective actions must be instituted whenever there is any positive growth, and documented. The machines should be cleaned per manufacturer's guidelines. Finally, staff should have adequate training in the use and care of the machines, which must be documented and reflected in

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the Human Resources Department files. Annually, there must also be documented a chemical analysis of the Healthcare organization's water.

Healthcare providers are key to meeting the patient safety, quality, and satisfaction targets the Dialysis Service strives to achieve. Here is a list of elements that should be considered:

- Initial competency, on hire, is assessed, documented, and mitigated if necessary;
- A Job Description is signed by the Healthcare provider and is on file;
- Primary Source Verification of licensure/credentials is on file;
- Staff possess all competencies as defined in the job description;
- Staff receive orientation to the facility and to the department, which is documented and on file;
- Employee health files must be current with all screenings, vaccines and titers documented and any appropriate actions taken;
- Performance Evaluations must be current, conducted annually, and be on file;
- Staff receive education on: Standards of Care, Standards of Practice, pain management, infection prevention, mission of facility, life safety, policies and procedures, ethics, and how to report an environment of care risk and how to reduce or eliminate such risks;
- Staff comply with infection prevention practices, including hand hygiene;
- Staff utilize the two patient identifiers, per hospital policy, when treating patients;
- All medications are appropriately labeled and stored in a secure manner;
- Staff provide one level of care to patients, eg. Assessment by hospital or dialysis staff of bruits and thrills; and
- Documentation of orientation to dialysis machines in use and emergency measures.

The next component relates to Patient Care. Handoff (SBAR) is critical whenever there is a transition of the care of the patient to another healthcare provider. Allergy and other identification bands should be in place to alert the healthcare provider of any unique needs of the patient. The patient's Advance Directive should be known to staff and respected. The patient should be routinely screened for abuse, neglect, and potential for suicide. Pain is assessed, reassessed, and managed to meet the patient's stated goal. The healthcare provider contributes to the Plan of Care as it relates to dialysis. The medical record is protected for confidentiality. Orders are completed, signed, dated, and timed. Education is important to provide to both the patient and the family or significant other, and is presented in the preferred modality and language. Patients must be given informed consent by the physician prior to institution of dialysis treatment. If blood transfusion is necessary, the policies and procedures around consent, procurement, administration, and monitoring must be followed. Finally, safety in the event of an emergency, power failure, natural disaster, or Code Blue, must be provided through adequate staff training for awareness and response.

The environment is also important. One which is safe, secure, and comfortable for the patient must be provided. That means that all equipment and chemicals are stored securely when not in use. The equipment is kept clean and operational per manufacturer's recommendations. Dialysate and Endotoxin cultures are routinely performed, documented, and reported to the Infection Prevention Committee. Pharmaceuticals are supplied by the facility's pharmacy and are properly labeled and stored in secure area with appropriate temperature and light. If the patient is in isolation, the correct procedures are followed and PPE is worn by those entering the setting. Dialysis staff are not to keep personal items on the dialysis machine or on a cart.

The Medical Director of Dialysis has a distinct role and defined responsibilities to oversee the service. These leadership accountabilities include the following:

- Upholding the hospital's mission, vision and values;
- Maintaining quality improvement programs, using data and information that supports the quality of care, treatment and services;
- Maintaining the hospital's culture of safety and goals;
- Integrating the dialysis service into the organization's primary functions;

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Dialysis Service Meets Regulations Continued...

- Coordinating and integrating interdepartmental and intradepartmental services;
- Developing and implementing policies and procedures that guide and support the provision of dialysis services;
- Recommending a sufficient number of qualified and competent persons to provide care, including dialysis treatment;
- Determining the qualifications and competence of department personnel who provide patient care services and who are not licensed independent practitioners;
- Continuously assessing and improving the performance of care and dialysis services provided;
- Orienting and providing in-service training and continuing education of all persons in the department;
- Recommending space and other resources needed by the department; and
- Participating in the selection of sources for needed services not provided by the department or the organization.

Infection Prevention measures are critical to the patient population that is served. Central Line Associated Blood Stream Infection prevention practices must be followed for insertion and for routine care. Hand hygiene and isolation precautions must be routinely practiced. Proper water disposal coming off the machines should be followed. The equipment is to be cleaned per manufacturer's recommendations.

If these seven components are wholly in place, patients are safe, staff are competent, quality is high, and satisfaction with the service is meeting set targets. Survey results will follow without recommendation or deficiency. This means hard work in implementation, monitoring, and keeping the service on track.

Written by Beatrice "Betty" Newsom, RN, BSN, MA, CNAA of Associates

Why is CRE Getting So Much Attention Lately?

CRE, or carbapenem-resistant Enterobacteriaceae, are bacteria such as *Klebsiella pneumoniae* and *E. coli* that have developed high-level resistance to antibiotics used to treat infections caused by these germs. You may have heard them called KPC (*klebsiella pneumoniae* carbapenemase) and NDM (New Delhi Metallo-beta-lactamase). Essentially the bacteria have developed an enzyme, which has the ability to break down the antibiotic (carbapenems), rendering it ineffective. These infections are very difficult to treat and sometimes cannot be treated. CRE can also transfer their resistance to other kinds of bacterium.

Enterobacteriaceae normally reside in the human gut and usually do not cause infection in healthy people. People who frequently require complex healthcare, receive long courses of certain antibiotics, and require the insertion of medical devices such as urinary catheters, endotracheal tubes for ventilation, or central venous catheters are at risk for CRE infections. The infections can be serious, and require the patient to be admitted to an acute care hospital for treatment. The Centers for Disease Control and Prevention report that up to 50% of patients that develop a bloodstream infection with the resistant infection die.

You may recall two years ago when the L.A. Times reported on March 24, 2011 that a "Superbug" is spreading to Southern California hospitals. The paper reported results of an outbreak investigation completed by the Los Angeles County Department of Public Health stating that CRE had been reported predominantly from skilled nursing and long-term acute care facilities. 350 cases of *carbapenem-resistant Klebsiella pneumoniae* infections were reported during the outbreak. The mean age of patients affected by the resistant bacterium was 73.

CRE was initially identified in New York and New Jersey. Fast-forward to March 8, 2013 where the CDC has reported that 42 states have identified at least one patient with at least one type of CRE infection.

What can be done to prevent the spread of CRE?

The CDC's 2012 CRE Toolkit provides guidance to acute and long-term care hospitals to aid in the prevention of CRE to other patients. Eight core measures are recommended in the guidance document for all acute and long-term care facilities to implement.

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Why is CRE Getting So Much Attention Lately? Continued...

Hand hygiene is considered primary prevention in the spread of CRE and other multi-drug resistant organisms. Access to hand hygiene stations and supplies is essential. Providing feedback to clinicians on hand hygiene adherence is also helpful.

Implement **Contact Precautions** for patients identified with CRE. Contact Precautions include: hand hygiene, wearing of gown and gloves, and provision of dedicated equipment. The guide further discusses who should be placed into precautions: patients with an infection attributed to CRE and patients identified as high-risk for CRE infection (preemptive precautions) if CRE has been identified in the hospital's patient population.

Education of healthcare providers to hospital policy on the prevention of CRE transmission, which includes Contact Precautions and hand hygiene.

Daily Evaluation of the necessity of invasive devices such as: endotracheal tubes, urinary catheters, and central venous catheters. Devices should be reviewed daily for necessity and be promptly discontinued when no longer required.

Cohorting patients and healthcare providers is preferred. Patient placement in a single patient room is also recommended.

Laboratory identification and notification is important to alert clinical and infection prevention staff in order to implement transmission prevention strategies. The most current laboratory recommendations to determine susceptibility of carbapenems among Enterobacteriaceae are available from the Clinical Laboratory Standards Institute (CLSI) which were modified mid-2010 and again in January 2012.

Antimicrobial Stewardship is also a primary core intervention. Restricting the use of carbapenems has demonstrated lower resistance in one study.

Screening for CRE colonization by performing a point prevalence survey may be helpful to identify epidemiologically linked contacts when a hospital identifies a patient with CRE (outbreak or rare admissions of a patient with CRE infection). Rectal or peri-rectal specimens (sometimes wound or urine) are submitted for culture to determine the presence of CRE. The CDC has developed a laboratory protocol for evaluating rectal or peri-rectal swabs for CRE.

Additional measures have also been identified as helpful strategies, such as: active surveillance testing for CRE and chlorhexidine bathing. Assessing the efficacy of adherence to hand hygiene and Contact Precautions is also essential to prevent and/or interrupt transmission of CRE.

The majority of the recommended core strategies are basic tenets in most infection prevention programs today in acute care hospitals and should be applied in the longterm acute care setting as well. Getting back to basics and prompt identification of CRE will go far in preventing further transmission throughout the healthcare continuum.

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About Steven Hirsch & Associates

As recognized experts on Joint Commission, HFAP, and DNV accreditation, licensure preparedness and facility management issues, 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.

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