SSR Smith Seckman Reid, Inc.

Compliance News

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A Newsletter for Healthcare Executives and Facility Managers on Issues Related to Accreditation and Regulatory Compliance

When Was Your *Exposure Control Plan* Reviewed Last?

High injury and illness rates impact staff vacancies.

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INJURY AND ILLNESS RELATED TO OSHA VIOLATIONS MAY IMPACT STAFFING

The healthcare industry is experiencing staggering and, in some cases, debilitating staff shortages and *"Inspections of workplaces are up, and we are more effectively targeting where the hazards exist . . ."* (Elaine Chao, U.S. Secretary of Labor,12/5/02). State and Federal OSHA offices have increased their workplace inspection efforts. Over 500 hospitals received OSHA inspections during 2002. Historically, injury and illness rates at hospitals and nursing homes have exceeded private industry averages. The Bureau of Labor and Statistics reports the following injury and illness rates for 2001:

- Private industry nationwide average 5.7*
- Hospitals 8.8*
- Nursing homes and personal care facilities 13.5*

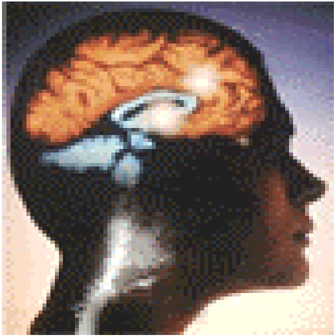
*Number of injuries and illnesses per 100 full-time employees

The relatively high injury and illness rates for hospitals and nursing homes impact staff vacancies and make them a target for OSHA inspections. Conservative estimates of staffing shortages of 11% Registered Nurses, 21% Pharmacists, 18% Radiology Technicians, 9% Ancillary Staff and 12% Laboratory Technicians are negatively affected when staff are unable to work due to illness or injury. Consequently, hospitals should periodically assess their compliance with OSHA standards and alter the work environment based on the assessment results. *(Continued on page 3)*

LOWER YOUR RISK OF TYPE I RECOMMENDATIONS: USE A BUILDING MAINTENANCE PROGRAM (BMP)

No matter how well prepared, during a JCAHO facility tour something always breaks down at the last minute that could spell trouble for your Statement of Conditions™ (SOC). One way to combat this problem is to implement a BMP. Part 3A, Section 6J of the JCAHO SOC permits the use of a building maintenance program. An organization may choose to establish a BMP to address deficiency types in lieu of identifying and listing their specific locations in a Plan For Improvement (PFI). If a Life Safety System component deficiency is not identified and listed on the PFI, it could become a type 1 or supplemental recommendation if found during a JCAHO survey building tour. *(Continued on page 3)*

RESPONDING TO TRENDS IN HEALTHCARE



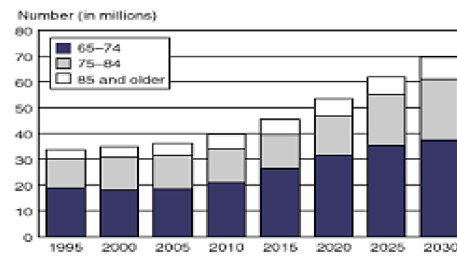
The future of healthcare will be based on today's trends.

If healthcare is to be a stable industry or perhaps even a thriving industry in the future, healthcare leaders must focus on the current data. When planning for the future, the following should be considered:

- Population
- Infrastructure
- Cost
- Technology
- Staffing
- Population Demographics
- Treatment Focus
- Access to Care Issues
- Patient Treatment Focus
- Quality of Care
- Regulations

Monitoring, assessment and planning will be the key to whether healthcare institutions, healthcare suppliers, technologies and providers exist in the future. So, what will happen in the next ten years based on what is happening today? See predictions below.

Effective leadership teams must use current data and future trends to review the current Strategic and Master Plans to ensure viability of their healthcare entity.



Ready or not, the future is coming . . . When is the last time your plans were reviewed?

CATEGORY	FUTURE
Population	See graph above
Infrastructure	Increase inpatient bed capacity to provide an additional 250,000 inpatient beds
Healthcare spending	An increase of 7% annually over the next 10 years
Technology	Increase in wireless technology - increase access to healthcare in rural areas and long term care centers - patient and staff education
Staffing	Increase utilization of foreign nurses, physicians and ancillary staff – to fill a continued void of healthcare workers
Patient treatment focus	- Wellness - End of life care - Disparity in care for minorities and women
Access to care issues	Care in the home by wireless telemedicine devices
Treatment focus	Wireless telemedicine
Quality of care	Improved, but still troubling due to lack of staff, failure to maximize technology, deficient measurements to quantify and qualify quality of care issues
Regulations	Increased regulations in response to continued quality of care issues

CEO AND FACILITY MANAGER AS STEWARDS OF HOSPITAL ASSET MANAGEMENT

Recognizing there is often insufficient funding to satisfy budget requests, the CEO and the Facility Manager (FM) must focus on the ever-tightening fiscal crunch. Budget requests typically focus on hospital infrastructure needs that affect patient safety, impact regulatory requirements such as HIPAA and the increase in the patient population.

As steward of the hospital's assets throughout their life cycle the FM role is integral. To further the goals and mission of the hospital by maximizing return on these assets, the CEO and FM should review the strategic planning for the hospital and jointly guide the infrastructure strategy to provide the most effective environment of care possible.

An axiom of modern healthcare is that "nothing is constant but change." For this reason alone, facility master plans have a useful life of only two to five years, requiring a continuous process and frequent updating because of the dynamic nature of modern hospitals. The infrastructure master plan must be integrated with the strategic business plan of the hospital and supported by a capital financing strategy. It is important to recognize that infrastructure capital planning can often require a three to five year window because many infrastructure projects are multi-year, multi-phased projects.

Experience has shown that costs of operations, space renovation, relocations and ongoing asset resource items quickly exceed initial construction costs. CEOs who support *(Continued on page 4)*

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Injury and Illness Related to OSHA Violations May Impact Staffing *(Continued from page 1)*

According to OSHA inspection data for the period October 2001 through September 2002, four of the most common standards cited during inspections of hospitals and nursing homes include the following:
- Bloodborne Pathogens
- Lockout/Tagout
- Hazard Communication
- Personal Protective Equipment

As a quick assessment of compliance with specific elements of these four standards, answer these questions as they relate to your facility:
1. Is your *Exposure Control Plan* reviewed annually?
2. Have you performed exposure evaluations for all jobs and tasks that may require exposure to blood or other potentially infectious materials?
3. Do you have written energy control (lockout/tagout) procedures?
4. Do you perform (and document) periodic inspections of energy control activities?
5. Do you have a list of all hazardous chemicals on your site?
6. Do you have a *Hazardous Drug Safety and Health Plan* for cytotoxic and hazardous drugs (OSHA recommendation)?
7. Have you performed (and documented) job hazard assessments to determine employees' needs for personal protective equipment?

For more information on developing and implementing an "Exposure Control Plan," contact:

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Lower Your Risk of Type 1 Recommendations
(Continued from page 1)

While completing a PFI is a required part of the SOC, it is equivalent to signing a contract with JCAHO, ensuring that the item identified will be corrected by a specific date. If not corrected by the date specified, the facility has a "Busted Plan." During a JCAHO (*announced or unannounced*) survey, a "Busted Plan" could result in three type 1 recommendations, one in each of the following functions: Leadership, Governance and Environment of Care - which may be noted at the start of the survey. These three type 1 recommendations could result in beginning the survey with a score of 91. ***What a way to start a JCAHO survey!***

A BMP is typically set up either as *(Continued on page 4)*

QUALITY IN HEALTHCARE: TAKING IT DOWN TO THE WIRE

Quality is the 'Q' buzzword floating around healthcare boardrooms. Quality is non-negotiable. The Department of Health and Human Services (HHS) and The Centers for Medicare and Medicaid (CMS) are taking on the quality healthcare challenge with full commitment to improve the quality of care provided to Medicare and Medicaid beneficiaries. Effective March 24, 2003, Centers for Medicare and Medicaid Services will require a QAPI (Quality Assessment and Performance Improvement) program much like the performance improvement program requirement for Joint Commission on Accreditation of Hospital Organizations (JCAHO). While the CMS changes mirror the JCAHO Performance Improvement function, managing an effective quality program is far from an easy task.

CMS and HHS recommend using Information Technology (IT) to improve quality. The January 23, 2003, CMS' press release describes the QAPI Condition of Participation (COP) as a rule that allows hospitals to implement IT as part of the QAPI program. HHS Secretary Tommy Thompson's *Hospital Quality of Care* initiative encourages the increased use of IT in healthcare as a method to reduce medical errors and increase quality.

As highlighted in our last issue, the opportunities for information technology are tremendous. Opportunities such as physician order entry, wireless telephony, digital charting, ER tracking systems, and telemedicine could improve patient safety and healthcare efficiency. An electronic medical record could contain all of the vital information to assess, diagnose and treat a patient. Information received is instantly recorded, stored, and can be immediately retrieved from a single database when the healthcare provider is ready. Timely data input and information retrieval may reduce errors and save lives, all possibilities with information technology systems.

Quality, regulatory compliance and accreditation issues are daunting but not impossible to manage. Take a cue from CMS and HHS - utilize technology systems. Proactively improve your quality program by taking it down to the wire.

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Lower Your Risk of Type 1 Recommendations

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part of the facility Preventive Maintenance Program or as a stand-alone database. An effective BMP must include the following:

- Identification of each program item listed in 6J
- Total number of each of the program items being inspected
- Frequency of inspection
- Average number of failed items found per inspection
- Time required to correct the item
- Expected failure rate of the item (MTBF)
- Percentage of compliance for each program item
- Percentage of compliance $\geq$95 for all program items

Detailing these items in your BMP documentation, along with the data aggregation, will meet the basic requirements for Section 6J. An effective BMP will help prevent a busted PFI plan, reduce the risk of type 1 recommendations related to an inaccurate SOC, and provide ***peace of mind*** during the JCAHO survey process.

For more information on developing and implementing a Building Maintenance Program, contact:

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CEO and Facility Manager as Stewards of Hospital Asset Management

(Continued from page 3)

their FMs and others in "right-to-left thinking" (considering all phases of a life cycle when decisions are made) will help assure that facility investments produce maximum value and reduce the Total Cost of Ownership (TCO) of these strategic assets. Examples of hospital life cycle costs are:

- Design, soft or indirect
- Initial construction, delays
- Operating and maintenance, energy and other utility
- Lost revenue, as a result of not undertaking appropriate life cycle activities, such as the economic impact of failures due to deferred maintenance
- Repairing and replacing building components
- Occupancy and use, technology realization
- Emergency management, disaster mitigation and contingency planning.

For more information on selling maintenance and engineering initiatives to hospital executives, contact:

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