Conducting a Mock Survey in the ASC

Marcia Patrick, RN, MSN, CIC, FAPIC

Mock surveys are a good way to assess readiness for a CMS or accreditation survey. The goal is continuous readiness, not preparing for the survey. The CMS and accreditation requirements are all about patient and staff safety, so should be followed all day, every day. It can be helpful to ask a colleague from another facility to do your mock survey- fresh eyes are a real asset.

A good starting point is the CMS Infection Control Surveyors' Worksheet- this is what the surveyor will use. Review this and use it to determine where your facility is compliant and where work needs to be done. There are also evaluation tools- one will be provided at the end of this article. If you're having an accreditation survey, know the IP requirements of your survey organization.

As part of the CMS Worksheet, you are asked to write down the nationally recognized guidelines you are following. Be careful here- it's best to indicate the chapters you follow, not the whole guideline. For example, AORN Guidelines for Perioperative Practice has many chapters, some of which do not apply to ASCs, and some that are specific for ASCs. Note the chapters you are basing your policies and procedures on, not just the whole thing. Otherwise, the whole thing is fair game for the surveyor. Same with the CDC Guidelines- for most ASCs, the Guideline for Prevention of Intravascular Device-Related Infections is only applicable for your peripheral IVs, as central lines aren't usually used. The new, 2017 SSI Guideline would be applicable.

Organization of your documents is important. One approach is to have a survey book containing the documents important to your program. These might include:

Your infection control program document that includes a description of your facility and patients;

The risk assessment that weighs and prioritizes the risks identified. There are many tools available on the internet for this. Remember this is a living document that changes as risks are eliminated and others added;

Risks selected to work on. For each, a goal and measurable objective(s) to fix the problem or reduce the risk; (this becomes the basis of your program!)

A dashboard that shows progress on the goals and objectives;

Minutes of the committee or group that oversees the infection prevention function in your facility. Remember to include approval of infection prevention policies and procedures on a schedule- these can be listed in the minutes. If there is contention or an issue, that can be called out in the minutes along with the decision that was made. Anything OSHA- Bloodborne Pathogens Exposure Control Plan, TB Exposure Control Plan, Hazard Communication (not infection prevention!) must be reviewed and approved ANNUALLY!

Surveillance data- the graphs or reports for the surveillance you are conducting, these may be monthly or quarterly, depending on your reporting schedule and frequency of the committee meeting;

Infection Prevention Manual or IP policies and procedures. This may be in a separate binder.

The advantage of having everything in a binder or computer file is that if you are not there when there is an unannounced survey, everything is available for the surveyor.

Surveillance

Surveillance is a required component of IP programs. Outcome surveillance looks at the outcomes of care- patient falls, med errors, wrong side, wrong site surgery, and infections related to procedures performed at your facility. The first ones aren't IP-related, just examples of outcomes. Surgical site infections are the most common, but some facilities put in central lines, so that might be an indicator they monitor, or in urology, urinary tract infections related to cystoscopy, etc.

It is VERY likely that by 2020 CMS will require ASCs to report SSIs through NHSN, the National Healthcare Safety Network at CDC. It's the largest infection database in the world and it's FREE! ASCs are already registered to report their compliance with flu immunization. Take a look at the NHSN website- it makes sense to register to report a surgical procedure- hernias, breasts, etc. Not all procedures are in NHSN, cataracts, for example, but other organizations have data bases you can join for a nominal fee and report to so you can benchmark against the larger group. For cataracts, AAAHC has a database and you don't have to be accredited by them. ASCA has some databases as well. Pick ONE high-volume, high-risk or problem prone procedure and start reporting. Then when the requirement comes, you'll be ahead of the game. Surveyors want to see what you're monitoring and that the results are compared to a national database.

So, for GI facilities, there are rarely infection issues related to endoscopy other than those terrible outbreaks of multidrug-resistant organisms related to improperly processed scopes. So, in this case, a process indicator would make more sense. Process indicators measure the processes of care- in this case, processing of endoscopes because we know this can be a problem. This monitoring would include thorough orientation and training on correct processing of each type of scope used in your facility, according to the current manufacturer's instructions, each and every time.

So, a checklist for each scope type, knowledgeable trainer, oversight, especially at the beginning to ensure proper procedures are followed, periodic monitoring of practice, using a checklist, and periodic, unannounced monitoring of EVERYONE responsible for scope processing. Check for proper equipment, cleaning supplies, PPE, quality monitoring- temp, minimum effective concentration (MEC) and QC of the dipsticks used for this and logged, the cleaning time and soak time, any cleaning quality measures you use, and blowing channels with alcohol and air at the end.

Or, proper functioning of the AER, required user and tech maintenance documented, MEC checked, thorough brushing of the scope and accessories, checking cleanliness before placing in AER, proper connections made between the scope and the AER, proper cycle run and completed, etc.

Set a number of checks you'll do (or whoever is going to do this) per month or quarter and be sure to check various employees. Sometimes shortcuts or work-arounds crop up and need to be extinguished ASAP. Posting the processing requirements can help as it provides a visual checklist for the techs. Be aware of the docs pressuring techs to get the scopes out faster- this can lead to skipping steps, not meeting the soak time on the HLD chemical label, etc. We all want the same thing, great outcomes for

our patients, safety for staff, and shortcutting steps will not do this. Get administration involved if this is an issue.

Be sure your staff know the surveillance you're doing and the IP issues you monitor, WHY that item is being monitored and how you're doing. If you present this at the monthly staff inservice, they should be able to tell the surveyor about it.

The Surveyor

ALWAYS be kind and polite, even if they are being awful. Sadly, sometimes they are. If they ask something you're not sure of, ask them to clarify. If they say something off the wall, for example, "Privacy curtains must be laundered monthly." (not true!) POLITELY ask them if they could tell you where that requirement exists as you'll have to provide it to your administrator to support the change in practice. "Can you tell me where that requirement is? I haven't come across it yet." For some surveyors, IP is threatening as they aren't experts in IP. Don't threaten them, it goes badly. Remember that you can include in your response to the written report that such a requirement doesn't exist, or the actual wording that supports your policy and procedure. Most accreditation organizations review the preliminary report of the surveyor and can catch those errors before the final report is written and sent to you. If you're new, tell them and ask them if they'd be so kind as to make any recommendations they see that would improve the program. **Don't forget the IP has to have education in IP- the APIC ASC Courses are a great resource!**

Environmental Cleaning

The facility should appear clean, neat, tidy and organized. Look for high and low dusting- air duct grilles must be clean, no dust on high surfaces like privacy curtain rails, tops of cabinets, etc. If carpets need cleaning, get this done. Carpet should always appear clean- it really isn't a good surface for healthcare. There are wonderful sheet vinyls that look like hardwood but are very easy to maintain, and easier to push gurneys across.

Get rid of clutter, no longer used equipment, supplies and junk.

Chemical germicides must be approved by the EPA for hospital use, search EPA-registered hospital disinfectants to check, as well as the label on the container. Be sure staff know the wet contact time for the chemical germicide you're using- and follow it! If the product requires dilution, staff must know the correct proportions of water and product and a measuring device used, not the eyeball method. If using a calibrated pump, check it periodically to ensure it is delivering the correct amount, log this to show you're checking. Weekly would be the longest time interval, daily is better.

Standardize cleaning procedures so everyone does things the same way. Elbow grease is necessary. If using pop-up wipes, be sure a wipe is used only on one surface. It cannot be used on the bed and then the overbed table. For larger surfaces, more than one wipe is necessary. If the surface dries before the label-indicated wet contact time, the surface must be rewiped to ensure the full contact time is met.

Privacy curtains must look clean. There is no standard for laundering or dry cleaning these, have a policy and follow it. Use of plastic pull rods or clip on handles can extend the clean life of the curtain.

Instrument/Scope Reprocessing

This is a point of focus in surveys. The surveyor will get into scrubs and observe at least one surgical procedure and/or endoscopy, and instrument reprocessing.

Instruments/scopes must be wiped or rinsed to remove debris before being taken to the decon area- this is a hot button for surveyors. It is to prevent formation of biofilm on devices. There are spray products that will keep instruments wet for various time periods- keeping them moist until processed is critical. This is especially important if instruments are shipped out for processing. For scopes, the outside must be wiped down and channels flushed before leaving the room. Instruments and scopes must be transported in a puncture-resistant, lidded, biohazard labeled container IF SHARPS ARE INVOLVED. Bags are OK for scopes as long as there is nothing sharp that could cause injury during transport. Some surveyors insist on a rigid container for scopes, but the requirement is from OSHA Bloodborne Pathogens and is for sharps. If buying new, I'd go with rigid containers.

In the decon area, or soiled utility room, flow of instruments must be from dirty to clean with no crossovers, no chance of mixing up a clean and dirty instrument. There needs to be a separate clean room, ideally with a pass-though window. The soiled side should have negative air pressure relative to the hall, and the clean room, positive pressure. If you don't have this, put it on your risk assessment!

Instruments and scopes must be thoroughly scrubbed, including channels, to remove all debris. Proper equipment is necessary- the correct brushes, chemicals, etc. If brushes are disposable, they must be discarded per manufacturer instructions and not used for multiple scopes. Many facilities are checking cleanliness using a borescope, ATP or other indicators to ensure scopes are clean. Given the problems with duodenoscopes, this is a must for these complex scopes, and highly recommended for all others. The most current manufacturer cleaning and processing instructions must be readily available in the processing area. Some scope manufacturers have posters that can be hung in the processing area for the tech to refer to.

High-level disinfectants are approved by the FDA -search FDA-approved high-level disinfectants to get the list. Not all HLDs are the same, different products with the same active ingredient may have different soak times and temperatures. Log the solution temp before each use. An external heat source may be necessary to maintain the HLD at the label-designated temp. Follow the soak time on the label- use a timer. The timer is set when the last item is placed in the solution. If an item is added after the timer is set, reset the timer to the full soak time. Floaters aren't allowed- syringes used for cleaning and flushing are single use and cannot be HLD.

Instruments must be packaged in the correct package for the type of instrument and the sterilization method. Sharp points must be protected, there are cards that will protect points and keep hinged instruments open. AORN has a chapter on packaging.

Sterilizers must be used per manufacturer instructions. The quality assurance monitors- physical, chemical and biological must be used and documented. Physical monitors are the time, temp and pressure- there MUST be a printout from the sterilizer for each load that is initialed and filed, showing it was checked before the load was released. The external indicator, usually autoclave tape, must change. This does NOT prove sterility- it just says the package was exposed to heat. The internal indicator, placed in the densest, most difficult place to sterilize within the set or tray, must also change, and the

tech or nurse setting up the instruments must check for this before the case begins. If it fails, the set is not sterile and must go back to decon and be completely reprocessed.

Biological indicators must be run at least weekly, or each time the sterilizer is used if less than weekly. Most ASCs use the capsules with an incubator method. You must have a written procedure for biological failures. It may require recalling of all the instruments since the last good load, and many have probably been used on patients. Daily biologicals will give you a quicker alert that there might be a problem, and running one with each load will ensure a non-sterile instrument will not reach a patient.

Competency evaluations on all staff processing scopes or complex instruments, including the fill-ins for illness or vacation, must be on file. These are done on hire, spot checked periodically, when changes to procedures or processes occur, and at least annually. This must be done for each different type of scope and complex instrument used. Manufacturers may have checklists for these.

Designating someone to oversee processing is a way to ensure consistency and safe instruments and scopes.

Operating Room

OR attire will be a focal point on survey. Is hair covered? Are you following the guideline you designated? The chapter on Surgical Attire in the AORN Guidelines for Perioperative Practice is probably the best one to follow. SHEA also has one for non-OR attire, available on their website. Another hot button is covering hair- lots of controversy about this, but if your plan says you're following AORN, you must follow it.

Between case cleaning must be consistent, wet contact time met, a checklist is a good way to ensure everything is cleaned properly. End of day cleaning also, and if following AORN, follow it to the letter.

Minimize OR door opening, people coming in and out- traffic reduction and use of intercoms or phones can help reduce this traffic.

Surgeon hand preparation must be in accordance with the products being used. Many facilities now use an alcohol-based handrub labeled as a surgical hand prep. This must be used per label instructions.

Tape for surgical dressings: single patient use, or the circulator with clean hands obtains the roll from the drawer, pulls off the desired amount of tape and hands it to the scrub tech or whoever will apply it, then returns the tape to the drawer. The roll should never go to the table where it may be touched with contaminated gloves or to the patient's skin, prepped or not.

Ultrasound performed in open cavities during surgery is a sterile procedure. The probe should be sterile or at a minimum, high-level disinfected and used with a sterile sheath and single-use sterile ultrasound gel.

Anesthesia

Another area of focus on survey. The hot buttons are use of single- and multidose med vials and prepping ports before injecting. Look in the anesthesia cart: there should NEVER be an opened single- or multidose vial. SDVs are for one patient, then discarded. Multidose vials accessed in the direct care area, including the OR and the anesthesia cart, become single patient use and must be discarded at the end of the case. Needles and syringes are single use. This is required by CDC Safe Injection Practices and

is on the CMS worksheet. (The OR and anesthesia cart are considered patient care locations regardless of where the cart is, or the presence or absence of a patient in the OR,)

There should be a pump bottle of ABHR on the anesthesia cart for hand hygiene.

Be sure there is cleaning of the cart between patients- anesthesia personnel often access the drawers with contaminated hands during a case, so the hand-touch surfaces and the top of the cart need to be disinfected between patients. If there is a towel on top of the cart, it must be changed between patients. Tape for the ET tube should be torn and hung on a clean surface to avoid contaminated gloves coming in contact with the roll of tape that will be used on others.

USP 797, endorsed by CDC, says meds drawn into a syringe must be injected within one hour of drawing. This means if your anesthesia person draws up all the potential emergency meds that might be needed, if not used they all must be discarded at the end of that case and redrawn for the next. Many just keep the sealed MDVs and SDVs in the cart, which is fine. CDC: one needle, one syringe, one patient, one time.

Preop/Postop

Hand hygiene between patients is a must- ABHR is the preferred method in both the CDC Guideline for Hand Hygiene, 2002, and the WHO hand hygiene guidelines. It must contain 60% alcohol. There are currently no "green" hand rubs that meet this requirement. The good ones have emollients and skin conditioners that help protect the skin. ABHR should be installed about 44" from the floor to the dispensing aperture- this is a NIOSH ergonomic thing.

Personal protective equipment worn when indicated, removed and hands cleaned. Gowns are ALWAYS single use- cannot be hung to reuse. This includes face/eye protection if spraying or splashing is likely.

Separation of clean and dirty is a must. Sink areas can be very contaminated and doing clean procedures near the sink isn't a good idea. Determine the splash zone for your sink by placing paper towels all around it, then turn the water on full blast. The drops on the paper towels will indicate the splash zone, no clean procedures like med prep should be done there. Stainless steel "walls" can be put on the sides of the sink to prevent splashing and reduce the splash zone.

Clean linens must be stored to protect from contamination. It is not acceptable to load up an open cart for the days' worth of sheets and gowns and leave it in the patient care area.

Soiled linens are collected in soiled linen bags. Keeping these small can reduce injuries related to overfilled, heavy linen bags. The bag must contain any moisture from the soiled linens. In most cases, all linens are handled the same way, placed in an imperious bag at the point of use. Linen contractors may have their own requirements. Standard Precautions must be followed.

Blood glucose monitoring can be a problem. First, the monitor you use must be designated for use on multiple patients. Most of the ones from Walgreen's and the like are not designed for this. There must be written instructions for disinfecting the device between patients, not just wiping with soap and water. Some say to use alcohol, not ideal, but OK. Better to buy one that can be wiped with your EPA-approved disinfectant wipe. Self-retracting lancets are required.

Be sure there is a policy and procedure for between patient cleaning of the environment, following label-indicated wet contact time. Gurneys should be clean and dust free underneath. Mattresses must be intact- no cuts, holes, tears, worn seams, etc. Tape, Opsite, etc., cannot be used to repair.

IV bags must be started on the patient within one hour of spiking, so no spiking a bunch of bags the night before or morning of surgery. (USP 797) An IV bag may NEVER be used as a source of flush solution on multiple patients.

There should be a med prep area where MDVs, if used, are accessed that is not in the patient care area. MDVs should not be taken to the bedside, if they are, they must be discarded after single use. MDVs must be dated when opened and discarded at 28 days. There are 28-day med calendars on the internet. Be sure to indicate what the date means- opened or expired, or use both. Don't just date it. The surveyor won't be able to tell if it was just opened or needs to be discarded. Meds should be stored separately- topicals, orals and injectables. Separate by shelf or use labeled containers to separate these. ALWAYS use oral med syringes for oral meds, never use an injection syringe.

Another USP 797 requirement: eye drops must be dated and discarded in 28 days. Containers labeled single patient use are for only one patient. Staff administering eye drops should have a competency evaluation done on hire, periodically and at least annually and documented. Hands must be sanitized and gloves, it used, changed between patients.

For topicals- ointments, creams and the like, buy the smallest practical size and use for a single patient. If using on multiple patients, obtain the desired quantity by squeezing or using a clean tongue blade to remove from the jar and place on a clean 2x2 or 4x4 and take to the patient. Lube (KY jelly) should also be purchased in the smallest practical size rather than large tubes that are used on multiple patients. Don't roll tubes to push up the product- usually the expiration date is printed on the crimp.

Expiration dates are low-hanging fruit. Check EVERYTHING for outdates, there is no excuse for a surveyor finding outdated items. Remember to check emergency carts or boxes. If your crash carts are locked, there should be a note on it with the date of the first item that outdates, so you know when to replace it. Sometimes med manufacturers will extend the expiration date in a shortage, be sure to have that documentation. Some products, like gloves, will have an hour-glass with a date after it- that is an expiration date! Have a policy and procedure for checking outdates- you can write it so items labeled with only a month and year, no day, are good until the end of that month.

Bottles of saline and water for irrigation have no preservatives in them. Most are now labeled "single patient use" or "use on one patient and discard." Be sure you're in compliance. The surveyor should not see any opened bottles of water or saline for irrigation unless in use. Purchase the smallest size practical. Often the price between a liter bottle and the half liter is negligible, sad to say.

Ultrasound used to start IVs is a STERILE procedure as you're accessing the vascular system which is sterile. The probe must be high-level disinfected at a minimum and a sterile sheath, sterile ultrasound gel from an individual container and sterile gloves worn.

Ultrasound on intact skin is a clean procedure, the probe low-level disinfected between uses and a clean sheath used. Bulk US gel is OK, but not recommended as it can become heavily contaminated and result in heavy colonization of the skin, that if incised later, can result in infection.

Trash/Infectious Waste/Sharps

Know your state/local requirements for what is considered infectious waste. Some places, it includes everything that was ever near a human being and others use the federal (OSHA) definition, blood or OPIM caked or soaked, or would extrude or flake blood if compressed. Trash doesn't cause disease unless you get naked, roll in it and have big open sores on your body. Don't do this! There is not a shred of science behind segregating waste, we do it because it's the law, so don't put stuff in red bags that doesn't belong there. Coke cans, pizza boxes, newspapers, OR wrappers don't belong there. It costs 4x as much to get rid of a red bag than a regular bag of trash.

Sharps absolutely can cause disease, so it is important to contain these in puncture-resistant containers at the point of use. Even safety sharps should go in sharps containers, not the trash- just in case the safety feature failed to engage fully. Sharps containers need to be at the point of use, no walking across the room to discard. Containers should be mounted 52-56" from the floor to the slot for standing use.

Employee Health

Policy and procedure for when to excluded employees from work – CDC Guideline for Infection Control in Healthcare Personnel and 2011 CDC Guideline for Immunization of Healthcare Personnel.

Bloodborne Pathogens Exposure Control Plan: sample plans at OSHA website. Write it exactly as the standard is laid out. Include sharps safety devices in use in your facility. Review annually, revise as needed. Sharps devices MUST be used if available- cannot opt out. Front line workers should have input into selection of safety devices. When doing trials, use an eval form and keep to show worker input.

Written plan for post-exposure management of employee contaminated sharps exposures. Most facilities do not have the expertise to manage these properly per CDC Guidelines. Contract with an Occ Med Clinic for this service.

TB program- follow state law, do TB risk assessment- CDC Guidelines for Preventing Transmission of Mycobacterium Tuberculosis in Healthcare Settings. Screen new hires for TB- if documented TB test (must be read in mm, not "positive" or "negative)" in the past year, single test is fine; if not, a two-step is required. One now, if no reaction, repeat in 1-3 weeks and use that result. Some states/counties require HCWs to have annual testing, others only post-exposure testing after the initial screen. Can use Tuberculin skin test- TST (PPD) or BAMT- blood assay for M. Tb. Comparable results. BAMT good if person has had BCG or previous positive test. Never skin test someone who says they sloughed skin from a TB test. For those positive on test, per CDC GL, do single CXR, do not test or X-ray again, screen annually for signs and symptoms, put in EH file.

Employee medical records should not be accessible by administration or management, can be difficult in small facilities.

Staff Education

An education calendar with a monthly IP inservice is a great idea. Do the annual OSHA-required education the same month each year. Annual requirement. Include a short summary of what you presented and have staff sign in. It's a good idea to have an IP orientation checklist for new employees- these will be different for EVS, nursing and the docs.

Front desk staff should know what to do when a patient comes in with an obvious illness- call a nurse to evaluate, give them a mask and tissues for upper respiratory problems, etc. The orientation checklist documents that new hires are properly informed of the IP policies and procedures that affect them and their practice.

Don't forget the docs- see if you can present surveillance data at a docs' meeting and share any issues that you've identified. Again, get the sign in sheet and note what you presented and discussed. EVERYONE must be involved in the IP Program! Or, the person taking the minutes can include in their minutes, just as long as it is documented somewhere.

Emergency Management

CMS now requires (as of Nov. 2017) to have an all hazards emergency management plan AND coordinate with the local emergency management officials and participate in community-wide drills. While not strictly IP, there could be scenarios where you might be asked to care for people after a disaster, including an infectious agent situation. More likely it would be trauma- an ASC could treat the walking wounded and keep them out of the EDs. An eye or GI center maybe not so much- might make sense to close and go help at the hospital. A multispecialty ASC- yes. But that must be coordinated with the locals, so they know your capabilities and what kinds of patients you could see. If no X-ray, probably not fracture patients. If you can't drill with the community, see if you can drill with the hospitals nearby- they probably would be delighted to be able to send ambulatory patients someplace else, so they could focus on the seriously injured or ill.

Miscellaneous

Have documentation of all required user and manufacturer maintenance for each piece of equipment. Have the most current instructions for use and FOLLOW THEM! There is user maintenance on desktop sterilizers that includes removing the racks- if not done monthly, they get VERY hard to impossible to remove, so it's easy to tell if this is being done or not.

If it isn't written down, it didn't happen. Keep good records- follow your state's laws regarding policy, document and medical records retention. For those not covered by law, a good idea is to keep survey to survey. Include in minutes that all the OR quality monitoring was good for the month(s) of… then if the logs are discarded, you have an official record that they were OK. Note exceptions and what was done. This should be a permanent agenda item for your committee.

There are certain patient exposures that surveyors are required to report to the local health authority- things like (as I discovered in one facility) not using a high-level disinfectant for soaking scopes, or using it past the discard date. Using the same syringe and or needle on multiple patients, things that would put them at risk for bloodborne pathogens exposure. Misuse of med vials.

If you find yourself in that situation- the HLD was used past the expiration date, although the MEC was good, YOU should notify the health department. They can assist in determining if the exposure requires follow-up- notification and testing of patients exposed, or not. In the case of the HLD, since it passed MEC, they likely would not advise follow-up. In the case of sharing needles and/or syringes, they would require this. Far better for YOU to report than the surveyor. Sometimes things happen despite our best efforts. The best thing to do is acknowledge the error, perform a root cause analysis, with help from the health department, and implement changes to ensure it doesn't happen again. Being open and honest is

much better than getting ratted out in the press. It is also the right and ethical thing to do for all concerned. In most cases, it is multifactorial, a system failure, rather than one person making a grievous error.

Consider having a communicable disease nurse from the health dept on the committee that oversees the infection prevention function. Surveyors love to see this.

Summary

Preparedness and documentation are the keys. The goal is continuous readiness, patient and staff safety and care free of infection. Infection Prevention is a highly complex specialty and in most cases, the people we work for are clueless about what we do. Using the risk assessment, goals and objectives for the program and for the IP can help communicate to your boss and everyone in the facility what the IP program is about and why things are being done the way they are.

"We've always done it that way" is NOT a scientific rationale. When confronted by others who don't want to change their practice to conform to current requirements, look for IP guidelines in their specialty- both anesthesiology and nurse anesthesiology have IC guidelines, search the internet. Ask them if they have scientific evidence to support whatever bad thing they're doing (because they've always done it that way) and in the absence of decent science, they must follow their professional guidelines and the IP national guidelines adopted by the organization.

NEVER be afraid to whisper in the ear of the surveyor, "When we go to X, take a look at…" whatever it is that you haven't been able to get traction on. A good surveyor will ask, "What can I do for you?" You've brought up the issue in committee, to your boss, etc., so they know this is a risk, and if the surveyor finds it and cites it, it'll probably get fixed! Patient and staff safety are paramount.