Steven Hirsch and Associates

# Accreditation News

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## Welcome to our First Issue!

Welcome to the inaugural issue of ***Accreditation News***. Our newsletter is intended to provide our current and previous valued clients with important news on accreditation updates, licensure requirements and other trends related to health care management. We also learn of valuable resources when providing services out in the field that we would like to pass on to our clients. ***Accreditation News*** is one way for us to stay in touch while providing useful information to health care executives.

This issue is a case in point. The accompanying article by David Woodard, M.Sc., CLS, CIC, CPHQ gives a concise overview of infection control and hospital epidemiology planning in light of the recent swine flu outbreak. In future issues, you'll also be able to "meet" the associates that make Steven Hirsch & Associates the premier consulting organization for health care accreditation and regulatory compliance. If you have an issue you would like addressed in this newsletter, please feel free to let us know. We look forward to your feedback and questions for future issues.

## Infection Control and Hospital Epidemiology Planning

There are number of important issues that need to be evaluated by each of our facilities, particularly in view of the recent AH1N1 (swine) flu outbreak and the WHO, CDC and California Department of Public Health (CDPH) responses; the changes in the CMS interpretive guidelines, The Joint Commission's (TJC) "direct impact" standards and the CDPH/CMS survey procedures.

TJC has announced that there are a number of "direct impact" standards that will be given special attention during upcoming surveys. While they are contained in all areas of the accreditation manual, this article will be directed at those in the Surveillance, Prevention and Infection Control section of the manual. The Standard that will probably get the most attention, and certainly is related to the CDPH/CMS survey process, deals with the cleaning of equipment and surfaces. TJC wants to know that equipment is cleaned and disinfected between uses. The recently adopted SB1058 (California-only) regulation also addresses a program to ensure that equipment and surfaces are cleaned and disinfected. CDPH will actually "time" the contact time for the surface disinfectant and compare it with the manufacturer's guideline – stop watches have been seen! Each hospital needs to ensure that ALL individuals who are disinfecting equipment understand the concept of "contact time," the manufacturer's guideline, and the proper techniques to accomplish the task. It is also important to review policies and procedures to ensure that some "urban myths" have not crept into the cleaning and disinfecting policy; wording such as "disinfected between each use" is very different than "cleaned between each use." Problematic areas include such items as blood-pressure cuffs and furniture. Do these items truly need to be disinfected between each use, or simply kept clean unless obviously soiled?

The most recent version of 42 CFR 482.42 et. Seq (Medicare Interpretive Guidelines) has in-

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# Continued: Infection Control and Hospital Epidemiology Planning

creased in complexity from approximately two pages to over eight, with some rather proscriptive language. Beginning with "The hospital must provide and maintain a sanitary environment to avoid sources and transmission of infections and communicable diseases. All areas of the hospital must be clean and sanitary….the infection control program must include appropriate monitoring of housekeeping…and other activities to maintain a sanitary environment." Clearly the housekeeping issues will be paramount in the next series of surveys.

The document also contains specific language directed to the management of multiple-drug resistant organisms (MDROs), which dovetails into the California required MRSA monitoring. Based on the language of the guideline, MDROs must be on the Joint Commission required risk assessment and their study and control must be well documented in training as well as surveillance activities. Special attention is expected to be directed to the nosocomial transmission, and consideration might be directed to doing a root-cause analysis of MDRO-HAI's. Of possible consequence is the fact that the NHSN is considering *C. difficile* infection under the umbrella of MDRO for reporting purposes and thus the survey process could also take this tack.

Other related issues that require attention and should be a line item in the infection control risk assessment include outbreaks of communicable diseases (such as the management of norovirus and now influenza) and the agents of bioterrorism.

The Standard is now also directing attention to the qualifications of the person(s) directing the program, although it is unclear if this means the physician chair or the Infection Control Practitioner (ICP). Again, California is directing specific educational requirements for physician chairs by 2010. The Society of Healthcare Epidemiology of America (SHEA) has such training programs, and is evaluating expanding them to distance learning formats.

Lastly is the issue of pandemic planning and its relationship with the recent AH1N1 (swine) influenza outbreak. Clearly, this was a harbinger of what could happen if there was yet again a "new and novel" virus that was able to successfully make the transition from its normal animal host to infect and be transmitted to humans. While this variant of the virus was somewhat self-limiting and did not have significant virulence when compared to the usual winter flu, which itself has a significant mortality, this preview should cause hospitals to evaluate their response in terms of:

- Staff Education – how were the staff kept aware of the current plans and workplace rules;
- Supplies and Equipment – what was the response of the vendors who had agreed to provide materiel as required, such as the N-95 respirator mask;
- Patient Placement – did the "pandemic plan" traffic pattern work; were the designated rooms adequate for airborne protections;
- Did the facility have a fall back plan if there was a "surge" of admissions;
- Did the emergency department implement syndromic surveillance programs;
- Was the hand hygiene plan responsive to the outbreak;
- Did the hospital have and implement its respiratory etiquette program;
- How did the hospital and medical staff coordinate its response (admission and discharge of patients, virus testing, medication ordering)?

It is essential that facilities conduct a critique of the response to the outbreak and warnings, and implement meaningful changes when deficiencies are identified. This exercise will also likely increase the response to the annual influenza prevention program, so consideration must be given to adequate amounts of vaccine.

# 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. 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 go to our web site at www.shassociates.com.