

COMPLIANCE NEWS



Knowing your codes and applicable editions is important and can save you money.

Inside this Issue

Life Safety Plans	1
Emergency Power Failure	
Training.....	2
Advisory Bulletin	2
Managing Security Risks	3
Publications/Seminars.....	4

Updating Life Safety Plans

by Ken L. Gregory - KGregory@ssr-inc.com

Facility *Life Safety Plans* are one of the key focal points for developing and maintaining a successful Fire Safety Prevention Program. However, many hospitals have never updated or, in many cases, even verified their facility's life safety plans. All too often hospitals depend on life safety plans created years ago when the facility was first built or has since had major renovations or additions. It is imperative to keep these documents and plans up to date and to be cognizant of any code changes that can be adopted and applied which might be of benefit for efficiently maintaining your building(s) as code compliant.

Today most hospitals have surveys performed by the Joint Commission and/or inspections completed by CMS (Centers for Medicare and Medicaid Services) per the 2000 edition of NFPA 101 Life Safety Code. The Joint Commission allows you to adopt a newer edition of the Life Safety Code; however, JCAHO must be informed of that fact and you must be prepared to show full compliance with that newer edition in its entirety. Note: Most new facilities are constructed in accordance with either the International Building Code or the National Fire Protection Association's NFPA 5000, Building Construction and Safety Code®, as well as the NFPA 101 Life Safety Code®.

Knowing your codes and applicable editions is important and can save you money. For example, understanding the difference between having two-hour "Building/Addition" separations (which may or may not be required) or having required two-hour "Occupancy" separations (which typically are required) could save valuable labor resources in maintaining the smoke and fire integrity of those separations, dampers, door assemblies and hardware, etc. As a result, many of the existing two-hour fire walls shown on current life safety plans installed originally as building separations may no longer be required. Of course there are many factors that come into play - for example, travel distance requirements, the potential need for a horizontal exit, and so forth. Know your codes and check with your AHJs (Authorities Having Jurisdiction) before making any significant modifications. Also, opportunities to downgrade from a LSC Healthcare Occupancy to a Business Occupancy in some areas of a hospital can also create savings through lessened requirements and having or maintaining a number of features of fire protection. Examples: Reduction in labor hours for maintaining previously classified fire and/or smoke walls that are no longer required; maintaining components of those

(Continued on page 4)

Compliance News

Raising the Bar - Emergency Power Failure Training for Clinical and Support Staff

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

Many healthcare facilities are familiar with the single page that summarizes building utility failures and the basic staff response that is expected for those events. A quick review might show that this document, if used as part of an organization's Emergency Management Plan or its Utility Management Plan, has a power failure entry similar to the top one shown. Although the entry does not stipulate that it only considers normal power failure, that fact is evident from a review of the detailed responses.

EMERGENCY CONDITIONS and BASIC STAFF RESPONSE			
BUILDING UTILITY FAILURES			
UTILITY FAILURE	WHAT TO EXPECT	WHAT TO DO	OTHER RESPONSES
Electrical Power Failure	Power only to corridor lights and RED plug outlets	<ul style="list-style-type: none"> Open Disaster Bin for flashlight, extension cords, etc. Know areas on emergency power 	<ul style="list-style-type: none"> Ensure that Life Support Systems are attached to RED plugs; be prepared to hand ventilate. Report to Supervisor.

JCAHO's September 2006 Sentinel Event Alert #37 suggests that healthcare organizations consider the

failure of emergency power, as well. An example of the impact of these additional considerations could be the addition of a new emergency power failure entry to supplement the existing normal power failure entry as illustrated. **SSR**

EMERGENCY CONDITIONS and BASIC STAFF RESPONSE			
BUILDING UTILITY FAILURES			
UTILITY FAILURE	WHAT TO EXPECT	WHAT TO DO	OTHER RESPONSES
Electrical Normal Power Failure	Power only to corridor lights and RED plug outlets	<ul style="list-style-type: none"> Open Disaster Bin for flashlight, extension cords, batteries, etc. Know areas on emergency power 	<ul style="list-style-type: none"> Ensure that Life Support Systems are attached to RED plugs; be prepared to hand ventilate. Report to Supervisor.
Electrical Emergency Power Failure	Power only to "normal" lighting, and gray or white plug outlets	<ul style="list-style-type: none"> Open Disaster Bin for flashlight, extension cords, batteries, etc. Check all patient care equipment and patient task lighting. 	<ul style="list-style-type: none"> Ensure that Life Support Systems are attached to gray/white plugs; or to BACKUP red plugs if available; be prepared to hand ventilate. Report to Supervisor.

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.

JCAHO Advisory Bulletin: AB #01-2007 Unannounced Survey Announcement & Black-Out Dates

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

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will be posting the following information to an organization's secure site on the Joint Commission's extranet at 7:00 a.m. Eastern time on the morning of an organization's unannounced survey:

- 1) Biographies and pictures of JCAHO surveyors assigned to conduct survey;
- 2) Survey agenda; and
- 3) Organization's Priority Focus Process (PFP) summary report.

Also, the Joint Commission is allowing accredited organizations to identify up to 10 days each year in which an unannounced survey should be avoided (black-out dates). These dates should not include federal holidays. According to the Joint Commission, they will make every effort to accommodate the organization's request but will reserve the right to conduct a survey during an "avoid period" if they feel the reason provided by the organization is not reasonable. **SSR**



Compliance News

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Proactive Process for Managing Security Risks

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

All of the JCAHO Environment of Care Standard's seven management plans have requirements for managing risks. EC.2.10 covers security risks. The "Rationale" for EC.2.10 states, "It is essential that a hospital manages the physical and personal security of patients, staff (including the potential for violence to patients and staff in the workplace), and individuals coming into the hospital's buildings. In addition, security of the established environment, equipment, supplies, and information is also important."

The following matrix contains an example of a security risk assessment where potential events in each of the three categories of Probability, Risk and Preparedness can be evaluated. Events may be potential security risks that could have a negative effect on the security and safety of a healthcare facility's patients, staff, visitors, equipment and property.

Scoring can be accomplished by multiplying the ratings for each event in the areas of probability, risk and preparedness. Then, the total values in descending order will represent those events most in need of remedial action. Since acceptance of risk is at the discretion of the organization, they should determine a value below for which no action is necessary.

In the below examples, scores of 5 and above warranted immediate response and monitoring. Scores of 3 to 4 called for enforcement of existing policies and monitoring. Scores of 2 or less only required further monitoring. As always, staff education is important in ensuring their understanding of established security policies and procedures that have been developed to achieve the lowest potential for adverse impact on security.

ENVIRONMENT OF CARE RISK ASSESSMENT SECURITY MANAGEMENT

Key: 02. Very Low Risk. No extraordinary actions required. Monitor
 3-4. Low Risk. Educate. Enforce existing policies. Monitor
 5-9. Moderate Risk. Educate. Emphasize during patrols. Respond to incidents immediately. Notify authorities if violations occur. Monitor.
 10+. High Risk. Educate. Emphasize during patrols. Respond to incidents immediately. Notify authorities if violations occur. Monitor.

COMPONENT	PROBABILITY				LIFE THREAT	HEALTH/SAFETY	RISK			PREPAREDNESS			TOTAL
	HIGH	MED	LOW	NONE			HIGH DISRUPTION	MOD DISRUPTION	LOW DISRUPTION	POOR	FAIR	GOOD	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	
VANDALISM		X							X			X	2
THEFT-AUTO		X	X						X			X	1
THEFT-HOSPITAL PROPERTY		X						X				X	4
THEFT-PATIENT PROPERTY		X							X			X	2
THEFT-VISITOR PROPERTY		X							X			X	2
THEFT EMPLOYEE PROPERTY		X							X			X	2
SENSITIVE AREA BREACH		X					X					X	6
IMPROPER/NO ID		X						X				X	4
UNAUTHORIZED ENTRY VISITOR		X						X				X	4
UNAUTHORIZED ENTRY VENDOR/ CONTRACTOR		X						X				X	4
UNAUTHORIZED ENTRY MEDIA		X						X				X	4
WORKPLACE VIOLENCE-VISITOR		X			X							X	10
WORKPLACE VIOLENCE-EMPLOYEE/CONTRACTOR/TENANT		X			X							X	10
INFANT ABDUCTION			X		X							X	5
VEHICULAR ACCIDENT		X						X				X	4
PARKING VIOLATIONS PARKING LOTS	X								X			X	3
PARKING VIOLATIONS FIRE LANES/BLDG ENTRANCES	X							X			X		12
UNAUTHORIZED SMOKING		X						X			X		8
GRAFFITI		X							X		X		2
ACCESS SYSTEM FAILURE			X			X					X		8
CCTV SYSTEM FAILURE			X			X					X		8



Compliance News

Updating Life Safety Plans

Continued from page 1

barriers such as dampers that could be permanently taken out of service or abandoned and no longer require maintenance/testing/replacement; field certifying or replacing damaged fire rated doors in certain walls with, in many cases, less expensive non-rated or lower-rated doors. Another option not used enough in today's hospitals is the advantage of designating suites to create fewer corridors, therefore reducing the maintenance on corridor doors, walls and clearance restrictions.

Per the 2000 NFPA 101 Life Safety Code, Section 4.6.12.2*, "Existing life safety features obvious to the public, if not required by the Code [LSC], shall be either maintained or removed." Section A.4.6.12.2 continues by explaining, "Examples of such features include automatic sprinklers, fire alarm systems, standpipes, and portable fire extinguishers. The presence of a life safety feature, such as sprinklers or fire alarm devices, creates a reasonable expectation by the public that these safety features are functional. When systems are inoperable or taken out of service but the devices remain, they present a false sense of safety. Also, before taking any life

safety features out of service, extreme care needs to be exercised to ensure that the feature is not required, was not originally provided as an alternative or equivalency, or is no longer required due to other new requirements in the current Code [LSC]. It is not intended that the entire system or protection feature be removed. Instead, components such as sprinklers, initiating devices, notification appliances, standpipe hose, and exit systems should be removed to reduce the likelihood of relying on inoperable systems or features." Example: Smoke or fire dampers no longer required could just be abandoned and not removed as they are typically not visible and obvious to the public.

Many opportunities can be realized by knowing your codes, having accurate life safety drawings, and sometimes by adopting newer code requirements. Please note that all applicable codes and standards requirements for national, state, and local codes have to be considered when updating your hospital's life safety plans. **SSR**

Publications & Seminars

Seminars in 2007

February 2	Louisiana Society for Healthcare Facilities Management, Shreveport, LA, "A-Z of BMP"
February 19	International Association for Healthcare Security & Safety, St. Petersburg, FL, "Joint Commission and the Role of Security & Safety Professionals"
April 19	California Society for Healthcare Engineering, San Diego, CA, "A-Z of BMP"
April 19	Texas Association of Healthcare Facilities Management, San Antonio, TX, "Life Safety Code & Electronic SOC"
April 20	ASHE Region 6 Annual Conference, Mankato, MN, "A-Z of BMP"
May 2-4	Alabama Society of Healthcare Engineers, Pensacola, FL, "Rx for Emergency Power Reliability"
May 3	HCPRO BHS Symposium, Las Vegas, NV, "Joint Commission EOC Standards 2006/2007 Survey Focus"
June 8	Georgia Society for Hospital Engineers, Calloway, GA, "Joint Commission EOC and e-SOC Update"
July 10	ASHE Annual Meeting, New Orleans, LA, "Planning for Power Failures" and "Selling the Maintenance Mission"



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A Newsletter Dedicated to Accreditation, Regulatory Compliance and Facility Management Issues for Healthcare Executives and Facility Managers

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