Steven Hirsch and Associates

Accreditation News

Winter 2014/2015

Volume 6, Issue 3

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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.

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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

Locum Tenens Practitioners: How Much Credentialing?

Locum Tenens (LT) privileges are given to practitioners who provide interim coverage for a current staff member when they are unavailable, such as when someone takes a temporary leave of absence or is out of town on vacation. The LT practitioner must hold the same clinical privileges as the physician for whom they are providing coverage.

Your Medical Staff Bylaws should describe Locum Tenens Privileges and it must be defined whether or not the LT practitioners are granted medical staff membership. The process for credentialing LT practitioners should be defined in a medical staff credentialing policy and procedure. When processing practitioners for LT privileges, one is required to verify current licensure, query the National Practitioner Data Bank, the Office of Inspector General and if required by your state, the website that validates whether a practitioner has been sanctioned by a state regulatory agency. To verify education, training, board certification and the status of licensure in other states, the American Medical Association Physician Profile may be beneficial and is accepted as primary source verification.

To determine current competency, peer reference letter(s) and verification of affiliation(s) with other health care facilities should be obtained. If the request for LT privileges has been received in a timely manner, it would be beneficial to request a patient activity log; a listing of diagnoses treated; and if the practitioner is a surgeon, request a procedure log. To facilitate this, you may need to request that the LT practitioner assist in the obtaining this data.

If the LT practitioner has their own professional liability coverage, the carrier should be contacted to verify coverage and claims history. If the LT practitioner is going to be covered under the policy of the physician who has requested their services, the liability coverage will usually only be provided for a specific number of days. Verify with the professional liability carrier the number of days that the LT can provide coverage in a calendar year. Obtain a copy of the insurance certificate; many carriers will list the dates that the LT is covered.

Check with the regulatory agency that has accredited your facility to see

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Locum Tenens Practitioners: How Much Credentialing? Continued…

whether there are any restrictions to Locum Tenens privileges.

For all new practitioners granted privileges, a Focused Professional Practice Evaluation (proctoring) must be conducted. Your medical staff bylaws/credentialing policy/ FPPE policy should state whether you will accept the proctoring completed while the physician is at your facility.

For LT's who will be with you for 30 up to 120 days, it may be beneficial to perform a full credentialing process, especially if the LT decides to stay with your facility.

In today's environment, it is best not to have two credentialing standards; especially for those LT's who will be with your organization for more than a few days at a time.

Written by Margo Smith, RHIT, CPMSM, CPHQ of Associates

Emergency Generator Batteries—Inspection Requirements

During accreditation surveys, as well as surveys conducted by state licensing agencies and the Centers for Medicare and Medicaid Services (CMS), there has been increased scrutiny observed relating to periodic maintenance of batteries used to initiate emergency generator service. Many organizations have maintenance free batteries which are not permitted. In accordance with NFPA 110, 1999 Edition, §3-5.4.5, "Starting batteries for Level 1 installations shall not be of the maintenance-free variety."

Periodic maintenance and inspection of batteries used to initiate emergency generator service is expected to include electrolyte levels, which are to be checked and documented weekly; inspection of terminals to make sure they are clean and tight, on a quarterly basis; inspect to assure batteries are free of corrosion, and that the exterior of the battery case is clean and dry, monthly; specific gravity is to be checked monthly; that the charger and the rate of charge are visually inspected monthly; and that equalize charge is checked monthly. It is expected that the generator batteries will be maintained in full compliance with manufacturer specifications, and that any defective batteries will be repaired or replaced immediately upon discovery of any defects.

A written record of these tests and inspections must be maintained along with emergency generator testing documentation. It is not uncommon for surveyors to request documentation of battery maintenance activities. Failure to produce these documents can result in findings relating to Joint Commission direct impact standards, and more frequently, during CMS surveys, under Tag K147 which states, "Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1".

While there are no specific requirements in accreditation standards for generator battery maintenance, inspections of generator equipment, including batteries, should be documented weekly, and that the emergency generator itself is required to be exercised under connected load on a monthly basis, for a minimum of thirty (30) minutes. NFPA 99, 1999 Edition states in §3-4.4.1.3 that "Storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects (See NFPA 70, National Electrical Code, Section 700-4)." NFPA 99 further states in 3-4.4.2 that "A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction."

Written by Steven R. Hirsch, MPA, FACHE of Associates

Immediate Use Sterilization

Immediate Use Steam Sterilization (IUSS) is an invaluable process used in the surgical suites to deliver medical devices to the surgeon in the event such an instrument is not available sterile, or has been contaminated during the surgical case. The process is not, nor was it ever, designed to replace the classical "Sterile Processing" delivered instruments.

IUSS, which for years was called "flash" sterilization must be a systematic process to clean, steam sterilize, and deliver patient care items to the surgical setting for immediate use during an operative procedure. As with all sterilizing processes, IUSS must be done in accordance with the manufacturers' instructions, and must mirror the process used in the sterile processing department in terms of cleaning, disinfection, inspection, and validation of function for each item processed.

There are critical processes defined by The Joint Commission (TJC) that include cleaning and disinfection, sterilization, and aseptic transfer. In addition, all facilities must carefully and clearly document the process to ensure that should any variance be detected, the affected patients can be identified.

The IUSS process is complex, but when done in a step-wise, standard procedure, should deliver a properly prepared, safe, and sterile device to the end user. To ensure that this occurs, the facility must develop a procedure detailing the process, monitor the process, and evaluate all failures. Failures can be errors of commission or omission, however, they must be studied and processes implemented to prevent further occurrences.

To minimize the use of IUSS, facilities must evaluate their current surgical instrument inventory, review scheduling processes (avoiding sequential cases requiring complex instrument sets of which there may be an insufficient number to permit complete and adequate processing).

A multi-society position statement addressing immediate-use steam sterilization of surgical instruments was jointly released by the American Association for the Advancement of Medical Instrumentation (AAMI), the Association of periOperative Registered Nurses (AORN), and several other national organizations in 2011.
https://www.aami.org/publications/standards/ST79_Immediate_Use_Statement.pdf

The AORN standards describe situations when immediate-use steam sterilization should be employed, and these are:

- When a one-of-a-kind instrument has been contaminated and needs to be replaced to the sterile field immediately.
- When an item has dropped on the floor and is needed to continue a surgical procedure.
- When specific instruments are needed for an emergency procedure.
- When there is no other sterilization alternative (AORN, 2011).

The AAMI ST 79 document addressing recommended practices for steam sterilization states that immediate-use steam sterilization can be performed when deemed appropriate and when all of the following conditions are met:

- The device manufacturer's written instructions on cycle times, exposure times, temperature settings and dry times are followed.
- Items are disassembled and thoroughly cleaned with detergent and water to remove soil, blood, body fats and other substances.
- Lumens are brushed and flushed under the water with cleaning solution and rinsed thoroughly.
- Items are placed in a closed sterilization container or tray, validated for immediate-use sterilization, in a manner that allows steam contact and aseptic transfer to the operating room (American National Standard, 2010).

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Immediate Use Sterilization Continued…

In addition to setting situations when IUSS may be performed, the Multi Society position, previously referred to, has defined the instances when immediate-use steam sterilization should never be performed, and they include:

- Implants, except in a documented emergency situation when no other option is available.
- Post-procedure decontamination of instruments used on patients who may have Creutzfeldt-Jakob disease (CJD) or similar disorders.
- Devices or loads that have not been validated with the specific cycle employed.
- Devices that are sold sterile and intended for single-use only.

Use of IUSS must be monitored to assure appropriateness. The IUSS rate may be calculated in the following manner:

Total rate = # cycles per month/# procedures per month
Individual rate = # specific cycles/# procedures related to the individual item per month

It may be valuable to track the total number of devices processed in this manner per month (e.g., # Bookwalter blades, # phaco hand pieces, etc). This can also be divided by the total # of cycles to determine a rate.

There are no established standards for the number of IUSS cycles performed, but surveyors are interested in the hospital specific rates and the processes used by the hospital to decrease this rate to an ALARA (as low as reasonably achievable) rate given that it is a process that cannot ever be totally eliminated.

Transport of IUSS items

The AORN recommends the use of rigid sterilization containers designed and intended for specific sterilization modes if items must be sterilized using sterilization methods other than conventional processing. The overall intent is to deliver the item to the point of use and sterile field in a manner that maintains sterility.

References

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Immediate Use Sterilization Continued…

Safety Checklist to Ensure Proper Indication for IUSS Usage

Completed	Surgical Parameter
☐	Surgical instrument made unsterile and/or is unusable (ie, dropped to contaminated area, broken)
☐	Surgical case cannot be completed safely without the contaminated surgical instrument
☐	There are no remaining sterile surgical instruments available that can accomplish identical goal of the contaminated surgical instrument
☐	There is no available surgical instrument on the scrub technician's tray
☐	There is no available replacement sterile surgical instrument in the operating room
☐	There is no replacement sterile surgical instrument available in the operating suite or supply room

This table is based on the information in: Zuckerman, Scott L., Ravi Parikh, David C. Moore, and Thomas R. Talbot. 2012. "An Evaluation of Immediate-Use Steam Sterilization Practices in Adult Knee and Hip Arthroplasty Procedures." *American Journal of Infection Control* 40, no. 9: 866-71.

Essential components the development of a IUSS procedure

Component	Definition/appropriate use
Cycle Time	Cycle time is recommended to range from 3-10 minutes depending on type of sterilizer, ie., gravity displacement, prevacuum, pulse gravity, or abbreviated prevacuum
Temperature	Temperatures should be set to 270-272 °F
Peak Pressure	Mechanical control monitors should be used to verify pressure
Biological Indicator	According to the Centers for Disease Control and Prevention, use of a BI is the most accepted means of monitoring lethality of the sterilization process because of its detection of resistant organisms. All BI's should be interpreted by qualified personnel and included in the sterilization records
Chemical Indicators	According to the Centers for Disease Control and Prevention, a CI assesses achievement of proper temperature and pressure for sterilization. All CI test results BI's should be interpreted by qualified personnel and included in the sterilization records.
Description of load items	Full, complete description of instruments placed in sterilizer is recommended

Zuckerman, Scott L., Ravi Parikh, David C. Moore, and Thomas R. Talbot. 2012. "An Evaluation of Immediate-Use Steam Sterilization Practices in Adult Knee and Hip Arthroplasty Procedures." *American Journal of Infection Control* 40, no. 9: 866-71.

Written by David Woodard, M.Sc., MT(AMT), CLS, CIC CPHQ of Associates

If It's Damaged or Torn, Throw It Out!

As Infection Preventionists, we are constantly on the lookout for potential risk of infection to our patients. Here's another item to add to our list…damaged or worn medical bed gurney mattress covers.

In 2013, the FDA issued an alert about damaged or worn covers for medical bed and gurney mattresses. According to the FDA Safety Communication, we should be concerned as these damaged or worn covers on medical bed and gurney mattresses pose a risk for contamination and infection. From January 2011 to January 2013, the FDA received 458 reports associated with medical bed and gurney mattress covers failing to prevent blood and other body fluids from leaking into the mattress. Some reports indicated that if blood and body fluids from one patient penetrate a mattress, they can later leak out from the mattress when another patient is placed on the bed or gurney.

Mattress covers should be replaced when torn or damaged and the mattress should be replaced if it is visibly stained. The practice of sticking needles into mattress should be avoided as this jeopardizes the integrity of the mattress cover that can be a source of infection to a patient and during outbreaks.

The FDA recommends:

- Regular inspection for any visible signs of damage or wear such as cuts, tears, cracks, pinholes, snags or stains;
- Immediately remove and replace; and
- Clean and disinfect undamaged mattress covers in accordance with manufacturers' guidelines.

With the advent of reporting healthcare associated infections (HAIs) through the Center for Disease Control (CDC) National Healthcare Safety Network (NHSN), hospitals are more than ever held accountable for these infections, which may have a financial impact on the facility. All healthcare workers (HCWs) are empowered with the ability to identify and report unsafe work practices that could potentially cause harm to our patients, employees, and visitors. To encourage HCWs to report incidents, some facilities have a quarterly employee recognition award which includes a plaque with a gift card. A subcommittee of the (Patient) Safety Committee is formed to review all entries and choose a winner. This has been a positive reinforcement for safe patient care and work practices.

For further information about medical devices go to http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices.

Written by Virginia "Ginny" Ginunas, Mt, CIC 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, 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.

Medication Administration: One TIP to Help Achieve Performance Improvement

We all are aware of the importance of medication management, especially in the hospital and clinic settings. A safe medication management system has many interrelated parts, including that of medication administration. Many hospitals have implemented direct observational audits of the staff while medication is being prepared and administered to the patient by the clinical staff. Benefits from performing such audits include identification of processes that are working well for the organization, as well as identification of potential "near miss" situations and of potential system failures that impact medication management. Additionally, clinical staff become more comfortable and confident during the observation. This is important because during a Joint Commission, HFAP, or DNV accreditation visit as well as state licensing or CMS surveys, surveyors actually do accompany staff members from the inception to the conclusion of medication administration to a patient. So be supportive of your staff on all shifts and in all settings in which medications are administered, and conduct routine audits to help them become accustomed to observation.

Certainly organizations can develop individualized audit tools. It is important to include the following practices into the audit tool:

- Use of proper hand hygiene before and after medication administration
- Preparation of medications for only one patient at a time
- Use of proper technique in cleansing vials prior to use, ensuring enough time and friction is used to disinfect the top of the vial
- Use of proper technique in crushing pills, one pill at a time
- Comparison of the Medication Administration Record (MAR) to the medication order
- Proper introduction to the patient
- Use of the appropriate patient identifiers
- Verification of patient allergies with the patient
- Performance of necessary pre-administration assessments
- Provision of name of the medication, the purpose and the side effects to the patient
- Observation that the medications are labeled throughout this process, that medications are opened from the unit dose package at the patient bedside and that the 7 Rights of medication administration are utilized. The 7 Rights of Medication Administration are:
    - Right patient
    - Right medication
    - Right dose/amount
    - Right route
    - Right time
    - Right documentation
    - Right to refuse treatment
- Observation that the correct technique is used to administer each medication
- Validation of patient understanding by use of "teach back"
- Provision of opportunity for the patient to ask questions and to demonstrate understanding
- Documentation of the medication administration on the MAR. If a patient refuses a medication, documentation of the refusal needs to occur as well as documentation of physician notification

Other areas of assessment may include:

- No interruptions or distractions during preparation or administration
- Correct disposal of pharmaceutical waste

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Medication Administration: One TIP to Help Achieve Performance Improvement Continued…

- Verification and signature on the MAR of a second nurse for high alert drugs in accordance with hospital policy
- Timeliness of medication administration
- Resolution of any issues prior to medication administration

Clean, uncluttered and functionally separate areas for medication preparation are an important adjunct to medication safety. Also, information on medication labels should be displayed in a standardized format. The patient should be as actively involved in the medication process as possible. In hospitals in which our team has conducted survey preparation and reviews and in which medication administration audits were conducted, we were happy to observe the ease and professionalism of the clinical staff administering medications. They seem well accustomed to the audit process and performed with great success and confidence. Additionally, the patients benefit from this approach to medication management and they seem to appreciate the process.

Written by Linda Paternie, RN, BS, MHA

Wishing You a Happy New Year!!!

From All of Us at Steven Hirsch & Associates