CASE STUDY

Dirty Surgical Instruments Lead to Immediate Jeopardy

Problem

When a patient enters a hospital for surgery, they expect their surgeon to operate with clean instruments. This expectation was not always met at a large hospital in the Rocky Mountain Area.

After an anonymous report questioning the sterility and condition of the surgical instruments at the facilities was submitted to the state, a Centers for Medicare and Medicaid Services’ (CMS) investigation found the presence of bioburden and non-medical items in instrument trays. Due to the errors in the sterile processing department and other concerns identified throughout the facility, the hospital was placed into Immediate Jeopardy and had 15 days to respond with an action plan or face loss of their CMS Deemed status. The loss of status would result in ineligibility for Medicare and Medicaid reimbursement, costing the hospital up to $10 million each year – a loss that could lead to facility closure.

Solution

As a member of ECRI Patient Safety Organization, the hospital reached out for assistance in establishing their action plan. With such a short timeline, the ECRI liaison had to act fast. Through onsite evaluation, the sterile processing expert was able to identify out-of-date policies and system bottlenecks. They discovered improper device utilization, technology gaps, and lack of understanding of the basics of infection prevention all of which contributed to failures in the sterile processing department, putting patients at risk of surgical-site infections.

Working with the hospital, the ECRI liaison helped to redesign the sterile processing department to maximize efficiency and workflow. Policies and procedures were rewritten to incorporate best practices, new policies were created where there was a deficiency noted, new technologies were scheduled to be implemented, and educational programs for staff were developed.

To ensure compliances with the identified action plan, weekly calls with the ECRI liaison were established.

Result

CMS reviewed and approved the hospital’s plan for improvement. Upon the onsite inspection 30 days after implementation, the member was able to maintain their CMS participation, their Deemed status was restored, and their doors were kept open. In the end, their CMS reimbursement of approximately $10 million per year was minimally impacted.

After this event, the member recognized that their sterilization processing department issues spanned multiple facilities. To ensure the safety of their patients, the health system began taking steps to implement ECRI’s technology, process, education, and procedure guidance at all their facilities.

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