

COMPLIANCE NEWS



... ensure that appropriate contingency plans have been developed ...

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JCAHO Sentinel Event Alert #37 "Clinical Contingency Plans"

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

Sentinel Event Alert #37 describes how each healthcare facility must assess the various risks of electrical power failure and suggests that plans be made to deal with such emergencies. SEA #37 also provides guidance on risk reduction approaches and facilitating the development of contingency plans for clinicians to follow in the event of a short term or prolonged power outage. The following are examples of provisions of "Clinical Contingency Plans" as listed in the October 2006, Volume 26, Number 10 edition of Joint Commission Perspectives®:

- Rapid deployment of battery-powered equipment (for example, portable suction units).
- Assessment of critical equipment to ensure it is plugged into back-up power outlets.
- Identification of available HIT (health information technology) systems or manual back-up systems.
- Establishment of timelines and pre-arranged options for diverting, transferring or evacuating patients.
- Care for ventilator-dependent patients and telemetry patients.
- Establishment of a command center.
- Provision for open lines of communication between on-site staff and any organization leaders who may be off-site.
- Access to and use of two-way radios.
- Establishment of a disaster bin for flashlights, extension cords, etc.
- Definition of precautions for immuno-compromised patients during HVAC failure.
- In the event of HVAC failure, provision for careful, manual monitoring of patient body temperatures.
- Establishment of a critical supply center for food, water, pharmaceuticals and linen.
- Assessment of critical refrigerators (such as those in the pharmacy, lab and blood bank) to confirm power supply.
- Assessment of automated drug supply cabinets to confirm power supply. *(Continued on page 4)*

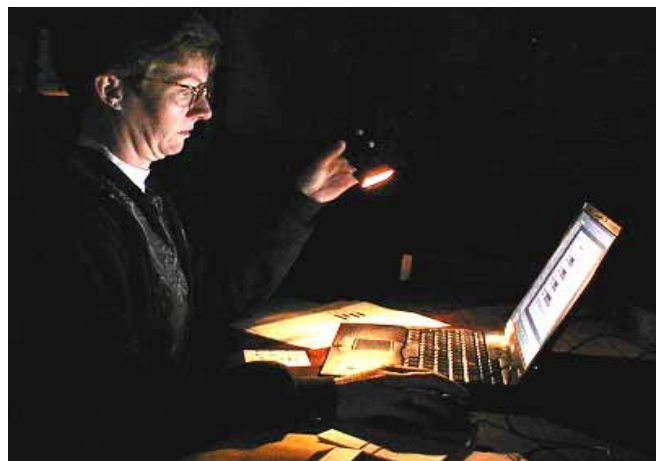
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Some Thoughts on Sentinel Event Alert #37

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

JCAHO's recent SEA #37 included a number of items for healthcare organizations to consider in formulating clinical contingency plans for emergency power (EP) system failure. Some additional thoughts are presented below for our readers' consideration. Each bulleted item is from SEA #37, with additional considerations in *italics*.

- Consider both brief and sustained loss of EP.
 - *EP can fail at any time, but also has planned outages for construction / renovation projects. EP also needs planned outages for maintenance.*
 - *Use all EP planned outages – planning and lessons learned – for training.*
- Include in orientations and periodic continuing education for medical and other clinical staff.
 - *Loss of normal power with EP available.*
 - *Loss of critical branch, life safety branch or equipment system.*
 - *Full power blackout (generator failure coinciding with utility failure).*
- Focus on EP requirements in EC.7.20.
 - *These are the standard EP loads with which we are all familiar.*
 - *What about everything else that has been connected to the EP systems in your facility? Is there flexibility to respond to internal failures?*
- Address continued availability of essential HIT systems or paper systems.
 - *Are on-site data center transfer switches tested?*
 - *What about off-site data centers that support the HCO's HIT systems, and the communications links between the off-site and on-site equipment?*
 - *What about data center, data closet and communications closet HVAC?*
- Rapid deployment of battery-powered equipment (e.g., portable suction units).
 - *Are the batteries still within their shelf life or fully charged?*
- Assessment of critical equipment to ensure it is plugged into back-up power outlets.
 - *What about equipment that is hard-wired rather than plugged in? What flexibility is there if its power source fails?*
- Access to and use of two-way radios; disaster bin for flashlights, extension cords.
 - *Are there sufficient spare batteries available?*
 - *Are battery charging stations on EP?*
- Assessment of critical refrigerators (pharmacy, lab, blood bank, etc.) – also automated drug supply cabinets – to confirm power supply.
 - *Is this equipment plugged in or hard-wired?*
 - *What flexibility is there for internal failure response? **SSR***



NFPA Disclaimer: Although the author is Chair of the NFPA Technical Committee on Emergency Power Supplies, which is responsible for NFPA 110 and 111, the views and opinions expressed in this message are purely those of the author and shall not be considered the official position of NFPA or any of its Technical Committees and shall not be considered to be, nor be relied upon as, a Formal Interpretation. Readers are encouraged to refer to the entire text of all referenced documents. NFPA members can obtain NFPA staff interpretations at www.nfpa.org.

Corridor Clutter

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

One of the more common findings during Joint Commission surveys continues to be for what is often called “corridor clutter,” including general storage and equipment stored in the egress corridors. The intent of the JCAHO standards and the NFPA 101 Life Safety Code® is “to avoid any obstructions to the convenient removal of non-ambulatory patients.” (See 2000 NFPA 101 Life Safety Code 19.2.3.3.) However, it is not feasible to keep corridors free of certain pieces of equipment at all times as that would not be practical or feasible in a hospital setting caring for inpatients. LSC Annex A.19.2.3.3 provides some clarification stating, “It is not the intent that the required corridor width be maintained clear and unobstructed at all times . . . it is recognized that wheeled items in use (such as food service carts, housekeeping carts, gurneys, beds and similar items) and wheeled crash carts not in use (because they need to be immediately accessible during a clinical emergency) are encountered in healthcare occupancy corridors.” The Joint Commission also permits “isolation carts” parked just outside of the room’s entrance when a patient is assigned to and occupying an isolation room. Annex A.19.2.3.3 continues stating, “The healthcare occupancy’s fire plan and training program should address the relocation of these items during a fire. Note that “not in use” is not the same as “in storage.” Storage is not permitted to be open to the corridor unless it meets one of the provisions permitted by 19.3.6.1 and is not a hazardous area.” **SSR**

Storage Under Sink Cabinets

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

Another common finding by Joint Commission surveyors is for the storage of certain types of items and materials in undersink cabinets. What may and may not be stored within cabinets under sinks has been an issue and a matter of interpretation by Joint Commission surveyors for a long time. While the Joint Commission standards do not specifically address this matter, in the past the standards have provided some guidance within their *Environment of Care News* and on their website under Frequently Asked Questions. This is certainly a risk assessment issue that needs to be performed, policies and procedures established and staff trained accordingly.

One of the main concerns is if the sink or drain pipes leak. This could result in damage or contamination of materials stored, an infection control issue, or possible reactions of reagents and chemicals with moisture or each other. The Joint Commission says that, “The area under a sink should be considered a soiled environment.” They further say that, “Storage of reagents and chemicals in undersink cabinets, in quantities allowed by both OSHA and the fire protection Authorities Having Jurisdiction (AHJs), would be permissible per Joint Commission standards as long as the reagents and chemicals couldn’t react with each other or with moisture. If further enclosure of these chemicals is necessary to ensure non-reaction, then those steps should be taken . . . [and] strict storage control is a must.” Don’t forget to check with your local or state AHJs for any specific requirements they might have concerning this matter. **SSR**

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The previously listed examples should be shared and discussed with the hospital emergency management committee, as well as the safety or environment of care committee, to ensure that appropriate contingency plans have been developed as needed and the necessary training provided to appropriate staff, including clinicians. **SSR**

Publications & Seminars

Look for these articles in publication

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

Upcoming seminars in 2006

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| November 1-2 | South Carolina Society of Hospital Engineers Fall Educational Program, Columbia, SC, "Electronic SOC & EC Standard on Utilities" and "EC Standards on Life Safety and Medical Equipment" |
| November 2-3 | Midwest Healthcare Engineering Conference, Indianapolis, IN, "Unannounced Surveys: Ready or Not" and "Facility Electrical Maintenance" |
| November 16 | Mississippi Hospital Association Society for Healthcare Facilities Management & Biomedical Engineers and Infection Control Practitioners, Madison, MS, "Infection Control and the Facility Manager" |
| December 4 | Courtemanche Annual Conference, Orlando, FL, "Building Maintenance Program" |

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