Article PCI.5ME4

The April 2019 issue of JCInsight identified the top scored measurable elements for the Joint Commission International Accreditation Standards for Hospitals and Academic Medical Centers (AMC), 6th edition for surveys conducted in 2018. The frequently cited measurable element in seventh place was PCI.5ME4 “The hospital has implemented strategies, education, and evidence-based activities to reduce infection risk in those processes.” The focus of Standard PCI.5 is that the organization has designed and implemented a comprehensive infection control program that identifies all the procedures and processes within the organization that poses a risk for infection and that actions are taken to mitigate those risks. Consideration for the types of patients cared for at the organization, the services offered and the geographic area the organization is located assist with determining the risks. If an organization performs surgery, surgical site infections must be considered. An organization located in an area where tuberculosis is prevalent, must plan for the safe care of those patients. Every area of the hospital must be considered for the impact on patients and staff. Included in this assessment are the vaccination program for staff and patients, the hand hygiene program, the antibiotic stewardship program, and surveillance to detect and respond to outbreaks. This risk assessment and mitigation activities are an essential component of the infection control program and must be a continuous process as new risks or infections become known to the organization. The following are actual survey findings for this measurable element.

The following risks were observed:

1. Humidity was not monitored and/or recorded in multiple sterile equipment storage areas.
2. On several patient care units, clean equipment was stored in dirty utility rooms, creating risk of cross contamination.
3. Refrigerators were located in patient rooms for the storage of food. The temperatures of the refrigerators were not monitored, nor was there a process to inspect the contents of the refrigerators to assure that the food stored in the refrigerators was not outdated.
4. In multiple patient care units (including an isolation room in the ICU) it was observed that there were un-patched holes in the walls, peeling paint, cracked tiles in bathrooms, and ceiling penetrations, creating a risk of microbial contamination.
5. Doors to the operating rooms did not close completely and had gaps, therefore positive pressure was not maintained.
6. Sterile supply rooms in the operating room and Central Sterilization were not positive pressure in relation to adjacent contaminated rooms and hallways.
7. Dirty linen was found in several overfilled infectious waste bags rather than the appropriate bags for linen.
8. Two cardiotocography units, to include the toconometer, belly bands and equipment cart, on Labor and Delivery were visibly soiled.
9. In Neonatal Intensive Care Unit, layers of adhesive remained on the outside of disinfected incubators.
10. In Central Sterilization and several other patient care rooms throughout the hospital, the floors were tiled with thick grout which had blackened with dirt over time because of the challenge of surface cleaning. The walls of Central Sterilization were also of this material and appeared soiled.

The following were observed:

1. Throughout the facility patient rooms had windows without screens. This could pose a risk of transmission of insect-born infection or disease.
2. In the operating theaters: Paint was chipped and peeling from the walls along the hallway. Mosquitos were observed in operating theaters. There was dust on the wall in the sterile supply storage area and on the sterile supply elevator.

The following were observed:
1. The laboratory specimen collection area used a torn, visibly soiled pillow covered with torn paper as an arm rest for the patient.
2. The urine specimen bottle presented by the patient was wet on top and urine/water dripped into the laboratory receiving tray. Staff had gloves on and moved the wet container, then without changing gloves began typing on the keyboard. Staff said the receiving tray was cleaned once per day rather than whenever needed.
3. In the sterile supply room, cloth and paper wrapped sterile packs were stored on the bottom shelf of wire storage racks that would expose these packs to inadvertent and unrecognized contamination during routine housekeeping activities.
4. The type of personal protective equipment required for the Neonatal Unit was not standardized. The survey team and hospital staff were required to wear a mask while staff in the Neonatal Unit were not required to wear a mask.