

COMPLIANCE NEWS



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OSHA Provides Guidance on Glutaraldehyde Use

by Leo Old, MS, CIH, PE, CHFM - LOld@ssr-inc.com

Glutaraldehyde is a chemical commonly used in healthcare environments. It's most often used as a cold sterilant for the disinfection of heat-sensitive instruments, such as endoscopes, bronchoscopes and dialysis equipment. Glutaraldehyde may also be used in X-ray development and pathology tissue fixation. Consequently, healthcare employees that perform these actions may experience airborne and skin-contact exposures to glutaraldehyde, which can cause a variety of symptoms, including occupational asthma and contact dermatitis.

The Occupational Safety and Health Administration (OSHA) does not have a permissible exposure limit (PEL) for glutaraldehyde; however, some state occupational safety and health agencies have a 0.2 part per million (ppm) ceiling exposure limit for glutaraldehyde. The American Conference of Governmental Industrial Hygienists (ACGIH) recommends a threshold limit value (TLV) of 0.05 ppm, measured as a ceiling exposure concentration.

In order to address occupational health concerns associated with glutaraldehyde exposure, OSHA published a new guidance document this year: *Best Practices for the Safe Use of Glutaraldehyde in Health Care*. Within this document, OSHA describes recent research associated with glutaraldehyde exposures in healthcare. The research indicates that healthcare occupational glutaraldehyde exposures vary depending on a number of factors, including concentration of the glutaraldehyde solution, type of process and ventilation conditions. OSHA also offers recommendations regarding engineering controls, work practices, personal protective equipment, disposal and spill clean-up procedures. Healthcare organizations may want to consider recommendations within this document, when addressing glutaraldehyde exposure concerns at their worksites.

To obtain a copy of the best practices document, individuals should visit OSHA's website: www.osha.gov. **SSR**

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EC.7.40 Revisions Strengthen Emergency Power Testing Requirements

by David Stymiest, PE, CHFM - DStymiest@ssr-inc.com

JCAHO recently issued its Standard EC.7.40 revisions, publishing them in the June 2006 issue of Joint Commission Perspectives®.¹ Three new Elements of Performance (EP's) contained in these revisions require a triennial 4-hour load test and also stipulate what actions are necessary if a generator fails any of its load tests.

New EP-5 requires a 4-hour load test at least once every 36 months, with the first such test required before July 1, 2007. The test loading must be at least 30% of the nameplate rating of the generator and either static (load bank) or dynamic (actual) loads can be used for this test. Since JCAHO did not stipulate which of the two common nameplate ratings to use (the prime power rating or the higher standby rating), I recommend that organizations use the higher standby rating to be prudent and to provide a more rigorous test.

The 30% loading requirement is even relaxed somewhat, but only for organizations “that cannot achieve a minimum load of 30% of the emergency generator’s nameplate rating.” Since load banks are permitted to be used for this test, it calls into question how an organization would be able to document that it cannot achieve the 30% load. However, an organization that chooses to take this approach “must assess the prime movers’ exhaust gas temperature and meet the minimum temperature recommended by the manufacturer” [to prevent engine damage].

Prior operation in compliance with the requirements for 4 or more hours after July 1, 2004 could satisfy the first testing requirement, but the date of that prior operation would then start that organization’s 3-year cycle calendar for future testing.

If actual facility loads are used, and the standard monthly testing requirements are also satisfied, this 4-hour test can take the place of one of the EP-1 required monthly load tests. EP-5 also requires that any problems identified during the test be resolved promptly, and states that the fuel supply should be replenished after the test.

EP-1 (the monthly load test requirement) was also modified to require compliance with NFPA 110-2005 testing and maintenance requirements when the monthly load tests do not meet the 30% loading criterion.

If a test required by Standard EC.7.40 test fails, new EP-6 requires interim measures until necessary repairs or corrections are completed, and new EP-7 requires a retest after completion of the necessary repairs or corrections.

Visit www.nfpa.org to obtain a copy of NFPA-110-2005. **SSR**

¹Joint Commission Perspectives®, June 2006, Volume 26, Issue 6, Copyright 2006, JCAHO

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ECAB #05-2006 Testing Battery-Operated Task Lights in OR's

by Dean H. Samet, CHSP - DSamet@ssr-inc.com

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) provided a recent clarification on the testing of battery-operated “task lighting” typically provided in OR’s (and other anesthetizing locations) that is used to bridge the 10-second gap between a power failure and when the emergency generator comes on-line.

This task lighting should not be equated with “egress lighting” as described in the NFPA 101 Life Safety Code® and, as such, is not required to be held to the testing requirements of JCAHO Standard EC.7.40 – EP 3, which addresses all battery-powered lights “required for egress.”

However, such task lighting still needs to be tested and maintained for reliable operation. Therefore, per JCAHO Standard EC.7.10 – EP 10, the Joint Commission leaves it up to the accredited hospital to develop “appropriate strategies for all utility system equipment on the inventory for ensuring effective, safe, and reliable operation of all equipment in the inventory.” This should include the emergency task lighting in OR’s, as well as any other anesthetizing locations. **SSR**

ECAB #06-2006 Life Safety Code Specialist "Interim Exit Briefing"

by Dean H. Samet, CHSP - DSamet@ssr-inc.com

JCAHO will be conducting an “Interim Exit Briefing” by the Life Safety Code Specialist surveyor at the end of their one-day survey. This will only be for hospitals with 200 or more licensed beds where a LSC Specialist surveyor will be joining the usual survey team, consisting of at least one physician, one nurse and typically an administrator surveyor.

The LSC Specialist surveyor will share and review their observations and address any questions that the organization may have about any Life Safety Code deficiencies discovered during the building tour. The LSC Specialist surveyor will not be able to share any scoring information about this portion of the report. That information will be provided at the “CEO Exit Briefing” after all surveyor findings have been aggregated into the survey team leader’s computer and a final report generated. **SSR**

Summary of 02 E-Cylinder Storage Requirements

by Dean H. Samet, CHSP - DSamet@ssr-inc.com

There still seems to be a lot of confusion regarding what the Joint Commission and the NFPA 99, Standard for Health Care Facilities (2002 edition) requirements are for the storage of nonflammable medical gases such as oxygen, especially with those small E-cylinders. *(Continued on page 4)*



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Summary of O2 E-Cylinder Storage Requirements

Continued from page 3

The Joint Commission has adopted the 2002 edition of the NFPA 99 language that allows up to 12 of the small E-cylinders (24.9 cu.ft. each) within any one smoke compartment to be left outside of rooms or special enclosures as long as they are properly secured from tipping or falling over.

Twelve E-cylinders would equate to just under 300 cu.ft. of compressed gas. One NFPA 99 limitation is that there should be no more than 300 cu.ft. of gas (or 12 full E-cylinders) stored outside of any rooms or other enclosures within any one smoke compartment. Also, these gas cylinders are considered "in-use" and not "stored" by the Joint Commission if they are on a gurney or anesthesia machine. I would hope that the Joint Commission considers cylinders on crash carts and wheel chairs as "in-use," as well. The Joint Commission does not count partial or empty cylinders as part of the 12 E-cylinders allowed to be left outside of rooms or other enclosures as already described. However, they do expect that the partial or empty cylinders be removed per hospital policy to an appropriate area, as permitted and delineated by the NFPA 99 requirements.

Note: There is a maximum limit of up to 3000 cu.ft. of compressed medical gases (120 E-cylinders or combination of cylinder sizes) that can be stored in an enclosed interior room or space of noncombustible or limited combustible construction only. Such rooms or spaces would need doors that can be secured against unauthorized entry. However, if more than 3000 cu.ft. of gases are to be stored indoors, the rooms or spaces should be constructed of a minimum 1-hour fire resistance rating with 1-hour walls, floors, ceilings and doors. Special electrical and ventilation requirements would also be required when storing more than 3000 cu.ft. **SSR**

Publications & Seminars

Look for these articles in publication

"Position of Power," *Health Facilities Management*, July 2006

"Managing Hospital Emergency Power Systems" (2006 Edition, now available on ASHE's website, www.ashe.org)

Upcoming seminars in 2006

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|---------------|---|
| July 11-12 | ASHE Annual Meeting, Boston, MA, "A-Z of BMP," "Misinterpreted Aspects of the Life Safety Code" and "Managing Hospital Emergency Power Systems" |
| August 7 | North Carolina Healthcare Engineers Association, Myrtle Beach, SC, "ASHRAE - New Standard on Ventilation of Healthcare Facilities" |
| August 10 | West Virginia Society for Healthcare Engineering, Snowshoe, WV, "Rx for Emergency Power Reliability" |
| September 7-8 | Georgia Society for Healthcare Engineers, McRae, GA, "Advanced Management of Emergency Power Testing" and "Risk Assessments in EC Management Plans" |
| October 11 | Informa Healthcare Safety Conference, Chicago, IL, "Environment of Care: Hot Topics and Critical Issues" |
| October 18-20 | Decision Health 2006 EC Summit, Orlando, FL, "Unannounced Surveys and New EC Targets" and "Infection Control's Impact on the Environment of Care" |
| October 24-26 | Healthcare Design Symposium, Chicago, IL, "Post Occupancy Evaluations for Healthcare Facilities" |
| November 2-3 | Midwest Healthcare Engineering Conference, Indianapolis, IN, "Unannounced Surveys: Ready or Not" and "Facility Electrical Maintenance" |



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