Joint Commission: Tall Tales and Truths: Preparing your unit for inspection

Cindy Taylor MSA, BSN, CGRN
Nurse Manager - Gastroenterology
Hunter Holmes McGuire VA Medical Center
Richmond, Virginia
Panic Run Hide
Endoscopy Related Outbreaks

**Risk of Transmission:**
- Incidence of transmission 1:1.8 /1:10
- 2008 - Las Vegas, Veterans Hospitals
- 2010 - ASCs, Minnesota HD
- 2013 - Atlanta Surgery Center
- 2014 – Illinois, New Delhi (NDM) producing Escherichia coli-elevator channel

**Risk of Infection:**
- HEP B: 5 cases, disinfection and cleaning processes, HLD exposure time
- HEP C: 8 cases, needles, multi-dose vials, syringes,
- HIV: No cases published in world literature
- Bacteria: Pseudomonas 216 cases, Salmonella 48 cases, reprocessing failures, channels, water supply, AER failure
- H. Pylori: 12 cases, inappropriate LCG, inadequate exposure time, PPE
- Prions: no reported cases
- + NDM-producing E coli- 9 patients>27

**Causes of Infectious Outbreaks:**
- Environmental contamination
- Failure to follow guidelines, reprocessing steps, manufacturer’s instructions for use (IFU)
- Break down in general infection control principles and practices
- Chemical Failures
- AER Failures
- Human error
- Lack of Education and Training
Endoscopy Related Outbreaks

**Prevention of Outbreaks**
- Oversight
- Follow manufacturers instructions
- Education and training
- Standard precautions
- Contact precautions
- Aseptic technique
- Follow multi-society guideline
- Current and Competent Certification

**Reporting a Breech or Outbreak**
- Infection Control personnel
- Local and state public health agencies
- FDC
- CDC
- Manufacturers
  - Endoscope
  - LCG
  - AER
- The Patient
## Top High Risk Direct Impact

**Hospital Standards**  
N=32 Hospital Surveys

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Standard</th>
<th>Standard Text</th>
<th>Percent of Organizations Scored</th>
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| Record of Care, Treatment and Services       | RC.02.01.03 | Patient’s medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia,  
<pre><code>                                                             | 21.88%  |
</code></pre>
<p>| Information Management                        | IM.02.02.01 | The hospital effectively manages the collection of health information.                                                                                                                                     | 21.88%  |
| Provision of Care, Treatment, and Services   | PC.01.02.08 | The hospital assesses and manages the patient’s risks for falls.                                                                                                                                           | 6.25%   |
| Rights and Responsibilities of the individual | RI.01.05.01 | The hospital addresses patient decisions about care, treatment, and services received at the end of life.                                                                                                   | 6.25%   |
| Provision of Care, Treatment, and Services   | PC.01.02.03 | The hospital assesses and reassesses the patient and his or her condition according to defined time frames.                                                                                                 | 6.25%   |</p>
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<th>Problem Area</th>
<th>Description</th>
<th>Strategy</th>
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| Propped open doors  | To help with airflow, ventilation, or temperature control, staff prop open a door. Most doors that open onto a corridor must be self-closing and remain closed at all times to separate the corridor from the room in case of fire. | • Evaluate the effectiveness of the heating, ventilating, and air conditioning (HVAC) system. Confirm that the system is functioning as designed. It is possible that the system needs additional controls to meet the occupants’ needs. 
• For doors that can be kept open, install a magnetic “hold open” device interfaced with the fire alarm system. In case of fire, the magnetic connection is severed, and the door closes automatically, protecting the room’s occupants. |
### Frequently occurring EC safety hazards and strategies for improvement

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| Space heaters | Since space heaters increase fire risk, they are prohibited in patient sleeping and treatment areas (which includes the nurses’ station). | • Perform a detailed evaluation of your HVAC system to see if performance can be enhanced throughout the facility.  
• Not using space heaters is the safest course of action, but space heaters are allowed in an office – such as a nurse manager’s office – or an admitting area, which is separated from all sleeping and treatment areas by a door or wall. |
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<td>Personal protective equipment (PPE)</td>
<td>Staff doesn’t follow the organization’s policy for wearing PPE.</td>
<td>- During the EC tour, verify that staff understand and consistently comply with the organization’s PPE policy. For more guidance on proper PPE for specific situations, see the Occupational Safety and Health Administration (OSHA) guidelines (for example, 29 CFR 1910.132).</td>
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<td>PPE is not in good working order.</td>
<td>- Have proper signage indicating when PPE is necessary.</td>
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<td>- Periodically evaluate lead aprons and other protective gear to ensure that there is no cracking or shielding material displacement.</td>
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<td>- Periodically evaluate equipment used to protect patients, such as the collars placed on patients during an X-ray.</td>
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<td>Lighting</td>
<td>A burned-out light bulb in an exit sign can be a significant safety hazard. Appropriate lighting is important for patient care areas to ensure that staff can correctly read identification badges, charts, and information.</td>
<td>• The Joint Commission requires organizations to have two-bulb exit fixtures so that the loss of one bulb will not leave an area in total darkness. • Assess lighting conditions at various times to gauge whether lighting is suitable for the activities taking place. If lighting levels are not sufficient, explore ways to add lighting. • Ask staff members about their perceptions of lighting to see if there are any concerns about light level and intensity.</td>
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<td>Cleaning</td>
<td>Accumulation of dust, dirt, and potential microbial contaminants on and under environmental surfaces serves as a potential reservoir for microorganisms. Odors from trash or cleaning products may be offensive to patients and staff. In order to clean, housekeeping staff may raise alarm pulls, display wet floor signs, open drawers, or in other ways alter the clinical environment so that it is not ready for use.</td>
<td>• Routine environmental cleaning is necessary to maintain a standard of overall organizational cleanliness. There are requirements, established by government regulation and guidelines issued by the Centers for Disease Control and Prevention (CDC), for maintaining the cleanliness of the health care environment. • Each health care organization must have and follow written policies and procedures for environmental cleaning. • Have processes in place for limiting and managing odors. • Check that these processes are consistently followed. • Empty trash more frequently or at different times.</td>
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| Lack of responsibility for environmental risks         | Staff members ignore spills and other hazards                    | • Standard EC.03.01.01, elements of performance 1-3, require organization staff and licensed independent practitioners to remain vigilant about physical risks and take responsibility for addressing them.  
• Ensuring a safe environment requires commitment from all staff. When such a commitment is present, an organization can foster an environment that supports the best possible care for patients. |
Prevail during your next Joint Commission Visit

Methods to prepare
• Tracers
• Educate staff
• Patient safety posters
• Newsletters
• Education Fair
• Games
• The four Rs for facing JC Surveyor
  • Relax
  • Rephrase
  • Resources
  • Respond

Clarifications and Expectations

Keeping It Clean: The EC professional's role in supporting thorough and reliable endoscope reprocessing

Joint Commission Perspectives®

Source: Environment of Care News, Volume 17, Number 4, April 2014, pp. 5-7(3)

Publisher: Joint Commission Resources

• Reprocessing Problematic
  • Failure to follow guidelines
  • Decentralized procedures
  • Time pressures
  • Poor Training

• What can EC professionals do to support effective scope reprocessing
  • Develop good working relationships
  • Visit areas during Environmental Rounds (checklist)
  • Verify suitable ventilation
  • Enable regular and effective endoscope maintenance
  • Remain vigilant
Joint Commission Checklist for an Environment of Care Survey

The list is a starting point for assessing the environment and verifying that it supports consistent and reliable endoscope cleaning and disinfection.

Joint Commission Perspectives®
Source: Environment of Care News, Volume 17, Number 4, April 2014, pp. 5-7(3)
Publisher: Joint Commission Resources
Tall Tale or Truth?

- Time Out
- Oxygen Tanks
- Crash Carts-Laryngoscopes
- Ceiling tiles, floors and baseboards
- Verbal orders
- Dilator Carts
- Towels in bottom of scope cabinets
- Ventilation requirements
- Hang Time
- AER precleaning claims
- Eye wash stations
- Soiled Linen and trash
Time Out

• In several procedural areas the attending physician supervises multiple trainees and goes from room to room to assist/supervise key portions of procedures. Is a new time out necessary each time the attending, enters the room? In addition, is a time out required again each time a new person enters the room—circulating nurse, relieving resident or a trainee who just may be observing?

• “A time out is required whenever any member of the team changes. If the supervising physician is considered a member of the team then a new time out is required to bring the physician up to speed on who the patient is, what procedure is being performed, the site and the current state of the patient and the procedure”.
Oxygen Tanks

- Can Empty and Full Oxygen tanks be stored in the same location?

  - No. Empty and full racked separately, EC.02.06.01 EP 1 (Unsafe Condition)
  - Store in appropriate area, EC.02.03.01 EP 1 (Fire Risk)
  - Unsecured cylinders
  - The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital’s facility
Crash Cart-Laryngoscope

• Laryngoscopes can be stored unwrapped in or on top of the crash cart.

• Examples of compliant storage include, but are not limited to, a peel pack post steam sterilization (long-term) or wrapping in a sterile towel (short-term). Examples of noncompliant storage would include unwrapped blades in an anesthesia drawer, as well as unwrapped blades on top of a code cart.

• Processed via either sterilization or high-level disinfection. Packaged in some way. HICPAC guidelines do not specify the manner in which laryngoscope blades should be packaged.

• Store in a way that will prevent recontamination.
Ceiling Tiles, Floors and Baseboards

Water Stain
Verbal Orders

- The moderate sedation documentation needs to include a statement for “Verbal Order and Read Back”
- NPSG #2:
  - Improve the effectiveness of communication among caregivers
  - Write down, read back, receive confirmation
Dilator Carts

• Cleaning policy-Cart
• Expiration Dates
Towels in Scope Cabinets

• Can towels be placed in scope cabinets to collect water, alcohol?
• Yes, as long as lint free
• No, infection control issues
Ventilation Requirements

• Negative or Positive Pressure Rooms?

• 1996-2010:
  • Air pressure for procedure rooms: neutral>negative>neutral>positive
  • Air changes per hour (ACH) 6-15

• JC adopted 2010 FGI EC.02.05.01, EP6 applies to new construction and is not enforceable to older designs.

• Reprocessing Room:
  • The room’s air pressure must be negative to the surrounding spaces. For example, the air must move from a corridor into the endoscopy equipment processing room.
  • The air must exhaust directly outside; the air cannot be reused somewhere else in the building.
  • The air must be changed a minimum of 10 times per hour; 2 of the 10 air changes must be fresh, outside air.
  • There are no requirements for relative humidity (RH) or temperature.
Scope Hang Time

• AORN – 5 Days
• No Joint Commission standard, however asking about policy
• Organizational policy
AER Pre-Cleaning Claims

• Joint Commission queried staff about Sterilization/disinfection of scopes and AER claims of no “pre-processing claims”

• Organizations should be guarded against claim that scope does not have to be pre-processsed with AER. Follow guidelines to clean and flush with detergent prior to HLD or sterilization.
Eye Wash Stations

- Eye wash stations are required wherever there is a possibility that caustic or corrosive chemicals can splash into the eye of health care provider. (ANSI standard Z358.1-2009)
- Blood and body fluids: not considered caustic or corrosive
- PPE/MSDS/15 minutes
- JC does not specify location-facility to perform risk assessment
- 10 seconds travel time-55 feet of the hazard
- Tepid water with weekly activation and testing (Bacteria)
- Caution portable eye wash bottles vs plumbed eye wash stations.
Soiled Linen and Trash Receptacle

• Is it acceptable to have containers that are designed with a capacity greater than 32 gallons in a healthcare or ambulatory occupancy?

• Yes, provided they are in a room designated as a hazardous area as defined in Life Safety Chapter (see also NFPA 101-2000 18/19.7.5.5; 18/19.3.2.1 and 20/21.7.5.5).
  • Container located outside of a hazardous room exceeds 32 gallons the following will need to occur:
  • A means to limit the internal capacity (such as an insert) to < 32gallons (.5 gallons per square foot in any 64 square foot area)
Under Sink Cabinet Storage

Do the Joint Commission standards prohibit use of under sink cabinets for storage?

No. The Environment of Care and Infection Control standards do not specifically address under sink storage.

• Conduct risk assessments
• Organizations should also check with applicable agencies, safety officers and building engineers
• Chemicals - quantities allowed by both OSHA and the fire protection Authorities Having Jurisdiction (AHJs)
• Chemicals - do not react with each other or with moisture.
Who is the Authority?

• Smooth walking surface: Surveyor or Building authorities?
• Who do we follow?
• Must follow the most restrictive of all the authorities who inspect your facility.
  • If the city says you do not need a sidewalk but the accreditation organization says you do, then you must follow the accreditation organization, since their interpretation requires a smooth walking surface and is more restrictive.
• Many different authorities having jurisdiction (AHJ)
• Typical hospital has 5-6 different AHJs
  • Accreditation organizations (Joint Commission, HFAP, DNV)
  • CMS
  • State department of public health
  • State fire marshal
  • Local fire inspector
  • Insurance carrier
• Any one of these AHJs can make an interpretation of the codes, and hospitals would need to comply with it.
• No single AHJ can over-rule another AHJ’s decision
Joe’s Findings