Steven Hirsch & Associates

Accreditation News

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Steven Hirsch & Associates

This issue offers important updates on licensing issues that may impact your successful accreditation.

For over 32 years, Steven Hirsch and Associates has been one of the foremost authorities on successful accreditation, licensure, and Medicare certification. Feel free to contact us with your most pressing regulatory questions and concerns.

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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.

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Staff Ask Us "WHY?"

By Linda Paternie, RN, BS, MHA, CJCP

Many times while conducting mock accreditation surveys in hospitals, the staff asks us "WHY?" when a certain observation or finding is made. The questions are always encouraged and the answers may help promote greater understanding of accreditation standards. So getting to the "WHY?" can be an effective approach to survey readiness. Here are ten questions that have been posed to us. Answers provided!

Why is Pharmacy asked about contrast media used in radiological procedures in the hospital?
Contrast media is considered to be a medication and therefore, Pharmacy is responsible for providing oversight.

Why are you asking to see copies of FDA and California state licenses for tissue products implanted in patients?
The FDA mandates that companies that sell and distribute tissue products to hospitals be registered annually with the FDA. Additionally, California requires these companies to be licensed in the state.

Why are you looking at ECG electrodes that have been removed from their packaging?
The question related to these electrodes is a result of their ability to provide safety and functionality, per manufacturer instructions for use, once removed from the package. Only the original package is dated. Organizations need to know and follow the manufacturer requirements for shelf-life.

Why are you looking at opened containers of ultrasound gel?
Once again, the reason relates to manufacturer instructions for use. Some manufacturers indicate that the gel is to be used within a certain specified timeframe and therefore, labeling of an opened container with a "Use by" date is required.

Why are you looking at peel packs?
Manufacturers specify the length of time in which a peel pack is to be used. Yes, manufacturer recommendations on the shelf life of the peel pack are to be known and followed by hospitals.

Why are you looking at glucometers, IV caddies used to carry IV insertion supplies,

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Staff Ask Us "WHY?"

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and anesthesia caddies used to carry supplies used for insertion of arterial lines performed at the patient bedside?

Any supply, device or equipment that is transported from bedside to bedside must be completely cleaned and disinfected after each use, including the items mentioned in this question.

Why should the list of medications in the Malignant Hyperthermia (MH) cart be affixed to the cart?

Since the MH cart is used infrequently, surveyors want to assure that staff is able to rapidly access the life-saving medications. If the list is placed in a binder, there is a potential for the binder to become separated from the cart, making the reference list for use not immediately available during a medical emergency.

Why do we observe where staff food and drink are kept in the work area?

OSHA regulation prohibits the consumption of food and drink in areas where work involving exposure, or potential exposure, to blood or other potentially infectious substances exist, where exposure to toxic agents exist, or where contamination of work surfaces can exist.

Why are you looking at the fans used in the hospital?

Fans are to be on a regular cleaning schedule to assure that they are dust free. The fan, including the protective grate AND the fan blades are to be routinely cleaned.

Why are you looking at the spices used/stored in the kitchen?

All food items, including seasonings and spices, whose packaging has been opened, must be labeled and a discard

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 our website at www.shassociates.com.

Management of Linen in Healthcare Facilities

By Kari Wawro, RN, BS, CIC and David Woodard, M.Sc., MT(AMT), CLC, CIC, CPHQ, FSHEA

The Joint Commission (TJC) standard IC.02.01.01, EP 1 addresses the hospital implementing its infection prevention and control activities to minimize, reduce, or eliminate the risk of infection. The healthcare accrediting agencies (TJC, HFAP, DNV) as well as the CMS expect that laundry and linen are cleaned, disinfected and stored in a manner to minimize the risk of transmission of pathogenic microorganisms.

There are multiple standards for laundry including ANSI/AAMI, OSHA and the CDC. In addition some state health departments have regulations addressing the handling of soiled and clean laundry for medical facilities. As part of the overall Infection Prevention and Control Program, the facility's management/Infection Preventionist (IP) should make an onsite visit to the laundry facility to assure recommendations and requirements are being followed, and they should verify that all employees have received training in the linen handling and laundry processes as well as bloodborne pathogens. This site visit is specifically required by regulation in some states. Observation from the linen processing site visit should be documented. Contact our office for a linen site checklist to assist in documenting this evaluation of your contract linen service.

Organizations are required to store dirty linen in a location that is separate from clean linen to prevent cross contamination. The dirty linen generated during care should be placed into bags or other appropriate containers with minimal agitation away from the patient. Soiled laundry containers should be marked or color-coded for recognition, although there is no requirement that soiled linen be identified as "biohazardous."

The CDC Environmental Guidelines recommend that soiled laundry be washed for a minimum of 25 minutes in water with a temperature of at least 71°C (160°F) or with chlorine bleach. After completion of the laundering process (sorting, washing, drying, and folding), the linen should be packaged and stored or transported in a manner that will prevent contamination.

Clean linen should be stored at least six inches above the floor, and the bottom shelf on all linen storage racks should have a solid barrier to prevent contamination during mopping or contamination with dirt from the floor.

Clean linen should be stored in a dedicated "linen room," and can be uncovered if absolutely nothing else is stored in that space. However, if the linen is stored in a room/closet that has other functions such as storage of equipment, the linen must be covered. All linen carts used on the units must be covered at all times. Care must be taken to ensure that linen including pillows are not stored on the tops of the linen carts. The carts that are used to contain or transport soiled linen to the commercial laundry must be washed and sanitized after soiled linen is off-loaded. The inside of the laundry truck itself also must be cleaned and disinfected. If the laundry service uses a circuit method to deliver and collect linen, the entire delivery of clean linen must be completed before any soiled linen is placed in the truck.

The Joint Commission (TJC) standard IC.02.01.01, EP 1 and CMS 42 CFR 482.42, address the hospital implementing its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. These standards are often cited when a surveyor finds linen handled inappropriately. The Joint Commission has indicated that as part of "Leading the Way to Zero," they will evaluate this component of Leadership, Infection Control, and Human Resources standards compliance.

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Best Practice: Reciprocal Proctoring Reports

By Margo Smith, RHIT (Retired), CPMSM, CPHQ

As part of the Focused Professional Practice Evaluation (FPPE) process required by The Joint Commission, most of us in the field of Medical Staff Services have a policy that states that to facilitate the FPPE (proctoring) process, your facility will accept, from another Joint Commission accredited facility, up to 50% of the proctoring reports or a letter stating that the provider has successfully completed the accredited facility's proctoring requirement.

In the Standards FAQ section of The Joint Commission website, dated May 9, 2019 the following question was presented, "What data sources can be used when evaluating practitioner performance after new privileges have been granted?"

Answer: "A period of focused review is required for all new privileges. This includes all privileges for new applicants and all newly requested privileges for exiting practitioners. There is no exemption for board certification, documented experience, or reputation. All applicants for new privileges must have a period of focused review."

The data source used for the FPPE process is limited to practitioner activities performed at the organization where privileges have been requested. This would include activities performed at any location that falls under the organization's single CMS Certification Number (CCN). For example, if an organization operates two hospitals that fall under the same CCN number, data from both hospital locations may be used. In the case of a multi-hospital system where each hospital operates independently under its own CCN number, data from the FPPE evaluation from these separate entities cannot be used.

What should we do next? Take this to your next Credentials Committee, along with your FPPE policy and have the Committee review all the information.

What does it mean for the FPPE (proctoring) program in your facility? To meet TJC standards, you will probably need to revise the FPPE policy. The providers will need to be proctored (can be retrospective or concurrent) at your facility and you can no longer accept proctoring reports or summaries from other facilities to complete the proctoring requirement.

There are options: Look at the number of cases needed for the FPPE process. Can the number of cases required for proctoring be reduced to an acceptable level, where you still will be able to determine the competency of the practitioner? Does your organization allow retrospective proctoring? Look at the types of specialties in your facility. Internal Medicine is usually the largest department. In ambulatory services that are part of your hospital license, providers are granted privileges and are proctored according to your credentialing policy. Are there some sub-specialties, such as dermatology or allergy, that are non-hospital based (community providers) and can be made exempt from proctoring? Typically these specialists are providers who are granted medical staff membership only (with no privileges) and are not subject to FPPE (proctoring). Are there sub-specialties that do not do invasive procedures that can have all their proctoring done on a retrospective basis? For specialties that admit through the hospitalist program, such as Family Medicine/Pediatrics, and that only provide the history and physical for surgical clearance, can the proctoring process be revised so that the history and physical can be reviewed and a proctoring report can be completed? I am certain there are other ways to change the policy, but still keep within TJC standards.