

## ➡ **Environmental “Flash” Tour:**

Purpose - To observe the patient care-related areas for conditions which may have immediate impact on patient safety in infection control, physical environment hazards, serious lapses in equipment and building maintenance, and availability of emergency equipment.

**Observe these four patient-related areas of the facility:** *This is a “flash” look at the patient-related areas listed below, looking for observable indicators of patient safety concerns.*

**Ask staff about the facility “culture of safety”** *in the patient-related areas listed below. Early in the survey is a key time to begin to look for evidence of a culture of safety in the facility. Getting an idea of whether the facility culture supports open communication, clarity for staff on the expectations of their roles, and all levels of staff engaged in identifying and effectively addressing risks and errors in its operations is important to evaluating the strength of the QAPI program and how patients are protected from recurring medical errors. To help understand the role the direct care staff play in this process asking technicians and nurses about actions taken when errors or “near misses” occur can demonstrate if the program is active and effective. Asking staff questions about the facility culture early in the survey is recommended.*

### ***Examples of questions for staff:***

- What can a technician or nurse here do to prevent or reduce treatment errors?
- What errors or near misses are staff expected to report?
- Do you feel comfortable reporting errors, or making suggestions for improvement at the facility?
- How and to whom would you report an error or near miss you observed or were involved in?
- Would your reporting responsibility be different if you made the error or near miss or simply observed it?
- How would you expect the error or near miss to be addressed? What is your role in follow up?
- How are you involved in the QAPI program? What are the goals and activities of the QAPI Team?

**In-center dialysis patient treatment area - *Observe a sample of 25% (minimum of 3) dialysis stations with patients undergoing treatments and the availability and functionality of emergency resuscitation and evacuation equipment. Observe the patient, their vascular access, and the surroundings of the dialysis station. This is a “flash” look, and not a verification of their dialysis prescription delivery, which is done during “Observations of Hemodialysis Care and Infection Control Practices.”***

### ***Triggers for citation or more investigation of concerns:***

- Dummy drip chambers present in the patient treatment area (V400, 403)
- Patients' vascular accesses covered, not consistently uncovered/corrected by staff (V407)
- No RN on duty (V759)
- Clear evidence of poor staffing, e.g., machine alarms not answered, patients not regularly monitored, no dietitian or social worker currently on staff (V757)
- Blood spills not immediately cleaned; equipment and/or surfaces visibly spattered with dried or wet blood (V122)

- HD machine transducer protectors wetted with blood not changed - *observe/interview staff regarding the practice of inspecting the internal transducer for blood prior to machine use for another patient* (V120)
- Insufficient space to prevent cross-contamination and use emergency equipment (V404)
- Functional emergency resuscitation equipment (i.e., AED/defibrillator, oxygen, suction, emergency medications, Ambu bag) not present (V413); emergency evacuation equipment insufficient or unavailable (V415)
- Hemodialysis machines in obvious poor repair (e.g., alarms not functional, missing components) (V403)
- If dialyzer reuse, strong germicide odors noticeable in patient treatment area (V318)
- Disrespectful communication, e.g., rude, demeaning, harassing, name calling, loudly calling out weight; disrespectful or punitive actions toward patients, e. g., physical or chemical restraints, involuntary seclusion (V452, 627)
- Failure to offer patients confidentiality when discussing their condition/treatment; failure to protect the patients' confidentiality by allowing exposure of patients' sensitive body parts during procedures (V454)

**Water treatment/dialysate preparation area - *Observe the carbon system, the chlorine testing equipment and reagents, and current day/shift total chlorine test results. Look at the alarm/monitoring systems for the reverse osmosis (RO) and/or deionization (DI) components, and the dialysate concentrate proportioning ratios listed on the packaging.***

***Triggers for citation or more investigation of concerns:***

- Carbon system: 2 or more carbon tanks, with sampling port between not present (V192), current shift total chlorine test not done, testing reagents not sensitive to 0.1mg/L total chlorine, expired or don't match testing equipment (V196)
- RO: absence of functioning water quality monitor; no audible alarm in patient treatment area (V200)
- If DI is present: absence of functioning resistivity monitor, no audible AND visible alarm in patient treatment area, absence of automatic divert-to-drain or automatic cut-off valve to stop water flow to the dialysis stations if resistivity falls <1 megohm, DI not monitored twice/day (V202, 203)
- Water distribution equipment in obvious disrepair or contaminated state, e.g., the presence of algae or discoloration of water (V403)
- Acid and bicarbonate dialysate concentrates of different proportioning ratios present - *interview staff regarding the use of the different concentrates and verify only matching ratios are used with machines programmed to that ratio* (V249)
- Acid or bicarbonate dialysate concentrate mixing and distribution equipment in obvious disrepair or contaminated state, e.g., algae (V403)

**Reuse room - *Observe the condition of the reprocessing equipment, dialyzer storage, and dialyzer refrigerator, if present.***

***Triggers for citation or more investigation of concerns:***

- Stored reprocessed dialyzers aesthetically unacceptable, e.g., header caps full of blood, leaking, port caps off (V343)
- Stored dialyzers not protected from unauthorized access (V321)
- Reprocessing room or equipment in obvious disrepair (V318, 403)
- Dirty dialyzers kept at room temperature >2 hrs. before reprocessing (V331)

- Dialyzer refrigerator temperature not monitored (V331)

**Home dialysis training area - *Observe the physical layout, infection control and availability of emergency equipment with method for summoning immediate assistance.***

***Triggers for citation or more investigation of concerns:***

- Insufficient space in home dialysis patient training area to prevent cross-contamination between patients if >1 patient trained at a time (V404)
- Insufficient methods to provide home dialysis patient privacy (V406)
- Blood or PD effluent spills not immediately cleaned; equipment and/or surfaces visibly spattered with dried or wet blood or PD effluent (V122)
- No functional emergency resuscitation equipment present or immediately available (V413)
- No method for summoning immediate assistance for patient or solitary staff (V402)

***Extending the tour to other areas of the facility - Consider looking at other patient-related areas of the facility, e.g., waiting room, patient bathrooms, supply storage room, hazardous waste storage, laboratory area if you observe:***

- Evidence of serious lack of environmental maintenance that has the potential to impact patient safety, e.g., large areas of water damage, presence of mold in the patient-related areas; uneven/broken floor surfaces creating multiple trip hazards where patients ambulate (V401, 402)

