ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

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Regulatory Affairs Department

Joint Conference Committee (JCC) Regulatory Affairs Status Report: **July 2017** (reporting period June 22, 2017 – July 19, 2017)

I. PENDING SURVEYS

A. **Joint Commission Accreditation Validation Visit** –unannounced (open survey window)

II. COMPLETED SURVEYS

A. **Joint Commission Triennial Accreditation Survey** –unannounced (June 20-22, 2017) **Plan of Correction due 9/5/17**
B. **Joint Commission Clinical Laboratory Survey** –unannounced (July 18-22, 2017) **Plan of Correction due September 2017**

III. PLANS OF CORRECTIONS: Reports & Updates

A. **CDPH/CMS Re-Certification Licensing Outpatient Hemodialysis Survey** (June 12-15, 2017)

CDPH/CMS Re-Certification Licensing Outpatient Hemodialysis Survey		
Action Items :	**Update(s):**	**Target Completion Date:**
V121 494.30(a)(4) (i) IC-Handling Infectious Waste – The facility failed to ensure staff follow its policy on Infection Prevention and Control for one patient (Patient 10) out of 14 total patients when one staff, Registered Nurse (RN) 1 discarded four (4) blood filled syringes and other used items into a regular trash container instead of using the "red bag (biohazard) container".	1. The involved staff member was counselled immediately following the wasting of the syringes. 2. Incorrect information flyers regarding appropriate/correct medical waste-stream were updated to reflect the changes and updates. 3. Staff present at the time of survey were provided immediate information regarding changes to the flyers. 4. Dialysis staff were provided educational in-service on appropriate waste stream for discarding syringes.	6/13/2017 6/13/2017 6/13/2017 7/7/2017

	5. Visual cue/laminated placards were placed on trash containers indicating "do not discard syringes/sharps" and reference to appropriate waste container.	7/14/2017
V122 494.30(a) (4)(ii) IC- Disinfect Surfaces/Equip/Written Protocol The facility failed to ensure equipment was properly cleaned and maintained when: 1) The base of the 13 Hemodialysis Machines (HD Machines- a machine used to filter a patient's blood in order to remove excess water and waste products when the kidneys are damaged, dysfunctional, or missing) had discoloration and had white colored deposits. 2) The blades and grills of the six electric fans, located above and in between each of the 13 Stations/Chair (assigned area for a patient with chair, hemodialysis machine, and a television), had fuzzy, dark grey-colored matter, and were "dirty" and "dusty".	1. Upon discovery of the discoloration and white colored deposits on the bases of the hemodialysis machines, the ZSFG Biomedical Engineering team cleaned each Hemo-dialysis machine base. 1a.Dialysis staff were provided an educational in-service on the importance of cleaning the hemodialysis machines to ensure they are properly disinfected. The in-service included the need to lift the containers housed on lower level/ base of machine. Cleaning must be performed between each patient use in accordance with current policy/protocol. 1b. Prior to returning the machines to service, Biomedical Engineering will fully complete cleaning during routine maintenance checks. 2. Upon discovery of the soiled fans, each fan was thoroughly cleaned. 2a. The contract was reviewed by the Dialysis Leadership Team to incorporate quality metrics into the current contract. The external vendor was contacted in order to review the contract and to create a cleaning checklist. The cleaning checklist will be completed on a weekly basis then	6/15/2017 7/7/2017 Ongoing 6/12/2017 7/13/2017

	dated and signed by the vendor's employees to ensure the clinical setting is appropriately cleaned.	
V116 494.30 (a)(1) IC-IF TO Station= DISP/Dedicate or Disinfect The facility failed to ensure staff followed its policy on Infection Control for one Random Patient (RP) 13 when: one unopened bloodline tubing, and one unopened bag of one liter Normal Saline (NS), reserved for the next patient, were taken into Station 8, where RP 13 was seated and was currently receiving hemodialysis treatment.	1. All the hemodialysis stations were checked for equipment and pre-spiked bags, ensuring that station contained only equipment for the patient receiving treatment. 2. Dialysis staff were provided an educational in-service focusing on the importance of safety over workflow, and proper patient preparation. Safety information included appropriate infection control practices and the potential for error and patient harm. 3. Visual cue/laminated placards were placed on IV bag storage rack and bloodline tubing storage reminding staff to refrain from "pre-spiking" of IV bags until immediately ready for patient at time of treatment.	6/12/2017 7/7/2017 7/14/2017
V403 494.60(b) PE- Equipment Maintenance- Manufacturer's DFU The facility failed to ensure equipment was properly maintained when the three chairs in the Waiting Area of the Dialysis Unit had "tear" on the seat cushion.	1. The worn chairs were immediately removed and replaced with chairs free from tears, rips. 2. Dialysis staff were provided an educational in-service on infection control findings and the importance of reporting/requesting replacement furnishings upon identification of torn or ripped chair fabric.	6/15/2017 7/7/2017

V408 494.60(d) PE-Emergency Preparedness- Procedures The facility failed to ensure non-expired medical emergency supplies were stored, and would be available for use, in case of emergency when five (5) individually packaged 2x2inch sterile gauze sponges were kept inside the Patient Emergency Evacuation Kit (PEEK- kit that contains basic medical supplies needed in case of emergency such as bleeding) beyond expiration date.	1. All kits were checked to ensure there no expired items contained inside. 2. All kits now include an exterior label containing information of the earliest expiration date of the contents. 3. Dialysis staff were provided an educational in-service on the new policy and procedure requiring each kit now must contain an expiration label and be checked weekly or prior to using any products within the kit. 4. A policy was created to address expired medical supplies. 5. The Expired Medical Supply policy was reviewed during team huddle.	6/15/2017 6/15/2017 7/7/2017 7/12/2017 7/12/2017

IV. SITE VISITS

A. **CDPH Complaint/Self-Report Investigation Visit** (July 7, 2017) regarding a self-reported incident (Plan of Correction anticipated) and a complaint (no deficiency identified)

B. **CDPH Complaint Investigation Visit** (July 18, 2017) regarding two complaints originating in the Emergency Department (no deficiencies identified)