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A 000	INITIAL COMMENTS Facility ID: 830500 In-patient Census: 230 Surgical Suites: 8; Procedure Rooms: 3 Surgery/Procedure Cases Day One: 35; Day Two: 22 The purpose of this unannounced survey was for Complaint MI00081627 and validation of the Conditions of Participation for Infection Control and Surgical Services. The Department of Licensing and Regulatory Affairs has evaluated this facility and determined that it is not in compliance with federal certification requirements on the date(s) specified.	A 000	**The plan of correction is prepared in compliance with federal regulations and is intended as Detroit Medical Center (DMC) Detroit Receiving Hospital's ("DRH" or "Hospital") credible evidence of compliance. The submission of the plan of correction is not an admission by the facility that it agrees that the citations are correct or that it violated the law.** **Organization Minutes:** The confidential and privileged minutes are being retained at the facility for agency review and verification if required. **Exhibits:** All exhibits including revisions to Medical Staff Bylaws, reviewed/revised or promulgated policies and procedures, documentation of staff and medical staff training/education are retained at the facility for agency review and verification upon request.	
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, interview, and document review, the Infection Control Officer (ICO) failed to implement aseptic cleaning procedures between surgeries in 1 (#6) of 2 of operating rooms; failed to develop and/or implement infection control policies & procedures for 2 (#6, #8) of 2 observations of instrument cleaning immediately following surgical cases; and failed to ensure staff received education and were deemed competent in infection control policies & procedures for surgical housekeeping staff and central sterile processing staff, resulting in the	A 747	**Tag: A747** **Response:** The Detroit Medical Center's (DMC) Chief Operating Officer and Chief Medical Officer, have created a DMC Perioperative Improvement Council to oversee perioperative services on behalf of DMC hospitals including DRH. This Council is composed of representatives from the following departments of each hospital: DMC Board, Executive leadership, Surgery, Infection Control and Epidemiology, Central Sterile Processing, Operating Room, DMC Project Management, as well as Unity HealthTrust, and North Star Anesthesia. The Perioperative Improvement Council will meet monthly to review reports from the Perioperative Improvement Task Force and will take actions as needed. The Detroit Medical Center's (DMC) Chief Operating Officer and Chief Medical Officer, have also created a DMC Perioperative Improvement Task Force who is responsible for development and implementation of performance measurements for all perioperative services including Central Sterile	9/6/16 9/6/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 747	Continued From page 1 potential for unsatisfactory patient outcomes for all surgical patients served by the facility. A total of six surgical case observations were conducted. Findings include: See A748.	A 747	Processing, with a focus on aseptic cleaning procedures of operating rooms and the cleaning, processing and sterilization of surgical instrumentation. The Council will evaluate compliance with quality control requirements, electronic risk management reports (i.e. incident reports), Immediate Use Steam Sterilization rates, Surgical Site Infection rates and other issues associated with the perioperative environment.	
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.	A 747	The members of the Task Force include: the DMC Chief Operating Officer, DMC Chief Medical Officer, DRH Chief Administrative Officer, DRH Chief Medical Officer, Chief Operating Officer Children's Hospital of Michigan, Chief Operating Officer Sinai Grace Hospital, Chief Medical Officer Sinai Grace Hospital, Chief Medical Officer Huron Valley, Regional Chief Nurse Executive, DRH VP Service Excellence and Community Affairs, Unity Health Manager of Central Sterile Processing, DMC VP Accreditation and Regulatory Readiness, Infection Control Officer, Regional Medical Director of Infection Control and Epidemiology. The Perioperative Improvement Task Force will meet daily until all corrective actions have been fully implemented and monthly thereafter. The Task Force will report its findings to the Council on a monthly basis. **Policy & Procedures:** The Chief Nurse Executive, Chief Medical Officer, Infection Control Officer, and Central Sterile Processing Manager reviewed and revised the policy regarding cleaning procedures between cases and the pre-treatment of surgical instruments post-surgery, and central sterile processing (2 IC 016 "Cleaning, Disinfection and Sterilization Guidelines). This comprehensive policy is inclusive of content from the Association of Operating Room	9/15/16
	This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the Infection Control Officer (ICO) failed to implement aseptic cleaning procedures between surgeries in 1 (#6) of 2 of operating rooms; failed to develop and/or implement infection control policies & procedures for 2 (#6, #8) of 2 observations of instrument cleaning immediately following surgical cases; and failed to ensure staff received education and were deemed competent in infection control policies & procedures for surgical housekeeping staff and central sterile processing staff, resulting in the potential for unsatisfactory patient outcomes for all surgical patients served by the facility. A total of six surgical case observations were conducted. Findings include: Surgical suite cleaning of room seven, after case #6 (Between Case Cleaning) was observed on 8/29/16 between 1130 and 1215 revealed the following: On 8/29/16 at approximately 1130, Surgical Housekeeping Aide K was noted to wipe down areas but not getting all surfaces of the Operating			

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A 748	Continued From page 2 Room Table and wiping instrument cords but placing the cords low and near the blood stained floor. Cords later dropped to the blood stained floor at approximately 1145. Review of the employee's personnel file with Director S, revealed that the employee had infection control training documented 2/2/16, a satisfactory overall performance review dated 2/29/16, but a "Cleaning Step" overall percentage "Pass Score 48.39 %", also dated 2/29/16. On 8/29/16 at approximately 1145, Surgical Housekeeping Aide L was observed mopping the blood stained floor without moving cleaned equipment and the dirty mop touched clean equipment cords. One cleaned cord fell to the floor and was picked up and placed back in a low position by staff L. Interview with Staff L, on 8/29/16 at approximately 1215, revealed that she did not usually work housekeeping in the surgical suite. She stated, "I usually work (in the) discharge (areas)." Review of the personnel file of Staff L with Director S, on 8/29/16 at approximately 1500, revealed that this employee had been hired in May 2016 and had documented 'Surgical Between Cases Housekeeper Training' on 6/3/16. Director S also stated, "It was too early for performance review." On 8/29/16 at approximately 1200, Surgical Patient Care Assistant M was observed coming in to help with getting the room ready. Staff M pulled gloves out of the box, dropped some gloves on the dirty floor and placed the now dirty gloves back in the clean box of gloves. The surveyor stopped Staff M and queried, "Where did you put those gloves that you dropped?" At that point Staff M looked and then pulled the box off the cart and threw the box away. Review of	A 747	Nurses and the Association for the Advancement of Medical Instrumentation, and addresses initial pre-cleaning of instruments, safe transportation of pre-cleaned instruments, as well as disinfection and sterilization processes. Beginning October 1, 2016, the Infection Control Officer or designee will conduct an annual review all infection control policies and procedures and update as needed. The Infection Control Officer, the Manager of Central Sterile Processing and the Educator reviewed the Central Sterile Processing staff job descriptions to include job qualifications, experience and specific training and certification requirements. The DMC Infection Control Officer and the Infection Preventionist for each hospital have reviewed and approved all training and competency documents to assure alignment with DMC Infection Control Policies. **Training & Competency Assessment:** Environmental Services: The Infection Control Officer, General Manager of Sodexo Environmental Services, VP of Service Excellence and Community Affairs and the Manager of Central Sterile Processing developed and implemented educational modules for Environmental Services and Central Sterile Processing staff with regards to proper cleaning of the Operating Room and instrumentation respectively. The General Manager of Sodexo Environmental Services trained all Environmental Services personnel on the revised policies and procedures. The content included Between-Case Cleaning, End-of-Day Terminal Cleaning and Cycle Cleaning. Competency assessment was completed and documented for each employee.	9/24/16 9/15/16 9/6/16 9/8/16

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A 748	Continued From page 3 Staff M's personnel file on 8/30/16 at approximately 1330, revealed that the employee had recent infection control training in August 2016 and a recent (2016) "Satisfactory" performance review. Review of hospital policies & procedures, on 8/30/16 at approximately 0900, revealed the following: "Policy No. 2 ES 533, titled Surgery Suite Cleaning, dated 2/20/14," documented "Between Case Cleaning, 4. Wash OR table top to bottom, including the undersides of table pads. Move table and mop under it, return the table to its original position." "Policy No. 2 IC 022 & 2 POS 104 titled "Operating Room (OR) Infection Control, dated 10/18/13" documented, "4. Environment, A. OR Sanitation, b. Principles of aseptic technique must be followed meticulously." This had not been done by the above staff. Interview with the ICO, on 8/30/16 at approximately 1230, regarding infection prevention, surveillance, and recent concerns of the operating room and surgical instrument cleaning, revealed that she "had made weekly and now every two weeks of environmental rounds," but had not observed cleaning in the operating room or cleaning of instruments. On 8/29/16 at 10:30 AM, during a tour of the Central Sterile Processing (CSP) department, a tray of dirty instruments was observed with dried blood on the instruments in the decontamination side of the department. In interview with Staff Q, he stated that the new CSP management is in the process of revising the policy to begin pre-cleaning in the OR but that the new policy is not yet in place.	A 747	Central Sterile Supply: The Manager of Central Sterile Processing, the Central Sterile Processing Educator and the Operating Room Educators conducted competency assessments of all Central Sterile Processing personnel including verification of skills for cleaning and sorting of instruments, and the sterilization of trays. Competency assessment was documented for each employee. Competency requirements have been incorporated into new employee orientation and annual reorientation. The Chief Executive Officer engaged an external central sterile processing education and training resource (IMS) to provide both on-site and web based training modules that can be used to provide additional training of Central Sterile Processing personnel. Operative and Invasive Services: The Chief Medical Officer (CMO), Nurse Educators, Infection Preventionist, and Operating Room Educators developed and trained all OR staff with responsibility for handling soiled instrumentation. Training on the pre-treatment of instruments requiring sterilization by Central Sterile Processing included the rinsing or wiping of bio burden contamination, using the enzymatic product appropriately (the enzymatic cleaner is sprayed onto the soiled instruments), placing of instruments into appropriate containers, and transporting of soiled instruments to Central Sterile Processing. Any staff member absent during the training period will not start his or her next shift until after his or her training is completed and documented.	9/29/16 9/29/16 9/13/16 Training 9/29/16

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A 748	Continued From page 4 On 8/29/16 at 11:05 AM, during interview with Staff R regarding training of CSP employees it was stated that the previous CSP manager had thrown away training records prior to leaving the department, but there were some training records that had been found. When asked for all the training records for 2016 a folder of sign in sheets was provided by Staff R. During record review of these training records, it was noted that many employees had not attended the trainings, as demonstrated by not signing the sign in sheet. Review of the sign in sheets for the 18 training sessions conducted in 2016 are noted below. Additionally, supporting documentation for the specific content of the 18 training sessions conducted in 2016 was only available for 3 trainings: "AAMI ST79 Updates...", "Dress Code", and "Dispatch Cleaner Disinfectant". Training dated 1/13/16 titled "Weekend request/shift change forms/Weekend shift makeup..."; 39 of 74 employees did not attend the training. Training dated 1/27/16 titled "AAMI ST79 Updates..."; 26 of 75 employees did not attend the training. Training dated 2/10/16 titled "IMS Surgical Instrument Testing & Inspection Standards"; 47 of 74 employees did not attend the training. Training undated titled "BK Transducer Probes & Leak Testing"; 46 of 76 employees did not attend the training. Training dated 3/9/16 titled "Hitachi Aloka Ultrasound"; 25 of 74 employees did not attend the training. Training dated 3/16/16 titled "Emergency Doors"; 23 of 74 employees did not attend the training. Training dated 3/16/16 titled "Holiday policy"; 21 of 74 employees did not attend the training.	A 747	**Monitoring:** The Infection Control Officer updated the comprehensive auditing tools for use in pre-cleaning, Central Sterile Processing, and Operating Room areas. The Infection Control Officer and the Infection Preventionist for each hospital will conduct weekly monitoring of Operating Rooms and Central Sterile Processing using the following audit tools: Operating Room Infection Control Surgical Review Tool, Environmental Services Operating Room Survey Infection Prevention Tool, and the Sterile Processing Tracer Tool. The Operating Room Managers beginning October 10, 2016 will review cleaning logs on a weekly basis for four months to verify the cleaning of surgical suites is performed as outlined in policy. Environmental Services Supervisors will randomly observe 100% of environmental employees cleaning surgical suites between cases to confirm that cleaning is completed according to policy. Any identified issues will be addressed through 1:1 re-training. Observation will be performed weekly until compliance has been achieved for four consecutive months at which time the activity will be re-evaluated. Audit results and non-compliance with the policy will be reported monthly to the General Manager of Sodexo Environmental Services, the Perioperative Council, Infection Control Committee, Environment of Care Committee and the Leadership Performance Improvement Coordinating Committee (LPICC) for review and action as required. The Unity Health Director and Managers of Central Sterile Processing began daily Quality Control checks on September 19, 2016. The quality control checks include inspection of instruments for cleanliness, rust, lack of bio burden, and proper positioning (open verses closed); inspection of retractors, heavy	9/15/16 ongoing 10/10/16 and ongoing 9/19/16 and ongoing

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A 748	Continued From page 5 Training dated 3/30/16 titled "Power Equipment"; 46 of 74 employees did not attend the training. Training dated 3/31/16 titled "Matrixnuero ULP"; 38 of 74 employees did not attend the training. Training dated 4/18/16 titled "Use of Alex Gold in Decontamination"; 37 of 74 employees did not attend the training. Training dated 6/7/16 titled "Synthes Matrix ULP cart for refill"; 27 of 74 employees did not attend the training. Training dated 6/15/16 titled "Biological Indicator & Documentation"; 25 of 74 employees did not attend the training. Training dated 6/20/16 titled "dress code"; 34 of 74 employees did not attend the training. Training dated 6/28/16 titled "Dispatch Cleaner Disinfectant"; 46 of 74 employees did not attend the training. Training dated 6/29/16 titled "Back to Basics - Instrument Inspection"; 28 of 74 employees did not attend the training. Training dated 7/26/16 titled "Back to Basics"; 27 of 76 employees did not attend the training. Training dated 8/3/16 titled "CSP/Perioperative Services"; 39 of 76 employees did not attend the training. Training dated 8/4/16 titled "Implementation of Yellow DRH OR Instrumentation"; 51 of 74 employees did not attend the training. Of 18 training sign in sheets, 3 sign in sheets had supporting documentation of material that was covered during the training. On 8/29/16 at approximately 1130, Staff R was then asked how employees are trained if they miss the training date and how it is documented. Staff R then stated that the employee is trained on the missed subject at a future time but there is no follow up sign in sheet or other documentation.	A 747	instruments and strung instruments for functionality; evaluation of the use of tip protectors. These checks will continue on a random basis for the next four months. The results of all audits are sent to the Director of Clinical Quality Improvement for each hospital. The Director of Clinical Quality Improvement reviews and analyzes the data. This information is sent to the DMC Director of Quality for aggregation and analysis. Results are reported to the site Chief Operating Officer, Regional Chief Nurse Executive, the Infection Control Committee, Environment of Care Committee, Leadership Performance Improvement Coordinating Committee (LPICC), Perioperative Task Force, the Perioperative Council, the Joint Conference Committee and ultimately the Governing Board at their regularly scheduled meetings for review and action as required. **Responsible Person(s):** Infection Control Officer Infection Preventionist at each individual hospital DMC Board of Directors DMC Chief Operating Officer DMC Chief Medical Officer DMC Chief Nurse Executive DMC VP of Regulatory and Accreditation Compliance VP of Service Excellence and Community Affairs Director of Peri-Operative Services Unity Health Trust Management General Manager of Sodexo Environmental Services **Disciplinary Action:** Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.	10/28/16 and ongoing

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A 748	Continued From page 6 Staff R was also queried as to the availability of supporting documentation for what was covered during the remaining 15 training sessions. No additional documentation was available for review. On 8/29/16 at 1100, during observations at the end of surgery for Patient #8, Staff AA was observed collecting the surgical instruments and equipment at the end of surgery. Surgical instruments that were visibly contaminated with blood were observed resting on a table. The instruments were not wiped off or soaked to prevent tissue and blood from drying on the instruments. Staff AA collected the surgical instruments and piled them on top of each other in the instrument containers without wiping off the visible blood. On 8/29/16 at 1115, Staff AA sprayed the top of the visibly bloody instruments in each container with an enzymatic spray and closed the containers. The instruments were not completely saturated with the enzymatic spray, and were not covered with a moist towel before the containers were closed. On 8/29/16 at 1120, Staff AA Placed all the instrument containers from Patient #8's surgery into a case cart and took the cart to the hallway. At this time Staff AA was asked how surgical instruments were initially processed by the operating room (OR) staff before they were sent down to Central Supply Processing (CSP) for sterilization. Staff AA stated, "We mainly spray the bloody spots. We never wash or soak the instruments in the OR, just spray them with the (enzymatic spray product) and hold them in this cart until they do the massive cleaning	A 748	**Tag: A748** **Response:** The Detroit Medical Center's (DMC) Chief Operating Officer and Chief Medical Officer, have created a DMC Perioperative Improvement Council to oversee perioperative services on behalf of DMC hospitals including Detroit Receiving Hospital (DRH). This Council is composed of representatives from the following departments of each hospital: DMC Board, Executive leadership, Surgery, Infection Control and Epidemiology, Central Sterile Processing, Operating Room, DMC Project Management, as well as Unity HealthTrust, and North Star Anesthesia. The Perioperative Improvement Council will meet monthly to review reports from the Perioperative Improvement Task Force and will take actions as needed. The Detroit Medical Center's (DMC) Chief Operating Officer and Chief Medical Officer, have also created a DMC Perioperative Improvement Task Force who is responsible for development and implementation of performance measurements for all perioperative services including Central Sterile Processing, with a focus on aseptic cleaning procedures of operating rooms and the cleaning, processing and sterilization of surgical instrumentation. The Task Force will evaluate compliance with quality control requirements, electronic risk management reports (i.e. incident reports), Immediate Use Steam Sterilization rates, Surgical Site Infection rates and other issues associated with the perioperative environment. The members of the Task Force include: the DMC Chief Operating Officer, DMC Chief Medical Officer, DRH Chief Administrative Officer, DRH Chief Medical Officer, Chief Operating Officer Children's Hospital of Michigan, Chief Operating Officer Sinai Grace Hospital, Chief Medical Officer Sinai Grace Hospital, Chief Medical Officer Huron Valley, Regional Chief Nurse Executive, DRH VP Service Excellence and Community Affairs,	9/6/16 9/6/16

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A 748	Continued From page 7 downstairs." On 8/29/16 at 1145, Staff V was interviewed during setting up of surgical instruments on the sterile back table before surgery, and stated, "I always check inside (holding up hollow instrument). I've had it come up dirty before. The drill guide needs to be taken apart and cleaned inside. I always check it. Blood that's been through the autoclave (sterilizer) is easy to see because it's black." On 8/29/16 at 1505 the OR Nurse manager, Staff I was interviewed and reported that during surgery, Surgical Technicians were supposed to wipe tissue and blood off of instruments with a sterile towel and irrigate (force sterile water through) any blood or tissue contaminated hollow instruments, and soak used instruments in a bucket of sterile water to keep blood and tissue from drying into the instruments. On 8/30/16 at 1230 the hospital epidemiologist, Staff O was interviewed and stated that no infection control audits or direct observations of point of use initial cleaning of OR instruments had been done since 2015. On 8/30/16 at 1330, the OR Nurse Educator, Staff FF was interviewed and stated that OR staff were supposed to wipe visible blood and tissue off instruments with a sterile towel as soon as possible during surgery, and were supposed to soak used instruments in a bucket of sterile water and spray out cannulated (hollow) instruments as soon as possible. Staff FF stated that staff were supposed to wipe off all visible blood and tissue, spray with (enzymatic spray product) and cover them with a moist towel before packing the	A 748	Unity Health Manager of Central Sterile Processing, DMC VP Accreditation and Regulatory Readiness, Infection Control Officer, Regional Medical Director of Infection Control and Epidemiology. The Perioperative Improvement Task Force will meet daily until all corrective actions have been fully implemented and monthly thereafter. The Task Force will report its findings to the Council on a monthly basis. **POLICY & PROCEDURES:** The Chief Nurse Executive, Chief Medical Officer, Infection Control Officer, and Central Sterile Processing Manager reviewed and revised the policy regarding cleaning procedures between cases and the pre-treatment of surgical instruments post surgery, and central sterile processing (2 IC 016 "Cleaning, Disinfection and Sterilization Guidelines). This comprehensive policy is inclusive of content from the Association of Operating Room Nurses and the Association for the Advancement of Medical Instrumentation, and addresses initial pre-cleaning of instruments, safe transportation of pre-cleaned instruments, as well as disinfection and sterilization processes. Beginning October 1, 2016, the Infection Control Officer or designee will conduct an annual review all infection control policies and procedures and update as needed. The Perioperative Nurse Educator and the Director of Infection Control Officer reviewed and approved Hospital training guidelines contained in the Employee Development binder and the Sodexo Operation Manual (contracted Environmental services provider) and all hospital policies specific to surgical areas including: Between Case Cleaning, End of Day Terminal Cleaning, and Cycle Cleaning.	9/15/16 9/15/16

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A 748	Continued From page 8 instruments into the containers. ON 8/30/16 at 1400, Staff FF provided documentation of an OR staff inservice (training) entitled, "Instrument Care Post Procedure", held on 7/20/16. Review of the inservice minutes revealed the following Association of Perioperative Registered Nurses (AORN) guidelines were covered during the inservice: "Instruments must be cleaned and decontaminated as soon as possible after use. Preparation for decontamination of instruments begins at the point of use. Instruments must be kept free of gross soil during the procedure. During the procedure, the scrub person should remove gross soil from instruments by wiping the surfaces with a sponge and water. Instruments must be kept moist until they are cleaned in CSP. Spray (enzymatic spray product) and cover with a towel moistened with water." On 8/30/16 at 1420 The Manager of Patient Care, Staff DD was interviewed and reported that broken, missing and contaminated instruments was a process improvement project in 9/24/15. Review of the provided Process improvement project event goals dated 7/10/15 indicated that "bioburden" (blood and tissue) was one of three number one quality concerns. An attached e-mail provided with the Process Improvement information, dated 6/23/15 at 1100 documented a goal as "no bioburden". Review of an attached OR staff inservice dated 8/5/15 revealed the following items in the inservice outline, "The department was held responsible for returned dirty case carts that were noted grossly bloodied... and instruments "thrown into pans or basins. Keep instruments debris free, flush	A 748	**Corrective Actions:** The DMC Infection Control Officer and the Infection Preventionists responsible for the individual hospitals have reviewed and approved all training and competency documents to assure alignment with DMC Infection Control Policies A review of all employee files for Central Sterile Processing staff was conducted to identify individuals requiring additional training, education and competencies. As noted above, 100% of employee competency has been conducted, and is now documented in the employee file. The General Manager of Sodexo Environmental Services will continue to be responsible for maintaining the documentation of education and training as well as the annual evaluation of competencies in the Environmental Services employee files. **Training & Competency Assessment:** Environmental Services: The General Manager of Sodexo Environmental Services and his designees provided additional education to members of the Operating Room designated Environmental Services staff and their "relief" staff regarding the proper procedures for Between-Case Cleaning, End-of-Day Terminal Cleaning and Cycle Cleaning. Staff training included infection control, hand hygiene, routine cleaning, and cleaning of surgical/invasive areas and delivery rooms. Any staff member absent during the training period will not start their next shift until after his or her training and competency assessment is completed and documented. Documentation of the training and competencies are noted in the TRAKKAR electronic system which is maintained by the contracted vendor. This information is readily available to the facility.	9/15/16 9/1/16 9/8/16

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A 748	Continued From page 9 suction tips and tubing and clean used instruments when no longer needed. Pre-soak instruments to prevent blood and debris from drying on the instruments and spray with enzymatic pre-cleaning solutions." On 8/30/16 at 1430 Staff DD was asked whether audits of point of use surgical instrument cleaning and decontamination were done. Staff DD stated, "Doing audits has been a problem." When asked about this, Staff DD stated that residual bioburden on surgical instruments was a lower priority problem than the other two problems identified for process improvement, so no audits were done in 2016. When asked how surgical instruments should be cared for in the OR before they were sent down to CSP, Staff DD stated, "Instruments should be soaked or wiped down during the procedure to remove bioburden. I should keep instruments moist by covering with a towel and spraying with (enzymatic spray product) before they're sent down to CSP." Staff DD was asked if there was a policy for point of use cleaning and decontamination of surgical instruments and the following were provided: A facility Epidemiology document dated 4/2015, entitled, "Medical Equipment Pre-Cleaning Concepts" noted the following, "Medical equipment should be cleaned immediately after use because dried blood, mucous, and other biological material on the surfaces of equipment reduces the effectiveness of disinfection and sterilization." A facility policy dated 12/10/14, entitled, "Pre-Cleaning of Reusable Medical Instruments", noted the following, "Blood and body fluids can cause pitting of instruments and, if left to dry, can	A 748	Operative and Invasive Services: The Chief Medical Officer (CMO), Nurse Educators, Infection Preventionist, and Operating Room Educators developed and trained all OR staff with responsibility for handling soiled instrumentation. Training on the pre-treatment of instruments requiring sterilization by Central Sterile Processing included the rinsing or wiping of bio burden contamination, using the enzymatic product appropriately (the enzymatic cleaner is sprayed onto the soiled instruments), placing of instruments into appropriate containers, and transporting of soiled instruments to Central Sterile Processing. Any staff member absent during the training period will not start his or her next shift until after his or her training is completed and documented. Central Sterile Supply: The Manager of Central Processing in collaboration with Unity Health Trust developed a baseline skills assessment tool for Central Sterile Processing staff. The Manager of Central Processing, the Operating Room educators, Central Sterile Processing educators and supplemental Central Sterile Processing staff implemented the tool and completed the baseline assessments for Instrument Associates which included Prep and Pack, Decontamination, Case Carts, Sterilization, Repairs /replacement stock. The assessment for Central Supply Associates addressed Disinfection, Decontamination, Case Carts, Peel Packs, and Case Cart Delivery. Competencies have been completed and documented. The Chief Executive Officer engaged an external central sterile processing education and training resource (IMS) to provide on-site training modules that can be used to provide additional training of Central Sterile Processing.	Training 9/29/16 Training 9/29/16 9/13/2016

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A 748	Continued From page 10 be difficult to remove. If blood and body fluids are not removed, they reduce the effectiveness of high level disinfection and sterilization. As soon as it is done being used, equipment should be soaked to keep it from drying out." On 8/30/16 at 1440 the director of the facility's CSP contracted provider Q was interviewed regarding CSP expectations for OR cleaning and decontamination of surgical instruments and stated, "Gross contamination should be cleaned off, lumens (hollow centers) cleaned out. The instruments should be placed in the tray they came in on on top of a towel and sprayed with (enzymatic spray product) and covered." On 8/29/16 at 1125, during observations at the completion of surgery for Patient #6, Staff Z brought the case cart from the Operating Room to the area outside of the soiled utility room. At approximately 1130 Staff JJ transported the case cart to the Central Sterile Processing (CSP) Department. Upon arrival to the decontamination area of CSP the case cart was opened, all instrument sets appeared dry, without evidence of enzymatic foam spray having been applied. Staff II confirmed the instrument sets had not been sprayed with enzymatic foam spray. Staff II stated, "All instrument sets are suppose to be sprayed before leaving the Operating Room and coming to CSP." On 8/29/2016 at approximately 1200 surveyor examined the contents of three (3) sterile instrument sets that were stored on supply carts, available for patient use when requested for surgical cases. One (1) of three (3) sets examined, a Neuro Surgical tray, contained multiple weitlander retractors, found in the closed	A 748	Hospital Educators will complete all training (unrelated to cleaning and sterilization in operative areas) identified during the survey as lacking documentation of employee attendance within 90 days. Attendance will be documented in employee files. **MONITORING:** The Infection Control Officer and hospital assigned Infection Preventionist conduct weekly monitoring of Operating Rooms and Central Sterile Processing using the following audit tools: Operating Room Infection Control Surgical Review Tool, Environmental Services Operating Room Survey Infection Prevention Tool, and the Sterile Processing Tracer Tool. Designated, trained Residents, Fellows and Quality staff monitor all hospital-based units and clinics, as well as non-hospital-based units and clinics (e.g. offsite clinics) on a weekly basis using the Soiled Medical Equipment & Instrument Pre-cleaning Infection Prevention Audit Tool (aka "SIP" tool). The above monitoring will be conducted weekly until 100% compliance is achieved for four consecutive months at which time the monitoring will be monthly. Monitoring encompasses every operational unit that participates in sterilization and disinfection across Detroit Medical Center. The Executive Team (Chief Executive Officer, Chief Administrative Officer, Chief Medical Officer, Chief Nursing Officer, Chief Financial Officer, and Chief Operating Officer) monitor all hospital based ORs, sterile processing, and hospital-based units and clinics through executive rounding on a weekly basis, beginning September 16, 2016, as part of the hospitals performance improvement activities. The Executive Team will document and communicate outcomes immediately to the unit/department manager, and verbally the next	10/28/16 Ongoing 9/19/16 and ongoing 9/16/16

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A 748	Continued From page 11 position with instrument surfaces touching. The Director of Clinical Operations (HH) and the Owner (GG) of the newly hired management organization, for the CSP Department, were present and confirmed the set had not been properly sterilized. According to Perioperative Standards and Recommended Practices of the Association of Perioperative Registered Nurses (AORN); 2013: 485-504, "All hinged instruments should be sterilized in the open position ... The rationale behind the practice is to expose all surfaces to the sterilant."	A 748	day with the management team. Monitoring will continue for four months and at the end of four months this process will be re-evaluated by the Executive Team to determine the frequency of future monitoring based on compliance results. The Unity Health Director and Managers of Central Sterile Processing began daily Quality Control checks on September 19, 2016. The quality control checks include inspection of instruments for cleanliness, rust, lack of bio burden, and proper positioning (open verses closed); inspection of retractors, heavy instruments and strung instruments for functionality; evaluation of the use of tip protectors. These checks will continue on a random basis for the next four months. Unity Health Trust Operating Room Liaisons assess Operating Rooms on a daily basis using the Operating Room Liaison Tracking Tool. Assessment includes Operating Room trays, Operating Room case carts, and Operating Room post-case pre-cleaning processes. The Operating Room Liaisons will document outcomes to Unity HealthTrust management daily. Assessments will continue until there is 100% compliance for a minimum of four consecutive months. After reaching sustained compliance for four consecutive months the monitoring process will be reevaluated by the Perioperative Task Force. Beginning October 10, 2016 the Operative Room Managers will review cleaning logs weekly for four months to verify the cleaning of surgical suites is documented as outlined in policy. Environmental Services Supervisors randomly observe 100% of environmental employees cleaning surgical suites between cases to confirm that cleaning is completed according to policy. Any identified issues will be addressed through 1:1 re-training. Observation will be performed weekly until compliance has been achieved for four	9/19/16 and ongoing 9/1/16 10/10/16 9/6/16 and ongoing

consecutive months at which time the activity will be re-evaluated. Audit results and non-compliance with the policy will be reported monthly to the General Manager of Sodexo Environmental Services for review and action as required.

The results of all audits are sent to the Director of Clinical Quality Improvement for each hospital. The Director of Clinical Quality Improvement reviews and analyzes the data. This information is sent to the DMC Director of Quality for aggregation and analysis. Results are reported to the site Chief Operating Officer; Regional Chief Nurse Executive; the Infection Control Committee, Environment of Care Committee, Leadership Performance Improvement Coordinating Committee (LPICC) Perioperative Task Force; the Perioperative Council; the Joint Conference Committee and ultimately the Governing Board at their regularly scheduled meetings for review and action as required.

Responsible Person(s):
Infection Control Officer
Infection Preventionist at each individual hospital
DMC Board of Directors
DMC Chief Operating Officer
DMC Chief Medical Officer
DMC Chief Nurse Executive
DMC VP of Regulatory and Accreditation Compliance
VP of Service Excellence and Community Affairs
Director of Peri-Operative Services
Unity Health Trust Management
General Manager of Sodexo Environmental Services

Disciplinary Action:

Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human
Resources policies and procedures.