Report from Executive Briefings

Equivalency process permits more liberal hall storage policies for certain equipment

You may soon be able to store patient lift and transport equipment in the hallway outside of patient rooms and in dead-end hallways without violating Joint Commission life safety standards, according to an announcement that drew an audible, surprised reaction from attendees at the recent Joint Commission Executive Briefings on Sept. 4 in New York.

An additional change will allow you to potentially install fixed seating in your hallway for patients and guests to rest as they go from one area of the hospital to another, said George Mills, director of engineering for the Joint Commission.

But before you line your hallways with wheelchairs and gurneys, understand the steps you have to take in order to take advantage of these changes to the 2012 Life Safety Code.

(see equivalency, p. 6)

Patient safety

Become a high-reliability organization by anticipating problems before they happen

Develop a culture that focuses on preventing quality problems before they arise. Several hospitals are experimenting with proactive solutions to reduce the rate of issues like medication errors, hospital-acquired infections (HAIs) and hand-off miscommunication. One hospital was able to significantly reduce the number of patients it sent to the ICU simply by increasing communication through daily huddles.

The Joint Commission, in cooperation with the Institute for Healthcare Improvement (IHI), is backing these initiatives with the goal of creating high-reliability organizations by changing hospital culture.

(see high reliability, p. 7)
Infection control

Create an infection control plan for electronic devices in patient care areas

Expect greater attention to the way you clean your computer keyboards and related equipment. The government has increased its focus on hospital-acquired infections (HAIs) just as the use of electronic health records (EHRs) and other health IT has begun to skyrocket – and these electronic surfaces can be a hotbed of infection.

Standard IC.02.02.01 requires hospitals to implement infection control activities to minimize, reduce or eliminate the risk of infection, says Bret Coons, Joint Commission media relations specialist. The Centers for Disease Control and Prevention (CDC) have identified patient care items and environmental surfaces such as bedrails, blood pressure cuffs and computers that come into contact with skin but not mucous membranes, as areas that need to be disinfected.

“This is only one of many surfaces that require regular disinfecting,” says John Rosing, VP and principal of Patton Healthcare Consulting in Milwaukee, Wis.

However, EHR computer keyboards and related equipment, such as computer mice, are being overlooked and not being adequately cleaned, increasing the risk that patients will acquire HAIs, warns Harry Furey, with Man and Machine in Landover, Md. The keyboards are touched frequently by multiple providers during and after patient contact in clinical areas; they're also touched in non-clinical areas, such as patient kiosks and check-in tablets. And since hospitals are using more electronic equipment for patient care, the risk is increasing, and there's greater potential for cross-contamination, he warns.

Unfortunately, computer equipment can harbor a lot of bacteria from blood splatters or people's hands. “People would be stunned. One study found keyboards and mice had 400 times more bacteria per square inch than a toilet. Keyboards will be a source of problems for years to come,” says Kevin Donnelly, chief operating officer of emrapproved.com, in Lake Bluff, Ill.

Keyboards, mice becoming a survey issue

Joint Commission surveyors are not conducting “specific” infection control evaluations of an organization's computer mice and keyboards, according to Coons. However, Furey knows of at least two instances where providers were cited for this reason.

“These things are innocent and go unnoticed but could be a key transmitter of organisms. There are consequences to the patient and costs to the hospital in dealing with the HAI,” warns Rosing.

HAIs are also a front burner issue for CMS, since recent research indicates a “strong link” between HAIs and hospital readmissions, according to the American Medical Association.
Part of the problem is caused by users of the equipment, who don’t take adequate precautions. The equipment is also not being cleaned adequately by housekeeping. The CDC itself notes in its infection control guidelines that reusable cleaning cloths are “often” not adequately cleaned and disinfected. Housekeepers are also touching surfaces with dirty gloves or not even wearing them, says Joe Gordon, technical advisor for Inside the Joint Commission and president of Survey Resources in Manchester, N.J.

“This is something hospitals should worry about,” he warns.

Many options, little guidance

However, there are no official standards or guidelines from regulating agencies or professional organizations that require health care organizations to sanitize or decontaminate keyboards and other electronic equipment on a routine basis, or provide detail on how to do it, says Coons. So hospitals can choose different options for cleaning these surfaces. None of them are perfect.

“It’s a dilemma what type of equipment to be looking to use with your new EMR investment,” says Furey.

For instance, certain chemicals that can be used to clean these surfaces can kill a lot of organisms, but there’s no clear consensus on which ones are better, and some eat away at the plastic or leave a chalky residue that makes the keyboard look dirty, says Rosing. Some sanitizers can seep into the keyboard or touchscreen and cause product failure; keyboard covers tear or wear out, says Furey.

Some hospitals have turned to using cheap keyboards, treating them as more or less disposable. Some use “washable” keyboards, but they need to be disconnected to be cleaned, and don’t always fare well when exposed to the heat of the dishwasher. Some hospitals have opted to purchase medical grade keyboards, using sealed silicone and lockable keyboards so they can be left on during disinfecting, but these are more expensive.

“There’s not necessarily one best practice [for cleaning these]; the best practice is to show that you’ve given it some thought,” says Gordon.

But keyboards and mice do need to be part of the disinfectant process. “A decontaminated keyboard is only as sanitary as the next set of unclean fingers to touch it. Currently the best practice is to consider all computer keyboards and mice contaminated and train staff to take appropriate steps for maintaining proper hand hygiene,” says Coons. – Marla Durben Hirsch (mhirsch@decisionhealth.com)

Resources:
- AMA article http://www.ama-assn.org/amednews/2012/05/28/prsc0528.htm
- CDC guidelines http://www.cdc.gov/hicpac/Disinfection_Sterilization/2_approach.html

Reduce the risk of infection from computer keyboards and mice

- Make sure your infection control policies and procedures cover computer equipment and other health IT devices, such as patient kiosks. “Hospitals need to identify these noncritical pieces of equipment, and decide who’s responsible for cleaning them, the frequency of cleaning and what procedure will be used for disinfection,” says John Rosing, VP and principal of Patton Healthcare Consulting in Milwaukee, Wis.

- Make sure staff are trained in the appropriate way to clean/disinfect these surfaces. For instance, if the keyboard is in the patient’s room, make sure that the keyboard is cleaned when the patient is discharged and the room is turned over to the next patient,” says Rosing. Some hospitals have nurses wipe down their own keyboards before they start working, says Joe Gordon, technical advisor for Inside the Joint Commission and president of Survey Resources in Manchester N.J.

- Keep the process as simple as possible so it’s easier to execute. “Narrow the choice of effective disinfection products staff may use in the hospital,” says Rosing.

- Improve overall hand hygiene in the hospital. “Theoretically if you’re doing that properly, you’ve killed everything on your hands” and thus aren’t infecting the keyboard, says Rosing.

- Be prepared for this issue to crop up in surveys. For instance, staff will need to be able to articulate how they clean the keyboards and verify the process, says Gordon. “Surveyors will use observation, verbal testimony and written documentation,” he points out. – Marla Durben Hirsch (mhirsch@decisionhealth.com)
Use CMS interpretive guidelines to review your patient privacy policy

Review your policy on patient privacy and record confidentiality with staff to be sure they understand what information is protected. CMS surveyors were instructed earlier this year to review patient privacy issues and question staff members on how your hospital protects patient rights.

The new instructions came in the form of updates to interpretive guidelines in the Conditions of Participation. CMS is clarifying its guidance on patient privacy and medical record confidentiality and is instructing surveyors to look out for certain conditions when surveying your hospital. The updates provide details on what your hospital needs to do to protect both the physical privacy of the patient – including issues like video recording of medical procedures – as well as the confidentiality of patients’ medical records.

“One of the reasons CMS issued the guidelines is that [its] coverage of patients’ rights had been pretty light,” says Frank Ruelas, principal with HIPAA College in Casa Grande, Ariz. Hospitals should already have policies in place for most of the requirements noted in the interpretive guidelines under their Health Insurance Portability and Accountability Act (HIPAA) compliance program, Ruelas notes. CMS has been “a little behind the curve” getting its policy up-to-date with HIPAA, he says.

“Even if the hospital has a privacy policy in place, it would be a good idea to use the CMS guidelines to review your policy and identify risk areas for training purposes” says Ruelas. “Now that CMS surveyors are instructed to look for these privacy issues, there is a greater chance they’ll come under scrutiny,” he says.

Document consent when monitoring patient activity

A standout in the guidelines is the need to obtain informed consent from your patients before they are put in situations where they will be observed by individuals outside the care team or be recorded for any reason. “This is an area where I see hospitals falling down during surveys,” says Joe Gordon, technical advisor for Inside the Joint Commission and president of Survey Resources in Manchester, N.J.

Tip: Watch out for patient monitoring that replaces direct observation in places like X-ray waiting areas. “You have the transports bringing patients down to X-ray and the technicians get backed up and patients are waiting outside of X-ray on their stretchers,” says Gordon. “I’ve seen hospitals put cameras to observe [the patients] to make sure they aren’t falling off their stretchers instead of getting an actual person to stay with them and watch them,” he says. “If this video monitoring is being recorded,” you need to get the patient’s consent first.

Balance privacy and patient safety

CMS expects you to review your policy to determine what steps are reasonable to safeguard patient information while still allowing clinicians to deliver safe patient care. The guidelines specifically indicate that clinicians should not be overly burdened by administrative rules to the extent that they impede their ability to effectively treat patients.

“This is a really important distinction in the guidelines,” says Ruelas. “There are some people who take an extreme view on HIPAA and patient privacy,” he says. If this goes too far, care team members may hold off on necessary communication for fear of violating HIPAA. “With these guidelines, CMS is saying that it is okay to put a patient name on a white board or on the outside of a patient chart if that is what you need to do to provide the best care,” he says.

The guidelines specifically allow you to put up patient care signs such as “falls risk” or “diabetic diet” at the bedside or outside the patient door. They also allow you to display patients’ names on the nursing station whiteboard or outside an operating suite.

Provide “reasonable safeguards” for patient privacy

You are not required to eliminate all risk of “incidental use and disclosure” of patient information, according to the guidelines. CMS defines incidental use and disclosure as “disclosure of patient information that cannot reasonably be prevented.” For example, a hospital visitor may overhear a health care professional’s confidential conversation with another health care professional. What you do need to show is that your hospital attempts to provide “reasonable safeguards” to minimize accidental disclosures.
Examples of reasonable safeguards include:

- Requesting waiting customers stand a few feet back from a counter used for patient registration;
- Use of dividers or curtains in areas where patient and physician or other hospital staff communications routinely occur;
- Limiting access to areas where white boards or X-ray light boards are in use, or posting the board on a wall not readily visible to the public; and
- Health care staff speaking quietly when discussing a patient’s condition or treatment in a semi-private room.

**Tip:** Be sure your staff members are sensitive to their surroundings when discussing patients and their medical issues, says Ruelas. “The example I always use is, don’t discuss a patient in a crowded elevator if it can wait until you are somewhere more private,” he says.

### What surveyors are instructed to look for

CMS instructs surveyors to conduct observations and interview patients to determine whether you are providing them with a reasonable amount of personal privacy and whether you are providing reasonable safeguards to reduce any incidental disclosure of patient information. Surveyors will also be interviewing staff to see if they are aware of your privacy policy, and what steps they take to ensure it is followed.

**Tip:** Make sure your clinicians and staff can identify the designated privacy official, says Ruelas. You want that to be a common point of reference. “If they don’t know the answer to a particular privacy issue during a survey, at least they will be able to communicate that they know who to go to if there are questions,” he says. “Even if they can’t answer directly, they are able to provide a solution which should be sufficient to satisfy a surveyor.” – Kevin McDermott (kmcdermott@decsionhealth.com)

### Infection control

#### Treat water sources as bacterial breeding grounds and infection risks

Work with your facility manager and IC team to determine a frequency of testing your water supplies that reconciles the need to control infection with the ability to manage your facility.

“The facilities team keeps us informed about all water issues in the facility from water intrusions like leaks or flooding, to accumulation of mold in damp areas,” says Nancy Pratt, senior VP of clinical effectiveness at Sharp HealthCare in San Diego. The infection control team also has to review any additional water-related items, from decorative water features to plumbing fixtures.

Sharp removed all faucet aerators in its facility to reduce the chances of bacteria collecting in the fixtures.

The more input the IC department has, the better, says Thomas Haupt, epidemiologist with the Wisconsin Division of Public Health. Facilities managers often won’t be actively involved with the infection control team, even though that team is best positioned to warn of potential airborne pathogens associated with different areas of the hospital.

When a particularly elusive outbreak of legionella occurred in the Milwaukee area in 2010, Haupt and his team had to track down the source, which they eventually traced to a decorative water feature located in the lobby of St. Luke’s Aurora (Wis.) South Shore hospital.

“It was a tough case to identify because none of the people infected were inpatients [at the hospital] and were actually from five different jurisdictions in our region,” he says. Haupt was finally able to locate the source by interviewing all of the infected patients to find the commonality.

“Initially, we asked if they had been patients at any area hospitals recently,” he says. “When that came up negative we asked if they had visited any hospitals or health care facilities and found out that they had all visited [St. Luke’s] for one reason or another, to pick up medications, visit other patients or drop off packages, and were exposed to the fountain in the lobby.”

The water feature was an ideal breeding ground for legionella, Haupt says. The water was warmed by lamps and a fireplace located near the feature, the bottom of the feature was lined with a spongy foam where the bacteria could thrive, and the mist from the falling water enabled the bacteria to get into the air and more easily make contact with people in the area.

“This is the type of situation that an infection control specialist would have been able to spot as a potential hazard,” Haupt says.
Even though the Centers for Disease Control and Prevention (CDC) recommend routine culturing of water as part of a comprehensive control program for legionella, testing can be very expensive and not all hospitals do it routinely, says Haupt. You need to be very aware of a potential outbreak and be ready to identify the source of potential problems, he warns. “Any time there is more than a single case [of legionella], you need to test your entire environment to identify the source and prevent further exposure,” he says. – Kevin McDermott (kmcdermott@decisionhealth.com)

**equivalency**

*(continued from p. 1)*

The 2012 Life Safety Code has not yet been adopted by CMS and adoption isn’t likely until late 2014 or early 2015. Until then, your hospital must be granted an equivalency from the Joint Commission in order not to be cited for the obstruction, says Joe Gordon, technical advisor for Inside the Joint Commission and president of Survey Resources, LLC in Manchester, N.J.

Another major concession the Joint Commission made in its announcement: You can get the equivalency by applying to the Joint Commission based solely on the finding of a local official that your hospital remains safe from a fire despite the changes. Previously, the Joint Commission could completely disregard the findings of local officials when issuing deficiencies for violations of the Life Safety Code, Gordon points out.

**Options for your equivalency**

One type of equivalency is a Fire Safety Evaluation System (FSES), a process of assessing your own life and fire safety features and offsetting deficiencies to establish overall fire safety. But Mills warns you to avoid FSES as a means of proving an equivalency unless your hospital has a year of experience in doing fire safety offsets because it is a harder equivalency to prove.

That leaves the second approach, a Traditional Equivalency (TE). A TE allows you to engage a registered architect, fire protection engineer or local Authority Holding Jurisdiction (AHJ) to do a field verification. The verification is designed to identify alternative methods of fire safety to offset the deficiency, and allows you to develop a relationship with a local official who can make that assessment without fear that it will be upended by a survey, Gordon points out.

Your best bet is to use the AHJ because it will likely cost less than finding an architect, and the AHJ official is more likely to relate to your efforts based on his or her own hospital experiences, Gordon says. The AHJ official is often the fire marshal, but the specific title of the person responsible for ensuring fire safety may vary in your location, he adds.

**Tip:** Make sure you don’t end up with a deficiency because you neglect to actually update your fire plan to account for the storage in the hallway and how it impacts your ability to evacuate the hospital, Gordon says.

**How to get the equivalency**

Ask the AHJ who inspects your hospital to specifically note that the changes you have made, whether it’s using the hallway for storage or installing fixed seating, don’t hinder your fire safety and fire prevention efforts, Gordon suggests. That way, you will have written documentation that directly addresses the reasons for the TE if a surveyor comes in and tries to issue a deficiency.
Tip: Make multiple copies of this documentation and ensure that you have a secure copy you can produce on demand in case of a survey. The last thing you want is to not have the proof you need when a surveyor arrives, Gordon says.

Demonstrate to the AHJ that you have offset your changes with a fire safety plan, which could include proof of effective fire drills or the ability to evacuate, Gordon points out.

With your documentation in hand, apply to the Joint Commission for the TE through your portal. It should be granted without the need for an on-site visit. Retain the documentation even once the TE is granted because when you are surveyed, the surveyor might not know about it or acknowledge it otherwise. The surveyor might be particularly focused on life safety issues and require proof of your TE, Gordon says.

Note: A traditional equivalency won’t get you completely out of the woods. Each of the two areas where you can seek a TE – storage in dead-end hallways and means of egress, and installation of fixed seating – come with specific conditions attached which must be met, even with the TE.

For storage in the means of egress, you need to do the following:
• Maintain a five-foot clear corridor;
• Address the change to management of storage in your fire plan;

• Accommodate your current equipment in use.

For installation of fixed seating, remember to:
• Provide six feet of clear width after the installation;
• Ensure each grouping of seats is no more than 50 square feet in size, with at least ten feet between groupings.

For end-of-hallway storage, consider the following requirements:
• The storage area must be no more than 50 square feet;
• It must not impede access to the stairwell or to the doorway of any patient room (see diagram on p. 6).

– Scott Kraft (skraft@decisionhealth.com)

high reliability
(continued from p. 1)

“We still see routine safety processes like hand hygiene, communicating across transitions of care, medication administration… failing routinely at very high rates,” says Mark Chassin, president of the Joint Commission Center for Transforming Healthcare. “There is a steady stream of preventable adverse events like wrong-site surgery” despite ongoing efforts to improve quality and safety, he says.

High reliability is defined by the Joint Commission as consistent, high levels of patient safety that can be sustained over long periods of time.
There are three components of high-reliability organizations that allow them to consistently perform at high levels of safety, says Chassin:

1. A leadership commitment to zero major quality failures;
2. A completely and fully embedded culture of safety; and
3. Very highly effective tools to perfect the processes these organizations use to get their business done.

There is an atmosphere in these organizations called “collective mindfulness,” says Chassin. “Everyone in the organization looks at every process every day to determine where problems could occur, even if the problems seem small.”

**Institute a safety mentality in your hospital**

Follow the example of high-performing hospitals to identify specific steps you can take to adopt a culture of safety. Hospitals often rely on their clinicians to instinctively identify the presence of risk, says Stephen Muething, VP of safety at Cincinnati Children’s Hospital Medical Center. Rather than hope that the right person is in the right place to anticipate and prevent problems, make a plan for any eventuality at an organizational level, he says. “Write [the plans] down, speak them out and practice them day after day, shift after shift, patient after patient,” he says.

**Example:** Every eight hours, the leaders of each of the 16 separate units at Cincinnati Children’s get together for a “safety huddle” and openly share with each other what their predictions are for the next eight-hour period. The discussion includes which children aren’t progressing as expected, who had difficulties in the previous eight hours, who might need special care or attention and much more. The care teams focus on a concept called “identify, mitigate and investigate,” says Muething. They identify which children are at higher risk, make sure there are enough resources on hand to mitigate that risk, and investigate alternatives to prevent further deterioration.

The huddles have become so effective that all charge nurses can now predict whether they will need a rapid response team on hand in the next eight-hour period, says Muething. “After a year and a half of doing this, [our nurses] can identify any risk factors with an incredible amount of confidence,” he says.

**Champion your program with documented results**

**Tip:** Track your improvement rates to justify safety programs in your hospital. Data can be very powerful in getting physicians on board with a quality improvement program, says Anne Lyren, strategic advisor for quality and safety at Rainbow Babies and Children’s Hospital in Cleveland, Ohio. Do everything you can to get “resistors” on board, she says. “When you show them how much harm is happening and how much good can be done with just making some small changes, it has a big impact.”

Cincinnati Children’s monitored the number of high-risk patients transferred to the intensive care unit in need of intubation or massive fluid resuscitation. Before the program, Children’s had a patient that needed to be transferred to the ICU every eight days. After the program, the hospital has gone up to 90 days without transferring a patient to the ICU, Muething says.

---

**Perform a self-assessment to identify areas of concern in your hospital**

Don’t rely on fixes that work in other hospitals to work in your facility. The root causes of safety inefficiencies are different for every organization, says Anne Lyren, strategic advisor for quality and safety at Rainbow Babies and Children’s Hospital in Cleveland, Ohio. Each hospital must first analyze its weaknesses before identifying solutions.

**Example:** The Joint Commission’s hand hygiene program identifies ten main reasons clinicians fail to wash their hands in a clinical setting, including ineffective placement of dispensers or sinks, ineffective or insufficient education, distractions, lack of accountability and a safety culture that does not stress hand hygiene at all levels. The commission found that different hospitals identified different reasons for failures. Without a self-assessment to identify problems, hospitals may focus on areas where they don’t actually need improvement and neglect the real source of the problem, says Lyren.

**Tip:** Get a complete picture of the entire care process by talking to the one person who is present at every step. Getting patients engaged is a good way to identify problems with hand-offs, says Maureen Bisognano, president of the Institute for Healthcare Improvement (IHI). Each individual clinician may be providing a high level of care for his or her patient, but there may be periods during the hand-off where the patient’s care might be falling through the cracks, she says. – Kevin McDermott (kmcdermott@decsionhealth.com)