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Patient Safety: The Challenge for 2003

Elevated concentrations of fungi and bio-aerosols have been attributed to increased nosocomial infection rates and death.

Infection Control Risk Assessment

Healthcare facilities are constantly making changes to their environment through construction and renovation processes to address an increasing patient population. Construction and maintenance activities can cause potentially fatal infections in patients.

Construction activities produce relatively high concentrations of airborne dust, fungi, and other bio-aerosols. Elevated concentrations of fungi and bio-aerosols have been attributed to increased nosocomial infection rates within populations of patients with weakened immune systems. Even relatively minor work can cause serious infections, if performed near susceptible patients. Infection control is a serious issue, especially during renovation or construction. Printed articles in healthcare journals and local newspapers throughout the world have cited deaths that correlate patient bacterial and fungus contamination with construction activity. Patient exposure to fungus and bacteria during construction and renovation projects will continue to claim lives.

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Medical Communications: More than a Good Idea

In this issue . . .

MEDICAL COMMUNICATIONS IMPACT SAFETY

Speak to any healthcare IT manager and many, if not all, will say that communications systems no longer play a mere support role in facility operations. Rather, they are vital and integral to the success of the organization. Why? Because rapid advances in medical technology and convergence and integration of systems offer incredible tools to caregivers - tools that can enhance efficiency and safety, thereby reducing cost and liability. In today's healthcare climate, facilities cannot afford to ignore the benefits of technology. Survival and safety will depend on their successful application and integration.

Central to this theme is the concept of the electronic medical record. Most every type of patient interaction may be recorded in the digital environment: radiology (PACS), charting, physician orders, lab results, physiological monitoring, and the list goes on. Advances in software integration enable a patient record to be available to multiple caregivers at once. While a true "paperless" facility may not be a current reality, the electronic medical record offers incredible efficiency and accuracy for the organization. The network and communications infrastructure which supports this concept now takes center stage. *(Continued on page 3)*

Patient Safety Standards are a Shared Responsibility Between Leadership and the Environment of Care

GOALS

In July of 2002, the Joint Commission's board of commissioners approved the Joint Commission 2003 National Safety Goals. JCAHO established these goals to address specific areas of concern regarding patient safety. To ensure a greater focus on priority-safe practices, no more than six goals are established by JCAHO for a given year.

For 2003, six National Patient Safety goals were established: two of the goals directly relate to the Environment of Care, as follow:

- **Improve the safety of using infusion pumps:** Ensure free flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization (organization implies: healthcare, ambulatory, LTC, and business occupancies on and off campus where infusion pumps are used).
- **Improve the effectiveness of clinical alarm systems:** Implement regular preventive maintenance and testing of alarms systems. Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distance and competing noise within the unit. Included, but not limited, are: ventilators, infusion pumps, cardiac monitors, elopement/abduction alarms, alarms for measuring hazardous gases (ETO sterilizers, etc.), blood bank refrigeration alarms, medical gases alarm panels, etc.

Although the leadership of the organization is responsible for meeting all six National Patient Safety goals in their organization (CAMH Standard LD.5.2), the two goals shown clearly fall into the domain of Facilities Management.

STANDARDS

The patient safety standards are a shared responsibility between Leadership (LD.5.2) and the Environment of Care (EC.4.1-EC.4.3). Healthcare organizations for many years have been doing an excellent job reducing and preventing potential safety risks in the Environment of Care. The focus of the Patient Safety Standards (which are above and beyond the general safety addressed in the seven Environment of Care management plans and should be incorporated into these plans and programs) is as follows:

- **Preventing infant abductions**
- **Minimizing environmental risk of suicide**
- **Environmental solutions for fall reductions**
- **Appropriate use of restraints**
- **Prevention of wandering in dementia units**
- **Mercury reduction**
- **Reduction in improper storage of flammable substances**
- **Weather-related fall prevention**

For information on developing and implementing an effective patient safety program, contact:

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OSHA EXPANDS THE ROLE OF THE FIRST RESPONDER

Hospital personnel, who are expected to treat contaminated patients during a hazardous material emergency, must receive emergency response training. Hazardous material emergencies include industrial accidents, other chemical exposures, or suspected terrorist acts. According to OSHA's Hazardous Waste and Emergency Response Standard (29 CFR 1910.120), medical personnel, who will decontaminate victims, shall be trained to the "**First Responder Operations Level**." First responders at the operations level shall receive at least 8 hours of initial training or demonstrate competencies in selected emergency response topics. The training should emphasize the use of personal protective equipment and decontamination procedures. First responders must also receive annual refresher training.

If housekeepers or other personnel clean the decontamination area, they shall also receive health and safety training related to their specific tasks. This training includes, but is not limited to, hazard communication, emergency action plan procedures, and respiratory protection.

There are a variety of ways of conducting the training. Hands-on training should be stressed whenever possible. Critiques of incidents (i.e., successes, failures, opportunities for improvement) may be counted as training time. Instructors should be knowledgeable of and have experience with emergency response operations.

For more information on developing and implementing a "First Responder Operations Level" training program, contact:

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Infection Control Risk Assessment

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if an appropriate risk assessment is not completed and utilized to protect patients.

Background

Before 2001, limited regulations or guidelines existed which were pertinent to the design and construction process. To date there have been countless exposures with media coverage and deaths related to exposures but limited court litigation. In 2001, AIA developed broad infection control guidelines for construction and renovation. The year 2002 brought JCAHO standards that focus on deaths due to infection control exposure and require an ICRA. As the standards of care are being developed, it is becoming clear that the responsibility and liability of developing an effective infection control policy resides with the Owner.

Owners' Solution

Healthcare facility ***Owners*** could benefit from greater awareness of: a) the standards and guidelines and their complexities; b) Joint Commission on Accreditation of Hospital Organization (JCAHO) standards; and c) the American Institute of Architects (AIA) guidelines. The ***Owner's*** familiarity should include ICRA patient safety and legal vulnerability associated with the failure to complete an ICRA. Owners must have a working knowledge of the four components in the process requirements. The required process must include pre-design assessment, implementation, monitoring and documentation.

Medical Communications Impact Safety

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Also relevant is the rapid integration of communication systems. While not a totally new concept, the opportunities are tremendous:

- Integration of a wireless telephone system into the nurse call system. Patient calls are forwarded directly to the caregiver's handset, reducing response time and enhancing efficiency, in addition to increasing patient satisfaction and confidence.
- Integration of that same wireless telephone system into the wireless data network as voice-over-internet protocol (VOIP). Now a single wireless network handles both voice and data needs.
- Wireless data network to include monitor alarms deployed facility-wide, providing mobility to basic caregiver functions.
- Integration of security and building automation into the hospital data network, reducing the need for

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JCAHO Environment of Care Standards Update for 2003

- Chapters that have been reorganized and renumbered for the 2000 LSC:

  Chapter 18 New Healthcare Occupancies
  Chapter 19 Existing Healthcare Occupancies
  Chapter 20 New Ambulatory Healthcare Occupancies
  Chapter 21 Existing Ambulatory Healthcare Occupancies
  Chapter 26 Lodging or Rooming Houses
  Chapter 28 New Hotels and Dormitories
  Chapter 29 Existing Hotels and Dormitories
  Chapter 38 New Business Occupancies
  Chapter 39 Existing Business Occupancies
- For hospitals and nursing homes, corridor doors may now be held open with friction or magnetic catches that release when door is pushed or pulled.
- Ambulatory healthcare occupancies have their own chapters.
- New and existing ambulatory healthcare facilities must be divided into at least two smoke compartments unless they are: (a) less than 5,000 sq. ft. and protected by a smoke detection system; (b) less that 10,000 sq. ft. and protected by a sprinkler system; or (c) an area in an adjoining occupancy may serve as a smoke compartment if: there is a 1-hour separation; the ambulatory facility is less than 22,500 sq. ft. and access from the ambulatory facility to the adjoining occupancy is unrestricted.
- Design and construction lighting standards will be questioned in 2003 to ensure that facilities are addressing proper lighting levels for inside and outside the facility environment.
- Moving equipment out of an egress hallway(s) with the intent to return it after survey can be considered "falsification" and may stop the survey.
- Surveyors will question patient elopement prevention procedures.
- Sample surveyor questions include: Where do housekeepers wash their hands while working in patient care areas and how often do they change gloves in between rooms, etc.?
- Potential disaster response survey questions include: What is the plan for addressing competencies of volunteers (physicians, RNs, engineers, etc.) offering assistance during a disaster? How is documentation noted? Does your hazard vulnerability analysis address all "foreseeable" events? Does your evacuation plan include a list of staff to go to offsite areas for care giving? Suggestions include: Have a well-defined backup plan for your command center structure (ex., New York Emergency Management hub was in theWorld Trade Center); consider an alternate (second) ID for off-duty emergency response to enable access to areas during an emergency.
- Existing SOCs at facilities should be evaluated for changes in conjunction with 2000 LSC after March 1, 2003.
- Surveyors will be required to see the facility's SOC, equivalencies, and current status of PFIs when visiting a facility for any reason.
- Surveyors will be looking for protection measures associated with critical utilities systems.
- New scoring regarding smoking is being developed to include, but not be limited to, the following:

Faint smell of smoke	no score
Presence of old cigarette butts	no score
Smoke entering the building	2
Strong smell in building	2
Appropriate area does not have enough exhaust	2
Physical evidence of smoking in building	3
Uncontrolled indiscriminate smoking	5

Medical Communications Impact Safety (Continued from Page 3)

separate wiring and infrastructure.

- TV over intranet, enabling live or archived video at the click of a mouse, for patient education, clinical education, or consumer entertainment over the facility's network infrastructure.

Opportunities such as those previously mentioned are a mere snapshot for leveraging technology and communications systems to benefit the organization. Be sure your facility undertakes a thorough evaluation of all appropriate technology and how it can benefit patient safety as well as the bottom line. It is imperative that medical communications is viewed as a "mission critical" element in the success of the delivery of safe, quality healthcare.

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