Lions & Tigers
&
The Joint Commission
OH MY!

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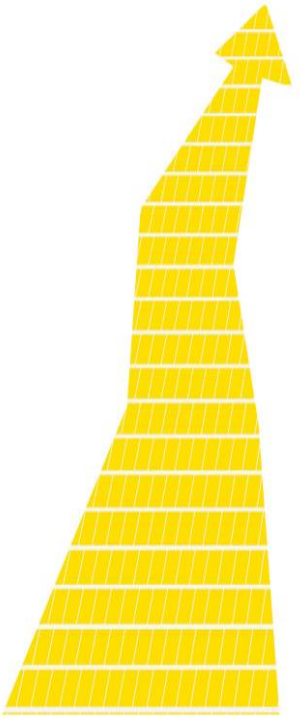
Certified Black Belt Lean Six Sigma, Certified Change Agent

November 2019

Objectives



- Recall two elements that should be assessed for compliance during a tracer on the Environment of Care for ligature risks.
- Identify one methodology that could be implemented to mitigate ligature risks in the Environment.
- Recall two elements that should be assessed for compliance during a tracer for Infection Prevention and Control
- Identify one methodology that could be implemented to improve safety in Infection Prevention and Control.

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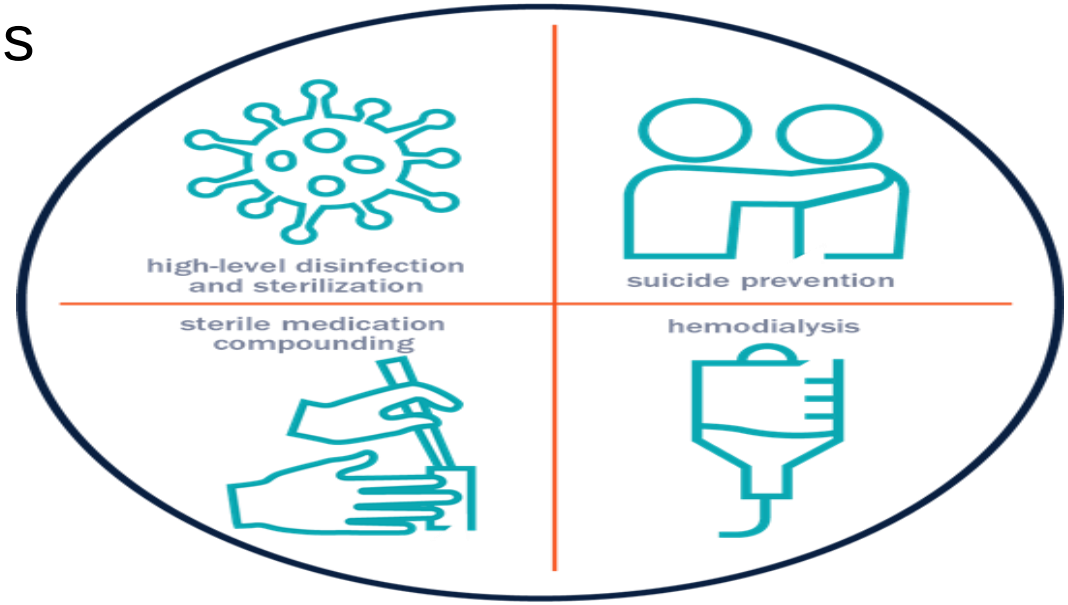
An important mission of The Joint Commission is to continuously improve health care. In that vein, Joint Commission surveyors now are enhancing their evaluation of four high-risk areas during onsite surveys:

- Sterile medication compounding
- **Suicide prevention**
- **High-level disinfection and sterilization**
- Hemodialysis



4-1-1 on Survey Enhancements

PREMIER

Suicide Risk Assessment and Ligature

CMS & The Joint Commission

- CMS adopts The Joint Commission's content related to suicide risk.
- **CMS sends a transmittal out on December 7, 2017 (attached in email).**
- Over the past year CMS works with The Joint Commission and Behavioral Health Specialists throughout the country to attempt to mitigate these risks.

CMS works with The Joint Commission and other Accrediting Bodies Follow…

- Achieved consensus on terminology of “ligature resistant” vs “ligature-free”
- **Evaluated different environments for applicability**
- Increased alignment with CMS (TJC, DNV, HFAP and CIHQ).

***Must be* ligature resistant:**
• Inpatient psychiatric units, in both psychiatric and general/acute care hospitals, dedicated spaces in the Emergency Department

***Not required* to be ligature resistant:**
• But *are required* to have conducted an environmental risk assessment, steps, protocols, safeguards, etc. in place to protect suicidal patients:
• EDs, general med/surg inpatient units, residential, partial hospitalization, day treatment, intensive outpatient programming

The Physical Environment and Monitoring

Ligature Risk Deficiencies Do Not Qualify for Life Safety Code (LSC) Waivers:

Ligature risks are not LSC deficiencies. Therefore, a LSC waiver may not be granted.

Screening and Assessment

- Identify patients at risk for suicide.
- **Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.**
- Address the patient's immediate safety needs and most appropriate setting for treatment.
- **When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.**

Note:

This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Topics of Revised Elements of Performance

National Patient Safety Goal 15.01.01

1. Environmental Risk Assessment
2. Screening for Suicidal Ideation
3. Assessment of Suicide Risk
4. Documentation of Risk & Mitigation Plan
5. Policies and Procedures for Monitoring High Risk Patients
6. Counseling at Discharge (Safety Plan)
7. Monitoring Policies and Procedures and Improving Performance

Revised Elements of Performance for NPSG 15.01.01

They Did NOT:

- **Expand screening requirement to other patient groups or settings**
- **Create requirement for post-discharge care**

Immediate Jeopardy and Suicide Risk Reduction

Most Frequently Cited Areas related to Immediate Threats

- Environmental Risks
- High Level Disinfection and Sterilization
- Immediate Threat to Health and Safety
- Leadership Oversight
- Suicide Risk: Immediate Safety Needs

- **While Immediate Threat findings are situational and dependent on a combination of factors, some examples include:**

- **Environmental risks to the built environment, specifically related to ligature and self-harm**

- **Failure to address high risk patients' immediate safety needs**

- **Failure to appropriately screen and assess patients for suicide**

Data - Environment of Care

- Doors and door hardware
- Drop Ceilings
- Beds with ligature risks
- Light Fixtures
- HVAC Vents

- **Non-Tamper Proof Screws**
- **Sprinkler Heads**
- **Bathroom Fixtures (plumbing, toilet paper dispensers, paper towel dispensers, etc.)**
- **Grab Rails**
- **Window Treatments**

Test Time! Is this a Ligature Risk?

Door Handles

Ligature Risk?

- Yes
- No

Test Time! Is this a Ligature Risk?

Door Handles

Ligature Risk?

- Yes
- No

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Test Time! Is this a Ligature Risk?

Door Handles

Ligature Risk?

- Yes
- No

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Test Time! Is this a Ligature Risk?

Doors

Ligature Risk?

- Yes
- No

Data - Leadership

No policy or ambiguity of policy to guide:

1. Completion of suicide risk assessment
2. Interventions to be implemented based on level of risk

Data

- No comprehensive assessment
- Incomplete suicide risk assessment
- Inaccurate/inconsistent with clinical information in medical record
- Not completed per policy
- No synthesis of assessment to determine level of risk nor interventions

Data

Policy not followed:

- Level of patient surveillance based on level of suicide risk
- Special precautions

Orders not followed:

- Interruption in continuous observation
- No documentation to reflect clinical justification for interventions including level of observation

What are the Identified Causes?

Causes

Environment

- Lack of understanding risks
- Responsibility of one individual versus organizational commitment

Leadership

- Lack of oversight
- Policies
- Lack of financial support
- Lack of organization-wide suicide risk reduction program

Causes

Human Resources

- Human factors: complacent with surroundings and patients
- Lack of training/competency
- High staff turnover
- Ineffective handoff

Documentation

- Disjointed documentation with change from paper chart to EMR
- Lack of timely medical record audits

The Solutions

Corrective Actions

- Initial and/or reassessment
- Environment of Care rounds by leadership

Policy creation and/or revision:

- Suicide risk assessment
- Tool
- How often?
- By whom?
- Interventions
- Define monitoring procedures

Corrective Actions

Human Resources

- Staff education/re-education (SRA)
- How?
- When?
- By whom?
- What do I do with this information?

Staff Demonstrated Competency (SRA)

- Who?
- When?

Corrective Actions

Accepted

Observation: In chart reviewed during individual tracer activities, patient scored ‘24’ which indicated high risk for suicide; patient was not placed on suicide risk precautions per policy; no further documented to justify lack of suicide precautions found in medical record.

Assigned Accountability: Chief Executive Officer (CEO)

Leadership Involvement: The Chief Executive Officer, Chief Nursing Officer, Risk Manager, Director Quality Dept, and Director Clinical Services met to review/discuss finding.

Preventative Analysis: The Leadership team met and asked "How can Leadership prevent this from happening again"? The Leadership team analyzed the patient's treatment and determined the need to focus on the following aspects of the treatment process: 1. Admission process 2. Physician to physician communication process 3. Chain of command process 4. Suicide risk assessment and re-assessment process and 5. Discharge Process.

Corrective Actions

Accepted

Corrective Actions: Revised the suicide risk policy to include: how risk factors are utilized to determine the level of observation, interventions to be taken based upon suicide risk assessment, and the frequency of suicide risk assessments to include at time of discharge. Developed suicide risk assessment training for RNs, Mental health technicians, Therapists, Intake Staff, and Medical Staff to include a pre and post test along with demonstrated competency assessment to ensure accurate suicide risk assessment along with appropriate interventions. This mandatory training will be completed during orientation for new hires and now annually for all employees.

Sustained Compliance: 50 weekly chart reviews will be completed to ensure accurate completion of suicide risk assessments per policy. Follow-up with noncompliance will be conducted in real time. Audit data and follow-up activities will be reported weekly to the CEO and reported monthly to the Quality Council.

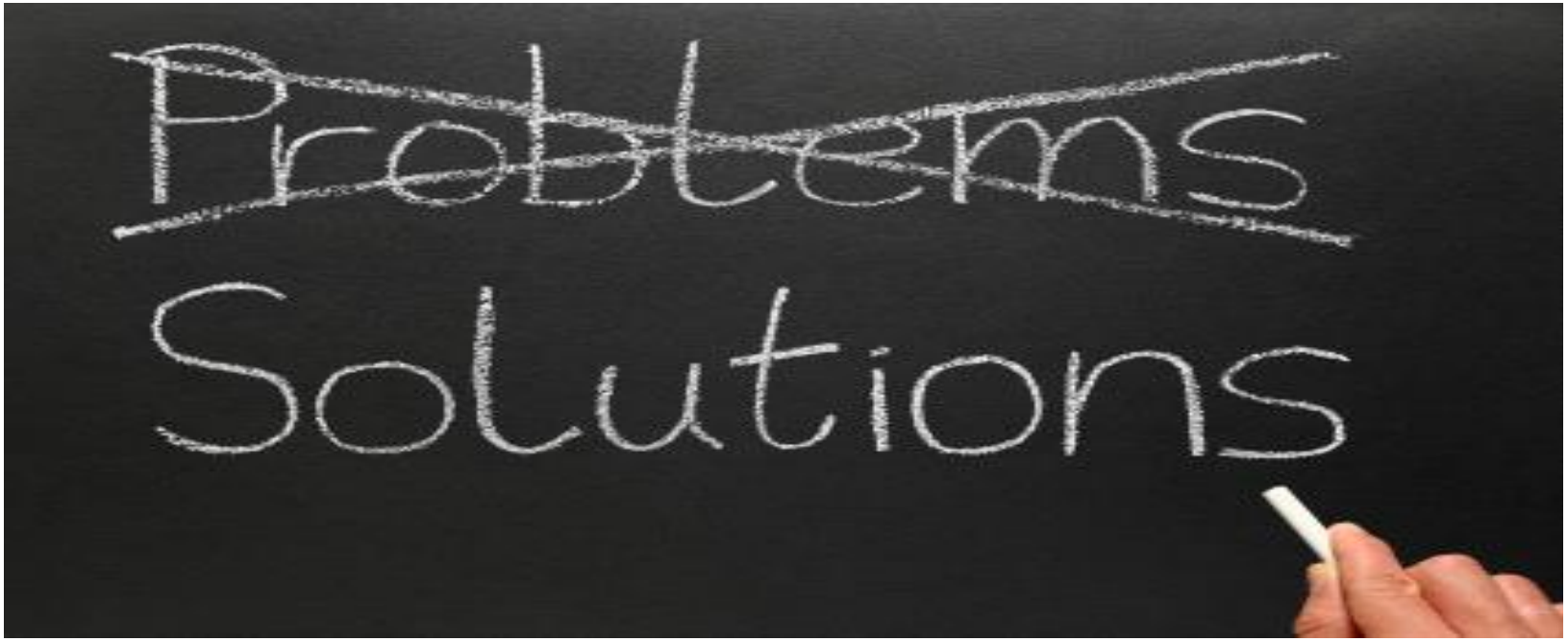
PREMIER

Infection Prevention and Control

Problematic Standards, Elements of Performance and Observations

related to

Infection Prevention and Control



Infection Prevention and Control

IC.02.01.01: The hospital implements its infection prevention and control plan.

EP 1: The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection

Observation:

Staff could not speak to when the patient curtains were to be cleaned in the Emergency Department.

Infection Prevention and Control

IC.02.01.01: The hospital implements its infection prevention and control plan.

EP 1: The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection

Observation:

Linen was uncovered on stretchers and/or beds throughout the organization. There was no risk assessment completed by the organization.

Risk Assessment

Perspective ►	1a Current Issue/Condition			1b Alternative Condition/Proposed Change		
Discussion Topics ▼	Benefit	Risk	Rationale/Examples	Benefit	Risk	Rationale/Examples
Patient safety	5		Linen management is in accordance with NAILM and CDC			
Patient satisfaction	5		No complaints were reported on pre made beds being dirty/ dusty/ soiled			
Outcome (quality) of patient care	5		Timely care			
Staff and volunteer safety	5		Linen management is in accordance with NAILM and CDC			
Staff and volunteer satisfaction	5		Pre made beds give staff and/ or volunteer enough time to properly prepare the bed for the next patient			
Visitor safety	N/A					
Visitor satisfaction	N/A					
Environment safety, including building and grounds	5		Patients rooms are positive pressure, rooms are daily cleaned, patients rooms are low traffic area, in an instance where a patient is placed on precautions in a 2 bedded room, both beds are cycled cleaned once the infectious patient is taken off precautions or discharged.			
Financial operation, budget	N/A					
Work flow efficiency	5		Fast bed turnover, better work flow, beds are ready to receive a patient once admitted or transferred from one unit to another.			
Compliance with regulatory requirements	**5**		**Compliant with NAILM**			

Infection Prevention and Control

IC.02.01.01: The hospital implements its infection prevention and control plan.

EP 1: The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Observation:

An anesthesiologist was observed coming out of a c-section room with gloves and a dangling mask. She removed both but did not wash her hands.

Infection Prevention and Control

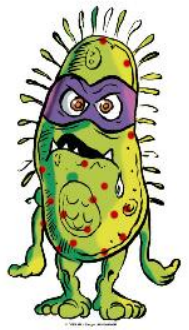
IC.02.01.01: The hospital implements its infection prevention and control plan.

EP 1: The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Observation:

Numerous staff in the Operating Room had their hair and **ears** showing (outside of bouffant and skull cap). The organization's policy indicated that all hair and ears must be covered.

Infection Prevention and Control



IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 4 The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Observation:

The Endoscopy area was using sterile water for 24 hours. The rigid bottle indicated on the label was sterile and to discard after use.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 4 The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Observation:

A multi use ultrasound gel bottle was found without an expiration date on the ICU nursing station counter. Manufacturer stated expiration date after opening was 30 days.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 4 The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Observation:

There was no evidence that the hepa filters for the Mass scope units were changed every 4 months as required by the manufacturer in Endoscopy.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 4 The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Observation:

A sterile yankauer and sterile tubing was opened in OR room 3 without anticipation of a patient.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 4 The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Observation:

A bottle of sterile iodoform packing strips was opened and ready for use. The manufacturer indicated it was one time use only.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 4 The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Observation:

Numerous patient supplies were observed in the medication room that had expired in 2015 and 2016.

PREMIER

Infection Prevention and Control
Cleaning, Disinfection and Sterilization

Let's Trace A Case Cart!

Follow the case cart from an OR suite to decontamination…….

- How are contaminated instruments contained during transport? If the organization does not have a case cart system, containment may be an issue.
- How are contaminated instruments transported in a timely manner?

Standards Interpretation Group Says?

Is there a requirement/expectation that case carts coming from an operating room to decontamination through the semi restricted area (not public area) have a biohazard label on it?

Standards Interpretation Group Says?

“I would recommend reviewing the evidence-based guidelines your organization has chosen to adopt and implement related to instrument reprocessing. I have provided an example of guidelines related to transporting instruments from OSHA, AAMI and AORN below for your reference:

OSHA requirements state: Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be: (A) Puncture resistant; (B) Labeled or color-coded in accordance with this standard; (C) Leakproof on the sides and bottom; and (D) In accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.

Standards Interpretation Group Says?

AAMI 6.5.4 Hand transport
Prior to transportation, items contaminated with blood and other potentially infectious materials should be placed in a container that is puncture-resistant, leak-proof on the bottom and sides and labeled as biohazardous. Containers used to transport contaminated items by hand should be carried in a position parallel to the floor.

AORN I.V.b.

Soiled instruments must be transported to the decontamination area in a closed container or enclosed transport cart. The container or cart must be
• leak proof, 39 (OSHA)
• puncture resistant, 39 (OSHA)
• large enough to contain all contents, and
• labeled with a fluorescent orange or orange-red label containing a biohazard legend. (OSHA)”

Thank you,

Maura Naddy ,
Division of Healthcare Improvement
The Joint Commission
www.jointcommission.org

Standards Interpretation Group Says?

With a written risk assessment, may an organization transport scopes (no sharp instruments) in a sealed bag with a biohazard label on it from an Endoscopy suite to decontamination?

Standards Interpretation Group Says?

“Based on your description, it appears that this would be an acceptable practice as the items being transported do not have sharp edges or points. I have provided further guidance below for you to reference when reviewing this process.

The type of container that should be used depends on the items being transported. Bins with lids, enclosed or covered carts, containment devices, and impermeable bags are among the types of containers that may be used alone or in combination to transport contaminated items. Puncture-resistant, leak-proof, closable, and labeled containers must be used for devices with edges or points capable of penetrating skin or the container.

The primary concern during transport of soiled/contaminated instruments is the potential risk of exposing staff to contaminants. Therefore, OSHA requires compliance with the following guidelines: The minimum expectation for containers with reusable sharps requires compliance with 29 CFR 1910.1030(d)(2)(viii) of OSHA’s bloodborne pathogens standard. Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be: (A) Puncture resistant; (B) Labeled or color-coded in accordance with this standard; (C) Leakproof on the sides and bottom; and (D) In accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.”

Transport to Decontamination…

- During transport to a decontamination area, are the instruments contained in a leak-proof container to minimize the risk of exposing personnel to contaminants during transport?

- How does the OR Technician or Nurse deliver the case cart to decontamination? Does he/she cross the line into decontamination? If so, is there appropriate PPE for him/her to change into prior to entering decontamination?

Decontamination

Upon entering decontamination.....

- Does the staff in that area instruct you to put appropriate PPE on?
- Is the PPE available without you having to enter decontamination?

Is there an Eyewash Station present?

- Is the eyewash station hooked up to **only cold water?**
  - **If so, a risk assessment is necessary.**
- How often does the staff check the eyewash station?
  - *Weekly per ANSI standards with a thorough maintenance check annually.*

Eyewash Station

- Ask staff how many minutes they run the eyewash for during their check?
  - 2-3 minutes per ANSI standards (no longer part of ANSI requirements. You set your policy).

- Are the eye pieces in place and good condition?

- Ask the staff to test the eyewash station. Is the pressure enough to push the eye pieces off?

Please email me for an electronic copy –
Sandy_Garcia@premierinc.com

Sample Eye Wash Inspection Record

Eye Wash Inspection Record

1. Eye washes must be tested and inspected weekly
2. Run the eye wash for 2-3 minutes
3. Ensure the water has sufficient water flow
4. Ensure that there is only cold water running through the eye wash
5. Note whether the hands-free mechanism is functioning
6. Outlet heads (lids covering where water flows from) should be kept closed when not in use. These lids should pop off upon activation of the water
7. Initial the appropriate box below to document a passing inspection
8. If inspection fails, notify all users and call Plant Operations immediately at _____.

Should an exposure occur, flush the affected eye(s) for 15 minutes.

To ensure adequate flushing, hold eyelid(s) open and roll the eyeball

Month/Year	Week 1	Week 2	Week 3	Week 4

Supervisor/Manager Monthly Review: _____

Note: Preventative Maintenance will occur annually to check for problems such as valve leakage, clogged openings and lines and adequacy of fluid volume (.4 gallons per minute for 15 consecutive minutes). These records will be kept within Plant Operations.

Decontamination Room

- Ask the staff if this room is positive or negative pressure?

- How often is the room temperature and humidity checked? What are the appropriate temperature and humidity ranges for this room?

  - Review logs to ensure negative pressure
  - Decide who's standard your organization is able to meet for temperatures, humidity (30-60% CMS) and air exchanges.

- Minimal requirements to follow.

Ventilation (Table 7-1)

Function	Pressure Relationship	Min Outdoor ACH	Minimum Total ACH	All Room Air Exhausted Directly Outdoors	Relative Humidity	Design Temp. °F
Equip. Room	Negative	N/R	10	Yes	N/R	N/R
Soiled or Decontam	Negative	2	6	Yes	N/R	72 – 78
Clean Work Room	Positive	2	4	N/R	Max 60	72 – 78
Sterile Storage	Positive	2	4	N/R	Max 60	72 – 78

ANSI/ASHRAE/ASHE Standard 170-2008 Table 7-1

Humidity….

Achieving the right balance of humidity in anesthetizing locations, such as the operating room, can be challenging. Too much moisture in the air can lead to mold growth, while too little presents the opportunity for static electricity, increasing the possibility of fire if a spark ignites a fuel source near combustible material. Over the years, the requirements for relative humidity levels in anesthetizing locations have evolved as underlying risk factors have changed. The National Fire Protection Association (NFPA), the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), and The Joint Commission have worked with the Centers for Medicare & Medicaid Services (CMS) to come up with a cost-effective relative humidity range that meets patient safety requirements.

The only WAIVER left!

- On April 19, 2013, CMS adopted the ASHRAE-defined range for relative humidity, issuing the "Waiver of Life Safety Code Anesthetizing Location Requirements" (S&C 13-25-LSC & ASC). The waiver adjusts the lower range of relative humidity to 20 percent, which aligns with the Facilities Guidelines Institute's (FGI) 2010 edition of *Guidelines for Design & Construction of Health Care Facilities*. CMS requires that an organization declare at the beginning of any CMS-conducted survey that it has elected to use this waiver. Organizations must document their decision to use the waiver; in addition, they must demonstrate compliance with the ASHRAE standard by documenting the range in which they plan to keep humidity levels.

- Possible ways to communicate this information include:
- Annotating the Statement of Conditions™ in the Basic Building Information (BBI) in the “Additional Comments” text box
- Delineating the humidity range in organization policy
- Either of these methods is acceptable, but the preferred approach is to involve the safety or environment of care committees in the decision about appropriate humidity levels. The decision would then be documented in committee minutes. Once a range has been identified, a health care organization must monitor (and document) relative humidity levels in anesthetizing locations and respond when levels are out of range.

Decontamination Room

Are doors kept closed in this room at all times?

Is there a pass through window? Is this window kept closed when not in use?

What supplies do you use and have available in decontamination?

•Minimally the decontamination area should be stocked with soft-bristle brushes, cleaning cloths, alcohol and appropriate PPE. Enzymatic cleaner is used for manual and automated cleaning of instruments. Alcohol is used to render instruments safe to handle after cleaning, if not rendered safe by another means. OSHA requires that personnel wear skin and mucous membrane protection (i.e. fluid-resistant or impervious gown, gloves and face protection).

Decontamination Room

Manual Cleaning Process

- Which sink is used for soaking and which sink is used for rinsing? Are these labeled as such?
- Are instruments rinsed with cold running water before beginning the cleaning process? This will remove gross debris and help prevent coagulation of the blood present on the instruments. Some facilities use a spray.

Decontamination Room

- How much enzymatic cleaner is used per gallon of water?
- How do you know how much water is in this sink?
- How do you know how much enzymatic cleaner to use? Do you measure the cleaner when adding?
- Does the manufacturer of the cleaner require a temperature range of the water? If so, how do you ensure the temperature?
- Does the manufacturer require a soak? Do you time this process?

Decontamination Room

- Does the manufacturer of the cleaner require a temperature range of the water? If so, how do you ensure the temperature?
- Does the manufacturer require a soak? Do you time this process?

Decontamination Room

- Is there a separate sink designated for hand washing? (AAMI ST79 Section 3)

Decontamination Room

Sonic Washers and Upright Washers

- What is the daily routine maintenance that is required on the sonic washer or upright washer? *Review the manufacturer's guidelines.*
- Who is responsible for the routine maintenance? If the answer is biomed, pull biomed records. Usually, biomed will do the PM's annually but will not do the other routine cleaning and maintenance.
- Does the organization have documentation supporting this routine cleaning and maintenance?

CIDEX OPA

- Is cidex OPA used in this area or any other area of the hospital (check respiratory, radiology, OB/GYN offices/clinics).
- How long is the cidex good for? (14 days)
- How long are the quality strips good for?
- When a new bottle of strips is opened, what is the process?

- Check QC under the attached instructions for the strips. Normally, a negative and positive needs to be conducted when a new bottle of strips are opened **and on a regular basis thereafter as outlined in policy.**
- A container of full-strength cidex and a container of half cidex and water needs to be prepared.
- Dip three test strips into each solution. Hold for 1 second and read after 75-90 seconds (check strips). Document the positive and negative controls before using that bottle of test strips.

Sample Cidex OPA Daily Record

Cidex OPA Daily Record

(New record should be initiated with any change of solution, strip bottle or lot numbers)

Cidex OPA Solution: Lot #:_____ Date Opened:_____

Exp. Date of Solution:_____

Note: Unused Cidex OPA solution should be discarded 75 days after opening or by expiration date (whichever comes first).

Cidex OPA Test Strips: Lot #:_____ Date Opened:_____

Exp. Date of Strips:_____

Strip QC (Required when new bottle of test strips opened)

Positive Control (use with full strength solution - should pass): Pass Fail

Negative Control (use half strength solution – should fail): Pass Fail

Note: Refer to QC instructions on insert attached to each bottle of strips. Discard test strips 90 days after opening or by expiration date on bottle (whichever comes first) or if QC of new bottle fails.

Cidex OPA Solution must be tested prior to each use with single test strip in actual soak solution. Change soak solution every 14 days or when it fails test strip test (whichever comes first)**

		** Solution Tested				Comments
Date	Item	Pass	Fail	Time In/Initials	Time Out/Initials	

Sterile Processing

- Ask the staff if this room is positive or negative pressure?

- How often is the room temperature and humidity checked? What are the appropriate temperature and humidity ranges for this room?

  - Review logs to ensure positive pressure
  - Decide who's standard your organization is able to meet for temperatures, humidity (30-60% CMS) and air exchanges.

- Minimal requirements to follow.

Ventilation (Table 7-1)

Function	Pressure Relationship	Min Outdoor ACH	Minimum Total ACH	All Room Air Exhausted Directly Outdoors	Relative Humidity	Design Temp. °F
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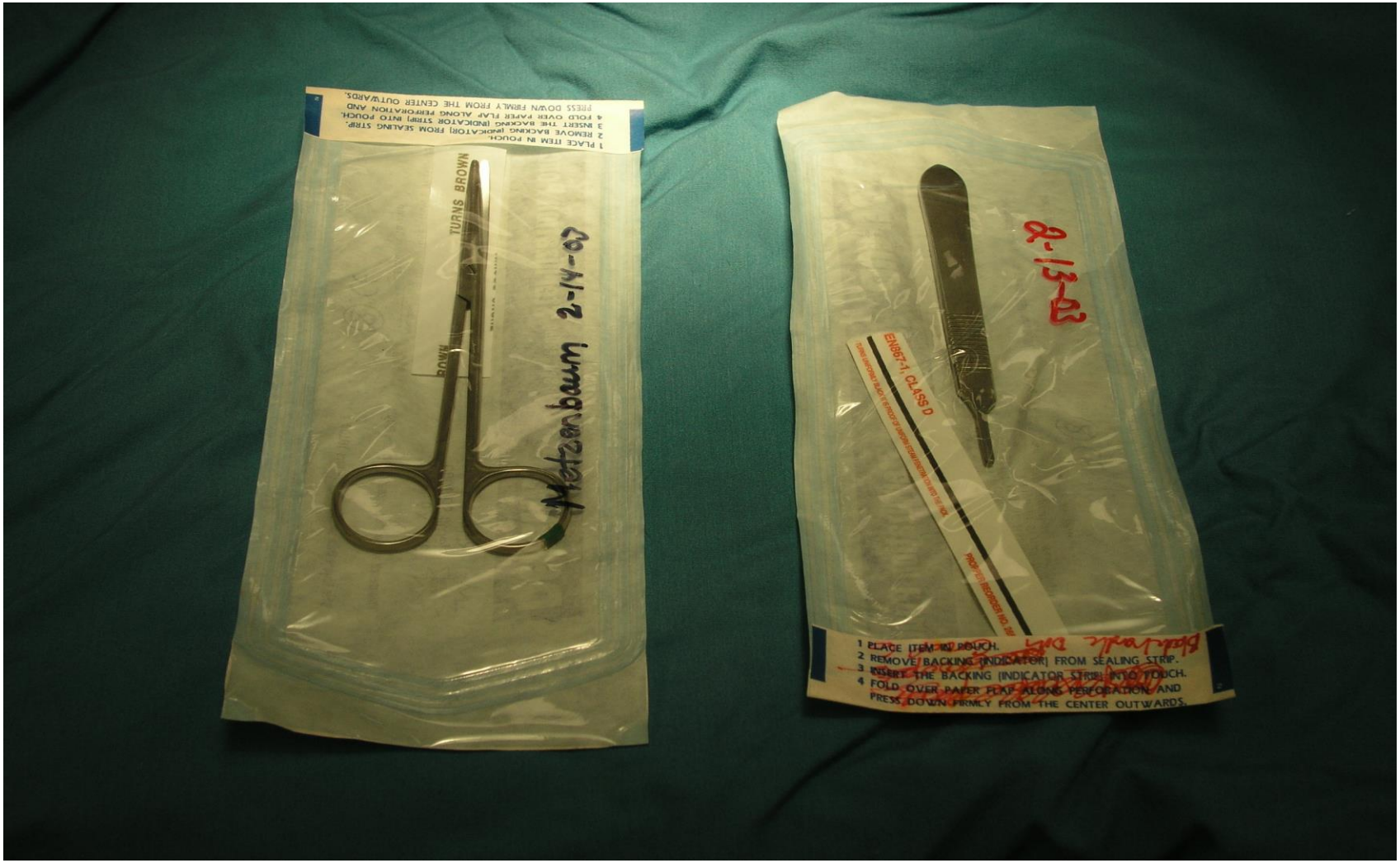
ANSI/ASHRAE/ASHE Standard 170-2008 Table 7-1

Sterile Processing

- Are paper-plastic pouches double pouched?
- Minimal
- Ensure inner pouch is not folded
- May these pouches be placed in trays? **No**
- Are towels placed on the bottom of trays or used to wrap trays? If so, have you seen the data from the manufacturer of the towel that the towel has been validated for this purpose (Medical Device Manufacturer Instructions for Use [MDU IFU])



Event Related Sterility – No More!

Blue Wrap:

Manufacturer Dictates

Hard Type Trays:

Genesis and V.Mueller: 180 days

Aesculap: 360 days or Event Related?

Peel Packs:

Manufacturer Dictates

Upright Washers

- Are you performing TOSI or Verify tests on your washers?
- How often? How did you determine the frequency?
- Show me the documentation.
- If not, how do you ensure that the instrumentation is clean after processing through your washers?
- How do you ensure that the proper temperature is reached during a wash cycle?

Sterilizers, Sterrad

- What is the daily routine maintenance that is required on the sterilizer/sterrad? *Review the manufacturer's guidelines.*
- Who is responsible for the routine maintenance? If the answer is biomed, pull biomed records. Usually, biomed will do the PM's annually but will not do the other routine cleaning and maintenance.
- Does the organization have documentation supporting this routine cleaning and maintenance?
- Are alarms audible?
- How often are alarms checked?

Note: If the department does not bring down (turn off) the steam sterilizers weekly, they may not meet the weekly requirements of the manufacturer. Quick question to ask and will give you a lot of information.

Routine Cleaning and Maintenance - Checklist

Day of Week	1
Sterilizer: Amsco Century Medium Steam Sterilizer	
Routine Cleaning and Maintenance (as outlined in the Operator's Manual)	
Daily (Before running first cycle)	
Remove the drain strainer from the drain in the bottom of the chamber.	
Remove any obvious debris from the strainer. If necessary, clear the screen in the strainer using a brush, wire, or similar tool.	
Reverse flush the strainer under running water.	
Replace the strainer in the chamber drain.	
Weekly	
Note: Flushing chamber drain not required as outlined in the addendum from Steris titled, "Technical Bulletin". Recommends an every 6 month cycle now.	

Quality Monitoring

- Is every package able to be tracked?

- Do the sterilizer records contain lot number, load contents, cycle parameters, name of operator, results of Bowie-Dick tests, results of biological monitoring and chemical indicator responses?

- If surveyor asks why Bowie Dick logs do not have expiration date, AAMI no longer requires this because the expiration date can be tracked from the lot number.

Quality Monitoring

- When are Bowie-Dick tests run? Should be run after warm-up cycle. Please remember to check the Bowie-Dick tests that are run on the sterilizers within the Operating Room.

Immediate Use Sterilization

Recommended Standard Definition

to Determine Rates:

instruments flashed per month/total number cases in month

Are implants flashed?

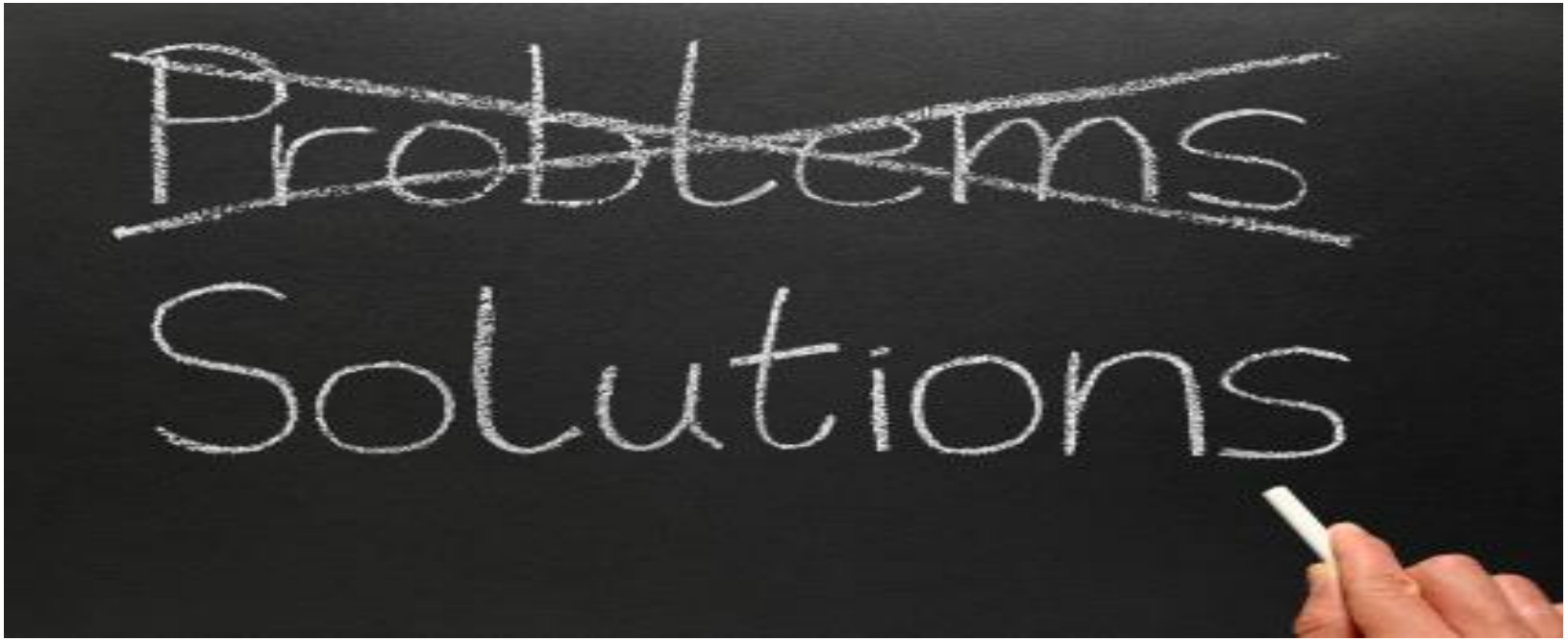
- No

Is there a process for the Infection Control Committee lead by the ICP to review rates? Do you trend the data? Does this committee and/or ICP review what items are flashed?

More Problematic Standards, Elements of Performance and Observations

related to

Infection Prevention and Control



Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 2: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)

Observation:

It was observed in soiled/clean utility room used by the Emergency Department that several trays of blue wrapped sterile instrument trays were expired but ready for use. The sterilization dates for two trays were 2006 and 2008. The validation studies for the wrap was 1 year.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 2: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)

Observation:

A Magil forceps was observed in a crash cart, ready for use, but was not sterilized as required by the manufacturer.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 2: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)

Observation:

There was no evidence of routine cleaning and maintenance on the sterilizers to include daily cleaning of the drain strain and interior chamber cleaning as required by the manufacturer.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 2: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)

Observation:

There was no evidence of routine cleaning and maintenance on the washers to include daily cleaning of the drain strainer and other maintenance as required by the manufacturer.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 2: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)

Observation:

Several V. Mueller and Genesis trays were observed ready for use but had expired. The manufacturer of the tray indicated once sterile the shelf life was 180 days.

Infection Prevention and Control

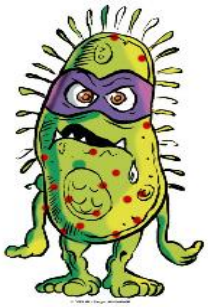
IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 2: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)

Observation:

Several peel packs were observed in a clinic, ready for use, but had expired. The manufacturer of the peel pack indicated once sterilized the shelf life was 6 months.

Infection Prevention and Control



IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 2: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)

Observation:

Several Aesculap trays were observed in Sterile Storage that had expired. The manufacturer of the peel pack indicated once sterilized the shelf life was **360 days or event related**.

Infection Prevention and Control

IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

EP 2: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)

Observation:

The Cidex OPA strips had quality control completed every time a new bottle was opened, but not on a **"regular"** basis as defined by the organization. The package insert required the organization to set a "regular" timeframe for additional quality control.

Infection Prevention and Control

EC.02.05.01: The hospital manages risks associated with its utility systems.

EP 15: In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity. Note: For more information about areas designed for control of airborne contaminants, the basis for design compliance is the Guidelines for Design and Construction of Health Care Facilities, based on the edition used at the time of design (if available).

Observation:

Numerous peel packs and instrument trays were observed in the Emergency Department without temperature and humidity monitoring. No risk assessment was completed by the organization.

FAQ – Frequently Asked Question

Temperature and Humidity - Monitoring Requirements for Sterile Supply Storage Areas

Modify | July 11, 2017

What are the requirements for temperature and humidity monitoring in areas in which sterile supplies are stored ?

“Decentralized locations where small quantities of sterile items are stored close to treatment/procedure areas that are outliers to areas described above can be managed through staff surveillance during the regular course of performing their duties. Examples of these decentralized locations could include labor and delivery areas without C-section procedures, imaging areas, emergency department (small storage), etc. Staging of sterile items outside of procedure room (like an operating room) for a limited period of time would also apply.”

Full FAQ:

https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=1686&ProgramId=46

PREMIER

Questions

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