CMS AND TJC UPDATES

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Statewide Program for Infection Control and Epidemiology (SPICE)

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OBJECTIVES

1. Discuss the CMS Hospital Conditions of Participation (CoPs)
2. Discuss the CMS revised infection control worksheet and survey process
3. Introduce a standardized approach to infection control TJC standards

CMS QUALITY, SAFETY AND OVERSIGHT GROUP (QSOG)

Federal

CMS Headquarters -------AOs

10 Regional Offices

https://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/RegionalMap.html

State Agencies

ORGANIZATION OF QUALITY, SAFETY AND OVERSIGHT GROUP (QSOG)

- Division of Acute Care Services (DACS)
  - Acute Care Hospitals, LTACs, CAHs, ASCs, Rehab, Psychiatric
- Division of Nursing Homes (DNH)
  - Nursing Homes
- Division of Continuing Care Providers (DCCP)
  - Home Health and Hospice, ESRD, Psychiatric Residential Treatment Facilities
- Clinical Laboratory Improvement Amendments (CLIA)

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Deemed organizations: Healthcare entities who participate must comply with:

Conditions of Participation (CoPs) - (hospitals, CAHs, ASCs)

Conditions for Coverage CfCs - (ESRD, LTC/NH, ASCs)

- Minimum health and safety **standards** that providers and suppliers must meet in order to be Medicare and Medicaid certified and receive reimbursement.
- The Interpretive Guidelines (IGs)provide instructions to the surveyors on how to survey the CoP. *Note: key are "should" versus "must" statements*

cms.gov

CMS HOSPITAL INTERPRETIVE GUIDANCE – ORGANIZATIONAL POLICIES

- Designate in writing infection control officer(s)
  - Must be qualified
  - No specification on number of IPs or hours
- Develop and implement policies governing control of infections/communicable disease

WHERE TO SUBMIT A QUESTION OR INQUIRY TO CMS ?

Division of Acute Care Services (DACS)

- PFP.SCG@cms.hhs.gov

Division of Nursing Homes (DNHs)

- DNH_TriageTeam@cms.hhs.gov

ESRD Survey & Certification Group

- ESRDSurvey@cms.hhs.gov
- Find resources for compliance with the ESRD Conditions for Coverage here:
- www.cms.gov/GuidanceforLawsAndRegulations/05_Dialysis.asp

SCG General Information

- **http://www.cms.gov/SurveyCertificationGenInfo/**

TJC HIERARCHICAL APPROACH TO INFECTION CONTROL RELATED STANDARDS

RULES AND REGULATIONS

CoPs and CfCs

Manufacturer's Instructions for Use (MIFU)

Evidence-based Guidelines and Standards

Consensus Documents

Organizational Infection Prevention and Control Policy and Procedures

For organizations that use deemed status the accrediting organizations must use the CoPs.

RULES AND REGULATIONS

Common sources of infection control related regulation:

- Occupational Safety and Health administration(OSHA)
- Food and Drug Administration (FDA)
- Environmental Protection Agency (EPA)
- Local or state health authority having jurisdiction (AHJ)

OSHA

1910.1030 - **Bloodborne Pathogens Standard (1991) and the**

2000 Needlestick Safety and Prevention Act,

– PPE, exposure control plans, engineering and work practice controls, hepatitis B vaccinations, hazard communication and training, and recordkeeping. deemed necessary to protect from exposure to blood and other potentially infectious materials linked to transmission of bloodborne pathogens

1910.134 - Respiratory Protection Standard (1994)

- Applies to PPE deemed necessary to protect workers from infectious disease that does not fall under coverage of the BBP standard (e.g., implementation of isolation)

- Respiratory Protection Program

SCORING EXAMPLE

Observation: Quality minutes about staff in the ICU and emergency room being exposed to blood splashes of the face during emergency resuscitations on multiple occasions over the last year.

Survey Inquiry: What PPE employees were required to wear to prevent splash exposures?

Is this an issue for TJC compliance?

IS THIS AN ISSUE FOR TJC COMPLIANCE?

Yes!

Answer: Organization did not evaluate the type of exposures anticipated and determine the type of PPE required based on the anticipated exposure.

Rationale: Despite documented staff exposures during emergency resuscitations, the organization had not evaluated the type of personal protective equipment that should be worn by staff to prevent exposure.

Finding under: IC.01.03.01 EP1

FDA GUIDANCE FOR USERS

Reprocessing Patient Care Equipment

1. Check the label for date of issuance or the date of the latest revision
2. Contact the manufacturers technical service representatives for new instructions that comply with the FDA Reprocessing Guidance
3. Search the FDA 510(k) database

– https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfp mn/pmn.cfm

CONSISTENT INTERPRETATIONS

Updated scoring criteria published in August 2019 Perspectives

- Personal protective equipment (PPE) consistent with exposure risk was not available. (IC.01.02.01 EP3)
- The organization did not evaluate the type of exposures anticipated and determine the type of PPE required based on the anticipated exposure. (IC.01.03.01 EP1)
- The organization did not provide sufficient training or assess competency to ensure that staff know which PPE to don, it's proper use, limitations, or how to don and/or doff PPE safety. (HR.01.05.03 EP1)
- Use of PPE was not enforced. (IC.02.01.01 EP2)
- Leadership was unable to provide evidence that action had been taken to improve the use of PPE (PI.03.01.01 EP2)

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CMS HOSPITAL INTERPRETIVE GUIDANCE

Infection Control Program must:

- Be incorporated into hospital-wide QAPI program
- Include nationally recognized practices, guidelines, and regulations
- Have active surveillance component covering patients and personnel that conduct surveillance facility-wide (all locations, departments, services, campuses), follow NHSN
- Develop and implement IC interventions to address issues identified through detection, and monitor effectiveness of interventions.
- Appropriately monitor housekeeping, maintenance, and other activities to ensure sanitary environment

CMS HOSPITAL INTERPRETIVE GUIDANCE

IP(s) must

- Develop and implement infection control measures for HCPs
- Mitigate risk (POA and HAI)
- Active surveillance
- Monitor compliance with policy and procedures
- Program evaluation and revision
- Report communicable diseases
- Maintain sanitary physical environment

HOSPITAL AND CAH RULES TO PROMOTE INNOVATION, FLEXIBILITY, AND IMPROVEMENT IN PATIENT CARE 2019

- Hospital-wide IPC and antibiotic stewardship programs (ASP);
- Designate leaders of the IPCP and the ASP respectively, who are qualified through education, training, experience, or certification.
- Quality Assessment and Performance Improvement (QAPI) program incorporate quality indicator data related to hospital readmissions and hospital-acquired conditions;
- Competencies documented for IPC training

TJC CROSSWALK FOR TAG A-0747

TJC STANDARDS

0747

Hospital **must provide a sanitary environment** to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

- **EC.02.05.01 – Hospital manages risk associated with its utility systems.**
  - EP 1 – Designs and installs **utility systems** that meet patient care and operational needs. (Disruptions to grid, FGI Construction and Renovation Guidelines)
  - EP 5 – Minimizes pathogenic biological agents in **cooling towers, domestic water systems, and other aerosolizing water systems** – (Legionella and WBP control limits)
  - EP 6 – Control of airborne pathogens **–** (ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration)

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TJC STANDARDS

- **EC.02.05.05 –**
- **Hospital inspects test, and maintains utility systems**
  - EP 4 – Hospital inspects, test and maintains the following: infection control utility system components on the inventory. Activities are documented. (Air exchange rates, and filter banks changed per MIFU)

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TJC STANDARDS

- **EC.02.06.01 – Hospital establishes and maintains a safe, functional environment**
- EP 13 – Hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment and services provided **(Reprocessing and central sterile services have the right temp, humidity and AER monitored and documented.)**

This is where current AORN Standards, ASHREA and AAMI standards are to be referenced by policy and followed.

- EP 20 – Areas used by patients are clean and free of offensive odors. **(Dust balls, tape on transport and patient care equipment**

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TJC STANDARDS

EC.02.06.05 – Hospital manages its environment during demolition, renovation, and new construction to reduce the risk to those in the organization

EP 2 – When planning for demolition, construction, or renovation, hospital conducts a preconstruction risk assessment for air quality, infection control, utility systems, noise, vibration, and other hazards that affect care. (evidence of an ICRA documented and implemented)

EP 3 – Hospital takes actions based on its assessment to minimize risk during demolition, construction and renovation. (Was there a plan for moving immunocompromised patients from areas near or under construction? Daily review by IP? Is there education of outside contractors or a checklist for contractor to follow?)

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TJC STANDARDS

IC.01.02.01 – Hospital leaders allocate needed resources for IC program

EP 1 – Provides access to information (Intranet, training and education)

EP 2 – Provides laboratory resources (Outbreak DNA testing)

EP 3 – Provides equipment and supplies (Computer and surveillance programs)

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HKK1

TJC CROSSWALK FOR CMS TAG A-0747

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TJC STANDARDS

- **IC.01.03.01 – Hospital identifies risk for acquiring and transmitting infections**
- EP 1 – identifies risk for acquiring and transmitting infections based on: its geographic location, community, and population served (annual risk assessment: geographic, MDROS, community served…retirement, migrant, miners)
- EP2 – Identifies s risk based on: The care treatment and services it provides. (surgical specialties, treatments)
- EP 3 – Identifies risk based on: analysis of surveillance activities and other IC activities (high risk M&M)
- EP 4 – Reviews and identifies its risk at least annually and whenever significant changes occur with input from IPs, medical staff, nursing, leadership (ICC)

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Slide 25

HKK1 Hoffmann, Karen K, 4/2/2021

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Hospital must provide a **sanitary environment** to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

- **IC.01.05.01 – Hospital has an infection control plan (ICP)**
  - EP 1 – When developing plan, hospital uses evidence-based national guidelines, or expert consensus (e.g., CDC, AAMI)
  - EP 2 – ICP includes written description of the activities, including surveillance, to minimize, reduce, or eliminate risk of infection (PI programs for reducing CAUTI, Central line, SSI, Bundles, ASP)
  - EP 3 – ICP includes description of the process to evaluate ICP

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INFECTION CONTROL RISK ASSESSMENT: REFERENCES

- Infection Control Risk Assessment APIC 2011-Baltimore (Web search)
- http://oregonpatientsafety.org/healthcare-professionals/infection-prevention-toolkit/section-1-infection-prevention-programdevelopment/473/oregonpatientsafety.org/healthcare.../**infection**...**tool**kit/...**infection**.../473/

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FACILITY BASED RISK ASSESSMENT

There are somethings that cannot be "risk-assessed."

Do NOT write a policy that conflicts with

– Regulations

– CoPs– look at interpretive guidelines or seek clarification from CMS (HospitalSCG@cms.hhs.gov)

– Manufacturer instructions for use – must resolve conflicts

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TJC STANDARDS

IC.01.05.01 – Hospital has an infection control plan (ICP)

- EP 5 – describes the process for investigating outbreaks (what is reporting system of outbreaks to public health? who is in the communication lead? following thresholds based on national recommendations like with the second case of Legionella… then putting these steps go into place.)
- EP 6 – All hospital components and functions are integrated into IC activities (OCC Health, Product selection, Construction Comm)
- EP 7 – Hospital has method for communicating responsibilities about preventing and controlling infections to LIPs, staff, visitors, patients, and families. (Messaging by training, posters, computers, pamphlets)

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TJC STANDARDS

IC.01.06.01 – Hospital prepares to respond to influx of potentially infectious patients

- EP 4 – Hospital describes in writing how it will respond to influx of potentially infectious patients. (triage in tents outside ED, where will chairs, patient screening equipment, computers, etc.)
- EP 6 – When necessary, hospital activates its response to influx of potentially infectious patients. (SARS, Swine flu and COVID-19)

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TJC STANDARDS

IC.02.01.01 – Hospital implements its ICP

- EP 1 – Hospital implements its IC activities, including surveillance, to reduce risk of infection. (other e.g. ASP, PI projects)
- EP 2 – Hospital uses Standard Precautions to reduce the risk of infection. (PPE availability at point of use, glove mouth and eye protection, surgical mask for epidural)
- EP 3 – Hospital implements Transmission-based Precautions. (Contact precautions for patients with epidemiologically significant multidrug-resistant organisms (MDROs)

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TJC STANDARDS

IC.02.01.01 – Hospital implements its ICP

- EP 6 – Minimizes risk of infection with storing and disposing of infectious waste (Follow state medical waste rules)
- EP 7 – Implements methods to communicate responsibilities for IC to LIPs, staff, visitors, patients, and families. (Implementation methods)
- EP 8 – Reports infection surveillance, prevention, and control information to the appropriate staff within hospital (also part of NPSGs of MDROs, SSI, HAI dashboards)

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0747

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TJC STANDARDS

IC.02.02.01 – Hospital reduces the risk of infection associated with medical equipment, devices and supplies

- EP 1 – Implements IC activities during: Cleaning and low-level disinfection (non-critical reusable patient care items using MIFU; can staff articulate the process?)
- EP 2 - Implements IC activities during: intermediate and high-level disinfection and sterilization (make sure the policy is consistent for ultrasound, TEE probes in outpatient areas)
- EP 3 – Disposing of medical equipment, devices, supplies (OSHA BBP, and state medical waste rules)
- EP 4 – Storing medical equipment devices and supplies. (Follow MIFU and CDC guidance for HLD including storage of scopes horizontally.)

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TJC STANDARDS

- IC.02.03.01 – Hospital works to prevent transmission of infectious disease among patients, LIPs, and staff
  - EP 1 – Makes screening for exposure/immunity to Infectious diseases available to LIPs and staff (CDC OCC Health Guidelines)
  - EP 2 – Refers/provides LIPs and staff with an infectious disease for assessment, testing, prophylaxis/treatment, and counseling…(OSHA BBP and CDC OCC Health Guidelines)
  - EP 3 – Refers/ provides occupationally exposed LIPs and staff for assessment, testing… (BBP, TB, Meningococcemia per CDC OCC Health Guidelines)
  - EP 4 – Patients exposed to infectious diseases, hospital provides/refers for assessment, testing…

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TJC CROSSWALK FOR CMS TAG A-0747

0747

Hospital **must provide a sanitary environment** to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

- **IC.03.01.01 – Hospital evaluates the effectiveness of the IC plan**
  - EP 1 – Hospital evaluates IC Plan annually and whenever risk change
  - EP 4 – Evaluation includes: implementation of IC plan activities…(is the plan working are HAIs reducing?)
  - EP 6 – Findings from evaluation communicated annually to individuals/group that manages patient safety program
  - EP 7 – Uses findings from evaluation if IC plan when revising IC plan

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TJC CROSSWALK FOR CMS TAG A-0748

0748

Organization and Policies: A person(s) **must be designated as infection preventionist to develop and implement policies governing control of infections/CD.**

TJC STANDARDS

- **IC.01.01.01 – Hospital identifies individual(s) responsible for the IC program**
  - EP 1 – Identifies individual(s) with clinical authority over the IC program
  - EP 2 – When individual with authority over IC program does not have expertise in IC, he or she consults with someone who has such expertise to make decisions…(LHD or APIC Consulting)

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TJC CROSSWALK FOR CMS TAG A-0748

0748

Organization and Policies: A person(s) **must be designated as infection preventionists to develop and implement policies governing control of infections/CD.**

TJC STANDARDS

- **IC.01.01.01 – Hospital identifies individual(s) responsible for the IC program.**
  - EP 3 – Hospital assigns responsibility for daily management of IC activities…(written from CEO)
  - EP 4 – Deemed status purposes: Individual with clinical authority is responsible for:

-Developing polices

- -Implementing policies
- -Developing system for identifying reporting, investigating and control infections/CD

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TJC CROSSWALK FOR CMS TAG A-0749

0749

Infection preventionist must develop as system for identifying, reporting, investigating, and controlling infections/CD of patients and personnel.

TJC STANDARDS

- **HR.01.04.01 – Hospital provides orientation to staff**
  - EP 4 – The hospital orients staff on the following:
    - Specific job duties, including those related to infection prevention and control.
    - Orientation completion is documented

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TJC CROSSWALK FOR CMS TAG A-0749

0749

Infection preventionist must develop as **system for identifying, reporting, investigating, and controlling infections/CD of patients and personnel**

TJC STANDARDS

- **IC.02.01.01 – Hospital implements IC plan**
  - EP 9 – Hospital reports infection surveillance, prevention, and control information to local, state, and federal public health authorities. (Communicable disease and outbreak reporting structure.)

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TJC CROSSWALK FOR CMS TAG A-0756

Responsibilities of CEO, Medical Staff and Director of Nursing must:

1) Ensure that the hospital-wide QAPI program and training programs address problems identified by the infection control officer(s)
2) Be responsible for implementation and corrective actions

TJC STANDARDS

- **IC.01.01.01 – Hospital identifies individual(s) responsible for the IC program**
  - EP 3 – The hospital assigns responsibility for the daily management of infection prevention and control activities…(documentation)

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TJC CROSSWALK FOR CMS TAG A-0756

A-0756

Responsibilities of CEO, Medical Staff and Director of Nursing must:

1) Ensure that the hospital-wide QAPI program and training programs address problems identified by the infection control officer(s)
2) Be responsible for implementation and corrective actions

TJC STANDARDS

- **HR.01.05.03 – Staff participate in ongoing education and training**
  - EP 1 – Staff participate in ongoing education and training to maintain and increase competency. Staff participation is documented

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TJC CROSSWALK FOR CMS TAG A-0756

A-0756

Responsibilities of CEO, Medical Staff and Director of Nursing must:

1) Ensure that the hospital-wide QAPI program and training programs address problems identified by the infection preventionist. Be responsible for implementation and corrective actions

TJC STANDARDS

- **IC.01.05.01 – The hospital has an infection prevention and control plan**
  - EP 6 – <u>All hospital components and functions are integrated into the infection prevention and control activities</u>

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TJC CROSSWALK FOR CMS TAG A-0756

A-0756

Responsibilities of CEO, Medical Staff and Director of Nursing must:

1) Ensure that the hospital-wide QAPI program and training programs address problems identified by the infection control officer(s)
2) Be responsible for implementation and corrective actions

TJC STANDARDS

LD Responsibilities of CEO, Medical Staff and Director of Nursing must:

1) Ensure that the hospital-wide QAPI program and training programs address problems identified by the infection control officer(s)
2) Be responsible for implementation and corrective actions

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TJC CROSSWALK FOR CMS TAG A-0749

0749

Infection Preventionist must develop as **system for identifying, reporting, investigating, and controlling infections**/CD of patients and personnel.

Note: No Log required for HAIs

TJC STANDARDS

- **IC.01.05.01 – The Hospital has an IC Plan**
  - EP 8 – Hospital identifies method for reporting infection surveillance and control information to external organizations

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ENVIRONMENTAL SERVICES

Environmental service worker PPE use ***(07.03.08)***

- Patient care area cleaning processes—high touch areas are cleaned daily
- Terminal Cleaning and removal of linen
- Use of cleaners and disinfectants reflect MIFU

Clean cloths for each patient room/corridor ***(07.03.06)***

- Mop head and cloth cleaning daily
- Blood and body fluid cleaning process--spills

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ENVIRONMENTAL SERVICES

- Equipment cleaning schedules (HVAC, eyewash stations, ice machines, refrigerators, scrub sinks and on faucets)
- Handling of clean and dirty laundry with no potential for cross contamination
- Bagging and storage of dirty linen - Segregation of clean from dirty in laundry processing area

(07.04.01 for all three)

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NC DIVISION OF HEALTH SERVICES REGULATIONS

NCDHHS

RULES AND REGULATIONS

HOSPITALS: 10A NCAC 13B .1906 POLICIES AND PROCEDURES

The governing board shall assure written policies and procedures which are available to and implemented by staff. These policies and procedures shall cover at least the following areas:

(6) infection control which must include, but shall not be limited to, requirements for sterile, aseptic and isolation techniques; and communicable disease screening including, at a minimum, annual tuberculosis screening for all staff and inpatients of the facility;…

https://info.ncdhhs.gov/dhsr/testrules.htm

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PROGRAM SPECIFIC STATE OPERATIONS MANUAL

Regulation

A-0940 (Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08

§482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care …

Interpretive Guidance

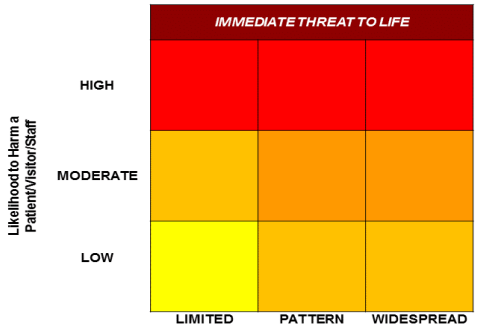
…access… is limited

…clean surgical costumes…designed for maximum skin and hair coverage

…equipment … is monitored, inspected, tested, and maintained …in accordance with Federal and State law, regulations and guidelines and manufacturer's recommendations;

TJC SCORING

Survey Analysis for Evaluating Risk (SAFER) Matrix



The Joint Commission

IMMEDIATE THREAT TO HEALTH & SAFETY (IJ)

– Expedited decision of Preliminary Denial of Accreditation (PDA) issued by The Joint Commission

– Results in notification of CMS and State Health Department – PDA remains in effect until corrective action is validated during on-site follow-up survey

– After corrective action is validated, organization's accreditation status will change to Contingent Accreditation pending follow-up survey to assess ongoing implementation of corrective action

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MANUFACTURER'S INSTRUCTIONS

Medical Device Manufacturers

– experts on their own devices

– responsible for validating the specific cleaning, disinfection and sterilization methods

– Biologic compatibility does not mean an item is chemical or functionally compatible

– Focus on areas where there is risk

MANUFACTURER'S INSTRUCTIONS

– Organization must know how the item will be used

– Staff must have access to instructions

– When conflicts are identified, organization must resolve

– Contact equipment manufacturer

– Contact product manufacturer(s)

MANUFACTURER'S INSTRUCTIONS

Examples of High Risk MIFU - HLD

- High Level Disinfection (HLD) tested before or after each use according to instructions.
- Cannot use beyond solution beyond expiration
- Test strips may be product specific
- Additional items may be necessary…watch/timer, paper towels
- Includes training instructions
- Follow each step as written
- Only FDA approved HLD and compatible with product

MANUFACTURER'S INSTRUCTIONS

Process is often based on product choice!

Enzymatic Detergent A: Dispense gel over surgical tray of instruments to ensure soils are evenly covered. (No instruction to reapply)

Enzymatic Detergent B: Place items in clearly marked decontamination area. Thoroughly spray directly onto instruments…reapply as needed to keep instruments moist.

Enzymatic Detergent C: Spray directly on soiled instruments immediately after use. Allow foam to stay on instruments and scopes until ready for cleaning. Apply more as needed to keep moist.

EXAMPLE OF HOW SCORED

Observation: The facility was using a tonometer which touches the eye during use. The physician stated that he uses the item, wipes it with a pop-up wipe and places it back in the case.

Review of the pop-up manufacturer IFUs indicated that the disinfectant being used was not a high level disinfected.

Finding: IC.02.02.01 EP2

The tonometer which touches the eye was not being high level disinfected after each use.

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EVIDENCE-BASED GUIDELINES AND NATIONAL STANDARDS (EBG)

Facilities must use evidence-based (EBG) guidelines and standardize infection prevention and control activities (IC.01.05.01s (EBG)

– EBG should be available (IC.01.02.01 EP 1)

– Facilities should be able to articulate the source of their IC practices if they are based on multiple EBG, a facility might choose:

  – AORN for dress code and aseptic practices in the OR
  – AAMI for reprocessing of sterile instruments
  – SGNA for reprocessing endoscopes
  – CDC Guidelines

EVIDENCE BASED GUIDELINES AND NATIONAL STANDARDS (EBG)

CDC Core Practices: Standard Precautions

– Hand hygiene

– Environmental cleaning and disinfection

– **Injection and medication safety**

– Appropriate use of personal protective equipment

– Minimizing potential exposures

– Reprocessing of reusable medical equipment between each patient and when soiled

EXAMPLE OF HOW SCORED

Observation: Three staff members (one in orthopedic clinic, one in the operating room and one in the ICU) did not disinfect the diaphragms of medication vials before inserting a needle into the vial.

Staff members did not adhere to standard precautions required when accessing a medication vial as described in CDC Core Practices for all Healthcare Settings: Standard Precautions

Finding: IC.02.01.01 EP2

EVIDENCE BASED GUIDELINES AND NATIONAL STANDARDS (EBG)

Some EBGs are required by regulation or The Joint Commission standards

- CDC / WHO Hand Hygiene
- CDC Transmission based precautions
- CDC Standard Precautions
- Some EBGs are chosen: AORN, ASHRAE, SGNA, AAMI
- Chosen EBGs cannot be less strict than regulation, CoPs, or IFUs

EVIDENCE BASED GUIDELINES AND NATIONAL STANDARDS (EBG)

Your choice may affect your survey outcome, for example

"Hang-time" for endoscopes

- SGNA: "supports a 7-day storage interval for reprocessed endoscopes-but only if they were reprocessed and stored according to professional guidelines and manufacturer instructions."
- AAMI: "Due to the lack of consensus and evidence on the storage time, it is recommended that the health care facility conduct a risk assessment to determine the maximum storage time for an endoscope…"

EVIDENCE BASED GUIDELINES AND NATIONAL STANDARDS (EBG)

Your Choice Guides Your Practices

AMMI (ST91 2015) states

10 Storage of reprocessed endoscopes

10.1 General Considerations

The endoscope should be hung vertically with the distal tip hanging freely in a well-ventilated, clean area, following the endoscope manufacturer's written IFU for storage…Store endoscopes in a manner that will protect them from damage or contamination…Special storage cupboards or cabinets…are commercially available…Regardless of whether a special cabinet is used, the temperature and humidity in the area where the scopes are stored should be monitored.

EVIDENCE BASED GUIDELINES AND NATIONAL STANDARDS (EBG)

Your choice of Guidelines at Your Practice

AORN (Effective February 1, 2016) Guideline for Processing Flexible Endoscopes states

IX. Flexible endoscopes and endoscope accessories should be stored in a manner that minimizes contamination and protects the device or item from damage

IX.b. Flexible endoscopes should be stored in accordance with the endoscope and storage cabinet manufacturers' IFU.

IX.b.1.Flexible endoscopes should be stored in a drying cabinet

IX.b.2. If a drying cabinet is not available, flexible endoscopes may be stored in a closed cabinet with HEPA-filtered air that provides positive pressure and allows air circulation around the flexible endoscopes.

TJC HIERARCHICAL APPROACH TO INFECTION CONTROL RELATED STANDARDS

RULES AND REGULATIONS

CoPs and CfCs

Manufacturer's Instructions for Use (MIFU)

Evidence-based Guidelines and Standards

Consensus Documents

Organizational Infection Prevention and Control Policy and Procedures

For organizations that use deemed status the accrediting organizations must use the CoPs.

CONSENSUS AND POSITION STATEMENTS

Guidelines for the cleaning and sterilization of intraocular surgical instruments

David F Chang [1], Nick Mamalis [2], Ophthalmic Instrument Cleaning and Sterilization Task Force

Abstract

These Guidelines for the Cleaning and Sterilization of Intraocular Surgical Instruments were written by the Ophthalmic Instrument Cleaning and Sterilization (OICS) Task Force, comprised of representatives of the American Society of Cataract and Refractive Surgery, the American Academy of Ophthalmology, and the Outpatient Ophthalmic Surgery Society. These consensus subspecialty guidelines include evidence-based recommendations regarding issues that may be unique to the cleaning and sterilization of intraocular instrumentation. A newly published OICS Task Force study supports the safety of common short-cycle instrument processing practices for sequential same-day anterior segment surgery. Other studies substantiate the risk of toxic anterior segment syndrome from routine use of enzymatic detergent, whose microscopic residues are difficult to eliminate from intraocular instrumentation. Finally, based on published international outcomes and endophthalmitis rates, future studies should critically evaluate a variety of operating room protocols that may increase cost, waste, and carbon footprint, without any actual safety benefit.

SCORING EXAMPLE

Observation: The organization was cleaning ophthalmology instruments with other surgical instruments. When asked which EBGs had been adopted, the CSP Manager stated that she was not aware of any recommendations specifically related to ophthalmology instrument reprocessing.

– The organization did not adopt evidence-based national guidelines or, in the absence of such guidelines, expert consensus guidance when developing IC activities…

Could be scored at IC.01.05.01 EP1

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FACILITY POLICY AND PROCEDURE

Facilities develop IC related policies and procedures that address the unique aspects of the organization

– Care settings

– Equipment, products and supplies

– Physical space

– Staffing

– Facilities in multiple states

42 CFR § 482.42 - CONDITION OF PARTICIPATION: INFECTION PREVENTION AND CONTROL AND ANTIBIOTIC STEWARDSHIP PROGRAMS

CFR

(e) *COVID-19 Reporting.* During the Public Health Emergency, as defined in § 400.200 of this chapter, the hospital must report information in accordance with a frequency as specified by the Secretary on COVID-19 in a standardized format specified by the Secretary.

CMS ICW STRUCTURE

5 Modules

1 – Infection Control/Prevention Program

2 – General Infection Control Elements

3 – Equipment Reprocessing

4 – Patient Tracers

5 – Special Care Environments

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-1.pdf

CMS ICW STRUCTURE

20 Sections

4 tracers

- Urinary Catheter Tracer
- Central Venous Catheter Tracer,
- Ventilator/Respiratory Therapy Tracer
- Surgical Procedure

Ideal self assessment tool for compliance with minimum standards (49 pages)

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-1.pdf

SURVEY TIPS

- During Survey – Issue resolution session –Present all written documentation – Collaborative call with Central Office
- After Survey "After a survey event, organizations have the opportunity to submit clarifying ESC if they believe that their organization was in compliance with a particular standard at the time of Survey."

QUESTIONS?