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TJC ISSUES 2014 NATIONAL PATIENT SAFETY GOAL ON CLINICAL ALARM SYSTEM SAFETY By David Stymiest, PE, CHFM, CHSP, FASHE

In its Joint Commission Online article, dated June 26, 2013, (www.jointcommission.org/assets/1/23/jconline_June_26_13.pdf) The Joint Commission announced a new 2014 National Patient Safety Goal NPSG.06.01.01 on clinical alarm safety for both hospitals and critical access hospitals. The July 2013 issue of Joint Commission Perspectives discusses the new NPSG in detail.



The NPSG requirements include 4 elements of performance (EPs) all with the Risk [R] icons that were recently established by TJC to identify patient risks due to a system's proximity to patient, probability of harm, severity of harm, and number of patients at risk. The 4 EPs are invoked in a phased process:

- Starting on January 1, 2014 and completed by July 1, 2014, hospital leaders are required to establish clinical alarm system safety as a hospital priority. This EP-1 requirement is scoring category A.
- Starting on January 1, 2014 and to be completed no later than the end of 2014, hospitals are required to identify the most important clinical alarm signals to manage based on their own internal situations. The EP-2 details include five separate issues (including published best practices and guidelines) to be considered during this identification process. This EP-2 requirement is scoring category A.
- As of January 1, 2016, hospitals will be expected to establish policies and procedures for managing the alarms previously identified. The EP-3 details include a minimum of eight separate issues to be factored

into the required policies and procedures. This EP-3 requirement is also scoring category A.

- And finally, as of January 1, 2016, hospitals are required to educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible. This EP-4 requirement is scoring category C.

It comes as no surprise that TJC has issued this NPSG. We wrote about clinical alarm safety in a late 2012 *Compliance Newsletter* article about the ECRI Institute's 2013 top 10 health technology hazards. Clinical alarm hazards were #1 on that list of top hazards. (The previous article is available at <http://ssr-cfm-articles.blogspot.com/2012/12/compliance-news-ecri-institute-lists.html>.) The NPSG's current wording is not the end of the story - TJC also states within the NPSG's Rationale that the NPSG will be updated to reflect best practices as further clinical alarm system management solutions are identified.

THIS MONTH'S TOPICS:

1 2014 NPSG ON CLINICAL ALARMS ISSUED

2 TJC STRENGTHENS EMERGENCY MANAGEMENT LEADERSHIP REQUIREMENTS

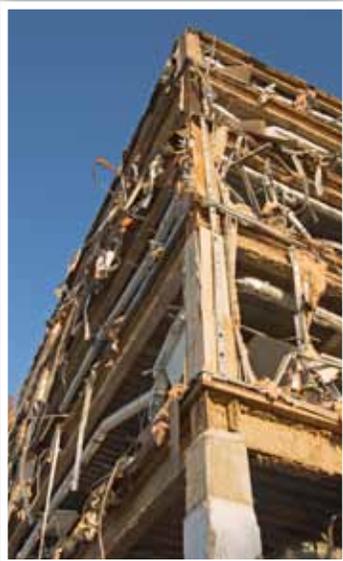
3 MEETING PROBLEMATIC LIFE SAFETY COMPLIANCE REQUIREMENTS

3 IMPROVED HVAC DESIGN MANUAL FOR HOSPITALS & CLINICS

TJC STRENGTHENS LEADERSHIP ACCOUNTABILITY FOR EMERGENCY MANAGEMENT

By David Stymiest, PE, CHFM, CHSP, FASHE

In the July 2014 issue of Joint Commission Perspectives, TJC officially issued new and revised leadership requirements intended to provide “a clearer description of leadership-level oversight of emergency management.” The new and revised elements of performance are all effective January 1, 2014.



- Within Leadership Standard LD.04.01.05 (the standard requiring effective management of programs, services and departments) TJC added a new EP-12 that requires the organization to identify a leader to be accountable for implementation of the 4 phases of emergency management, the 6 critical areas of emergency management, hospital-wide collaboration, and collaboration with community-response partners. This new EP is

scoring category A.

- Within Standard EM.03.01.01 (the standard requiring evaluation of the effectiveness of emergency management planning activities) TJC added a new EP-4 requiring that planning reviews be forwarded to senior (vice president and officer level) leadership for review. This new EP is scoring category A.
- Within Standard EM.03.01.03 (the standard on evaluating the EOP effectiveness), TJC modified EP-13 (the EP requiring evaluation of all exercises and responses to actual emergencies) to require that relevant input from staff at all affected levels also be considered. Within the same standard, EP-15 regarding communication of emergency management deficiencies and opportunities for improvement was modified to require communication of this information to senior leadership.
- And finally, within Leadership Standard LD.04.04.01 (the standard requiring that leaders establish performance improvement priorities) TJC added a new EP-25 that requires senior leaders to direct implementation of selected hospital-wide improvements in emergency management based on three listed considerations. This new EP is scoring category A.

In explaining the reasoning behind the above changes, TJC stated “hospitals plan and respond more effectively when accountability for hospital-wide emergency management is assigned to leadership at a high level of the organization.” Since many hospitals consider the performance improvement activities for each year in January of that calendar year, SSR recommends that these changes be discussed in the near future to ensure that required activities have been completed on time. Besides appearing in Perspectives, the full text of these new requirements will also appear in 2013 Update 2 to the Comprehensive Accreditation Manual for the hospital and critical access hospital programs as well as in the fall 2013 Joint Commission online manual update.

UPCOMING SEMINARS

July 21-24

American Society for Healthcare Engineering (ASHE) 2013 Annual Conference, Atlanta, GA, “Managing Electrical Systems for Reliability” and “Just Ask ASHE” Plenary

August 7-8

Vanderbilt University’s Healthcare Design & Construction Symposium, Nashville, TN “Smart Technology for Care Delivery”

August 9

Texas Association of Healthcare Facilities Management (TAHFM) Regional Seminar, Plano, TX “Rx for Emergency Power Reliability”

October 7-8

Florida Agency for Health Care Administration (AHCA) Seminar, Orlando, FL “Expanding the Concept of Emergency Power Reliability”

October 9-11

Alabama Society for Healthcare Engineering (AlaSHE) Fall Conference, Orange Beach, AL “Managing Emergency Power Expectations and Realities” and “Continuous Compliance – Maintaining Constant Survey Readiness”

October 23-25

Decision Health 17th Annual EC Summit in Las Vegas, NV “After the Storms-A New Paradigm in Emergency Power Reliability”



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ASHRAE PUBLISHES IMPROVED HVAC DESIGN MANUAL FOR HOSPITALS & CLINICS

By Ron Holdaway, PE, CEM, LEED AP

ASHRAE recently published the 2nd edition of the HVAC Design Manual for Hospitals and Clinics. ASHRAE states that this book, a complete rewrite of the 1st edition, focuses specifically on HVAC system design for health care facilities, omitting general system descriptions that are readily available in other ASHRAE publications.

This new ASHRAE publication is an excellent resource on current HVAC design topics for today's health care facilities. Topics range from HVAC Systems, Infection Control, Utilities, O&M, and Infection Control Risk Assessments (ICRA) to sustainability in healthcare facilities and seismic design for HVAC systems in healthcare. All of these are very relevant topics for design engineers and building owners of health care facilities.

The new ASHRAE book has an entire chapter on Infection Control. Generally the ASHRAE design manual acknowledges a lack of definitive industry knowledge on mechanisms of transmission of airborne contaminants. The manual states on page 19 "Transmission of airborne hazards is influenced by factors beyond the control of the engineer that include movement of patients, undiagnosed patients, visitors, concentration of patients, and patient susceptibility. The nature of infectious pathogens, the modes of transmission, the causation of infections, and the relationships to HVAC system design are complicated and not fully understood."

However, the design manual does contain some specific suggestions such as the following excerpt from page 19: "HVAC systems can affect the distribution patterns of airborne particles by diluting or concentrating them, moving them into or out of the breathing zones of susceptible persons, or by accelerating or decelerating the rate of growth of airborne microbes." The design manual also cautions healthcare facility operations personnel that "Improperly operated and maintained HVAC systems can even become a reservoir for microorganisms."

The ASHRAE HVAC Design Manual for Hospitals and Clinics is available at the ASHRAE bookstore: www.ashrae.org/bookstore.

TJC PROVIDES TIPS FOR MEETING PROBLEMATIC LIFE SAFETY COMPLIANCE REQUIREMENTS

By David Stymiest, PE, CHFM, CHSP, FASHE

TJC Director of Engineering George Mills provides tips for meeting problematic life safety compliance issues in the July 2013 of The Joint Commission's EC News. This valuable multi-page article addresses the following elements of performance (EPs) and related types of survey requirements for improvement:

- The "all other" means of egress code requirements such as door width requirements that are commonly scored under Standard LS.02.01.20, EP-32.
- The smoke barrier door requirements such as fire ratings, swing directions, smoke door width and door edge treatments that are typically scored under Standard LS.02.01.30, EP-25.
- The fire alarm requirements such as pull station locations that are typically scored under Standard LS.02.01.34, EP-4.
- The automatic sprinkler system requirements such as water pressure inadequacies that are typically scored under Standard LS.02.01.35, EP-14.
- The "No Smoking" signage and ashtray requirements typically scored under LS.02.01.70, EP-4.
- The bedding, curtains, and other furnishings issues typically scored under Standard LS.02.01.70, EP-4 and Standard LS.02.01.35, EP-6.

