

Infection Control Evolution in the Healthcare Facility (Continued from page 1)

effort to develop and implement IC measures, they do not provide specific solution-level guidelines on how this is to be achieved. Most facilities initially responded with development of an infection control policy of some sort, outlining IC objectives to be achieved on any given project. Even these, however, often failed to define project specific solutions, given the wide range of project scope features that are faced.

The process necessary to provide these project specific IC answers represents the essence of the Infection Control Risk Assessment (ICRA) intent and purpose. At the heart of the ICRA process is the absolute need for establishing criteria and specific projects requirements for IC measures. This process is based on a relative assessment of risks, costs and impact to hospital operations that will be unique for each project.

This ICRA process must be executed for all areas of IC concerns, such as maintaining negative air pressure within construction work zones, construction zone barriers, personnel and material transportation, above the ceiling accessibility, projects phasing and a host of other issues. A critical factor in an effective ICRA program is timing, in terms of when a potential project is first scrutinized from an IC perspective. Owners should have a pre-established IC committee that is educated and available to review and assess projects at the earliest programming and planning stages.

The bottom line for the astute facility manager is to ensure that an effective ICRA process is in place, and is executed on every project. While the specific events or circumstances that cause an infection of a patient are varied and generally indeterminable, and whether the presence of construction on site has any impact to such an event, it is prudent to take every reasonable precaution available. Addressing the issue in a proactive and consistent manner will be the best way to minimize the risk, protect the patient and deliver projects on time and within budget.

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OSHA Enforces Tuberculosis Exposure Protection (Continued from page 1)

To meet the requirements of OSHA's general industry respiratory protection standard, employers should verify that the following are being/have been performed:

1. The employer shall develop and maintain a written respiratory protection program.
2. The employer shall designate a respiratory protection program administrator.
3. Employees, who use respirators (including N95 respirators for TB protection), shall receive a medical evaluation to determine their ability to use respirators. A physician or licensed healthcare professional shall perform the evaluation.
4. Employees, who use tight-fitting facepiece respirators (including N95 respirators), shall receive an annual fit test.
5. Employees, who use respirators (including N95 respirators), shall receive annual respiratory protection training.
6. The employer shall evaluate the workplace periodically to verify that the written respiratory protection program is being properly implemented and that it continues to be effective.

For more information on respiratory protection, please contact
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PUBLICATIONS & SEMINARS

Look for these articles in publication

"Powering down - An orderly process for switching off hospital electrical equipment," *Health Facilities Management* magazine, June 2004.

Upcoming Seminars

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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Related to Accreditation and Regulatory Compliance

OSHA ENFORCES TUBERCULOSIS EXPOSURE PROTECTION

Effective July 1, 2004, the Occupational Safety and Health Administration (OSHA) began enforcing their Respiratory Protection Standards for Tuberculosis (TB) exposure. OSHA withdrew its proposed standard for Occupational Exposure to Tuberculosis on December 31, 2003. The proposed standard was withdrawn because they believed the occupational risk of acquiring TB infection is lower than originally estimated. OSHA also observed significant compliance among healthcare employers with TB prevention guidelines from the Centers for Disease Control and Prevention.

The proposed TB standard contained respiratory protection requirements for TB exposure that were less stringent than the general industry respiratory protection standard. Because of the withdrawal of the TB proposal, OSHA will begin applying the general industry respiratory protection standard for protection against the disease. Enforcement of the respiratory protection standard (for TB exposure) was delayed until July 1, 2004, in order to give affected employers adequate time to come into compliance with the additional requirements. (Continued on Page 4)

INFECTION CONTROL EVOLUTION IN THE HEALTHCARE FACILITY

Much has been written on the subject of infection control (IC) measures for healthcare facility expansion and renovation projects, but one aspect of the subject has been non-debatable: the IC issue is here to stay and is changing the face of how we upgrade, modernize and maintain our facilities.

The issue has been exacerbated by the wide gap that exists between general infection control objectives provided by the standards that do exist, and the critical need for project specific infection control measures, defined and detailed for each individual project feature.

The issuance of the 2001 AIA Guidelines for Healthcare Facility Construction, and the JCAHO requirements effective January 1, 2002, both planted the IC "ball" squarely in the design and construction court. However, while these standards place responsibility on the owner to drive the (Continued on Page 4)



The employer shall develop and maintain a written respiratory protection program.

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2005 NPSG ANNOUNCED BY JCAHO



On July 20, 2004 JCAHO announced the following National Patient Safety Goals for hospitals, effective January 2005:

Goal: Improve the accuracy of patient identification.

- Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.



Goal: Improve the effectiveness of communication among caregivers.

- For verbal or telephone orders or for telephonic reporting of critical tests, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- (New) Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

New National Patient Safety Goals for Hospitals



Goal: Improve the safety of using medications.

- Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
- Standardize and limit the number of drug concentrations available in the organization.
- (New) Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.



Goal: 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.

Goal: Reduce the risk of health care-associated infections.

- Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

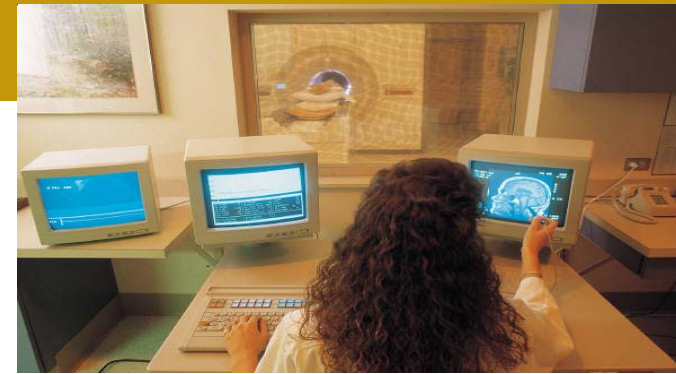
Goal (New): Accurately and completely reconcile medications across the continuum of care.

- During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.
- A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

Goal (New): Reduce the risk of patient harm resulting from falls.

- Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medications regime, and take action to address any identified risks.

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INFORMATION TECHNOLOGY (IT) ENHANCES PATIENT SAFETY INITIATIVES

The Health Information Technology (IT) challenge is so fundamental to health care reform, it has been included in the presidential election platforms. In response to President Bush's goal, the first strategic framework report was released at the Secretarial Summit on Health Information in Washington DC, on Wednesday, July 21, 2004. The framework provides a strategic plan for widespread adoption of health IT, and is the result of a 10-year initiative to develop electronic health records and other uses of health information technology.

In those organizations which have embraced the challenge of advancing IT, the priority efforts have been concentrated on improving clinical quality. They have focused on improving safety at the point of care by providing information to the decision maker as soon as possible.

Improving the safety of medication administration has been the highest priority. Efforts have been directed towards getting the initial physician order correct by automating the ordering process, and administering it correctly by matching medications to patients electronically at the time of administration. It was estimated that in one hospital, this automated system prevented approximately 500 mistakes per month. In this process, each medication is bar coded at the unit dose level. The nurse uses a bar code scanner to identify the unit dose medication, and then identifies the patient by a bar coded armband. The five rights of medication administration are then verified by the nurse on a laptop computer located on a mobile cart. If something cannot be verified, the nurse is alerted by audio and visual alerts and then needs to respond to queries of the warning screen before the medication is given to the patient. Also available to the end-user on this lap-top is access to the patient's demographics, drug interaction

alerts, review of clinical laboratory results, as well as a medical image review.

In some facilities additional safeguards have been implemented, such as hard-stop pharmacy rules which prevent the pharmacist from entering medication orders if critical patient information is not available. In another project, the IT staff is collaborating with the pharmacist to create a set of medication alerts for high risk medications such as insulin, heparin, infusion therapies and anticoagulants.

Some other initiatives are utilizing smart IV pumps that will interact, through a wireless network, with the pharmacy system, the patient's bar coded armbands, IV bags and the employee's ID bracelet. The wireless systems have made the point of access a moot point by enabling universal access throughout the entire organization.

Although the implementation of bar coding technology is still considered state-of-the-art, migration to radio frequency identification (RFID) is just around the IT corner.

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JCAHO UPDATES

Effective immediately, JCAHO is surveying for compliance with the 2004 USP-NF Chapter 797 which contains the new requirements for compounding, preparation, and labeling of sterile drug preparations for health care facilities. Of significance, the requirements extend beyond the pharmacy to nurses and physicians preparing sterile drugs in patient care areas. (For more information refer to Compliance News, May 2004.)

On July 15, 2004, JCAHO's Quality Check™ began a new generation of reporting quality and safety information from accredited organizations. The use of symbols such as stars, pluses, checks and minuses allows for comparison of reports by consumers. Included in the available reports are: accreditation decision and effective date; health care services provided by the organization; the organization's performance on National Quality Improvement Goals, as well as National Patient Safety Goals; special quality awards and other distinctions; a commentary about the Quality Check report; and requirements for improvement, if applicable.