August 2007 Issue 11

TSIG NEWS

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Inside this issue:

If you would like to contribute and article on a topical matter, or share your recent JC Survey experience with your fellow professional, please send your emails to

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Continuing Education Units (CEU's)

TSIG is now part of the award winning AIA Continuing Education System, as a Registered Provider.

Professionals attending Workshops or In-Service presentations are now eligible to receive Learning Units.

Did you know that you can now electronically schedule & track all your required JC/NFPA Testing?

(see bottom page 11)

Fire Watches

Written by: Ode Keil (guest writer)

The Joint Commission Interim Life Safety Measures include a requirement for a fire watch when a fire alarm is disabled for more than four hours in a 24 hour period. This requirement is taken directly from *NFPA 101 Life Safety Code 2000 Edition* ©. Section 9-6.1.7 requires that the fire watch be provided for all occupants who are left unprotected by the shutdown until the fire alarm is returned to service. The appendix note related to this section clarifies the intent. The minimum expectation is that someone be assigned to walk the affected areas during the time of the outage. The person assigned to the task should be specially trained in fire prevention and in the procedure for notifying occupants and the fire department should a fire be detected by the fire watch.

NFPA 51B Standard for Fire Prevention during Welding, Cutting, and Other Hot Work© defines a fire watch as a person. The purpose of the fire watch is to manage the risks of fire specifically related to the use welding or cutting equipment. The primary concern is to prevent sparks or flame from coming into contact with flammable or combustible materials directly or through heat or material transfer through adjacent walls or slabs.

The *Life Safety Code* modifies this concept by making the fire watch a combination of a fire detection and alarm system where the installed system is not functional. The Joint Commission further modifies the concept by requiring that the fire watch be implemented in areas where a fire suppression system is out of service either at the same time an alarm is out of service or independently.

Joint Commission surveyors, state licensing inspectors, and Medicare inspectors are all emphasizing how seriously the concept is taken by the severity of the recommendations or sanctions assigned when organizations do not measure up on this requirement. The Joint Commission routinely generates Requirements for Improvement in both life safety and leadership. They have also generated recommendations for Conditional Accreditation and in a few severe cases recommendations for denial of accreditation.

This level of risk demands more than casual attention during the assessment of the need for Interim Life Safety. Every Joint Commission accredited and/or Medicare certified hospital needs to develop a comprehensive policy addressing fire watch. The policy must include two major sections. The first is the classic fire watch during welding, cutting, and hot work. The second is the fire watch during periods of time when the fire alarm or suppression system is disabled.

The classic fire watch is easy to deal with. All the required activities are clearly spelled out in NFPA 51B. The procedure simply needs to adapt the requirements to an individual hospital. The only decision is to determine who is responsible for assessment of the area prior to commencement of hot work, granting a permit, and monitoring the operations in accordance with the requirements of NFPA 51B for the duration of the activity and the required additional time to be sure no lingering sparks or slag ignite a fire.

(Continued on Page2)

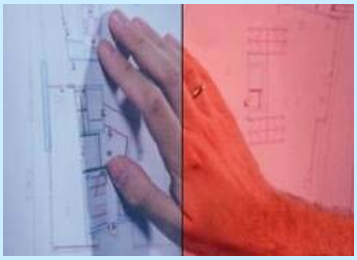
Fire Watches (continued)

The fire watch for disabled alarm or suppression systems is more difficult. An appropriate procedure needs to address the severity of the situation and the intensity of the fire watch. For example, if an area is being demolished, hot work is required, a required fire separation is removed and no temporary fire rated partition is in place at the same time a large area is left without fire alarm or suppression a full time fire watch may be appropriate to offset the increased risk. In contrast, if two smoke detectors are capped to prevent unwanted alarms during sheetrock finishing in a single room a walk through at one hour intervals or even longer intervals may be appropriate. These examples represent the range of situations to which the Joint Commission has applied the fire watch requirement. Surveyors have cited hospitals even when fire alarm or suppression systems were only out of service for an hour or less.

They key to being prepared for the Joint Commission and Medicare is to be proactive. At a minimum the procedure should include criteria for intensity, training for staff who will be assigned to be fire watches, and forms for both the assessment and the implementation of the fire watch. Although this level of intensity may seem excessive the downside risk of the threat of losing Medicare certification or Joint Commission accreditation is significant. It is just not worth getting burned by not preparing.

TSIG can provide a draft of a Policy and Procedures for the above, upon request.

Accurate Floor Plans; A True Return On Investment



During a recent interview with a Joint Commission Life Safety Surveyor, he mentioned that one of the most frequent recommendations he issues is a direct result of hospitals not having accurate life safety floor plans. In fact there is no requirement for facility's to have professionally drafted floor plans; "they could be in crayon for all we're concerned- the problem lies when organizations fail to represent accurate smoke and fire barriers, or when their drawings don't reflect the current floor plans."

We at TSIG Consulting concur with this surveyors recommendation; that accurate life safety drawings are essential to the effectiveness of maintaining a buildings structural integrity and aids in complying with Life Safety Code, but current, accurate and professionally drafted floor plans can offer healthcare organizations much more- a very quick return on their investment.

Aside from regulatory compliance purposes, seldom does a week go by when a facility manager is not tasked with referring to and/or providing these drawings, which must be dug out and hopefully, are available on CAD. Whether needed for space planning, evacuation mapping, labeling of utilities, their benefits and true value saving capability can really become evident when performing an assessment of your smoke and fire dampers. Yes, a damper assessment.

As a recent client experience illustrates, a client had drawings which had not been updated in many years. Over time, as happens in many hospitals, renovations were undertaken on some floors, while others had sprinkler systems installed and yet others had a change in occupancy- resulting in that many drawings were incorrect, outdated and just plain off course; creating those very same findings the Life Safety surveyor referred to.

When one client retained us to perform the testing of all their smoke & fire dampers, it became evident very quickly that we were testing dampers in unnecessary areas, such as compartments on fully sprinkled floors. This forced us to halt activities and seek the client's authorization to update the drawings in order to accurately complete the damper survey.

As a result of their agreement to proceed with an update of the drawings, it was discovered that we needed to only survey a fraction of the dampers, resulting in a significantly reduced cost for the survey process, as well as corrective repair costs.

There are many good reasons to have a complete set of accurate, professionally drafted drawings, especially when you consider how many hospitals are now developing Building Maintenance Programs for various life safety components, as outlined by the Joint Commission,. Sound and accurate prints can only help aid in defining locations for these specific components such identifying detailed locations of your exit signs, smoke and fire doors, linen / trash chutes, etc.

Therefore, if you have not updated your drawings in a while, you may seek to consider doing so. A very strong case can be made to Senior Leadership based on this recent experience.

Of course, we here at TSIG do this for a living-just in case you forgot.

THE GOOD, THE BAD & THE UGLY

JOINT COMMISSION EC UPDATE

By George A. Rivas, CHSP

Probably no one has been more vocal about Joint Commission's history in developing computer aided tools than yours truly. Many years ago, as a Director of Safety for a small community hospital in Chicago, I purchased their Electronic Statement of Conditions software in hopes that my organization would have the means to effectively enter and track the completion of our Plans for Improvements. (Folks, we're talking about way back in the days when we still used 3.5 in. floppy disks) Unfortunately, and to my utter dismay, the software never really worked as advertised- that was bad. When TJC then failed to offer sufficient support for this software- that was ugly!

So needless to say that I was hesitant when they announced that they were in development of an import function to allow electronically formatted copies of the SOC to be transferred into the eSOC on the JAYCO website. But to my surprise, I can offer no better praise for TJC, when I was invited to their beta test for the new import function at their corporate office, and participated within this educational program. Set aside the fact that our own SOC software matched perfectly with their Excel template, and I was able to complete the transfer of numerous PFI's in a matter of minutes, but what most impressed me was the overall process they established to verify that users could manage the import function as seamlessly as possible. You see, TJC not only took proactive measures by inviting a group of hospitals and consultants to participate in the beta test, but they also assembled a team of their IT people to be present and aid the attendees through the data transfer process. Being that I was one of the first to successfully make the data transfer, I had the opportunity to casually observe TJC's staff of EC and IT representatives assist those struggling with their own import.

To summarize my observations in a single word: Impressive! This was surely a sign of true customer service. So for all the critical things I've said about the TJC in the past (related to computer aided tools), all is forgiven.

They've proven that they can not only develop an effective data import process, but have the professional fortitude and foresight to include users in the test process and have technical support available to field questions and accept input- that is good, really good! So how user friendly is the import process? Well, if you are proficient with working the basics of Excel, and already have your PFI's in an electronic spreadsheet, it's relatively easy. However, you must follow the instructions to the letter or else you will receive error messages. Does it save time? You bet! Is it laborious & temperamental? You bet, especially the first time you may try it, but it's better than having to enter multiple PFI's, one-by-one, manually. And for that, I am thankful. For those of you who chose to attempt using the import function on your own, make sure you read not only the instructions, but also the FAQ page and the "Narrative of a User" summary on the TJC 'Connect' website. This information is extremely useful. For those of you who don't have the time or patience to deal with converting electronic files, just send us an email and we would be glad to assist you.

Until next time, take care.

Looks Familiar ?

Is it or isn't It?

Great Storage Place

Too bad we can't reach the Fire Extinguisher

Who came first

Oops

Revised Emergency Management Standards for 2008

The Joint Commission recently released the changes in the Emergency Management standards that are based on multiple emergency scenarios that occur simultaneously. These new standards take effect Jan. 1, 2008 and were reviewed by George Mills at the July ASHE Conference held in New Orleans this year. Mills reported that the emphasis of said changes was on a "scalable approach"; to help hospitals manage their response plans to a combination of escalating events. These changes cam about as a result of the Joint Commission's study of a variety of disasters that impacted health care organizations, including floods, widespread electrical utility outages, the terrorist attacks of September 11, the four back-to-back Florida hurricanes of 2004, and the Katrina and Rita hurricanes that struck the Gulf Coast in 2005. Furthermore the standards include six critical functions and new drill requirements.

- Communications: The standard will focus on ensuring Hospitals identify back up and redundant methods of communication (e.g. wireless phones, land lines, bulletin boards, fax machines, satellite phones, ham radio, text messages) during emergency conditions.
- Resource management: Hospitals will need to be self sufficient for at least 96 hours with their own resources and identify what resources they have, how long they will last, how they will be procured, distributed and accounted for. Federal support might not be available for a long period of time, if ever. The hospital will be expected to have plans to collaborate with health care organizations outside of the community as well as in the geographic area.
- Safety and Security Management: Hospitals will be required to provide internal security and safety operations for the protection of patients, visitors and staff since the Police/Sheriff may be detained with other emergent situations. In addition, the hospital will be responsible for coordinating safety and security activities with the community agencies (e.g. police, sheriff, national guard, etc.).
- Competency: Hospital staff, including licensed independent practitioners and volunteers, will be required to have orientation and training for their assigned roles/responsibilities during emergency conditions.
- Utility Management: Utilities are needed during emergency conditions therefore a new requirement is proposed for having an alternative source for fuel for building operations and essential transportation activities. The rationale for the utility management proposed changes is that Memorandums of Understanding (MOUs) be current and in place as well as the hospital identify other suppliers outside the local area.
- Clinical Activity Management: The hospital must have predefined triage and tracking mechanisms in place; established processes for managing clinical services for vulnerable populations (e.g. pediatric, geriatric, disabled, mental health and/or addictions). Mortuary service management is also included in this proposed update

The new standards also include the addition of a requirement for escalating at least one exercise per year to evaluate the effectiveness of the organizations performance when it cannot be supported by the local community. The rational is that exercises should stress the limits of the organization's emergency management system. The goal of this testing is to assess the organization's preparedness capabilities and performance when systems are stressed during an actual emergency.

With more than thirty new Elements of Performance added to this standard, it may appear trying for those who must manage their Emergency Management compliance programs, however many of these changes are necessary based on recent events and the feedback from those hospitals that have suffered through catastrophic events may very well lead to improvement in your organizations capability to respond.

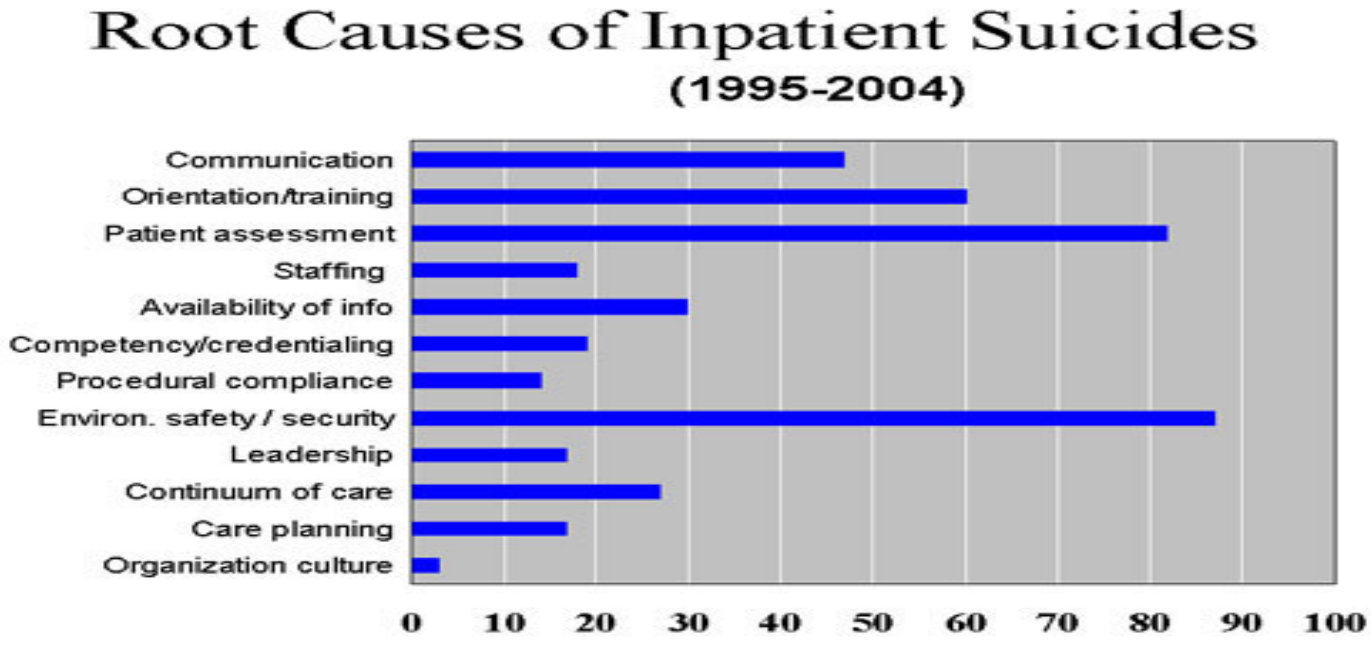
Reducing the Risk of Patient Suicide (Part 2)

Long before the Joint Commission published its 2007 National Patient Safety Goals, patient suicide was at the forefront of their concerns. They published a sentinel event alert (#7) back in 1998 and patient suicide has consistently remained to date, the single most reported sentinel event since the inception of the sentinel event policy back in 1996. Shorter lengths of stay, sicker patients, and higher patient to staff ratios challenge the ability of the hospital to maintain safety.

Risk factors associated with the physical environment of the inpatient psychiatric unit, cited as the most common root cause of inpatient suicide, may be neglected because evaluation of these factors is generally not included in medical education and training. In 75 percent of the cases, the method of suicide was a hanging in a bathroom, bedroom or closet. Twenty percent of the suicides resulted from patients jumping from a roof or window. Minimization of fixtures that can facilitate strangulation and other high risk aspects within the hospital environment is an important element in the prevention of suicide. However it takes more than just assessing the risk of the patient care environment to minimize the risk of inpatient suicide because the environment itself is not the only identified root cause for said events.

When assessing the risk, organizations should first start by conducting a root cause analysis. The Joint Commission data reports that organizations have reported the following root causes of inpatient suicides include:

- The environment of care, such as the presence of non-breakaway bars, rods or safety rails; lack of testing of breakaway hardware; and inadequate security.
- Patient assessment methods, such as incomplete suicide risk assessment at intake, absent
- or incomplete reassessment, and incomplete examination of the individual (for example, failure to identify a con traband).
- Staff-related factors, such as insufficient orientation or training, incomplete competency review or credentialing, and inadequate staffing levels.
- Incomplete or infrequent patient observations.
- Information-related factors such as incomplete communication among caregivers and information being unavail able when needed.
- Care planning, such as assignment of the patient to an inappropriate unit or location.



The next step would be to evaluate current measures in place, test their effectiveness and then redesign and/or develop new risk reduction measures for any weak links discovered in the chain. Organizations who have suffered the experience of patient suicides recommended the following risk reduction strategies:

- Revising suicide risk assessment/reassessment procedures (for example, using a standardized procedure).
- Updating the staffing model.
- Enhancing staff orientation/education regarding suicide risk factors.
- Updating policies and procedures for patient observation.
- Monitoring consistency of the implementation of observation procedures.
- Revising procedures for contraband detection and engaging family and friends in the process.
- Identifying and removing or replacing non-breakaway hardware.
- Implementing education for family/friends regarding suicide risk factors.

The U.S. Department of Health and Human Services also offers some sound recommendations to minimize the risk. They include:

1. **Promote efforts to reduce access to lethal means and methods of self-harm.**

   Studies have shown that suicides are committed on the spur of the moment, resulting from a combination of despair and the availability of means to inflict self-harm. Health care professionals need to know how to assess items that may constitute lethal means in the environment. All staff need to observe security measures, such as keeping doors to stairs and cleaning closets closed and/or locked and making sure that patients do not have access to sharp objects or other potentially harmful items. Individuals responsible for the environment of care should identify and remove/replace non-breakaway hardware, including shower bars, closet bars, and shower heads.

2. **Implement training to recognize at-risk behavior & deliver effective treatment.**

   Many health care professionals do not have sufficient training in properly assessing, treating, and managing suicidal patients, nor in dealing with the special needs of suicide survivors. Staff need to be taught how to conduct assessments with sensitivity and identify which characteristics (for example, patients with multiple diagnoses, the elderly, adolescents) might indicate a high-risk potential for suicide. Family members can be important allies in watching high-risk patients, so educate family and friends as well as staff to recognize risk factors.

3. **Develop & promote effective clinical & professional practices.**

   Suicide screening should be part of both initial assessments and reassessments. Assessment findings determine the degree of observation each patient may need, and organization policies may need to be updated to ensure that criteria and procedures for patient observation are consistently applied. Other policies and procedures that may require review are those that deal with the transfer of information from one setting or unit to another. The periods immediately after admission and immediately before discharge from a specific area can present an especially high level of risk, and all staff should be aware of a patient's suicide risk potential.

4. **Improve and expand surveillance systems.**

   Note the importance of collecting data on suicide and suicidal behavior to examine differences between groups, locales, and health care settings. Knowing the risk factors that are specific to your population(s) can help you revise your assessment tools for greater efficiency.

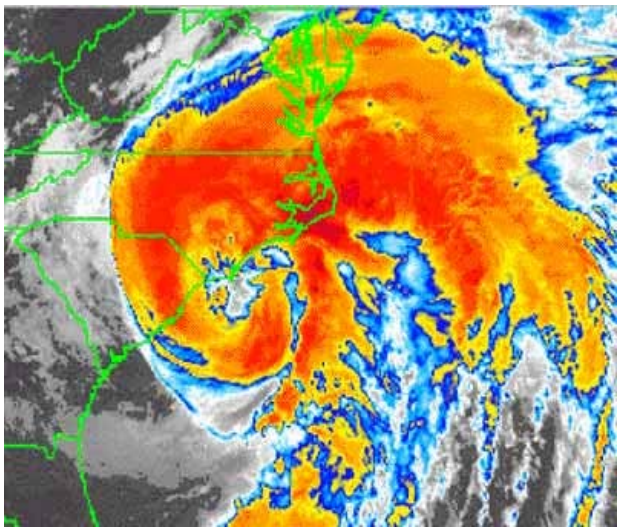
5. **Develop broad-based support for suicide prevention.**

   For prevention programs to be effective, they must follow patients along the entire continuum of care and take into account the resources and interventions available within the community, as well as those from other health care organizations. Again, good communication among caregivers and the timely transfer of information are essential.

Assuring that professional practice guidelines are in place and environmental concerns are addressed does not alone ensure these practices are sound. The only way to truly assess the effectiveness of these safe guard measures is to perform a risk assessment that puts these measures to the test. The tracer methodology is the perfect tool to evaluate their effectiveness. Follow a patient record from the admission process all the way through the time of discharge, verifying that all the above recommended safeguards are in place and actually practiced. Don’t be surprised if surveyors do the very same thing come time of your next survey!

What's in Your Emergency Power Forecast Today?

Is it time to forget about your vacation plans? The great Farmers Almanac tells us we are already in the Hurricane Season. It typically extends from June 1st through November 30th. In addition, there is a current heat wave affecting the whole country. The end result is the threat of severe thunder storms, heavy rains, and the dread fear of losing electrical power.



Nature's havoc creates demands requiring a prudent electrical emergency plan that overcomes any natural mechanical failure of the emergency power system. Coupled with the risk of patient safety, it becomes the fore-most important item on the mind of the facility manager. Developing a comprehensive program of demand performance, requires a consistent pattern of testing which tracks reliability levels of all associated equipment. The failure rate of power disruptions can be greatly reduced through careful analysis of testing reports. Reviewing problems encountered from past incident reports, can identify any trends or root problems causing electrical disruptions. These issues should be presented and reviewed by the Safety committee and Administration. It creates the basis for financial funding available to make immediate corrective improvements. The hospital must provide a system to communicate and promote the expectation of equipment maintenance as it relates to patient safety.

Standard EC.7.40 requires that hospitals maintain, test, and inspect their emergency power systems. This standard has many elements of performance to insure dynamic operation of the emergency power systems. Testing generators monthly ($\geq$ 20 and 40 $\leq$ days apart) by conducting dynamic load transfers of 30% of nameplate rating for a continuous 30 minute period, including the exercising the transfer switches, annual load bank test for those generators operating below the 30% nameplate rating, performing the new four hour test once every 36 months, all provide valuable test data for proactive risk assessment.

However, it is important for Facility Managers to ensure they also address the other Elements of Performance within this standard that sometimes get overlooked. These relatively new elements of performance include:

- EC.7.40.6; requires hospitals to prepare and implement interim measures to compensate for the risk to patients, visitors, and staff whenever a failure of the above test occurs until necessary repairs or corrections is completed.
- EC.7.40.7; requires hospitals to perform a retest of any equipment that fails the prescribed test, after corrective measures have been completed.

To minimize the impact of a failed device, preparing for this un-timely event requires thoughtful planning well in advance. One area of concern is to eliminate single point failures. This can be done by testing and understanding the emergency circuits feeding critical nursing units. This proactive planning is essential to analyzing potential circuit failures for all transfer switches, transformers, generators, main switchgear, and major risers. Consideration must be given to redundancy of critical circuits.

This information also provides the design backbone when considering parallel switchgear, which is more apparent in larger facilities.

The many levels of vulnerability exposed provide the basis for sound training of staff- including those support staff who are faced with troubleshooting problems during outages, as well as clinical staff who must implement their response procedures including the necessary clinical interventions. However, it is important to assure that appropriate notification of staff takes precedence whenever a failure occurs that necessitates interim measures. In fact, notification of staff should always be the first measure taken since staff will never know what actions to take if they are never informed of the problem. Therefore effective and timely communication is the key.

Another proactive measure recommended would be performing a comprehensive risk assessment of the organization to determine which areas face the greatest risk when emergency power is not made available. The various areas / departments of the organization should be assessed to determine not only high and low risk areas but also to determine what appropriate measures should be taken as a result of said risk. For example, the consequence of a power outage in the Accounting Department results in staff taking a nap and paychecks getting delayed- the results of a power loss in the Operating Room could result in the loss of life. Therefore by assessing the various risks within your organization, you can define where the first line of defense takes priority and establish department specific response plans that outline where the critical redundant equipment must immediately be established / provided.

In order to ensure that you meet the requirements for EC.7.40.6 & 7, documentation is the key. If equipment fails or breaks down upon testing, it is imperative that you maintain full circle and establish a closed loop of documentation related to the failure, your response and those corrective actions. This can be achieved by documenting the failures from beginning to end. This includes a detailed report of failure, the necessary repairs taken, records and evidence of interim measures taken including records of notification and training, and all documentation related to the repairs and retesting of the equipment.

Today, even those facilities engineers who have taken many steps to upgrade their electrical emergency systems have to be prepared to face the challenge of the unexpected. Even the best engineers and mechanics with the best equipment could suffer failed devices, at any moment in time which could lead to catastrophic results if left unattended. Therefore it makes perfect sense to take the following steps:

- develop a procedure that outlines how each failed emergency power test / device will undergo an assessment for interim measures
- document & implement the measures determined necessary based on your assessment (including notification process)
- verify that said measures are in place and proving effective via periodic surveillance
- make the necessary repairs in a timely fashion and keep the records for said repairs

Frequently Asked EC Question

Q. Can I combine my annual 2 hour load bank generator test with the new requirement for the 4 hour, 30% extended test requirement if we run the generator for an extended 1 1/2 hours ?

A. Fortunately for you, yes. Joint Commission recently published in their July 2007 issue of "Environment of Care News" a reverse position on testing requirement for EC. 7.40.5. In the past they held a position that the new 4 hour test, every 36 months required to be performed before July 1, 2007 could not be combined as part of the annual load bank test. However, they now state that it is permissible to combine said tests, provided the test meets the 30% of load requirement for the 4 hour duration.

"The Joint Commission has discussed this issue with the technical committee on Emergency Power Supplies of NFPA 110, whose consensus of opinion agreed that the combining of the 30 minute, the 2 hour load bank test, and the 4 hour triennial exercise into one event is acceptable (provided that the test at no time is less than 30% of nameplate, including during the initial start of the load bank test). "The consensus of opinion is not a formal interpretation of the NFPA, the combining of test into one event as described above will be permitted provided no other action is rendered from the NFPA"

EC INTERVIEW NOTES FROM RECENT SURVEY

A hospital that was recently surveyed provided the following notes regarding their surveyors focus on Environment of Care issues. *Disclaimer: Please be advised that each surveyor has their own different style and scope of interest and are sometimes subjective in their opinion, and or focus on issues which they may believe are required when in fact they are not. This should be considered when reading these notes. Therefore, please feel free to contact us should you have any questions or need any clarifications.*

Annual Evaluation

-Looking back at the past year's goals, What did you do if you did not meet them?

EOC Committee

-How many people make up your committee?
-What is quorum?
-Who and what departments make up the core?
-Talk to me about attendance. Did the primary or alternate make all meetings?
-Is each standard reviewed at least once a quarter?
-Talk to me about radiation safety and how it is involved with the committee.

Safety

-Talk to me about your laser safety process
-Talk to me about your OR fire safety training process
-Hazard surveillance-Show me a departmental matrix that defines when are where you performed rounds

Smoking

-Does your policy have any exceptions based on medical staff criteria?
-Does your policy have an exceptions based on physician orders?

Fire Prevention

-Challenged expected completion dates for new items (PFI's) on the SOC.
-Checked expected completion dates vs. actual completion dates for signed copy SOC.
-Any evidence of commitment for funds for repairs?
-Do we do any fire drills on weekends?
-Are at least 50% of the drills unannounced?
-How are the drills conducted as well as staff training and effectiveness evaluations?
-Show me and talk me through a fire drill in the psych ward.
-Medical gas valves-Who can shut a valve and when?
-What is your Fire drill frequency?
-Any fire drill deviations due to ILSM's?
-Provide some evidence of ILSM's.

Security

-How are security sensitive areas established and evaluated?
-Proof of security orientation and continued education as well as training.
-Do you have a Hostage policy?
-Do you have lockdown capability.
-Define the Security manpower for off-shifts.
-Does the Infant abduction procure address staff response for all locations?
-Explain what ED security measures are in place.
-How frequently do you report to the Executive Committee (Leadership) and what do you report?

Emergency management

-Did you meet the 4 and 8 month window as well as community involvement?
-Can you show proof of cooperative planning with other hospitals? Talk to me about resource sharing in particular antibiotics.

Utilities

-Do you test for purity of domestic water and fuel oil?
-Any risk of flooding of the emergency generator?
-Any evidence of a contingency plan?
-Show me evidence of Transfer switch testing.
-Evidence of EBPL 30 days and annual tests.
-Isolation room airflow and smoke testing evidence.
-Discuss with me how we proactively address waterborne and airborne pathogens and your relationship with IC for this and ICRA.

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