

WHAT SHOULD HOSPITAL CEOS AND COOS ASK ABOUT POWER SYSTEMS?

Are we maintaining our normal and emergency power systems?

All too often, uneasiness or clinical resistance postpones maintenance shutdowns. Does your hospital actually shut down (turn off) the normal, critical branch, life safety branch, and essential equipment systems for regular maintenance? If they are not maintained regularly, these systems will be more likely to fail unexpectedly – just like your car. Look for further discussion of this issue in future issues of this newsletter.

If you are conducting normal power maintenance shutdowns, are you also conducting emergency power maintenance shutdowns? Why is it so difficult to get approval for an emergency power system shutdown? Is it because there is insufficient normal power backup in critical care areas? What will happen when this emergency power system fails? And it will fail if you do not turn it off for maintenance.

Are we maximizing the benefit of our planned shutdowns?

Hospital construction/renovation (C/R) projects usually require carefully planned electrical shutdowns. While that portion of the power system is off anyway, why not also do the PM that is required? Many hospitals do not use C/R shutdowns for PM as well, but the low additional cost and high operational benefits indicate that this approach should be made into a Utility Systems Management Plan policy.

It is often necessary to power more equipment during a planned power shutdown than just code-required equipment that is already wired to the emergency power system. This is necessitated by the hospital's operating needs, and the extra equipment must be temporarily wired for the shutdown. Remember Y2K?



Use the lessons learned from these shutdowns in your emergency management plans.

For more information on preparing for power failures, electrical maintenance, and planned shutdowns, please contact: David L. Stymiest, PE, CHFM, SASHE, at DStymiest@SSR-Inc.com. Also refer to David's article entitled **Managing Hospital Emergency Power Programs** published in *Business Briefing – Hospital Engineering & Facilities Management 2004 (World Markets Series)* for the International Federation of Hospital Engineering (IFHE), January 2004.

PUBLICATIONS & SEMINARS

Upcoming Seminars

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| May 5 | South Carolina Society of Hospital Engineers, Myrtle Beach
“Healthcare Construction” |
| May 9 | American Industrial Hygiene Conference and Exposition, Atlanta
“Fire & Explosion Dynamics” |
| May 10 | West Region of Tennessee Hospital Engineers Association, Memphis
“Building Maintenance Program” |
| May 14 | Alabama Society for Healthcare Engineers, Fort Walton, Florida
“Managing Electrical Shutdowns in Healthcare Facilities” |
| May 25 | Kentucky Hospital Association
“Comprehensive OSHA Compliance for Healthcare” |
| July 26 | ASHE Annual Conference, Orlando
“My Job is Hard Enough - Why Should I Turn Off My Power” |

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Compliance News



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

EVIDENCE-BASED PATIENT SAFETY STRATEGIES

Patient safety information has flooded the healthcare market. For instance, a search on Google

provided over four million potential resources. This volume alone has crippled some organizations in their endeavor to identify and prioritize strategies to be implemented, and positively impact a safer environment for their patients.

The following organizations have taken a lead role in providing evidence-based patient strategies: the Agency for Healthcare Quality and Research, the American Hospital Association Quality and Patient Safety, the Centers for Disease Control, the Joint Commission on Accreditation of Healthcare Organizations, and the Leapfrog organization. Each of these entities has published findings and strategies resulting from clinically-based research which provided scientific evidence that each strategy significantly reduced avoidable dangers associated with medical errors.

This is not an all inclusive evidence-based strategy list, but rather it focuses on those strategies recommended by the leading organizations listed above. Many of the evidence based strategies listed here are *(Continued on Page 3)*

NFPA PERMITS ALCOHOL-BASED CLEANSERS IN CORRIDORS

On April 28, 2004 the National Fire Protection Association (NFPA) announced that the previously prohibited mounting of alcohol-based hand cleansers in corridors had been rescinded. Hospitals will now be allowed to place the alcohol-based cleansers in corridors where increased accessibility will encourage staff to use them more frequently, thus resulting in reduced healthcare associated infections.

This amendment to the Life Safety Codes (LSC) of 2000 and 2003 affects all healthcare agencies governed by the Center for Medicare and Medicaid Services (CMS), those accredited by the Joint Commission *(Continued on Page 3)*



... the three highest risks for medical errors are cognitive deficits, complex physiologic problems and complicated therapeutic regimens

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Obtain and document a complete list of patient's medications and other treatments



POTENTIAL 2005 JCAHO NATIONAL PATIENT SAFETY GOALS (NPSG)

The **potential** Joint Commission's NPSG for 2005 includes 3 new goals, and a total of 11 new elements:

- New Goal #8:** Accurately and completely reconcile medications and other treatments across the continuum of care.
Elements for goal #8:
(a) On admission to a new setting and with the involvement of the patient, obtain and document a complete list of patient's medications and other treatments, and reconcile the medications and other treatments with those at the previous setting of care; and,
(b) For each patient, identify a licensed independent practitioner who is responsible for coordinating the patient's care, including reconciling medications and other treatments during transition of care to other practitioners or other settings of care, and communicate the identity of that practitioner along with contact information to all staff caring for the patient.

- New Goal #9:** Reduce the risk of patient harm resulting from falls.
Elements for goal #9:
(a) Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regime;
(b) Implement a fall reduction program, including a transfer protocol, and evaluate the effectiveness of the program;
(c) Evaluate and, as appropriate, modify the environment of care to

minimize harm to patients if they fall;
(d) Install bed alarms for use with patients at high risk for falling;
(e) Use "low beds" for patients at high risk for falling; and,
(f) Do not use full-length bed rails.

- New Goal #12:** Reduce the risk of surgical fires.
Elements for goal #12:
(a) Educate staff, including operating licensed independent practitioners and anesthetists, on how to control heat sources and manage fuels with enough time for patient preparation, and establish guidelines to minimize oxygen concentration under drapes;
(b) Develop, implement and test procedures for the response of all surgical team members to fires in the operating room; and,
(c) Report surgical fires to pertinent agencies, such as JCAHO, ECRI, FDA and state agencies, to raise awareness and improve prevention.

SUMMARY OF USP 797 – PHARMACEUTICAL COMPOUNDING – STERILE PREPARATIONS

Source of base information – Pharmacopeial Form – Vol 29 (4) July – Aug. 2003. Effective date – January 1, 2004 FDA enforceable. Scope – "The content of this chapter applies to health care institutions, pharmacies, physicians practice facilities and other facilities in which compounded sterile preparations are prepared, stored and dispensed."

Facilities Impacted by USP 797

- Facilities in which sterile products are prepared according to the manufacturers' labeling and where manipulations are

Summary of USP 797 – Pharmaceutical Compounding – Sterile Preparations (Continued from page 2)

performed during the compounding of sterile products which increase the potential for microbial contamination of the end product.

- Facilities where products are compounded using devices or ingredients which are not sterile to prepare products which must be sterilized prior to use.
- Products may be biologics, diagnostics, drugs, nutrients or radiopharmaceuticals which include, but are not limited to, baths and soaks for live organs and tissues, implants, inhalations, injections, irrigations, metered sprays, ophthalmic and otic preparations.

The chapter addresses:

- Microbial contamination risk levels;
- Clean rooms;
- Equipment requirements;
- Barrier isolator (MIC);
- Quality assurance program;
- Minimum validation requirements;
- Cleaning and sanitizing the workspaces;
- Environmental Monitoring; and
- Verification of automated compounding devices for nutrition compounding.

For more information on USP 797, visit www.mic4.com/regulations/USP-797 or www.ashp.org/bestpractices/Chapter797-SterileCompounding.

NFPA Permits Alcohol Based Cleansers in Corridors (Continued from page 1)

on Accreditation of Healthcare Organizations (JCAHO), as well as local and state fire safety agencies. This significant change was the result of a yearlong collaborative advocacy effort of engineering, hospital associations, infection control and fire safety agencies. The amendment details the following specific conditions under which the dispensers can be mounted in corridors:

- The corridor width is 6 feet or greater and dispensers are separated at least 4 feet apart.
- The maximum individual dispenser fluid capacity is 1.2 liters for dispensers in rooms, corridors and areas open to corridors, and 2.0 liters for dispensers in suites of rooms.
- The dispensers are not installed over or directly adjacent to electrical outlets and switches.
- In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces



- are permitted only in sprinklered smoke compartments.
- Each smoke compartment may contain a maximum aggregate of 10 gallons of alcohol based hand cleanser in dispensers and a maximum of five gallons in storage.

Evidence-Based Patient Safety Strategies (Continued from page 1)

recommended by more than one of these leaders in patient safety:

- National Patient Safety Goals (see article on NPSG in this issue of *Compliance News*)
- Computerized Physician Order Entry
- Evidenced-Based Hospital Referrals
- Intensivist Physician Staffing of ICUs
- Pharmacists present in critical care and medical/surgical areas
- Change-of-Shifts Safety Checklists
- Universal Protocol for prevention of wrong site, wrong patient, wrong procedure surgeries
- Improving staff handwashing compliance
- Prevention of Central Venous Catheter complications by using maximum barrier precautions and antibacterial or antiseptic coated CVC lines
- Voluntary reporting initiative
- Promoting a high reliability unit through the use of a Situational Approach to communication (Situation, Background, Assessment, Recommendation {SBAR})

When an organization is prioritizing which evidence-based strategy(s) to implement, they should recognize that the three highest risks for medical errors are cognitive deficits, complex physiologic problems and complicated therapeutic regimes. Consequently, those patients at the greatest risks are the most elderly and the youngest because they lack physiologic and cognitive reserves.