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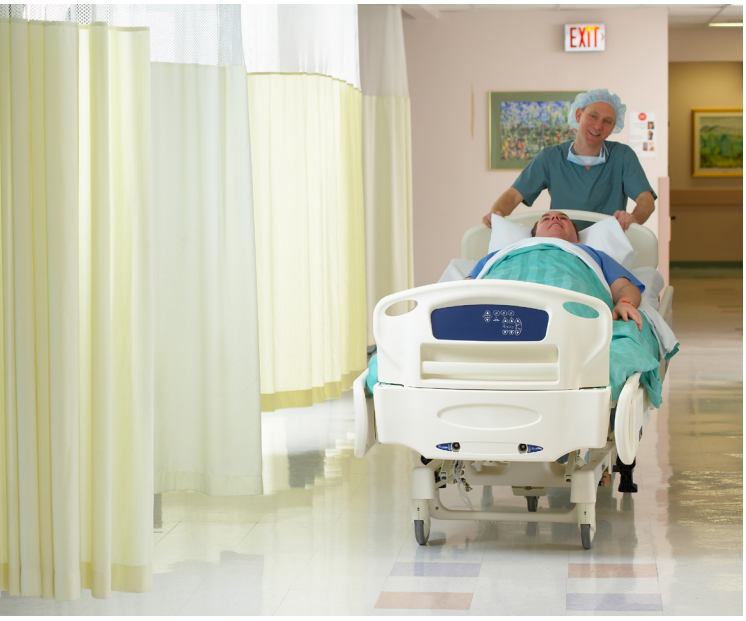

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HFAP

2019 quality review highlights common problems with ligature risk, IC, fire safety

By A.J. Plunkett (aplunkett@decisionhealth.com)

Ligature risk, building safety problems, and infection control were among the top problems identified by Healthcare Facilities Accreditation Program (HFAP) surveyors last year, according to the recently published *2019 HFAP Quality Review.*

HFAP and other accrediting organizations (AO) have been under pressure from CMS to do a better job of identifying *Life Safety Code® (LSC)*, environment of care, and infection control problems. The concerns have been made public in reports to *Congress reviewing the work of AOs (IJC 3/19/18)* and in memos to state survey offices emphasizing ligature risks and other environmental hazards patients can use to harm themselves.

The *HFAP Quality Review* calls on hospitals and other healthcare organizations to work more closely with HFAP staff before and after survey to concentrate on overall quality improvement. In addition, it calls for them to work on the specifics of the HFAP standards most often cited by surveyors.

The accreditor also wants organizations to better explain themselves during surveys.

"HFAP surveyors are trained to be opened to a variety of ways of achieving compliance," said **Gary Ley,** board chairman of HFAP's parent company, the Accreditation Association for Hospitals/Health Systems (AAHHS), in the report's foreword. "Your job is to be an advocate for your organization's approach. The more effectively you can paint that picture for your surveyor/survey team, the more they'll have to offer with regard to meaningful educational support."

The two standards posing the most problems for HFAP-accredited hospitals in 2018 were 11.00.01 on the Physical Environment, and 07.01.02 on Infection Prevention. For each of those standards, 68% of surveyed acute care hospitals were cited for deficiencies.

Physical environment

Standard 11.00.01 crosswalks with *Condition of Participation (CoP)* §482.41 on the Physical Environment, and requires a hospital to "be constructed, arranged, and maintained to ensure the safety of the patient," among other things.

Like many of HFAP's standards, the language largely mirrors the *CoP*—"The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community." And deficiencies are considered condition-level, meaning they trigger an automatic second survey from HFAP.

The report noted *LSC* deficiencies may also be cited under the *CoP,* but provided several examples of problems found solely under the Environment of Care. The citations included:

- Medical equipment management plans that had not been reviewed annually
- A lack of documentation that eyewash stations were tested and inspected
- Multiple patient rooms with emergency pull cords wrapped around the handrail
- Open ceilings next to patient treatment areas during construction projects

- A lack of emergency powered lighting in the hospital's generator room, generator automatic transfer switch room, and surgical suites

Infection prevention

HFAP standard 07.01.02 on Infection Prevention crosswalks with the infection control *CoP* §482.42(a) and requires the hospital "to develop a system for identifying, investigating, reporting and preventing spread of infections among patients and personnel."

An example of a surveyor citation was "significant rust on the horizontal top surface" on 13 metal cabinets—each located next to a patient bed in either preop or postop surgical services. Some of them had patient supplies stored atop the rust.

Other problems included:

- A review of policies and procedures for processing instruments that were several years old
- Items in the kitchen that did not have a "use by" date
- A pediatric bronchoscope that was stored uncovered with no apparent date of cleaning
- A review of scope processing logs that "indicated some scopes had not been reprocessed for up to 12 days"

The standard requires surveyors to determine if the hospital, among other things, "maintains a sanitary environment" and conducts "active surveillance"

The review offered a separate section just on problems found with Life Safety. The problems most often cited during more than 50% of hospital surveys involved testing of fire alarm systems, testing and inspection of water-based fire protection systems, gaps in ceilings with fire safety barriers, and a lack of labels on electrical panels connected to utility systems. (For more examples of Life Safety and other deficiencies, see p. 8.)

Take advantage of HFAP resources

In his foreword, Ley encouraged organizations to partner with HFAP staff to improve compliance and patient safety.

"Pre- and post-survey and throughout a term of accreditation, HFAP staff members are available to support problem-solving and lend process expertise. We use data—like the findings of this year's Quality Review—combined with knowledge gained from daily interaction with our accredited organizations to develop

tools and educational programming. We also use this information to enhance our customer service by bringing new solutions like HFAP Compass, our new IT platform, that will launch later this year," he wrote.

Founded in 1945 by the American Osteopathic Association, HFAP in 1965 was the first AO to be approved by Medicare to deem hospitals as eligible to bill CMS for services. HFAP was acquired by AAHHS in 2015, and while officials initially said there would be a name change, ultimately AAHHS went with the legacy branding of HFAP, recognizing its long history as an AO (*IJC 4/16/18*).

Like other AOs, HFAP has been updating its standards in the last few years to reflect many of CMS' concerns about patient safety, including ligature risk and suicide prevention. In addition, HFAP was among the AOs asked to provide information about how it conducts patient safety surveys after members of Congress expressed concerns.

In addition, late last year CMS published a request for public comment on whether AOs like HFAP, The Joint Commission, and others have conflicts of interest providing consulting services to the organizations they also survey. HFAP, like others, *told CMS* that educational resources offered to healthcare organizations are never conducted by anyone involved in the survey process.

Q&A

Inside Accreditation and Quality asked HFAP officials to discuss its most recent quality review and upcoming initiatives, as well as the changes and concerns from CMS. The following is the written response from **Angela FitzSimmons,** director of marketing and communications, **Deanna Scatena, RN,** assistant director, Certification/Accreditation SIT, and **Karen Beem, MS, RN,** with Standards Interpretation.

The questions and answers have been lightly edited for clarity.

Q: Your standards were recently updated, many to reflect CMS concerns about ligature risk and suicide prevention. Does this quality report include citations under the old or new patient harm risk standards? Were there other standards that are in this report that have since been changed, and if so, how?

A: The Quality Review covers all surveys that took place in 2018, and that was a year of significant regulatory change. In that time frame, there were three versions of the acute care hospital manual in effect: the 2017 edition (until March 1, 2018), the 2018 edition (until September 20, 2018), and the 2018v2 edition.

It's the 2018v2 manual that includes CMS regulatory changes related to environmental risk assessment for *ligature risk*, as well as new standards for *legionella risk*, texting of PHI, and swing beds. That means that a minority of the surveys reflected in this report include those standards.

Q: The introduction from Gary Ley talks about surveyors working with organizations to improve—is this part of the accreditation fee? Or are these consultant services, and if so, do you have a firewall between consultants work and the surveyors work?

A: HFAP's approach to accreditation for almost 75 years has been based on an educational survey experience for the organization. HFAP surveyors recognize that each organization has a distinct culture and a unique capacity for excellence. They bring evaluative expertise as they assess the organization's compliance with the standards, but they also bring the experience of having seen how many organizations have solved similar problems. They share observations about ways to improve—sometimes even in areas where the organization is already compliant.

Outside of the accreditation program, we do offer educational opportunities including webinars, classroom, and on-site programs. For all our surveyors, there is a firewall designed to prevent conflicts of interest—actual or perceived—between their work as HFAP surveyors and any other relationships they may have with an individual organization. But none of the programs under HFAP Academy are the kind of services a consultant provides.

Q: What is new about HFAP Compass, the new IT platform?

A: HFAP has undergone a change of ownership that has been a very careful, stepwise process. While CMS has a lot of experience with provider and supplier organizations changing ownership, an ownership change in an accreditation organization from AOA/HFAP to AAHHS/HFAP was a first.

The final piece of our CMS-approved transition is the implementation of our new IT system with a customer portal called HFAP Compass. HFAP Compass is a web-based platform where customers can login to

review the standards, manage their accreditation and certification applications and supporting documentation, communicate organizational changes, and access additional resources. It's going to streamline the process for the customer, for our staff, and for our surveyors by integrating data tools and giving us new data analysis capabilities.

Q: The summary notes that the top deficient standards involved physical environment and infection prevention, and Life Safety citations were also high. How does all this compare to previous years, and is this a reflection of concerns CMS has expressed to Congress?

A: Life Safety citations have been among the most frequent because a hospital's physical environment is in a state of constant change and the compliance requirements for Life Safety are very regimented. Infection prevention is a frequent citation because it's such a broad category of patient care and safety, encompassing every aspect and location of hospital services from clinical areas to storage.

Q: The report does a good job of providing tips for compliance and improvement—are there any general concerns or tips for compliance officers about what to focus on specifically? What is the overall concern for 2019 and going forward?

A: Frankly, reading the standards is always a good first step that many organizations overlook. HFAP would always encourage approaching the standards from the perspective of promoting patient safety and reducing the potential for harm or serious injury. Infection control practice and comprehensive environmental risk assessments are two areas where this connection should be obvious.

A newer concern is the development, or adoption, of patient screening tools to identify those at risk of harm to self or others. With these in place, hospitals are expected to provide orientation and annual training to all employees on the subject of identifying patients at risk.

Q: The report speaks for itself to a large extent. But there are a lot of hospitals struggling with making ends meet, and anything that costs more resources is a problem—yet patient safety is the main concern. What is the overall message that leadership or C-suite folks should hear from this?

A: The main message is that quality improvement is a cultural value. Leadership needs to understand that quality activities reduce risk and should be used along with financial metrics. Quality is intimately tied to finance because proactive evaluation and course correction is always going to be more cost-effective than remedial action taken after there has been a breach in quality.

If an organization views accreditation as a triennial exercise, there's almost certainly going to be a lot more resource expenditure than if the pattern of policy, implementation, evaluation, reporting (the basis of the standards) is recognized and consistently reviewed.

Additionally, when we conduct a survey and point out an area of noncompliance, we never expect a cookie-cutter plan of correction. Instead, we're looking for how this specific organization is going to make a change that will be meaningful and sustainable within its own setting.

Q: Besides the new IT platform, what changes, if any, are forthcoming to help hospitals, or to improve both hospital and AO performance?

A: HFAP tries to practice what we preach by working in an environment of continuous improvement. We're finding more ways to collaborate with other healthcare nonprofits; we hope to be sharing some of these new relationships in the near future.

We also try to create networking opportunities to connect customers with each other whenever possible. For example, our certified stroke centers can participate in quarterly community of practice calls in which they learn from each other. It fosters an enthusiasm about change when you see others succeeding and sharing lessons learned. That's what the Quality Review is intended to do.

Find the 2019 HFAP Quality Review online at *https://hfap.org/media/Annual_Quality_Report/2019_Quality-Report.pdf*. ■

Questions Comments & Ideas

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Infection control

Update policies against AORN's newest surgical attire guideline

By A.J. Plunkett (aplunkett@decisionhealth.com)

Bouffant caps only in the surgical suite? Skull cap? Both? It's your choice.

Just make sure your hospital policy on surgical attire is clear and that it is followed, or you may run afoul of CMS or other accreditation organizations. If you decide on changes, track your rate of surgical site infections to see if there is an impact and make adjustments accordingly.

After much debate in the latest round of guidance on surgical attire, the Association of periOperative Registered Nurses (AORN) has declined to recommend one type of head covering over the other, yet one change is clear: Scalp and hair need to be under cover.

AORN's 2019 edition of its "Guideline for Surgical Attire" is published on the organization's *Facility Reference Center*, the subscription-access site for its guidelines (*www.aorn.org*).

The guideline became effective July 1.

Gather a multidisciplinary team to review the guidelines and update practices and policies as your organization sees fit. The CDC, The Joint Commission (TJC), and others often point to AORN as one of the industry standard-setters for best practices.

The surgical attire recommendations will be included in AORN's *Guidelines for Perioperative Practice* book in January 2020, said **Lisa Spruce, DNP, RN, ACNP, CNOR, CNS-CP, ACNS, FAAN,** AORN's director of evidence-based perioperative practice and lead author of the surgical attire guideline. Spruce answered questions on the new recommendations by email.

"The entire guideline has significantly changed, and perioperative team members need to review the guideline in its entirety," said Spruce.

"One such change is the recommendation for hair covering. We recommend that the scalp and hair are covered when entering the semi-restricted and restricted areas; however, no recommendation can be made for the type of head covers worn. An interdisciplinary team, including members of the surgical team and infection preventionists, may determine the type of head covers that will be worn at the healthcare organization."

AORN became the center of a firestorm after it last revised its surgical attire guideline in 2014 to encourage the covering of ears, which became a debate over whether the guideline encouraged the use of bouffant caps instead of the traditional skull caps favored by many surgeons.

One group of doctors did their own study to show that bouffant caps did not protect against infection any more than other styles of head coverings *(IJC 7/23/18)*.

AORN has long used scientific studies, medical evidence, and expert reviews in developing its guidelines, and this time was no exception.

"The guideline was developed based on a systematic review of the evidence," noted Spruce. "A medical librarian with a perioperative nursing background conducted a systematic search of the databases Ovid MEDLINE®, Ovid Embase®, EBSCO CINAHL®, and the Cochrane Database of Systematic Reviews. Articles identified in the search were provided to the project team for evaluation."

That team consisted of Spruce as the lead author and one evidence appraiser.

"The lead author and the evidence appraiser reviewed and critically appraised each article using the AORN Research or Non-Research Evidence Appraisal Tools as appropriate. The guideline was then drafted with the input of AORN's Guideline Advisory Board members (see list of professionals below) and AORN's methodologist and editor in chief and was then placed on AORN's website for a public comment period of 60 days. The guideline was edited based on valid public comments and approved by AORN's Guideline Advisory Board in May," she said.

Those professionals included "the Guideline Advisory Board members, which includes liaisons from the American College of Surgeons, American Society of Anesthesiologists, American Association of Nurse Anesthetists, and the Association for Professionals in Infection Control and Epidemiology," said Spruce.

In addition, "as with all guidelines, any member of the surgical team can access the guideline while it is up for public comment to provide input."

The professional groups review "all guidelines and provide feedback from their associations prior to publication," she added.

This time around, there was no lack of public comment. Spruce said the surgical attire guideline was available to the public for 60 days, "and we received more than 500 comments; every comment was evaluated and edits to the document were made as appropriate."

While there is obviously more to the guideline than just recommendations on covering hair and beards, those recommendations "are based on the available evidence, some of which was new since the last revision of the surgical attire guideline in 2014. Changes were made based on that new research. AORN's guidelines are based on all available evidence and as valid research is published, guidelines are revised."

Concerns voiced by TJC and other professional organizations focused on infection control and patient safety, and AORN believes those concerns have been addressed, Spruce said.

However, "many policies will need to be determined at the facility level, where perioperative team members can assess individual patient risk factors and make policy decisions. We recommend facilities form an interdisciplinary team and include members of the surgical team and infection preventionists to read the evidence provided in the guideline and make policy decisions appropriate to their practice."

Make sure you read the new guideline "in its entirety," advised Spruce.

If your hospital or organization makes changes in surgical attire policies, follow up with a quality data review.

"They should track any changes in surgical site infection rates to determine if there is any impact to patient safety outcomes," she said.

AORN has already begun a public education program on the revised guideline. Besides publishing it on the Facility Reference Center, AORN has conducted two webinars on surgical attire, published an article in the *AORN Journal,* "and will be presenting on surgical attire at AORN's fall workshops which take place in several cities across the country." Other resources will be available through the online center and AORN's website.

Spruce also answered some frequently asked questions, published through AORN's publicly available online newsletter, *Periop Today*. That article, "3 Tough Attire Challenges Solved," discussed whether cloth caps were allowed, if arms should be covered, and how to deal with beards. The article can be found at *www.aorn.org/about-aorn/aorn-newsroom/periop-today-newsletter/2019/2019-articles/surgical-attire-challenges*. It includes links to key evidence on which the guidelines were based.

Whatever changes you decide to make to your policies, ensure staff are educated on the changes and the practices are enforced. Surveyors will be checking those practices against your policy.

Most instances of deficiencies in surgical attire called out by CMS surveyors in the last year were less about the choice of attire and more about the hospital's own policy not being followed, according to CMS inspection reports. ■

HFAP

New pharmacy certification designed to boost compliance

By A.J. Plunkett (aplunkett@decisionhealth.com)

Consider getting an accrediting organization to review and certify your hospital's drug compounding practices as scrutiny ratchets up on medication management of both sterile and hazardous drugs.

CMS' *State Operation Manual,* Appendix A (SOMA), which provides its surveyors interpretive guidance on enforcing the *Conditions of Participation (CoP),* requires hospitals to show that their drug compounding practices are equivalent to—or more stringent than—the standards set out by the United States Pharmacopeial Convention.

The SOMA cites both *USP General Chapter <795> Pharmaceutical Compounding—Nonsterile Preparations and General Chapter <797> Pharmaceutical Compounding—Sterile Preparations*.

Most recently, CMS expanded its guidance to surveyors after USP <797> was updated in 2017 following several deaths related to sterile compounding failures.

And CMS surveyors are checking closely on specifics.

In January, a hospital in Worcester, Massachusetts was cited under Tag A-0501, Pharmacist Supervision of Services, for a number of deficiencies at their compounding pharmacy department, including:

- Sprinkler covers that were not flush to the ceiling, leaving a "crack of space observed between ceiling and hanging sprinkler covers"

- A dirty floor "indicated by the appearance of hair strands located to the left of the Compounding Aseptic Containment Isolator (CACI)"
- Chipped paint on the lower edge of a wall near the CACI
- A lack of daily pressure monitoring "either by daily log or continuous recording device" between the ante area of the compounding room where staff were to put on their protective garb and the pharmacy department itself
- A lack of documentation "of minimum displacement airflow of 40 ft per minute or more from the buffer area across the line of demarcation into the ante-area (open architecture design requirement)" for one of the days preceding the survey
- Failure to follow the hospital's own waste disposal policy using color-coded bins

While the standards of all four CMS-approved hospital accrediting organizations must adhere to the *CoP,* only two have additional compounding certifications.

The Joint Commission launched its Medication Compounding Certification in 2017, followed by HFAP's (Healthcare Facilities Accreditation Program) Compounding Pharmacy Certification in 2018.

In a news release announcing its program in December 2018, HFAP's **Marci Ramahi, CAE,** director of accreditation/certification operations, noted that while the certification was not required for accreditation, the program "aims to instill best practices into everyday activities, ensuring pharmacies and specialized pharma products meet the highest standards of quality."

Adhering to higher standards will not only help hospitals meet CMS drug compounding expectations but can better prepare hospitals and their pharmacy operations as newer requirements become effective for the handling and disposal of drugs considered hazardous to both humans and the environment, Ramahi tells *Inside Accreditation and Quality.*

USP General Chapter <800> Hazardous Drugs—Handling in Healthcare Settings is effective December 1. While that chapter sets requirements for protecting staff during the handling of hazardous drugs, a new final rule from the EPA published in February sets out new regulations on the disposal of drugs hazardous to the environment. (For background, see *Inside the Joint Commission, 3/4/19*.)

HFAP will be updating its standards as new requirements are adopted. The USP is revising both USP <795> and <797> this year. And HFAP will update its certification requirements once <800> becomes effective, says Ramahi.

Pharmacy compounding requirements and safe medication practices have long been outlined in HFAP's manual on *Accreditation Requirements for Acute Care Hospitals,* especially in the Nursing Department and Pharmacy/Medication Use chapters, notes Ramahi.

But now, new science and new standards are changing practices, she says.

The Compounding Pharmacy Certification was created to help hospitals navigate the growing concerns and requirements regarding drug management. The 140-page certification manual covers various requirements, from expectations of leadership to provide a safe environment and oversee infection control, to the specifics of the physical environment including cleaning materials and practices, to staff training and patient education, to quality control and performance improvement activities.

While the pharmacy leadership should be driving compliance with drug handling requirements, Ramahi stresses it takes a multidisciplinary team to ensure safe practices overall.

That team must include nursing, because they are responsible for point of care, as well as facilities management, which must tackle air pressure relationships, repairs, and maintenance issues. And of course, the overall hospital leadership must be involved because "generally, when you start talking about changes like this, it does take resources, time, and money," says Ramahi.

It also takes planning, especially if major construction is involved.

"It's always a challenge to make changes in a facility," says Ramahi. "If they have to change the air handling system, it's a pretty big project."

But organizations must also pay attention to the details, she says.

While overall HFAP looks for organizations "to take a holistic approach and not have everything in siloes," says Ramahi, the requirements for pharmacies and compounding tend to be "much more granular." With that, expect surveyors to be asking about compliance with a specific standard.

Here are some common challenges to watch out for, according to Ramahi:

- **Be aware of every location where compounding of drugs may occur.** During a recent survey, a hospital's main compounding pharmacy did well in meeting requirements, but an off-campus location did not fare so well. Remote locations "may not get as much attention," Ramahi says. Ensure good communication with the nursing leadership because compounding is often done by nursing staff at the point of care.
- **Expect to need more resources for hazardous drugs and materials.** The certification requirements do not cite USP <800> now, but they still outline several key concerns about the use and handling of hazardous drugs and other hazardous materials used as part of the compounding process. That includes not just the personal protective equipment needed by staff, but airflow requirements during processing, as well as staff training in use and precautions, the availability of safety data sheets (SDS) as required by OSHA, and the proper handling and disposal of hazardous materials and drugs.
- **Pay close attention to your infusion centers.** Medications used at infusion centers must be properly packaged, transported, and stored until administration, and the requirements can get very technical, notes Ramahi. "The policies and procedures become very important," as do "the training on policies and procedures."
- **When changes are made, ensure everyone is educated on those changes.** "People get used to doing something one way," says Ramahi, and it's important staff understand when and how practices change.
- **Ensure compounding pharmacy staff can demonstrate competency in their given tasks.** Compounding pharmacy training is very specific, and you must test staff's competency—surveyors can and will ask for demonstrations, warns Ramahi. Competency must be built into the training.
- **Maintain a current inventory of drugs.** Hospitals must be aware of the drugs they use that are on the CDC's National Institute for Occupational Safety and Health (NIOSH) list of antineoplastic and other hazardous drugs. The current list is from *2016* but is being updated. And staff must be aware of the drugs they are handling and the documented risks for each drug, notes Ramahi.

While the upcoming requirements on hazardous drugs and materials, both in use and disposal, are not currently specified, hospitals must be aware they are upcoming.

"They should be doing self-assessments where they may not be meeting the guidelines and coming up with a plan of action," advises Ramahi, "building that into planning."

Remember also that surveyors will be looking at hospital policies and procedures, and "they'll be asking staff for their ability to access local, state, and federal regulations—we do expect every hospital to be aware of their local regulations, for example transporting hazardous materials," says Ramahi.

Surveyors may also ask where a hospital is getting the information on which the policies and procedures are based, possibly posing the question to frontline staff. "If they are handling a product that has an SDS, then they should know how to access that. And it should be readily available."

Find the various compounding standards at *www.usp.org/compounding*. Find the NIOSH hazardous drugs list at *www.cdc.gov/niosh/docs/2016-161/default.html*. ■

HFAP

HFAP citations review offers key compliance tips on toughest problems

By A.J. Plunkett (aplunkett@decisionhealth.com)

HFAP surveyors will be looking for increased follow-through on a hospital's evaluation and implementation of organizational policies. They'll also want much better documentation, plus improvements in fire safety, suicide prevention, and infection control.

The Healthcare Facilities Accreditation Program, or HFAP, recently posted its *2019 HFAP Quality Review* on its website. It is recommending healthcare organizations use the report to evaluate their compliance performance against the trends identified in the review.

According to the HFAP announcement, the review shows that "incomplete processes and insufficient documentation remain the main concerns cited during accredi-

tation surveys. To prevent these citations, HFAP recommends healthcare teams review standards by assessing existing policy, implementation, evaluation and reporting practices to ensure all requirements are fulfilled."

The quality review not only outlines the most deficient standards for hospitals, but also comments on the problems most often behind the citations, with examples and tips for compliance.

Physical environment, IC top citations

Among acute care hospitals surveyed by HFAP in 2018, 68% faced a *Condition of Participation (CoP)*–level deficiency regarding two standards: Standard 11.00.01, on providing building safety in Physical Environment, and 07.01.02, requiring leadership and planning in Infection Prevention. A CoP-level deficiency leads to a follow-up survey to check that compliance has been corrected. (For examples of problems under those standards, see p. 1.)

Tips for compliance are plain and to the point.

Hospitals failing under the Physical Environment standard—which could include ligature risk problems as well as some Life Safety violations—are advised to "read and understand each standard under Chapter 11 to be sure you have a process and the documentation required by the standard," according to the review.

HFAP also advises hospitals to follow their own rules and procedures. "Be sure that patient safety risk assessments are written and used per policy."

Hospitals failing under the Infection Prevention standard are advised to "teach staff to recognize infection control concerns and report to the infection control practitioner. Effective cleaning cannot occur where rust, torn furniture, walls and floor divots, and separating in flooring are noted."

And in a note hospital compliance officers everywhere might recognize, regardless of accrediting organization, HFAP reviewers warn: "Cardboard boxes cannot be stored in the hospital due to the risk of vermin."

Overall, the review is broken into four parts: Standards within the Physical Environment, Administrative Oversight, Patient Care and Safety, and Life Safety, which comprises the bulk of the problems as has been the case with all accrediting organizations for several years.

Within the first three categories, only 11 standards were considered problematic in at least 10% of HFAP hospitals surveyed in 2018, and of those only four stood out as problems for 40% or more of hospitals. Besides the two already mentioned, the other standouts were Physical Environment standard 11.03.03, on ventilation, light, and temperature controls, and Administrative Oversight standard 01.01.23, on quality monitoring of contractors.

For 47% of surveyed hospitals, the majority of problems identified under Physical Environment 11.03.03 were related to incorrect air pressure relationships that could lead to infection control issues, pushing those citations to condition-level problems, say reviewers. Examples of problems included:

- Negative air pressures in spaces adjoining operating rooms (OR)
- Clean supply rooms with negative pressures relative to adjoining areas
- Dust and rust on air vents in the emergency department and kitchen
- Missing daily temperature and humidity logs in required areas
- ORs with equipment specific to 30% relative humidity (RH) but with an RH of 20% and no documentation of a risk assessment to support the RH reduction, as required by CMS

Compliance tips include having policy and documentation to verify air pressure relationships are checked as needed in critical areas and having a means to verify HVAC air vents are maintained in a clean condition.

"Remember that high-airflow—especially in ORs—can collect a lot of lint from scrubs and linen," say HFAP reviewers. "Ever notice that lint build-up is the color of your scrubs?"

C-suite under scrutiny too

Under Administrative Oversight, standard 01.01.23 on contractor monitoring makes the hospital's governing body "ultimately responsible for all services provided whether by employees, formal contract, joint ventures, informal agreements, shared services, or lease arrangements," says the review.

Half of the hospitals surveyed by HFAP in 2018 failed that requirement.

At one hospital, during a review of the quality assurance and performance improvement (QAPI) program, "it was noted that five contracted services

failed to report data to the QAPI program and therefore did not report data to the Governing Body." The services included laundry, biohazard waste, the medical director, a confidential shredding service, and dialysis.

At another hospital, "there are 155 agreements for services for which no documentation exists demonstrating that an evaluation has been completed." Another facility had a process for evaluation, "but the mechanism did not include the use of relevant and meaningful indicators to assess the quality of services rendered."

To comply with this standard, hospitals are advised to develop a written policy describing the evaluation process for contracted services and ensuring that evaluations "travel through the quality review process up to the governing body."

Life Safety leads numbers

The largest number of problems were identified under 33 Life Safety chapter standards, although only 11 of those were consistently identified at 40% or more of hospitals surveyed. Those 11 standards, with compliance tips from HFAP experts, include:

13.01.05, Means of Egress (50% of hospitals surveyed): Examples included multiple doors leading to a public area in the middle of the facility that were not safe exits in the event of a fire and didn't have signs saying "NO EXIT," as well as exit signs that were not illuminated at the entrance. A document review showed the monthly inspection was only of battery-powered exit signs and not all exit signs.

Compliance tips—Use facility rounding to manage recurring compliance issues and "do not believe or portray these issues as insignificant: coworkers will believe the same." Also follow-up and train, and ensure staff are "well-versed in identifying egress compliance issues."

13.02.02, Fire Detection Systems, fire alarm testing (56%): Reviewers note fire alarm system testing was not compliant "far more frequently than system installation and maintenance." Examples included a report that six devices or dampers in air handling units were listed as failing to alarm during tests, but the hospital couldn't clarify what the issues were or if they had been corrected. Water flow and tamper switches were tested annually instead of semi-annually as required, and the heat and duct detectors installed didn't match testing documentation.

Compliance tips—Review testing requirements as set out by the NFPA and HFAP; verify that documentation reflects testing and provides evidence of correction and retesting. "Since these activities cannot be witnessed by surveyors, the testing documentation is legal proof and evidence of how you performed an activity and the results of that activity."

13.03.01, Fire Suppression Systems, water-based system installation and maintenance (47%): Installation problems most often involved items stored so that they blocked the spray from fire sprinkler heads. Examples included a sprinkler head covered with what appeared to be paint and sprinkler heads in patient room closets installed within six inches of the shelves.

13.03.02, Fire Suppression Systems, testing and inspection (53%): Examples included a hospital unable to show documentation of monthly control valve and pressure gauge inspection tests, and another facility that could not show evidence of monthly inspection of fire sprinkler control valves.

Compliance tips—Review the testing requirements and verify that testing documentation accurately reflects testing activities; follow through on deficiencies, providing evidence of correction and retesting to compliance conditions.

13.04.01, Fire Safety Systems, fire-rated barriers (44%): Here, reviewers state simply: "Whether a fire safety deficiency is observed as a single example or in multiple locations, each observation will be cited." Examples included unsealed conduits above ceiling grids or the use of expanding foam that did not appear to be tested as a fire-stopping product.

13.04.01, Fire Safety Systems, smoke barriers (41%): Examples included a smoke barrier wall that had been cut open to expose a valve and was left unsealed in a soiled utility room, and unsealed areas round conduits in smoke barrier walls.

13.04.07, Fire Safety Systems, fire-rated door assemblies (50%): Examples included holes left behind when magnetic locks removed from double doors, and a lack of a fire-rating label as required.

13.04.09, Fire Safety Systems, ceilings (59%): Examples were gaps at ceiling tiles and pipes penetrating the ceiling with large gaps in an area formerly used for central sterile processing.

Compliance tips—Review the physical state of rated assemblies and smoke partitions, especially when there

is work on above-ceiling systems. Rated doors are high-use items and compliance can change between annual inspections, so be sure "everyone knows to report maintenance issues promptly," and identify a list of fire-stopping materials and wall repair methods to use "consistently throughout the facility."

13.05.09, Building Services, utility systems (56%): Reviewers caution that "a process for review and acceptance of compliance testing documentation is required for every piece of evidence that is used to prove compliance." They advise that rounding processes should include "a review of standards compliance issues that are a result of staff action and attention." Examples of utility system problems were electrical panels that were missing labels, or missing the "required metal panel cover" altogether.

13.05.10, Building Services, medical gas systems and equipment, maintenance (47%): Medical gas problems included oxygen E-cylinders that were not segregated into full and empty storage, and storage was within five feet of combustibles. In one document review session, medical gas systems had not been tested within the previous year, a violation of the frequency set out in the hospital's own medical gas testing policy.

Compliance tips—Again, hospitals are advised to review the testing requirements as set out by the NFPA, and to provide adequate documentation that the work is being done. Follow-through and retest, and provide evidence of correction.

13.06.04, Operating Features, Life Safety drawings (44%): Deficiencies found here are always the result of the drawings not matching actual conditions. Examples were areas of buildings with sprinkler coverage that was not identified, as well as floor plans that did not identify furthest travel distance to the exits.

At one hospital, some rooms were identified as being hazardous areas when they actually weren't. And while these rooms didn't meet compliance in terms of the hazardous areas they were marked as on the Life Safety drawings, they were compliant for their actual uses. Reviewers note: "You will be surveyed to the greater of what YOU require or what HFAP requires."

Compliance tips—The drawings serve as a map for surveyors to review and determine compliance at your facility, say HFAP reviewers. Review them regularly and update them when there is a change in room use, or "when non-compliance is discovered and requires correction." And help yourself by helping whoever is creating or updating your drawings. "Forward a copy of the HFAP standards for life safety drawings to the entity or staff preparing your drawings; many deficiencies could be avoided by providing all elements noted in the HFAP Standard that do not appear on the drawings."

Find the full 2019 HFAP Quality Review at *https://hfap.org/media/Annual_Quality_Report/2019_Quality-Report.pdf*. ■

Case study

Minnesota center uses high harm debriefs to improve event reporting

By Jay Kumar (jkumar@hcpro.com)

After a CMS survey last summer resulted in a finding of Immediate Jeopardy, University of Minnesota Health (M Health) was able to quickly develop and implement a new system to bolster its response to patient harm incidents.

Speaking last month at the Institute for Healthcare Improvement Patient Safety Congress in Houston, representatives from M Health noted that the system had already begun training its staff in error prevention and leadership before the CMS surveyors arrived.

M Health began a partnership in 2017 with Healthcare Performance Institute, a Press Ganey affiliate, to train more than 11,000 staff and providers and 200 leaders, said **Michelle Hodge, MA,** vice president of operational excellence, quality and patient safety. The academic medical center has approximately 1,500 medical staff, 9,000 employees, and 900 allied health professionals. Starting in January 2019, M Health expanded its partnership with Fairview Health System, creating M Health Fairview, which has 12 hospitals, 56 primary care clinics, and 34,000 employees in the Minneapolis/St. Paul metropolitan area, surrounding areas, and greater Minnesota.

Extensive staff training

The staff training was focused on harm prevention using reliability behaviors and error prevention tools, while the leaders worked on building a culture of safety and supporting and sustaining error prevention work, she added.

The three-hour training emphasized the importance of event reporting and highlighted four reliability behaviors to prevent errors:

1. Speak up: I will demonstrate an open, respectful and 200% team commitment to safety.
2. Practice a questioning attitude: I will think it through and ensure my actions are the best for the situation at hand.
3. Communicate clearly: I am responsible for professional, accurate, clear, and timely verbal, written, and electronic communication.
4. Check details: I will act with intention and focus on the details to avoid unintended errors.

M Health also implemented the Daily Safety Huddle, also known as tiered management huddles, Hodge said. A frontline staff huddle is held at 8 a.m. every day, followed by a 10 a.m. huddle with the CEO. The huddles are used to communicate any important operational and safety issues, ensure two-way communication between frontline staff and leadership, and troubleshoot issues and ensure resources are available for safe and high-quality care.

The leadership methods course, which ran two to three hours, focused on finding problems and fixing causes, Hodge said.

"From a quality and safety perspective, we were feeling pretty good about our program," she added.

Quick response to IJ finding

But then last June, there were concerns about M Health's use of restraints, Hodge said. After a CMS survey, M Health had to submit a corrective action plan. CMS returned for a weeklong visit and placed the organization on immediate jeopardy status.

"It was a shocking experience," said **Jody Rock, MS, RN, NE-BC,** director of perinatal services. "It was disheartening as a leader."

M Health wasted little time in coming up with a solution.

"We had regulatory pressure to address these issues immediately," said **Christy Swarthout, MBA,** M Health's director of quality and patient safety analytics.

"We created a high harm debrief (HHD) script and checklist and trained a small group of leaders to conduct HHDs," she said. M Health went live with its HHD the day after the CMS finding and met several times in the following weeks to refine the process.

Swarthout said the HHD is a rapid response to a patient safety issue resulting in harm to the patient. The debriefs are led by a trained operations leader, including the staff and providers involved in the event. The HHD is meant to implement immediate stopgaps or actions to reduce patient harm and the risk of harm to other patients.

The initial rollout of HHDs focused on the inpatient section. In the last quarter of 2018, Swarthout said, it spread to the ambulatory areas, as well as the rest of the system.

The checklist includes questions about whether there were any deviations/variations from generally accepted performance standards, and if so, what stopgaps have been or should be implemented to reduce the chance of harm to other patients. In addition, the checklist asks if any equipment was involved in the event, and if so, that staff identify equipment possibly involved and verify that equipment has been appropriately sequestered.

Swarthout said there were several barriers to implementation:

- Providing the same level of standards and coverage 24/7
- Challenges/limitations with auto-notifications in the event reporting system
- Duplication of efforts with subject matter experts
- Manual process to audit compliance
- Retraining as the process was refined

"In the first two weeks, we trained all unit leaders," said Swarthout. M Health developed processes for normal business hours and "off hours" to ensure it worked around the clock.

Refining the process

It took time to develop an HHD documentation process within the patient safety reporting tool, Swarthout said. The second version of the HHD included a template that staff could fill in with details of each HHD.

M Health created a *YouTube video* to simulate an HHD in the post-partum unit, with a nurse manager, staff nurses, and a neonatal intensive care unit nurse practitioner, Rock said. The severity of the event will determine how long the debrief will take, but it usually goes quickly, she noted.

"It's important to debrief quickly after the event happens," said Rock. "Make sure to mention equipment involved."

Rock said the benefits of HHDs include:

- Real-time notification of events occurring in the acute care setting
- Increased ability to respond timely with staff involved
- Improved communication and follow-up between departments
- Increased accountability of leaders
- Ability to reinforce safety tools
- Reduces patient harm by implementing stopgaps and long-term process changes

Implementation of HHDs posed several challenges, including:

- Initial urgency of training
- Significant volume of leaders and staff to train
- Multiple notification process changes
- Sustainment
- Creation of accountability measures
- Quality of stopgaps, training of new leaders, transition of leaders

Among the program's initial successes was with M Health's Early Recovery After Surgery (ERAS) spine protocol, which has seen more than 600 HHDs completed, Hodge said. The protocol has been refined and now there are no more issues.

Event reporting has increased at M Health, added Hodge. There is approximately 95% compliance with the process. The weekly median event volume reported has increased from 308 to 374.

Next steps for M Health include integration of HHDs into a new event reporting system and system-wide adoption and refinement, Hodge said. ■

A version of this article originally appeared in Patient Safety & Quality Healthcare at *psqh.com*

We're seeking experts

Contact me and let me know your areas of expertise and interests in publishing or training.

– AJ Plunkett, Editor
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Harm Rating Scale

Any patient safety event submitted as category E or higher by reporter would require a high harm debrief.

A—Capacity to lead to error

B—Error did not reach patient

C—Error reached patient but no harm

D—Monitor/intervene to preclude harm

E—Temp harm/intervention

F—Initial or prolonged hospitalization

G—Permanent harm

H—Intervention to sustain life

I—Fatal

Patient engagement

3 ways to improve: Use nurse leaders to change workplace culture

By Jennifer Thew RN (jthew@healthleadersmedia.com)

To achieve organizational goals, nurse work environments must support an optimal staff member experience.

Healthcare leaders at North Carolina–based *Vidant Health* are putting the old adage "Happy nurses equal happy patients," to the test. The organization committed resources to change the workplace culture for its nurses with the philosophy that engaged and motivated nurses provide better care to patients.

Linda Hofler, PhD, RN, NEA-BC, FACHE, senior vice president and nurse executive at *Vidant Medical Center* describes the implementation as a "holistic approach to organizational excellence" that benefits the nurses and trickles down positively to the patients.

The goal of the approach, she explains, is "to improve team member experience and rebuild joy in the workplace. [It's not just] focused on patient experience but on team member, provider, and environmental experience as well."

The Institute for Healthcare Improvement treats on the idea that creating joy in the workplace is also an antidote to burnout, which is a major issue among clinicians. In 2017, the organization released its white paper, *IHI Framework for Improving Joy in Work.*

Hofler became interested in a holistic approach to improving organizational outcomes when Vidant's chief experience officer *Julie Kennedy Oehlert, RN, DNP,* was doing doctoral research on the healthcare environment.

"[Her idea was] that if you just focus on the patient experience that you [don't] really get the engagement of your team members," Hofler says.

To test this theory, Oehlert and Hofler, along with their chief quality officer, assessed correlations among data related to employee engagement, complaints and grievances, patient experience, employee turnover data, and various nurse sensitive quality indicators.

"Sure enough, there are patterns and trends that would lead you to believe—at least our theory is—that if

you *can improve the team member experience, then the other things will get better* too," Hofler says.

Better work environment, better outcomes

A recent *meta-analysis* from *Penn Nursing's Center for Health Outcomes and Policy Research* (CHOPR) seems to support this idea. CHOPR researchers synthesized 16 years of studies to show the association between the nurse work environment (i.e., organizational elements that influence nursing care quality, such as nurse-physician collaboration, nurse manager support, and nurse involvement in decisions affecting clinical care) and four sets of outcomes: nurse job outcomes, nurse assessments of quality and safety, patient health outcomes, and patient satisfaction.

"Our quantitative synthesis of the results of many studies revealed that better work environments were associated with lower odds of negative outcomes ranging from patient and nurse job dissatisfaction to patient mortality," says the study's lead-investigator *Eileen T. Lake, PhD, MSN, FAAN*, the Jessie M. Scott Endowed Term Chair in Nursing and Health Policy, in a news release.

Vidant's focus on its team members' experience has been occurring for about two years, Hofler says.

"This is probably the most rewarding work I've done in a long time, but it's hard work because in the business of healthcare, people want to check a box and go on to the next thing," Hofler says. "And this is not about checking a box. It's about building networks and finding ways to create new and different ways of doing and being."

In a recent interview with IAQ publishing partner *HealthLeaders,* Hofler shares three ways she and the leadership team at Vidant have reshaped the nurse work environment to achieve organizational excellence.

1. Nursing salons

In the tradition of Ancient Greece and the French Enlightenment, Vidant has launched small gatherings known as *salons*. Historically, salons have been places where individuals increase their knowledge and share ideas and experiences through rich conversations.

During Vidant's salons, attendees—with the help of a facilitator—focus on a specific topic and engage in dialogue and learning. Hofler says the groups are limited to no more than 30 participants and meet for about an hour.

For example, the organization has a salon for leaders that focuses on the topic of empathy and is designed to be *highly interactive*, where participants engage in storytelling and sharing of experiences.

"During that hour, not only are you learning content, but you're learning from the experiences of the other people in the room, so it becomes very rich," Hofler says of the group. "It's kind of a recommitment to why you came into a healthcare profession. For nursing, that resonates with folks because it's so easy in the business to forget why you really wanted to do the work to begin with."

2. Games

Adding a little friendly competition among nurses when practicing problem-solving skills seems to be paying off at Vidant.

"We did a game with all of my leadership team and their direct reporting lines where they had an hour to devise a plan for how they were going to do something to focus on engagement [with] their teams," Hofler says. "They were going to get $100, so [the question was], 'How would they use that [money to engage with their employees]?"

One group created a circus theme to help connect with their employees. They designed a cart that looked like a circus tent and they dressed like circus performers and took circus-related snacks to the employees on the unit. They used that as an opportunity to start conversations "about what was the most important thing that leadership should be doing to support patient care at the front line," she says.

In the end, Hofler estimates she spent about $1,500 on that exercise.

"They all implemented their projects, took pictures, and came back, and we had a celebration at the end. We saw a change in our [employee] engagement scores. It was a small incremental change, but that's what you want … small changes over time that are sustainable," she says.

Additionally, the organization had a "Rounding Olympics."

"It was a system process and it was to determine what units could get the highest scores [regarding patient] answers to the question, 'Did a leader round on you during your hospital stay?'" she says.

The winners received $1,000 to have a party or redecorate the breakroom.

"Again, not terribly expensive, and it got a ton of people engaged, and they were excited about it and it was fun," says Hofler.

3. Support Breaks

"[Part of Vidant's philosophy] is to create a culture where team members can be *resilient*, where they find joy in what they do, and where they're able to show up and be their best every day," says Hofler.

One example of this culture of support is a change that occurred in the emergency department, which sees about 120,000 patients a year, says Hofler.

On a particularly busy day, she asked to see the department's breakroom.

"They asked, 'Why do you want to see the breakroom?' I said, 'Well, [the ER] is like a war zone. People are just coming and there's no stopping. Where do you go get yourself centered again?'" Hofler recounts.

The answer was typical of most nurses: "We don't do that."

And, even if the nurses did take a break, the ED space was not conducive to grounding oneself during a frenzied shift.

Holfer was able to help carve out a space that is visually appealing, and is outfitted with refrigerators, a microwave, and a serenity room painted with calming colors and inspirational quotes.

"Now [nurses] will go in there and talk to each other," she says.

Hofler says getting the physicians and the nurses committed to taking breaks and having charge nurses ensure that staff members are taking the much-needed recovery time has helped the nurses' workplace experience. ■

Jennifer Thew, RN, is the senior nursing editor at HealthLeaders.

Questions Comments & Ideas

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