TJC Infection Control Standards for Medical Equipment, Devices and Supplies

By Dean Samet, CHSP - DSamet@ssr-inc.com

For 2010, The Joint Commission (TJC) has made several changes to its infection control standard IC.02.02.01 including a new “rationale” and revisions to elements of performance EP1 and EP2 which clarify requirements to reduce the risks associated with medical equipment, devices and supplies.

According to an October 2009 The Joint Commission Perspectives article, several significant issues have emerged related to the cleaning, disinfecting and sterilizing of medical equipment, devices, and supplies. TJC cites an example of the proper use of steam sterilizers as discussed in the July 2009 Perspectives.

Medical technology and instrumentation is a rapid and ever-changing field where new devices and new or resistant pathogens are emerging at an unprecedented rate.

2010 rationale for IC.02.02.01 states, “The Centers for Disease Control and Prevention (CDC) estimates that 46.5 million surgical procedures are performed in hospitals and ambulatory settings each year … Each of these procedures involves contact with a medical device or surgical instrument. A major risk of all such procedures is the introduction of pathogens that can lead to infection. Additionally, many more people are at risk of developing an infection from contact with medical equipment, devices, or supplies while seeking other health services. Failure to properly clean, disinfect, or sterilize, and use or store medical equipment, devices and supplies not only poses risk for the person seeking health services, but also carries the risk for the person-to-person transmission of infections.

“There are numerous steps involved in the cleaning, disinfecting, and sterilizing of medical equipment, devices, and supplies. It is critical that health care workers follow standardized practices to minimize infection risks related to medical equipment, devices, and supplies. In order to maintain a reliable system for controlling this process, organizations pay attention to the following:

- Orientation, training, and competency of health care workers who are processing medical equipment, devices, and supplies
- Levels of staffing and supervision of health care workers who are processing medical equipment, devices, and supplies
- Standardization of process regardless of whether centralized or decentralized
- Reinforcing the process (for example, the use of placards which lists the steps to be followed, according to manufacturers’ guidelines)
- Ongoing quality monitoring”

2010 Elements of Performance 1 & 2 for IC.02.02.01: The hospital implements infection prevention and control activities when doing the following:

C 1. Cleaning and performing low-level disinfection of medical supplies and devices.*

*Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions.

A 2. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.* (See also EC.02.04.03, EP 4: The hospital conducts (Continued on page 2)
In a June 3, 2010 News Release, The Joint Commission introduced Sentinel Event Alert Issue 45: Preventing violence in the health care setting. Health care facilities are confronted with and facing increased rates of violent crimes including assault, rape and homicide.

TJC defines a sentinel event as “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, “or the risk thereof,” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and response.”

The Joint Commission’s SEA Issue 45 suggested actions follow:

1. Work with the security department to audit your facility’s risk of violence. Evaluate environmental and administrative controls throughout the campus, review records and statistics of crime rates in the area surrounding the health care facility, and survey employees on their perceptions of risk.
2. Identify strengths and weaknesses and make improvements to the facility’s violence-prevention program.
3. Take extra security precautions in the Emergency Department, especially if the facility is in an area with a high crime rate or gang activity. These precautions can include posting uniformed security officers, and limiting or screening visitors (for example, wanding for weapons or conducting bag checks).
4. Work with the HR department to make sure it thoroughly prescreens job applicants, and establishes and follows procedures for conducting background checks of prospective employees and staff. For clinical staff, the HR department also verifies the clinician’s record with appropriate boards of registration.
5. Confirm that the HR department ensures that procedures for disciplining and firing employees minimize the chance of provoking a violent reaction.
6. Require appropriate staff members to undergo training in responding to patients’ family members who are agitated and potentially violent. Include education on procedures for notifying supervisors and security staff.
7. Ensure that procedures for responding to incidents of workplace violence (e.g., notifying department managers or security, activating codes) are in place and that employees receive instruction on these procedures.
8. Encourage employees and other staff to report incidents of violent activity and any perceived threats of violence.
9. Educate supervisors that all reports of suspicious behavior or threats by another employee must be treated seriously and thoroughly investigated. Train supervisors to recognize when an employee or patient may be experiencing behaviors related to domestic violence issues.
10. Ensure that counseling programs for employees who become victims of workplace crime or violence are in place.
11. Should an act of violence occur at your facility – whether assault, rape, homicide or a lesser offense – follow-up with appropriate response that includes:

(Continued on page 3)
**TJC Alert on Violence Rising at Health Care Facilities**

*(Continued from Page 2)*

- Reporting the crime to appropriate law enforcement officers.
- Recommending counseling and other support to patients and visitors to your facility who were affected by the violent act.
- Reviewing the event and making changes to prevent future occurrences.

TJC is also urging controlling access to facilities, greater staff vigilance, and advising organizations to mandate the reporting of all real or perceived threats.

See also TJC Standard EC.02.01.01: “The hospital manages safety and security risks” as well as The Rationale for EC.02.01.01 which states, “Safety and security risks are present in most health care environments… Examples of security risks include workplace violence, theft, infant abduction, and unrestricted access to medications… Security incidents are caused by individuals from either outside or inside the hospital.”

For the complete list and text of past issues of Sentinel Event Alert, go to The Joint Commission web site at www.jointcommission.org.

**TJC Eliminates 16 Hospital EPs**

By Dean Samet, CHSP - DSamet@ssr-inc.com

The Joint Commission eliminated 16 elements of performance (EPs) from their hospital accreditation program with a July 1, 2010 effective date, as announced in the June 9, 2010 Joint Commission Online publication.

These and other EPs went through an extensive evaluation process as part of TJC’s internal Robust Process Improvement (RPI) initiative started in mid-2008. The RPI establishes a measurement ranking scale against which all standards for all of TJC programs will purportedly be evaluated going forward. As part of this evaluation, more than 300 hospitals were invited to provide their perceptions of what constitutes a “valuable” standard and which standards they believed contributed the least value toward quality and safety.

TJC defines a valuable standard as one that:

- Supports a health care priority that affects patient safety or quality of care
- Has a solid evidence base or an iron-clad rationale
- Has a strong relationship to clinical care
- Supports the organization’s attainment of patient safety and quality care
- Judiciously uses an organization’s resources (that is, the benefit of implementing a requirement outweighs the cost of doing so)

52 EPs were identified by the participating hospitals as being of questionable value. Included were the following:

Standard EC.02.06.01
- EP 4. The hospital provides space for recreation and social interaction for patients who remain in the care of the hospital for more than 30 days.
- EP 5. The hospital provides storage space to meet patient needs.
- EP 6. When the hospital provides care for more than 30 days, it provides outside areas for patient use, suitable to the patient’s age, physical or mental condition, or other factors.  

*(Continued on page 4)*
TJC Eliminates 16 Hospital EPs
(Continued from Page 3)

-EP 18. Interior spaces accommodate the use of equipment, such as wheelchairs, necessary to the activities of daily living.

All of the 52 EPs were reviewed by TJC against their above-listed “valuable standard” criteria for which recommendations were made for final approval to The Joint Commission’s Hospital Professional and Technical Advisory Committee (PTAC) and also to TJC’s Standards and Survey Procedures Committee (SSPC) to keep, revise, combine, or delete the recommended requirements.

See the June 2010 issue of The Joint Commission Perspectives for the full text of the revised and eliminated requirements.

PUBLICATIONS & SEMINARS

Publications

“Opening Day - Transitioning from construction to survey-ready operation,” Health Facilities Management, June 2010

Speaking Engagements/Seminars in 2010

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 20-22</td>
<td>2010 Agency for Health Care Administration Conference, Orlando, FL, “Rx for Emergency Power Reliability”</td>
</tr>
<tr>
<td>October 4-6</td>
<td>EC Summit, Las Vegas, NV, “Construction to Occupancy - Are You Ready for Survey?”</td>
</tr>
<tr>
<td>October 5-6</td>
<td>Tennessee Hospital Association 45th Annual Technical &amp; Educational Exposition, Nashville, TN, “Regulatory Compliance Continuous Readiness,” “TJC Update on EOC,” and “Update the NFPA 101 Recent Survey, Discussion on Life Safety Codes”</td>
</tr>
<tr>
<td>October 28</td>
<td>Nebraska Society of Healthcare Engineers Fall Meeting, Lincoln, NE, “Emergency Power Challenges in 2011 and Beyond”</td>
</tr>
<tr>
<td>November 3-5</td>
<td>Midwest Healthcare Engineering Conference, Indianapolis, IN, “Integrated Project Delivery”</td>
</tr>
</tbody>
</table>

For more information please contact:

Dean Samet, CHSP
800-545-6732
dsamet@ssr-inc.com

Compliance News

A newsletter dedicated to accreditation, regulatory compliance and facility management issues for healthcare executives and facility managers.