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Fire Drills - Timing is Everything

By Steven Hirsch, MPA, FACHE

All accreditation organizations, based on NFPA Standards, require quarterly fire drills to be conducted in Healthcare Occupancies and Ambulatory Healthcare Occupancies. These fire drills are expected to be conducted at varying times, separated by at least one hour from shift to shift and quarter to quarter, for four consecutive quarters.

While the fire alarm signal within the Healthcare Occupancy may be silenced between the hours of 9:00 PM to 6:00 AM so as not to disturb patients, the fire alarm strobes (visual alarm notification) must remain active during that timeframe. In addition, for all fire drills, the fire alarm signal is required to be transmitted to the off-site monitoring vendor or central station.

As a quarterly requirement, fire drills must be held "every 3 months, plus or minus 10 days" as reflected in the Joint Commission Accreditation Standards for Hospitals. While this has not always been the interpretation applied in the field by surveyors, we have seen recently that healthcare organizations are being cited for conducting fire drills outside of the plus/minus 10-day window. This application of the quarterly fire drill standard was recently confirmed with The Joint Commission.

Each accredited healthcare organization is expected to have a Fire Response Plan. The Plan is often found to be generic, without identification of specific fire response duties or accountabilities for departments that have risk factors that differ from the main organization. These departments may include Dietary, oxygen enriched environments (OR, ICU, NICU, Cath Lab, Interventional Radiology, Hyperbaric Treatment), MRI, Clinical Laboratory, Behavioral Health Units, Post Partum/Nursery, etc. The Fire Response Plan should clearly describe unit and department specific fire response elements. Staff assigned to departments with specific fire response elements are expected to be evaluated during fire drills in accordance with the expectations as defined in the Fire Response Plan. For interventional settings that can be considered operating rooms or surgical suites, an annual fire exit drill must be conducted.

Fire drills should also include documentation of evaluation of structural features of fire protection, fire safety equipment (fire and smoke barrier doors) and fire alarm notification devices.

Training in fire response must be part of new hire orientation and documented for each employee as well as contract staff. Licensed practitioners also are required to receive fire response training and are expected to participate in fire drills. In addition, fire response training should be part of re-orientation activities that may be conducted annually or at least every 2 years.

Be sure that fire drills are well documented and include evaluation of staff (including Independent Practitioners) response according to defined responsibilities reflected in the Fire Response Plan. The fire drills must be conducted at varying times as noted above, and quarterly fire drills are to be held 3 months from the previous fire drill, plus/minus 10 days.

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The Importance of the
Quality Assurance and Performance Improvement Program

By Joann Saporito, RN, MBA, HACP

The Centers for Medicare and Medicaid Services (CMS) require hospitals to have a Quality Assurance/Performance Improvement (QAPI) program, regardless of the facility type (Hospital, Critical Access Hospital, Behavioral Health, etc.). Additionally, this is a requirement of all the Accrediting Organizations (AOs) such as The Joint Commission (TJC), Det Norske Veritas (DNV), and the Accreditation Commission for HealthCare (ACHC). It is important that healthcare organizations (HCOs) can demonstrate a comprehensive QAPI program that collects, analyzes, and uses meaningful data to monitor and make improvements to the quality and safety of care that is delivered. However, there are three areas where surveyors may cite an organization for non-compliance: not collecting relevant data, not using the data to make improvements, and not communicating the results. In this article, we hope to help facilities proactively address these potential findings.

When it comes to collecting data, it is first important to recognize that there are some quality indicators CMS requires. For example, hospitals must collect and report information on hospital readmissions and hospital-acquired conditions. In addition to these, it is expected that the hospital will focus on high-risk areas (such as restraint use or falls, for example), high volume and problem-prone areas. Other AOs may further detail specific indicators. For example, TJC includes in the hospital accreditation manual that blood usage and transfusion reaction data, adverse surgical events, adverse events related to radiologic procedures, cardiac arrest and resuscitation data, pain management data, medication event information (such as adverse reactions and medication errors), grievances, and information regarding the patient's perception of care are part of the QAPI program. However, CMS requires that the program "reflects the complexity of the hospital's organization and services" and "involves **all** hospital departments and services" (42 CFR 482.21). This would include any services provided under contract, such as dietary, dialysis or environmental services. Often these contracted or non-clinical departments are overlooked but are major contributors to the patient's care experience. Healthcare facilities would benefit from ensuring that their QAPI program is robust, comprehensive, and includes contract services and departments that are non-clinical as well, with a focus on improving health outcomes and the prevention and reduction of medical errors.

Collecting data simply to show a surveyor that data is being collected is meaningless if nothing is done with that information to improve care. Many organizations have been found to be reporting their results for the sake of reporting, but no identifiable action was taken to improve care. Surveyors will look for actions taken and the results of those actions through reports, meeting minutes, and staff interviews.

If the organization is not reaching its established targets, the expectation would be that adjustments are made during the processes to demonstrate improvement. This is often where HCOs can get cited. If the HCO is not reaching an established benchmark, a change should be made in the process and results measured to see if there is improvement.

Actions taken should be documented in meeting minutes. Once a target has been reached, celebrate but do not stop measuring until the achievement has been sustained (for example, six consecutive months at or above target). Once the benchmark has been sustained, the organization may consider removing that indicator (unless it is required by regulatory standards) and focus on something new and meaningful.

Finally, HCOs may have findings related to not reporting the information related to their QAPI program, from the ground level staff all the way up to the Governing Body. When surveyors query staff about their department specific performance improvement (PI) projects, it would be expected that employees could at least speak to what the project(s) is (even if they cannot speak directly to current performance). One observed best practice is for organizations to have a reporting calendar in the Quality Committee for the hospital departments or services, so that each department or service reports on a regular basis (for example: every three months) on their specific PI projects. This helps to prevent meetings from becoming lengthy and overbearing for the attendees due to the number of reports and information being shared. But departments or services should not work in silos. For example, medication events and errors should not stop at the "medication" committee; these are expected to be an integral part of the QAPI program. And QAPI data should be reported regularly up to the Medical Executive Committee and to the Governing Body, as the leadership of the organization has primary responsibility for the organization's performance.

It is important for HCOs to have a QAPI program that is relevant to the organization and includes all services provided. This article has focused on the acute care hospital setting but should be adjusted to reflect the HCOs demographic and services. Regardless of the facility type, it is expected that the QAPI program is robust and comprehensive, involves all departments and services, collects relevant data, acts on the data, and reports the results to all stakeholders.

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Enhancing Collaboration Between Infection Preventionists and the Healthcare Team

By Marietta Hickman, BSN, CIC

An effective infection prevention and control program requires close collaboration between the infection preventionist and the health care team that they work with. Collaboration creates an open environment where infection preventionists and staff can develop strategies together by sharing knowledge and exchanging ideas that promote patient safety and health outcomes. Increased collaboration can be accomplished by implementing several key strategies.

1. Staff engagement in infection prevention and control policies and procedures.

Staff input is critical to the promotion of effective policies and procedures within a healthcare setting. The frontline staff must adhere to these policies, therefore, it is important that policies are feasible for implementation in the given setting. Studies indicate that one barrier to utilization of policies is the length of the policy or protocol.[1] Policies should be succinct, current and easily accessible.

2. Frequent education.

Continuing education in infection prevention and control is essential for health care staff. Consistent training can enhance infection prevention processes and promote increased compliance. Education should occur at regular intervals, such as quarterly, biannually, or annually.[2] It should also occur on an as needed basis when new equipment, processes, policies, etc. are introduced. Allowing the staff to have input on the educational topics is a positive way to improve interest in the education being provided. Training frontline staff to provide the needed education is also effective in promoting staff learning and compliance. These frontline staff can provide just in time education as the need arises as well as aiding in the onboarding and training of new staff.

3. Regular updates on infection prevention measures.

Providing staff with regular updates on infection prevention and control measures will help keep staff and patients informed and educated. Infection preventionists should be aware of the latest Health Alert Network updates from the Centers for Disease Control and Prevention, as well as the health alert networks from their local and state jurisdictions. These updates include any current health issues in the community and jurisdiction, as well as new and emerging diseases to monitor for. Updates to staff can be in the form of weekly newsletters or bulletins posted in staff communal areas.

4. Staff involvement in the Infection Prevention and Control Committee.

The Infection Prevention and Control Committee should include key leaders of the organization. This is an important venue for infection prevention and control information to be disseminated through the organization. It should also include a robust team of employees from all divisions of the health care facility. The frontline staff are pivotal to the implementation of infection prevention and control practices. Their input during the committee and their involvement in decision making is impactful for the success of the infection prevention and control program.

5. Encourage patient feedback.

Allowing patients to provide feedback and suggestions on infection prevention and control practices aids in promoting a sense of ownership and collaboration. Giving patients the opportunity to tell their stories highlights the successes of the program and helps to motivate staff in infection prevention and control practices. This provides staff with the knowledge they need to promote a positive patient experience and prevent negative patient outcomes.

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6. Include an infection prevention and control section in your facility newsletter.

Providing a section dedicated to infection prevention and control in a facility newsletter is a creative way to engage staff in the infection prevention and control program. Allow staff to choose the topics that they would like Included in the newsletter. The newsletter is also an opportunity to provide fun and engaging games that promote learning.

7. Performance monitoring and feedback.

Identifying areas of strengths and weaknesses within the organization will enable process improvement. Observations, checklists, collaborative rounds, and timely feedback all support improvement strategies.[3] Staff feedback and reflection should also be used to drive practice change.

8. Provide rewards and recognition for successes in infection prevention and control strategies.

Providing rewards and recognition to frontline staff for accomplishing infection prevention and control goals can motivate and encourage staff to support strategies.[4] Rewards can come in the form of ice cream or pizza parties, tokens of appreciation or recognition in the facility newsletter.

Incorporating these strategies into your Infection Prevention and Control program can enhance interdisciplinary team engagement and collaboration, and promote a positive and robust program.

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