This is Part 1 of a Special Series addressing the EC angle on the critical problem of patient flow throughout a health care organization, a concern so serious that the Joint Commission has created a new Leadership standard to address the issue. EC professionals will play an important role in helping to meet this standard.

Moving patients smoothly through their hospital stay is essential to the prevention of patient crowding. Overcrowding can lead to lapses in patient safety and quality of care, and have a negative impact on patient and staff satisfaction.

The new “Leadership” standard that becomes effective for all accredited hospitals January 1, 2005, calls on leaders to develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.* Although the new standard focuses on leadership’s responsibilities for maintaining patient flow and avoiding overcrowding, EC professionals can and should help with the facility services, safety, design, and disaster aspects of this problem. This article, the first of a three-part series on the topic, addresses facility services and safety-related strategies EC staff can use to help improve patient flow.

Although overcrowding is most common in emergency departments (EDs) and post anesthesia care units (PACUs), every point along the patient care continuum, from initial assessment to discharge, is interrelated and contributes to this phenomenon. Improved management of organizational processes can reduce the risk of negative patient outcomes resulting from delays in the delivery of care, treatment, and services.

Leadership and the EC Staff
As part of the multidisciplinary safety committee (EC.9.20, EPs 1-9), EC leaders participate as integral members of the hospitalwide leadership team in planning for and providing the appropriate health care environment. EC professionals can take the following actions to work with leadership in

(continued on next page ➤)
EC Strategies for Patient Flow (continued from previous page)

ensuring smooth patient flow:
Alert leaders about possible environmental problems. In addition to direct care staff, EC staff members often are able to “sound an early warning” about crowding that could compromise patient safety and create other problems. “It’s up to EC staff to surface issues to leadership in an appropriate way by identifying how a risk can impact patient outcomes. Then, it’s up to leaders to identify and mobilize the resources needed to reduce or mitigate the risk,” notes Deana Bowlds-Williams, M.T., M.S.M., associate project director at the Joint Commission.

Participate in bed placement meetings. At the Medical Center of Central Georgia (MCCG) in Macon, which routinely operates at 95% inpatient capacity, optimal patient flow is critical. The nursing directors, environmental services director, emergency medical services director, and other leaders impacted by patient flow or with a hand in improving patient flow efficiency, come together for twice-daily bed placement meetings. “We look at admissions, discharges, surgeries, and other patient scheduling statistics for the day and work on a plan to place each patient. The high inpatient census limits our treatment-space options in such areas as the ED, PACU, and intensive care unit (ICU), so crowding is a daily challenge,” says Wanda Eaves, R.N., B.S.N., nursing director of emergency services.

Overflow Areas
Overflow areas can easily present Life Safety Code® (LSC), quality of care, and patient safety problems. Patients “parked” in hallways are particularly vulnerable. JCAHO’s “Management of the Environment of Care” standards require the provision of a safe, functional, supportive, and effective environment for patients and staff (EC.8.10, EC.1.10). “Patients in a hall bed don’t normally get the same level of services they would in a unit bed. There’s no access to call lights in hallways, no privacy, no confidentiality, and it’s very difficult for staff to provide the needed care. Moreover, it’s an obvious violation of fire safety codes because hallway beds prevent the safe egress of patients and staff (EC.5.10),” Bowlds-Williams says. However, in many organizations, the question—But where else can we place these patients?—is a legitimate one.

Conduct overflow space planning. EC staff should be integrally involved in identifying appropriate overflow areas. “Your average waiting room is not going to be an appropriate place to set up overflow beds, but maybe an ambulatory clinic run by the hospital could be considered for evening and holiday overflow,” Bowlds-Williams suggests. “Some clinical areas might be able to be modified to do ‘double duty.’ Proximity to the ED is important for ED overflow, because you don’t want to have to manage patients that are too far away from each other.”

Evaluate and equip overflow areas. EC staff helps assure that the hospital establishes and maintains a safe environment of care and proper equipping of overflow areas. Issues that need to be considered include the management of medical equipment risks (EC.6.10) and all the components of what makes a safe environment, such as those specified in the EC standards and required EC management plans. Heating, ventilation, air conditioning, emergency power, utility systems, medical gas and vacuum systems, and medical equipment each need to be addressed. “Don’t forget such things as flooring and width of doorways. Patients in critical condition usually need wider beds that require more doorway space,” Bowlds-Williams comments.

Because walk-ins comprise more than 80 percent of individuals presenting to MCCG’s ED, the triage area can occasionally back up. To address this problem, emergency

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Senior Editor: Kristine M. Miller, M.F.A.
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Division of Standards and Survey Methods: John Fishbeck, RA, Assoc. Director
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E-mail us at ecnews@jcrinc.com with your article ideas.
New Care Areas

Many hospitals are setting up ICU “step down,” “Fast Track,” and other patient care areas to improve patient flow. Often a separate section within the ED, Fast Track units allow individuals with obviously non-life threatening conditions who come to the hospital’s ED, such as those with sprains and breaks, to be triaged quickly and seen by a physician. Another type of new unit is in operation at MCCG. Two “Express Admission” patient care units serve the needs of individuals who know they will be admitted to the hospital for a nonemergency service and come with a physician’s order in-hand.

Evaluate and equip new care areas. Just as with overflow and all other patient care areas, EC staff evaluates and equips new care areas. “Our Express Admission units provide the same level of care and services as the ED and nursing units, and need to have the same monitors, crash carts, automated medication dispensing machines, and so forth,” Eaves describes. “Environmental services and infection control staff were involved in planning, evaluating, and inspecting the areas before we opened them. Route planning, life safety testing, and space configuration were addressed, among many other issues,” Eaves says.

Ongoing Challenges

Stay on top of potential problems. At MCCG, a member of the clinical engineering department is assigned specifically to the emergency services department. “During daily rounds, he checks all equipment and indicates any problems experienced with monitors, oxygen, suction, IV pumps, alarms, defibrillators, pacemakers, and other equipment,” Eaves describes. During weekly rounds, plant operations staff looks at lighting, heating, power, and other issues. Early warning signals can prevent the occurrence of major problems that could have a significant impact on optimal patient flow.

Improve response time for needed retrofitting. EC staff provides the needed retrofitting when an inpatient bed or equipment is available, but needs retrofitting or replacement. “Two- to three-hour delays in response time for switching equipment in a patient room are not going to be acceptable in most instances,” Bowlds-Williams says. Enhanced communication about needed equipment and supplies, such as using faxes instead of messengers, can reduce bed turnaround time, thereby improving patient flow.

Conclusion

Many organizations are reengineering their patient care units to help achieve optimal patient flow (to be discussed in detail in Part 2 of this series, May 2004). For many other organizations, redesign is a hope for the future, but not a present-day reality. EC staff thus plays a critical role in identifying and equipping all new and overflow areas intended to solve or ease patient crowding.

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Kristine M. Miller, MFA
Senior Editor
Environment of Care® News
Department of Publications
Joint Commission Resources
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Phone: 630/792-5494
E-mail: ecnews@jcrinc.com.
Managing Waterborne Bacteria

Legionella Contamination Curbed at Johns Hopkins Hospital

Hospital-associated infection is a critical problem for health care facilities. The new 2004 National Patient Safety Goal 7 underscores the importance of infection control (IC) (see box on page 5 for the goal and requirement language). Although not explicitly mentioned in Goal 7, certain aspects of managing the environment of care provide a foundation for basic IC throughout a health care facility. Without proper management of a facility’s buildings, air-handling systems, water, and much more, clinical aspects of IC would be undermined. This article focuses on the importance of ensuring the safety of a facility’s water supply.

When a waterborne bacteria such as Legionella enters a health care facility’s water-distribution system, it poses the threat of spreading the potentially fatal Legionnaire’s Disease among patients and staff.

Legionella can quickly multiply in a building’s piping system. Slow-moving water, stagnant water, and dead legs in the system (including rarely used plumbing fixtures and hot water systems) will make the bacteria grow faster.

The bacteria also develops a biofilm layer in piping systems that protects it and allows it to colonize. That layer makes it easier for the bacteria to spread in water systems and become aerosolized through sinks and showers.

Once in contact with the bacteria, patients who are immunosuppressed are at risk of acquiring Legionella pneumonia. According to the Centers for Disease Control and Prevention (CDC), an estimated 8,000 to 18,000 people contract Legionella every year, and five percent to 30 percent of them die from the illness.

“If a facility has susceptible patients, it must escalate its risk-management activities,” says Britt Berek, associate director, JCAHO Standards Interpretation Group. “Health care facilities must match their level of risk management with the level of risk they deal with. That can span a wide range, and it will be different for each facility.”

The Incident

In 2003 a trace of Legionella was found in the water supply at the Comprehensive Cancer Center at Johns Hopkins Hospital in Baltimore, M.D. The facility, which has 154 beds and an outpatient center, successfully managed the bacteria—no cases of Legionnaire’s Disease occurred.

The bacteria were found in the building’s hot and cold-water distribution systems and in the strainers where the city’s potable water enters the building. The bacteria was discovered when the city’s water service to the building was disrupted and heavy rains occurred due to Hurricane Isabel.

“To detect the bacteria, we used water sampling,” says Greg Bova, senior operations engineer at Johns Hopkins. “Hot and cold-water samples were taken regularly from taps throughout the building by opening the taps and letting the water flow for 30 seconds before the sample is collected. The samples were taken to our Department of Pathology lab for processing. Direct, concentrated cultures were performed from each sample.”

The hospital performed active clinical surveillance on patients for Legionella. Any patients with symptoms of pneumonia were evaluated for Legionnaire’s Disease with a urinary antigen test. Testing was not conducted on staff, but employees concerned about their own health—possibly because they were immunocompromised—were told to consult their personal physicians.

“Water restrictions were immediately imposed for the entire building,” Bova adds. “We placed prohibitions on showers, tub bathing, drinking from water fountains, using ice and drinking water from ice machines. Bottled water and waterless hand cleaner were provided, ice was provided from other buildings, and sponge baths were offered.”

Advantages of Using Chlorine Dioxide

To remove the bacteria, hot and cold-water systems were flushed and treated with elevated levels of chlorine dioxide disinfectant for six hours. Chlorine dioxide was pumped into water mains to maintain elevated, detectable levels at all fixtures.
Bova gives several reasons why Johns Hopkins chose to use chlorine dioxide instead of superheating water or using chlorine: “Superheating can’t be done on cold-water systems because hot-water temperatures over 160 degrees are required to kill the bacteria. Superheating has limited effect on fixtures because of the anti-scald devices that prevent hot water from exceeding 115°F at the fixtures. Superheating also has a limited effect on biofilm in the piping and minimal residual effect.

“Chlorine treatment requires pumping high levels of chlorine into the hot and cold-water piping and at all fixtures. Once the chlorine is in the piping system, sinks, showers, and toilets, they can’t be used for three to 24 hours depending on the level of chlorine used. When they are ready to use, the water system must be purged until the levels of chlorine are below EPA maximum limits.”

Using chlorine has other disadvantages. The water restrictions and flushing of highly chlorinated water and the strong odors that come with high levels of chlorine can be disruptive to patients, visitors, and staff in the building. Also, elevated levels of chlorine are corrosive to the piping system and chlorine has minimal residual effect on biofilm and bacteria even when used continuously at the maximum levels allowed by the EPA.

“Chlorine dioxide, however, is EPA-approved for potable water disinfection and it’s documented to be over five times more effective at killing bacteria than chlorine,” Bova says. “During remediation treatments with chlorine dioxide, drinking is prohibited but flushing toilets and washing hands at sinks are allowed. Chlorine dioxide odors are not noticeable during treatments; it has an excellent impact on biofilm and bacteria; and it has significant residual effect,” Bova explains.

If Legionella bacteria are detected in water systems at levels requiring corrective action, the organization should consider implementing an awareness program to inform patients, visitors, and employees of the biological hazard.

Management of Waterborne Bacteria

For health care facilities, management of waterborne bacteria, not prevention, is the right approach. “These events are not always preventable, but their impact can be minimized and made manageable,” Bova advises. “Closing of water valves, flushing the piping systems, and cleaning water devices such as aerators and strainers will limit the bacterial loading of the distribution system. If necessary, self-imposed water restrictions may be applied until flushing and treatment of the water system can be done. It’s important to review your Legionella control and prevention procedures and develop surveillance programs, water-treatment programs, and remediation plans.”


A consensus document developed by industry experts and CDC representatives, Guideline 12-2000 offers recommendations that apply directly to health care, including suggestions for appropriate times to monitor for Legionella. The guideline is also applicable for managing the following:

- Potable and emergency water systems
- Heated spas
- Cooling towers, including fluid coolers and evaporative condensers
- Direct evaporative air coolers, misters, air washers, and humidifiers
- Indirect evaporative air coolers
- Metal working systems
- Architectural fountains and waterfall systems

These recommendations are aimed at protecting high-risk patients in health care facilities, but building managers and IC personnel should know that following these guidelines may also help protect health care employees.
Every day our Joint Commission environment of care technical experts receive calls from readers like you. This Q & A column features answers to the questions our experts hear most often. If you’d like further information from our staff, please contact the Joint Commission’s Standards Interpretation Group in the Division of Accreditation Operations, at 630/792-5900, or e-mail them at ecnews@jcrinc.com.

Requirements for Ambulatory Health Care Occupancy

Q Our medical center’s outpatient care center is currently classified as a business occupancy but needs to be reclassified as an ambulatory health care occupancy. What standards and requirements will JCAHO require us to follow for the ambulatory health care occupancy classification?

A For this change from a business occupancy to an ambulatory health care occupancy, the Joint Commission would expect your organization to comply with the requirements of the 2000 NFPA 101 Life Safety Code®, Chapter 20 for New Ambulatory Health Care Occupancies. In addition, you should comply with local and state building codes, any other local and state requirements, and the Americans with Disabilities Act (ADA) requirements.

Privacy Curtains

Q What standards should privacy curtains in hospital and nursing home facilities comply with? I would also like to know what the rule is for hospital private patient rooms. Is the door considered the standard for privacy compliance, or is a cubical curtain necessary when the door is open?

A Joint Commission standards do not specifically address this issue other than a requirement to provide appropriate privacy to patients per standard RI.1.130. Regarding a private patient room, a door to the room could provide the necessary privacy, depending on the patient’s level of dress as well as the needs for staff in general to get into the room to perform their various duties without encroaching on the patient’s privacy.

Ceilings and Grab Bars

Q Our hospital received a supplemental recommendation for EC.1.10 in our psychiatric unit. The reference was to the potential for hanging oneself from grab bars and ceilings. The bathrooms have hard ceilings, but the patient rooms do not. I see that there is a requirement in the 2001 AIA Guidelines for Design and Construction for tamper resistant ceilings. Would clips of the tiles suffice? Also, no mention is made of grab bars.

A Joint Commission standards do not specify exactly what steps should be taken in this regard. Organizations should perform a risk assessment. You should first look at the patient population served, review any past attempted suicides and by what method, and then take the most appropriate actions possible to prevent or limit this occurrence from happening again.

Clipping down suspended ceiling tiles would certainly thwart an initial attempt in using the ceiling grid to tie on to.

Grab bars are another matter. They are needed to assist patients, especially the elderly, physically impaired, or infirm, in toilet and bathing locations. There are few or perhaps no choices available in obtaining a grab bar designed in such a way that something cannot be wrapped around it and used in an attempted hanging. There are showerhead and curtain rods that have a “break away” feature that causes them to break or pull away from the wall or wherever they are anchored when a designated amount of weight is applied. However, there is the potential for a patient to purposely dislocate or remove a rod or grab bar and use it as a weapon. Again, this takes us back to your risk assessment, evaluating the patient population served, and applying reasonable judgment as to what steps to take and where to apply the necessary safeguards.

Plants, Pets, and Fish Tanks

Q Is there a standard for managing plants, pets, and fish tanks in the hospital setting? If one exists, what is the standard?

A A JCAHO standard does not specifically exist. If the organization allows plants or pets, it should have policies on their care consistent with the organization’s goals and good health and sanitation requirements. These policies must also be consistent with standards in the “Surveillance, Prevention, and Control of Infection” chapter of the applicable accreditation
Written Performance Measures Format

Q: Is there a recommended format for the written performance measures for each environment of care area? For each EC area I am developing a goal, an indicator (what I am measuring), a control limit (the most we hope to see of an undesirable indicator or minimum of a desirable indicator), and how often the data are aggregated. Is that sufficient? Would I need any other documentation?

A: There is no one recommended format for the written performance measures for each environment of care area. Your proposed response appears to be heading in the right direction. As long as an example of your response is provided for each EC area to be addressed above, that should be adequate for showing compliance.

Collaborative Environmental Rounds

Q: Please clarify the requirements for collaborative environmental rounds as to frequency, documentation, and so on.

A: Standard EC.1.20 states, “The organization conducts environmental tours at least every 6 months in all areas where patients are served,” and “at least annually in areas where patients are not served... to identify environmental deficiencies, hazards, and unsafe practices.”

JCAHO expects that these tours or rounds be performed by individuals who can utilize their expertise in safety-related issues and look for potential safety problems as they are surveying an area or department. Often, this requires more than one discipline; hence the “collaborative” effort during these environmental rounds.

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Initial Electrical Safety Checks

Q: Must all incoming electrical line operated devices have an initial electrical safety check, including documentation that the safety check has been performed? We are quite aware that any such devices within the patient care vicinity certainly do need this check, but nowhere have we been able to find a requirement stating that other devices (for example, computers, pencil sharpeners, coffee pots) need to be checked. National Electrical Code (NEC) regulations spell out what needs to be done for patient care equipment but they do not give definitive guidance on all electrical line operated equipment. We are presently trying to update our in-house electrical policy and we would like it to reflect all present requirements related to electrical safety.

A: JCAHO standards do not specify. While it might be a good idea to perform an initial electrical safety check on the equipment examples provided, it is not mandated by JCAHO standards.
It’s not surprising that at George Washington University Hospital (GW), the level-1 trauma center closest to the White House, emergency preparedness is an exceptionally high priority. That preparedness paid off on the morning of October 7, 2003, when a gas leak occurred across the street from the hospital.

GW’s response began when EMS (emergency management services) personnel on the ambulance ramp smelled gas, notified the hospital that the facility was being closed to ambulance traffic, and alerted both the fire department and the gas company. Shortly thereafter, a passing car burst into flames, and the street began to burn. When the fire department arrived, they entered the facility, ordered an evacuation via the public-address system, and began a floor-by-floor sweep.

“Fire departments need to be aware of the consequences of asking for a hospital evacuation,” says John Rhodes, GW’s trauma coordinator and chair of its multidisciplinary emergency management (EM) committee. That morning, they had approximately 400 patients—including both inpatient and outpatient—plus family members and hundreds of staff members.

“Hospitals aren’t like office buildings, where people just stand up from their desks and walk out,” Rhodes says. In hospitals, people are in many states of ability and disability. “We had never evacuated before. Only about 2% of hospitals in the country have,” Rhodes says. “We drill, of course, but then we only move patients from one side of the floor to the other, or we use actors. No one knows what an evacuation will be like until they have to do it in a real emergency.”

The side of the hospital closest to the fire, including the emergency room, was cleared, with some emergency department patients transferred to other area hospitals. Approximately 120 people were moved to a nearby GW building, while other patients and family members were relocated to areas of the hospital farthest from the fire.

Meanwhile, in the surgical unit, the chief medical officer took charge of decision making. Those surgeries that had not yet started were cancelled; those patients who had already been given anesthesia were held in the recovery area until they woke up. A number of surgeries were in progress, and those continued, with DC fire personnel nearby, monitoring for gas levels. If they’d detected a problem, the chief medical officer would have had to reconsider the course of the in-process surgeries.

“When emergency preparedness committees write their evacuation plans, they often don’t think about who will make those kinds of medical decisions,” Rhodes says, glad that GW had thought to include such a procedure in its plan. “It has to be someone with administrative powers as well as medical expertise.”

As chair of the emergency preparedness committee, Rhodes becomes the advisor to the hospital administration during emergencies. He’s the person who knows GW’s plans the best, and he also represents the hospital on the D.C. Hospital Association Emergency Preparedness Committee, which plans the coordinated response of the whole district. He has a good background for

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**Case at a Glance**

**Main challenge:** Coordinate with outside responders in reacting to a gas fire and executing a partial hospital evacuation.

**Issues:** Emergency management; fire safety.

**Joint Commission Standards:** EC.4.10, emergency management; EC.5.10, management of fire safety risks.

**Solutions:** Work with all outside responding agencies on a communitywide emergency management program; assure that all outside responders know that (1) hospitals have their own emergency plans and (2) there is a designated person to whom they should talk.

**Outcome:** All key responding agencies are now represented on the districtwide emergency management committee.
the job. He started in EMS while attending nursing school, worked in an ICU, and then left nursing for four years to work as a police officer. When he came back to the hospital setting, he took a position in nursing administration. Now, schooled in the lessons of EMS, police work, and hospital work, he knows who needs to come together in an emergency.

In the case of GW’s gas fire, the right people came together: The gas leak was sealed after about 40 minutes. Firefighters and hazmat crews put out the fire minutes later. And at approximately 12 P.M., the fire department gave the hospital the all clear to move patients back into their rooms.

According to the Washington Post, some patients and staff reported the evacuation as a chaotic scene. And Rhodes somewhat agrees about the first few minutes of the response, attributing the panic to the evacuation order made via the public address system.

“GW has an emergency paging system that can alert up to 85 key people at once—all the administrators, supervisors, and key resident physicians—without creating anxiety in everyone in the facility.” Within minutes, this system was activated, allowing for more organization.

So what was the number one lesson learned during the gas fire emergency? Rhodes says, “All outside responding agencies need to know that (1) hospitals have their own emergency plans and (2) there is a designated person who they should talk to: the person who will be making the decisions for the hospital.” Once this crucial communication connection is made, inside and outside responders can act as a team, making decisions jointly.

True, the D.C. Hospital Association has an active emergency preparedness committee, of which Rhodes is a member. And the committee has representatives from a full range of relevant organizations—hospitals, military facilities, and emergency management agencies—working toward a coordinated response. But before the GW fire, one person represented both EMS and the fire department, leaving the fire department slightly out of the loop. Now, both services are represented.

Still, Rhodes acknowledges that EM planners face multiple challenges: First, it’s expensive to have a good EM program. “It takes so many hours to do plans—hours of thinking, writing, meeting with equipment vendors.” And emergency equipment is expensive—especially considering that it isn’t used very often; with luck, maybe never. “But if you don’t plan,” Rhodes says, “it could be even more costly. Trying to make up plans as you move through an emergency is not ideal.”

Second, without one or two vigorous EM champions in the organization, planning suffers. GW started disaster planning in the mid-1990s—in part due to the urging of two staff physicians with extensive EM experience responding to disaster situations both with FEMA and in hospitals all over the world. One of them was the original chair of D.C. Hospital Association’s emergency management committee. Clearly, organizations benefit by cultivating an EM champion.

Does Rhodes have other EM advice to share? He does.

■ Plans shouldn’t delegate the entire responsibility for emergencies to the emergency department (ED.) The whole hospital must be prepared—for example, with a plan for moving patients out of the ED as soon as possible so the ED is available to accept more victims.

■ Planners should include subacute hospitals and health care organizations in their planning processes, as during an emergency, such facilities may become essential. For example, they may be able to accept less-acute patients from trauma centers, so that trauma center beds can be used for med-surge care.

■ EM plans must get everyone “talking the same language.” During an emergency, outside responders don’t necessarily know the name of the person who will be the EMS coordinator, but they need to know there will be one, so they can say, “Let me speak to the EMS coordinator.” If Rhodes needs to contact the key person at the police or fire department, he needs to know who to ask for—not by name, but by title: the operations commander, for example. “That’s what the Healthcare Emergency Incident Command System (HEICS) is for,” Rhodes says, “so everyone uses the same terms.”

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Mayo Clinic in Scottsdale, Arizona was one of the hospitals that agreed to take part in piloting the Joint Commission’s new accreditation process in the Shared Visions–New Pathways® initiative. A core cadre of approximately 40 surveyors conducted the pilot surveys in organizations across the country. Many environment of care (EC) professionals are eager to know how EC issues are treated in the new accreditation process. Reporting on that pilot program for Mayo Clinic is Beth Heinrich, Mayo’s director of environmental safety and health. Her experience as an EC professional may prove instructive for others soon to undergo an EC survey.

Mayo Clinic in Scottsdale is one of three Mayo Clinic hospitals (the others are located in Rochester, Minnesota, and Jacksonville, Florida). Scottsdale is a 311-physician group practice employing nearly 4,000 people and delivering health care services in more than 66 medical and surgical disciplines.

At the start of the pilot program, Mayo Clinic completed its Periodic Performance Review (PPR), which was followed by a phone conference with JCAHO’s Standards Interpretation Group, during which standards were reviewed, questions were answered, and areas for further improvement were discussed.

Opening Conference and Orientation to the Organization

Next came an on-site visit by the Joint Commission’s team of surveyors, accompanied by several observers from the JCAHO Central Office.

One of the observers was Britt Berek, JCAHO’s associate director for the Joint Commission Standards Interpretation Group (SIG). Berek explains that the new accreditation process puts greater emphasis on whether all staff members know their roles. “Instead of looking at binders and charts and graphs,” he says, “the surveyors have shifted to listening to staff members talk about doing their job and responding to EC issues.”

As Mayo Clinic’s director of safety, Beth Heinrich was involved in the EC portion of the process, where she was joined at times by the hospital’s director of security, the manager of facility operations, the manager of biomedical engineering, the risk manager, the director of planning and design, and the hospital’s administrator.

“It’s hard for me to estimate how long it took to ‘prepare’ for the survey,” Heinrich says. “This is not something we do differently just because the Joint Commission is coming. This is something we try to do each day by maintaining an ongoing state of readiness.” Heinrich and her colleagues did keep on hand any supporting documents they thought the surveyors might want to review, including records that indicate how certain processes are managed.

The challenge, says Heinrich, was simply the unknown. “Of course, we hadn’t been through this before, and we realized that the surveyors were also learning a new process.”

Surveyor Planning Session

The planning session is designed to let the surveyors review and discuss data, select initial tracers, and plan the survey agenda.

Prior to the pilot program, this Mayo Clinic was last surveyed in September 2002. When asked why they agreed to participate in the pilot program so soon after the prior survey, Heinrich says, “The hospital’s goal is to provide the best care for our patients. We recognize that the Joint Commission wants to help facilities provide that kind of quality care. We see it as mutually beneficial to work with JCAHO in evaluating the new process.”

Conducting the Tracer

Under the previous process, surveyors looked at every hospital department individually and separately. However, the new tracer process involves following a patient’s care throughout the entire organization, from one department to the next, and looking at whatever contacts the patient may have with staff members, including
physicians. This enables surveyors to review multiple departments and analyze how they coordinate caring for patients.

“The tracer process was new to us, and we didn’t know how the methodology would impact this,” Heinrich says. She recalls a question that came up during the EC interview about a tracer patient the surveyors had encountered in one of the units. “Their question was about moving that patient to a different department for testing and how the nurse knew whether any issues came up while that patient was undergoing testing. It really concerned how we communicate between departments when patients are off the unit.”

Berek adds, “During the patient trac-ers, most of the questions are clinically focused, as one would expect. But I noted that if a caregiver was busy and the surveyors had to wait to interview them, the surveyors used the time to walk the unit and get acclimated.” Berek reports that the surveyors would typically look at EC issues, such as how waste is handled, how alarm response is managed, whether life safety features are in good condition, and whether the hospital layout is conducive to patient safety matters. “When the nursing staff became available, the surveyors would talk to them about the patient’s clinical issues. But sometimes as the surveyors were leaving the unit, they might look for other EC issues and confirm them with the staff.”

**Life Safety Code® Building Tour**

In the new accreditation process, the tour is intended to assess the buildings of the organization that are required to be designed and maintained according to the requirements of the Life Safety Code®. Heinrich reports that she and the surveyors were accompanied on this tour by the hospital’s facility operations director/manager, the hospital’s administrator, and the planning and design director.

“This building tour was very similar to tours that JCAHO has conducted in the past,” Heinrich says. It was a top-to-bottom review of the facility. The surveyors checked for penetrations, door closures, fireproofing, fire alarms, sprinklers—all the customary life safety issues.”

“The principal difference in the new process is that the focus is on life safety issues only, not dietary, infection control, med carts, or other concerns,” Berek notes.

**Other Issues**

Mayo Clinic found that most of the processes it had in place continue to meet JCAHO’s requirements. Says Heinrich, “In the past, the surveyors devoted much of the interview process to reviewing paperwork and documentation, such as fire-drill schedules to make sure we conducted them at the right time. Or maybe they looked at the safety minutes and the equipment management report.”

And this time? “The interview for the pilot program was more of a dialog. For instance, the Joint Commission asked us if we’ve made improvements in any of the areas we manage, such as safety management. Or were improvements even needed?” Heinrich sees the process as putting less emphasis on documentation and more on a discussion of how Mayo Clinic runs its programs from start to finish.

Heinrich reports that Mayo Clinic didn’t find anything that it needs to do radically differently because of the reorganization of the 2004 standards. When asked for suggestions for other hospitals and environments of care that have yet to be surveyed, Heinrich advises, “It’s a matter of getting the right people involved in the process and making sure it’s multidisciplinary.” She also noted that Mayo found it helpful to assemble a folder or 3-ring binder for each of the seven EC areas—general safety, security, hazardous materials and waste, emergency management, fire safety, medical/laboratory equipment, and utilities.

“We went through the performance measures and included examples of how we meet each measure, how we comply, and what programs we have in place to ensure and monitor that compliance,” Heinrich says. “That way, as we’re going through, we could show how all the different components of our EC program work.”

She cautions that an EC management program is holistic. “An EC management program is not a just a matter of safety issues or hazardous materials and waste issues but of the overall facility issues. You need to have all the right people in that room to show you handle each of those areas across the organization.”

Berek concludes, “Overall, if organizations are educating their staff in the new process, there shouldn’t be any need to change anything on a wholesale basis. The surveyors will talk to them in the context of their job and ask them what they do.” Moreover, says Berek, staff members won’t be quizzed in Joint Commission language or asked if they’re complying with standard two point ten point four point one. “Instead,” says Berek, “the surveyors will talk to employees about how they are doing their jobs, and the surveyors will categorize these observations into the appropriate standards slots.”

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