February 2008 Issue 12

TSIG NEWS

740 Broadway, New York, NY 10003

212-420-8724 www.tsigconsulting.com

Inside this issue:

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

heimanr@tsigconsulting.com

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.

Safely Managing Your Water Systems

Written by: Ode Keil (guest writer)

The Joint Commission requires that accredited hospitals manage water processing systems for dialysis to meet regulations, manufacturer recommendations, and hospital experience. Dialysis water treatment systems are one of several water management processes common in many hospitals.

Effective water treatment is an essential part of patient safety. It is also an essential part of maximizing the life cycle and efficiency of many plant engineering systems. Most hospitals elect to purchase services to manage water processes. They sign contracts with companies to have boiler and chiller water treatment equipment installed and chemicals delivered. They also frequently contract with an outside service to design, install, and manage dialysis water treatment systems. Some hospitals maintain systems designed to deliver reagent grade water to laboratory areas for mixing or diluting chemical reagents used in clinical laboratory testing. A likely outcome of choosing to rely on a purchased service to maintain water processing systems in the hospital is that the hospital staff does not understand the systems or the potential harmful effects of the treated water on the equipment it serves or patients.

The water that enters a hospital is generally supplied through a municipal water system and meets federal clean water standards. Once the water enters the building it is broken into different streams. Four water processing streams found in most hospitals are domestic, industrial, water processed to specific standards, and fire protection water. Each stream requires various processing steps to meet the demands of its intended end use.

Domestic water requires little additional processing. The only processing that takes place for most domestic cold water systems is softening and management of distribution and perhaps some filtering for infection control. Domestic hot water systems raise the temperature to a desired standard level, automatic tempering controls temper the water to meet state or federally mandated temperatures for patient safety. In some hospitals domestic hot water is treated to inhibit the growth of Legionnella.

Fire protection water is generally not processed further. It is generally held in a static state after wet sprinkler systems are filled. The primary issue with fire protection water is prevention of freeze up and prevention of backflow into domestic systems to prevent contamination.

Industrial water is used for steam generation, cooling towers, and similar plant engineering applications. Most industrial water is treated to protect equipment from rust, corrosion, or other factors that contribute to premature failure of systems.

Water processes that are designed to prepare city water for sensitive applications require use of special equipment to remove and/or add chemicals and to remove or prevent the growth of biological material fevers from endotoxins from the breakdown of gram negative bacterial cell walls.

(Continued on Page2)

Safely Managing Your Water Systems (Continued)

Written by: Ode Keil (guest writer)

The most common highly processed water systems in hospitals are those that are used to prepare municipal water for use during dialysis. When water is used for dialysis it is important that it be free of chemical contaminants that could result in some form of poisoning and free of biological materials to prevent infections.

The treatment of dialysis water begins with use of a break tank or back flow prevention device to separate the municipal water system from the dialysis system. Once the isolation point is reached, the water that is in the dialysis system may be softened, charcoal filtered, subjected to reverse osmosis, deionized, exposed to ultraviolet light, and filtered using submicron filters. All these steps are designed to remove either biological material or chemicals that could harm patients. Management of the systems requires recognition of the fact that any water supply can produce biological growth and that the processing of the water for dialysis is not one hundred percent effective in removing organisms or the potential food sources for them.

The management of dialysis water treatment systems is a dynamic process. The water that is processed for dialysis is generally stored in a tank designed to be a reservoir of sufficient size that daily demands can be met. Dialysis water systems are closed loops. The dialysis process draws water from the loop through connecting tubing and circulates it through the dialysis equipment. The carefully controlled chemical imbalances in the dialysate are used to draw unwanted chemicals from the patient's bloodstream using a semi-permeable membrane. Water that is not drawn from the system continuously circulated to maintain it.

Over time minor accumulations of organisms and food sources can lead to limited or even very significant bacterial growth. As the dialysis water system removes all chlorine and other common chemicals used to inhibit biological growth, the management plan for the system must focus on this dynamic. When growth in excess of recognized standards occurs, the system must be treated. The treatment may include adding small amounts of chlorine to eliminate bacteria and then flushing the system until the treatment dose is eliminated. It may also be as simple as flushing the system to mechanically remove accumulated materials from specific points. One common source of contamination is the flexible connections used to tap the system and connect it to the dialysis equipment. In some hospital settings these tubes may be in use for years without being cleaned. They can become reservoirs of significant amounts of biological materials that can be picked up and spread to patients or into the system. Either case is very undesirable.

Designing an effective water management plan is much more complex than simply treating and testing. Understanding the life cycle of the water streams in the hospital's systems is critical. Developing this understanding requires careful tracking of test results over time to determine if there is a growth cycle that can be predicted and appropriate action taken at appropriate times. The Ode Keil Consulting Group, TSIG Consulting and their partners have collaborated to provide healthcare facilities the necessary assistance to design effective water management programs. If you would like additional information about the concept of water management or a proposal for evaluating the water systems and equipment in your organization please contact: info@tsigconsulting.com

Special Legal Notice for NJ Hospitals & Healthcare Facilities

Violence, an ever-increasing challenge for hospitals and healthcare facilities throughout the United States, has prompted recent legislation towards protecting employees. A January 2008 law enacted in New Jersey will require hospitals and healthcare facilities to establish a violence prevention program. For this purpose, the program must include;

- Formulation of a violence prevention committee
- Development of a detailed written violence prevention plan identifying workplace risks and methods to address them
- Completion of annual risk assessments
- Annual violence prevention training to protect workers from physical assault or threatening situations

TSIG Consulting can assist your organization with this process. To obtain a copy of the new legislation or for assistance on a violence prevention program, contact us at info@tsigconsulting.com

When and How to Use Consultants

By Linda Jenkins, BSN, MBA (guest writer)

There are opportunities for most organizations to receive numerous benefits from the use of consultants. Leaders of course must be prudent when determining if consulting services are needed and particularly demanding when selecting the right consulting resources for that need. Everyone has heard horror stories about consultants being paid huge amounts to come into an organization and tell them what they already knew. Unfortunately this has made many organizations become hesitant to use consultants and to attempt making changes themselves without the expertise required for a successful result.

Restructure

Changes are often required to revitalize or even restructure organizational or departmental systems and processes. One example would be an ineffective Quality Program. If restructuring of the Quality Department is required, then the systems and processes for performance improvement must be carefully assessed. If you have data that is not being sufficiently analyzed to improve performance it is time to make necessary changes. It may be beneficial to hire an experienced and knowledgeable consultant to perform an assessment of the program and provide recommendations for improvement. Utilizing information provided from the assessment will help you determine if additional expertise is required to assist in planning and implementation of necessary changes.

Interim Leadership

Vacant executive and department director positions can create numerous problems for an organization. If more than interim management is needed, one solution may be to use an experienced consultant as an effective change agent while the position is being filled. It is vitally important to interview the specific consultant being considered for interim placement to assure their experience, interpersonal skills and leadership will meet the organizations needs. Establish a time frame for the placement and an option to extend if required. Bringing in another temporary leader could negatively impact the positive changes achieved and create a sense of instability to staff. If professional recruiters are unsuccessful, consider having the consultant train an internal candidate for the position and transition full responsibility to the newly trained person. Be sure to also establish a time frame for the transition with specific goals established. A minimum of 4 weeks should be anticipated for the training and a 90 day limit should be sufficient for evaluating the new manager's ability to function independently of the consultant.

Regulatory Issues

Survey Readiness

Many organizations use consulting teams to perform mock surveys to identify their level of readiness for an unannounced Joint Commission accreditation survey. Evaluate the consultation team expertise to assure all Elements of Performance (EP) will be reviewed in a similar manner that a Joint Commission team would survey. Request that the consulting company provide you with a detailed report of noncompliant areas and include their recommendations for corrective action for that EP. You may request the report in the form of an Excel worksheet for convenient use in assigning responsibility and time lines for each EP. It is most effective when the CEO or COO is responsible for frequent monitoring of the progress on corrective actions in weekly meetings with responsible staff and managers. Challenging time constraints on these positions can be assisted by having a survey expert/consultant manage the corrective action plans for a specific time frame. A survey readiness coordinator can be trained during this time to help the organization maintain regulatory compliance.

Poor Survey Results

The best of hospitals may find themselves in the situation of having poor results from a survey by Joint Commission for accreditation, or the State Department of Health Services for licensing or by CMS for validation to receive federal funding for Medicare patients. Depending on the time frame for corrective actions and internal expertise and knowledge of regulations, it may be prudent to bring in expert consultants to expedite compliance. It is suggested you research the experience the consulting group has with your particular needs before requesting a proposal.

Survey Feeding Frenzy

Many hospitals have found themselves immersed in a feeding frenzy of surveys from several regulatory agencies. This is the very time when a consulting group experienced in all areas of regulatory compliance can be a critical factor in retaining accreditation, licensing and federal funding. When licensing issues are at risk it is paramount to seek consultation from an expert on your particular states' Department of Health Services regulations. For Joint Commission and CMS, it is advisable to search nationally for consulting companies experience and comparative costs. Include in your request for proposal, the consultants list of experience and facilities with similar services to yours.

The use of consultants for specific expert needs most often can benefit organizations from both a cost and quality standpoint. First, decide when the consultant is needed. Secondly, select the specific qualifications and expertise required. Lastly, review experience and costs to make wise choices and you will not be disappointed with the outcomes.

Linda Jenkins is the CEO of Linbar and Associates, who has partnered with TSIG Consulting in performing comprehensive mock surveys for accredited health care facilities both Nationally and Internationally. For information on their services, please forward your inquiries to: info@linbar.org or 949-248-9833

WHAT'S NEW AT TSIG

Written: Ralph Heiman

TSIG Now Offers Office Based Surgery Consultation

As a result of New York State passing new legislation; requiring physicians performing office-based surgical procedures to become accredited by mid July 2009, TSIG Consulting has established a new division to ensure compliance with the legislation and assist Office Based Surgical Centers avoid potential liability and licensure implications.

Office based surgery is defined as any surgical or other invasive procedure requiring general anesthesia, conscious sedation and certain liposuction procedures. Minimal sedation is exempt.

Practices include GI practices that perform endoscopies under anesthesia, as well as some other practices using sedation. The practice must be limited to 4 physicians and have no more than three patients incapable of self preservation.
Building on our exceptional record of national healthcare accreditation consultation services, *TSIG-FD Accreditation Group* is now offering accreditation services to the OBS market place.

Our services include meeting with the physicians to review requirements and develop a schedule of deliverables, provide all required documentation for standard compliant Policies & Procedures, mock surveys, and any other assistance the physician requires in order to become accredited. New York State Department of Health designation of accreditation agencies include: The Joint Commission (TJC), AAAASF and AAAHC.

Each of the accreditation entities has a different set of requirements. However our *TSIG-FD Accreditation Group* can advise you on the differences and assist you in the accreditation process with the entity you select. It should be noted that these very same requirements exist for Office Based Surgical centers within the state of California and Florida as well.

Please visit our WebSite @ WWW.tsig-fdobs.com

Welcome our Newest Members

TSIG would like to welcome Fatima Lim David, R.N. as the head of our OBS Accreditation Group. Fatima is an experienced and dynamic healthcare professional with over thirty years of providing healthcare consultation. Fatima is nationally recognized as being committed to providing high quality consulting service in the areas of design, operation and accreditation of ambulatory and office-based surgery practice.

Her experience as a Registered Nurse includes: clinical nursing in the field of hospital medical/surgical, operating room and administration, as well as office based surgery practice management and clinical nursing. She completed graduate work in Healthcare Administration and Public Administration at Long Island University in 1991.

Fatima is an active member of the Association of Preoperative Registered Nurses (AORN), and works tirelessly with the organization on issues affecting patient safety and quality care.

Her commitment to patient safety and quality care is apparent in the way she holds clients' hands in preparing them to achieve accreditation status. We at TSIG welcome her style and expertise.

TSIG would also like to welcome Mr. Richard Morrow who has joined our professional Environment of Care consulting team. Richard has extensive experience in overseeing Healthcare Safety, Security and Fire Safety programs. Richard has significantly contributed to providing his professional expertise in developing Emergency Operations and Disaster Planning for healthcare facilities. As a former member of the American Red Cross Disaster Services Unit, Richard served on disaster relief assignments both locally and nationally. Richard's professional skills and expertise have been demonstrated by overseeing all aspects of Environment of Care compliance responsibilities, while also serving in the capacity as Emergency Preparedness Coordinator for a large Network of Hospitals and Care centers. Richard is an active member of the Emergency Management community by serving with the following agencies: NJ Department of Health and Senior Services, North East Region Advisory Council for Medical Coordination Centers and Homeland Security Urban Area Security Initiatives. Richard earned his Bachelors of Science degree in Criminal Justice at Rutgers State University and will have earned his Masters Degree in Public Administration in Emergency Management and Homeland Security (April 2008) at Metropolitan College of New York – where he currently serves as the Vice President for the International Association of Emergency Managers. Richard is also an active member of the National Fire Protection Association and The International Association of Hospital Safety & Security.

Welcome our Newest Members

Mark J. Agan
Vice President Business Development

Mr. Mark J. Agan brings over twenty years of strong Facilities Management and Contract Services experience to his position. In 1989, Mark joined Marroitt Facilities Services as a Director of Buildings and Grounds. He managed two different accounts during his tenure with Marriott. Mark was responsible for all-capital improvements and major maintenance projects at Palmyra School District. He oversaw the daily maintenance, custodial and grounds keeping. He served as project engineer for a 4.5 million-dollar new school construction and renovation project. In recognition of his performance at Palmira, Mark received the 1991 Marriott Unit Award of Excellence "Gold". Mark was promoted in May of 1992 to District Director of Facilities at Ridgewood School District. He was responsible for a 4.3 million dollar operating budget, which included a 1.6 million dollar capital budget for 96 major maintenance projects. Mark managed a total of sixty-two employees at eleven different school buildings totaling 875,000 square feet. Ridgewood was Marriott's first full service contract.

Mark joined Morrison-Crothall Facilities Services at Marian Community Hospital in Carbondale, Pennsylvania (110 beds). In recognition of his performance at Marian, Mark received the 1995 Quality Assurance Award for outstanding program implementation and quality. In April 1996, Mark was promoted to Lourdes Hospital a 350 bed Regional Cancer Center in Binghamton, New York. Mark was responsible for the daily maintenance, bio-medical, security and safety management at Lourdes. Mark served as the Hospital Safety Officer and managed a total of 62 FTE's for the four departments. In June 1997, Mark was promoted to Resident Regional Manager. As a Resident Regional Manager, Mark provided ongoing support to other facilities.

In December 1997, Mark joined Professional Facilities Services as a District Manager. Mark was responsible for providing support to new and existing accounts in the New York, New Jersey, Pennsylvania, Delaware, and Florida areas. In recognition for his outstanding performance, he received the 1998 Outstanding Service Commitment Award and in 1999, Mark was the first recipient of Professional Services President's Award. In December 2000, Mark was promoted to Director of Business Development. In January 2004, Mark went back into operations as an Assistant Vice President. Mark was responsible for Professional Services Engineering Division. Mark was successful in selling new business for both the Clinical Engineering and Plant Operations divisions. He is an active member of American Society for Healthcare Engineering, Healthcare Facility Managers Association of Delaware Valley PA, Pennsylvania Society for Health Facilities Engineering, and International Association for Healthcare Security and Safety.

Mark is a graduate from LaSalle University with a Bachelor of Science Degree in Business Management.

Mark served six and one-half years in the U.S. Navy, during which time he received eleven medals of honor to include a Joint Service Commendation Medal and Navy Achievement Medal.

Mark is married, has four children two sons and two daughters and lives in Springfield, Pennsylvania.

TSIG is Hosting a workshop called

Environment of Care Essentials—2008 and Beyond

On 2/15/08 at NYU Medical Center. 175 person from 60 tri-state Hospitals have signed-up.

Our thanks to Richard Cohen, VP of NYUMC for setting up the Seminar for us.

Recent Survey Experiences

Survey #1

While looking at the Fire Extinguisher log, which shows that each month the extinguishers were inspected, the inspector suggested that the specific date be entered. He was advised that the inspections are now logged by use of a "deggy" key that electronically records the exact date and time that the extinguisher was inspected. Security can provide a printout of this report for any month since this system was implemented (October – December 2007). He was impressed with this initiative and commented although not required by Joint Commission standards, it would probably be best to continue to keep annual tags in place and continue to date and sign them. This may help to prevent a fire inspector from questioning the inspection process.

Fire Drills – with Interim Life Safety Measures (ILSM) in effect due to hospital construction in the 3rd quarter of 2007, security increased fire drills from once per shift per quarter, to twice per shift per quarter. With the ILSM in place, he suggested that one of the two drills be conducted adjacent to the construction areas.

Fire Alarm Log – inspector was impressed with the chart / grid that depicted all of the dates and locations that the drills were conducted

When questioned about testing of Fire Alarm systems, we explained 100% of the system is tested twice per year. This includes audio, visual and relays (door releases), tampering flow, fire suppression system (halon), main drain valve, sprinkler system and fire dept. connections. Surveyor also checked/verified fire pump quarterly tests and suggested that an exact match of BSI rating should be questioned. Surveyor questioned the testing of signaling devices and was advised how HOSPITAL is self dispatched with no external monitoring company for fire alarms.

Surveyor mentioned locking doors and delayed egress and that many of the doors that are locked do not need to be. He thought that facilities should research this issue.

Inspector was pleased that with ILSM in place, security was conducting additional fire drills. He was also impressed with the fire drill grid that depicts all of the drills that were conducted in 2007.

He was impressed with the fact that with ongoing construction throughout the hospital (which is scheduled to continue into future years) that the ILSM were implemented that define the established practices that were put in place to insure patient / employee / facility safety.

Smoking Rounds were discussed. Security is presently monitoring smoking violation data to determine how to best deal with this situation; including the construction of additional smoking designated areas.

Significant discussion relating to fire safety and to the measures that HOSPITAL and other hospitals have taken in recent years to improve same included: removal of toasters and toaster ovens, microwave popcorn, and the trend towards smoke free hospital campus'.

SAFETY MANAGEMENT

Surveyor discussed analysis of employee injuries, what trends have been observed, safety devices/measures implemented, in-service training methodology, sharps / insulin syringes handling and disposal, medication errors, and what long term plans are associated with these hazards.

Surveyor was happy to learn that infection control and facilities worked together to conduct assessments prior to construction projects beginning to best determine how to mitigate any issues or hazards.

(Continued on next page)

Discussed the importance of a mitigation plan for contaminated water supply (see Ode Keil's article). He asked specific questions regarding the dialysis patients. We responded to his questions by discussing the water reserve systems in place, bottle water reserve supply and contract vendor arraignments to provide water tankers to the facility.

After reviewing the EOC meeting minutes, he was pleased with what he found contained in these documents and asked the committee to think about challenges that they faced in 2007, moving forward into 2008.

HAZARDOUS WASTE MANAGEMENT

Should interject notes on elimination of mercury, chemo waste, spill kits, spill response, and questioned integrity of our contracted hazardous waste disposal vendor. Noted that hospital should verify that their waste is being disposed as per the agreement with the vendor for proper disposal.

SECURITY MANAGEMENT

Security reviewed the past years incidents reports and discussed rankings, trends and plans for improvements. Discussed the recent implementation of the access control system, the Prosec – Infant Protection System, general security rounding I.E. Construction tours / fire watch, fire extinguisher monitoring (deggy tours).

Forensic Policies were explained and the need to develop a liaison with the Law Enforcement Departments that utilize HOSPITAL was discussed. The surveyor suggested precautions including; working with these departments to insure that the prisoner does not have the ability to make phone calls to friends or relatives prior to visiting hospital; pre-notification of elective procedures for all forensic patients; the type of loads that the escorts carry in their weapons; the training that the escorts receive prior to bringing patients into hospital.

VIP patient policy should be comprehensive and not limited to politicians or celebrities. Security discussed the recent event where a teenager on life support was visited by 250-300 friends and relatives. The surveyor was impressed when told about the coordination between security, facilities and social services to control the visitors and to insure hospital security while meeting the needs of the family and friends.

A tour of the Mother/Baby and Labor and Delivery. Surveyor was impressed with these units and the Prosec System. He discussed the importance of abductor profile training and gave actual examples of abductions that he was personally familiar with. He suggested continuous training in this area. He further suggested that hospital might want to consider putting the pink stripe on the back of the badge to prevent counterfeit IDs.

EMERGENCY MANAGEMENT

In an Incident Management situation , where the incident command plan is activated, he suggested that the Incident Command Center (board room) be equipped with a video feed from the security control room that will enable the incident command staff to actively monitor all live CCTV links.

Surveyor suggested that future drills test the sustainability of the hospital and should focus on the potential of losing either part , a large portion or your entire facility. Recovery is the most important part of a disaster and future drills should consider business continuity and long term recovery plans.

Survey #2

Life Safety Surveyor Notes

Our Surveyor was a former fire safety director from the VA where he was responsible for all fire departments nationwide at the VA.

We met at 8AM on Tuesday morning. He wanted to get started right away. He asked to perform the document review first. This is opposite from what everyone else has experienced. He indicated fire safety was going to be the main emphasis of the survey and he stuck with that. He was very informal and told us that he would give us the benefit of his experiences. He talked at great length on BMP's and we let him talk. In fact, he talked for over an hour which was fine with us. He reviewed our fire alarm testing, flow and tamper switches and generator logs. He was very happy with the generator matrix we use. He was so impressed that when we told him that the same person tests generators and exit lights, he did not want to review the exit light documentation.

He did not ask for fire damper or Med gas testing documentation. He reviewed the life safety policy and asked to see the risk assessments. He was not pleased with the risk assessment form that we use. This is the SMS form. He called it very weak. He wanted more of a matrix. He said that it was obvious that we were doing the work but because of the form, we were not getting the credit.

He found one project where we indicated ILSM was required and security could not produce the inspection backups. We tried to argue that we checked the wrong box, but he wasn't buying it. He dinged us for that.

The tour started at 10:30

He wanted to start at a top floor MER. We tried to steer him to our new building, but he asked to start in an old wing. He looked at just about every fire and smoke wall for penetrations. He tried every door. He entered every stairway looking for signage. He found one penetration on the 2"d floor and he was very complimentary on the condition of our partitions. He must have looked at 35 locations before he found the one. After that he did not look again.

He tried every coded entry (cipher lock) door to see if the default code was used. He was able to gain entry to 6 out of 13. Luckily none were Med rooms. He checked panel schedules in all electric rooms. He checked Med Gas zone valves for proper labeling. He asked if we had documentation on the elevator doors attesting that they were 90 min rated. We did not, but he didn't pursue this. He just went into a story about an institution that had to replace all the doors. After he checked the 2nd floor he was pretty comfortable with what he had seen and let us guide the tour. This was good (make that excellent) for us. When he discovered that we use different fire extinguisher types on the same floors he was concerned about staff knowledge and asked a few nurses what they would do with a small fire. He dinged us for this.

He found a few vent monitors in the corridor of IMCU unit and wrote it down. He talked about clutter at closing but nothing became of it. We still use laundry and trash chutes and he found one non-latching door. He recommended closing them off. Our surveyor was very fair, informal and informative.

Please be advised that although these summary reports contain valuable information to better prepare your organization for your next survey, some of the questions and comments made by the survey team members are subjective in nature and do not reflect actual standard and/or code requirements. Should you have any questions, please feel free to contact us via email at: info@tsigconsulting.com

Assessing Risks During Construction

Construction of new hospitals, as well as hospital additions and renovations have been occurring at a rapid pace and appear to be an ongoing process over the last ten years in response to the demand to afford effective space for health delivery services and maintaining an aesthetically pleasing environment of care. Creating these patient-friendly, healing environments is may also be attributed to the continued effort for maintaining or increasing market share, attracting the best physicians and nursing staff and providing the latest, most efficient medical equipment.

It's based on this activity that - along with the fact that according to the Centers for Disease Control, a patient has nearly a 1-in-20 chance of contracting a nosocomial infection – that the Joint Commission has determined that infection control during the construction of health care facilities is critical.

The Joint Commission references the use of guidelines for hospital assessments and monitoring activities such and those published by the American Institute of Architects (AIA) and the American Society for Healthcare Engineering (ASHE).

Therefore it is incumbent upon health care facilities to be fully cognizant of these standards before they break ground on new construction or undergo existing renovations within the hospital. Without recognizing that these standards go far beyond the scope of monitoring infection control measures, the organization, their patients and staff could be placed at risk.

Although the construction industry and hospital project planners are well aware of the existing need to establish an Infection Control Risk Assessment (ICRA), construction managers and their subcontractors need to ensure that have a tool to determine what other potential impacts might create a disruption to patient care services and / or pose the risk of adverse patient outcomes during construction activities.

Checklist for Assuring Compliant Assessments

There are a number of important components that must be addressed to assure compliance. These can be understood simply by reviewing The Joint Commission's standard: EC.8.30- that requires a proactive risk assessment be performed in order to identify any potential compromise to treatment and care services the organization defines and implements control measures to minimize the potential impact.

Within this Element of Performance, it is clearly defined that the following must be considered when assessing the risk related to construction activity:

- Air Quality
- Infection Control
- Noise & Vibration
- Utilities
- Emergency Procedures and
- Interim Life Safety Measures

One of the problems that many organizations face during survey is; when a surveyor asks to see an example of the Preconstruction Risk Assessment, and the only document provided is the ICRA form, the surveyor may often times ask: "where is the evidence to support the other components have been assessed?" Because clearly, Infection Control is only 1/6th the assessment defined by the standard and the ICRA document alone could result in a "Partial Compliant" score and possibly even an immediate Recommendation for Improvement (RFI).

Therefore, in order to ensure that your process is capable of meeting The Joint Commission standards, it may prove wise to evaluate the current tools you are using and verify that it addresses each of the required risk factors. Working in a new or existing hospital can be an incredible responsibility for a construction manager with all that they are responsible for, but it takes relatively little time and effort to re-evaluate the tools you use and assure they adequately address everything a surveyor will look for. This little effort might just produce significant impact come time of your next survey.

THE GOOD, THE BAD & THE UGLY

INTERIM MEASURES; BEYOND LIFE SAFETY

By George A. Rivas, CHSP

In our last issue I discussed what a Beauty and a Beast Interim Life Safety Measures can prove to an organization. And despite the few of our 'vegan readers'- that took offense to my reference of ordering beef with balancing Fire Safety or those I simply just lost with said analogy, I gather from the remaining feedback that my article proved worthy of mention, especially for one hospital in particular who underwent recent survey and followed my recommendation of assuring they completed an ILSM assessment for their Statement of Conditions- thus, dodging a RFI bullet that had their name on it. In fact, the Safety Officer for said facility thanked me personally because their Life Safety Surveyor asked for the ILSM assessment immediately after reviewing their SOC, and he fortunately completed one after reading my article. Now I can hardly say that every article I write is capable of proving equally as life saving during your survey, but I would again like to revisit the nature of Interim Measures- but this time on a subject outside the scope of Life Safety. A little known change to the Utility standards at the onset of 2007 was the addition of a small, but significant Element of Performance: EC.7.40.6, that requires organizations to implement interim measures whenever a component of the Emergency Power System fails. Personally, I welcomed this new EP under the auspice; "what took them so long for someone to decide we should have interim measures for more than just Life Safety". I am sure that most if not all would agree that this is a **GOOD** thing- to have some temporary measures in place for emergency power to minimize the risk of patient care activities when your facility has suffered a breakdown or equipment failure. The problem I see in the field however is that this new EP, despite being over one year in existence is still overlooked and some hospitals have still failed to address it within their Utility Management Plan. This is could be **BAD** come time of survey when the survey team examines your plan and fails to see how you addressed this requirement. To compound matters and make things even worse yet, what if you actually suffered an outage during a period when a system was down or out of service, without any proactive assessment and/or consideration for redundant measures. I mean, let's forget regulatory issues for a minute here and consider the potential consequences of such an event- worse case scenario- the incident / failure results in an adverse patient outcome and now the powers that be, upon cause analysis come to discover the fact that you knew about the problem all along but chose to do nothing. Ouch! That could prove **UGLY**. So to all the Facility Directors, Plant Operations Manager & Safety Officers out there, it may prove beneficial to first assure your Management Plans are up to date by addressing this issue, then verify that you have procedures / equipment / resources in place or if not, assess the risks for critical emergency power locations throughout your facility and create a safeguard process to assure the necessary interim measures are taken when and if the time comes. The rewards in return for this foresight will prove far more valuable than just a means of complying with some standard- it could very well save lives at your facility.

The Fire Safety Evaluation System (FSES) for Healthcare Facilities

The Fire Safety Evaluation System (FSES) for Health Care Facilities provides a means for meeting or exceeding the level of safety prescribed by the applicable code while providing the organization with a wide range of cost saving and functional options. The FSES has been adopted into building codes and similar regulations and have been institutionalized by the establishment of a special technical committee of the National Fire Protection Association (NFPA) charged with the responsibility for Alternative Methods for Life Safety in Buildings. This committee maintains NFPA Standard 101A in support of the FSES, thereby ensuring that each FSES remains current and an appropriate reflection of the changing safety levels prescribed by building codes and regulations.

The FSES for Health Care Facilities was part of a broad fire safety effort sponsored by the Department of Health and Human Service in response to an important need to develop a means for meeting the fire safety objectives of prescribed codes without necessarily being in explicit compliance with the code. In the 1960s, with the emergence of the Medicare and Medicaid programs, Congress prescribed conformance with the requirements of the Life Safety Code, National Fire Protection Association Standard 101, in all nursing homes and hospitals receiving funds under those programs. A nation-wide inspection and enforcement program was established to ensure compliance. Most, if not all, inspected facilities were found to be in some degree of non-compliance with the specific requirements of the Life Safety Code. A significant number were closed as a result. Others undertook correction programs. Many, including some of the Nation's largest and most prestigious hospitals, were declared to fail this safety standard.

The FSES for Health Care Facilities was developed to discover alternate solutions, delivering at least an equivalent level of safety as compared to that produced by exact compliance with the detailed prescriptions of the Life Safety Code. In the case of one large hospital complex, the use of the FSES reduced the cost of compliance from an estimated $30- $60 million to less than $2 million. Equally important, the development of alternative approaches allowed the improvements to be made without interruption of hospital services. The FSES is a grading system designed to determine the overall level of fire safety of an existing or proposed facility in comparison with a hypothetical facility that exactly matched each requirement of the Life Safety Code.

When prepared and evaluated correctly and if the score of the facility under evaluation equals or exceeds that of the parameters in all sub-objectives within the assessment, the facility is deemed to be in conformance with the objectives of the Life Safety Code. This is of significant importance considering the fact that both The Joint Commission and Center for Medicare and Medicare Services (CMS) accept the FSES as an alternate solution (formal equivalency) when completed correctly. The FSES for Health Care Facilities was adopted by the National Fire Protection Association as part of the 1981 edition of the Life Safety Code. It provided a recognized means of developing alternative approaches to determine compliance with the code in that and later editions of the Life Safety Code.

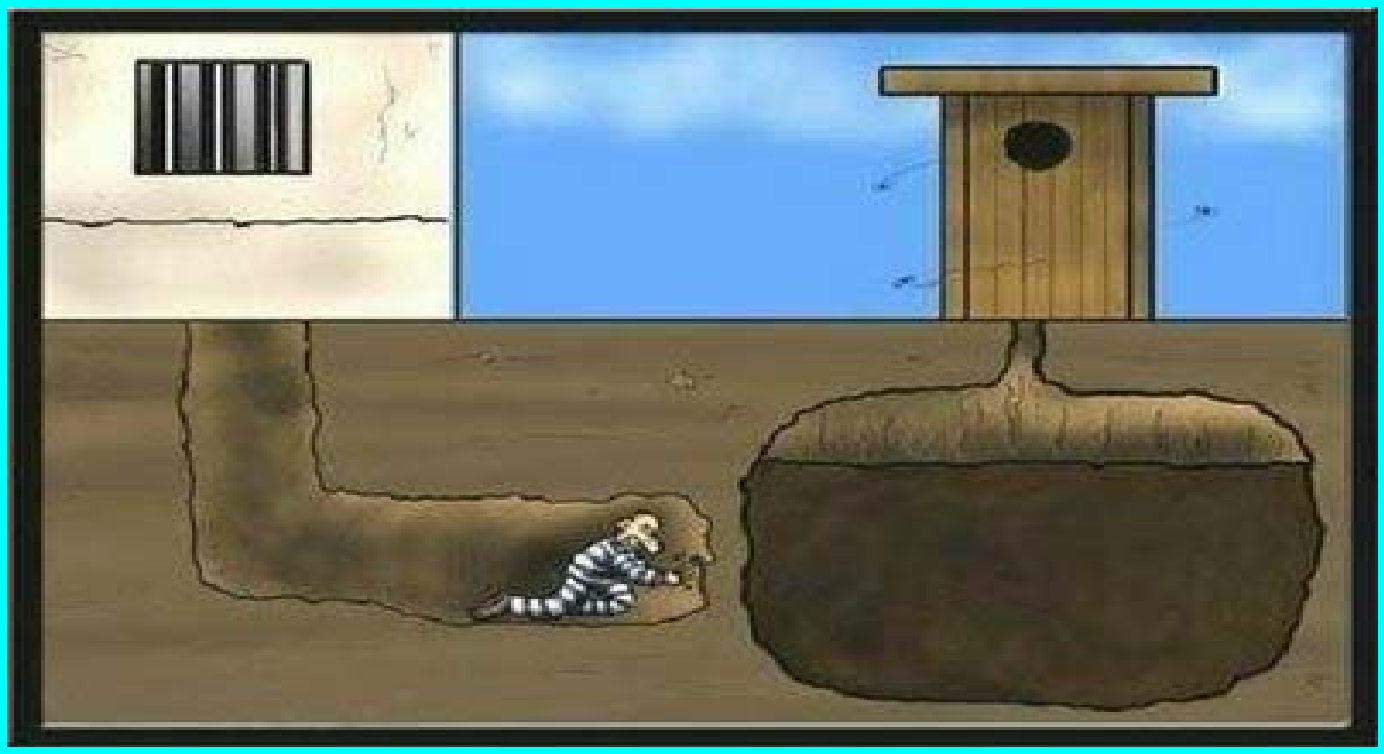
In 1995 the National Fire Protection Association created a new document NFPA 101A, *Guide on Alternative Approaches to Life Safety* to gather and contain the FSES in a single publication and place them in the care of a single technical committee. The FSES have stood the test of time and are now a regular part of life safety design in many buildings. They have both improved safety and reduced costs.

In the long term, the principal importance of the fire safety evaluation systems lies not only in the specific objective of delivering safety with lower cost and greater design flexibility, but also in the demonstration that a total performance approach to fire safety is feasible.

TSIG Consulting can provide FSES evaluations to aid those healthcare organizations that seek a formal means of equivalencies, to address those non-compliant Life Safety Code issues defined within the structural integrity of your buildings. For more information on FSES services, contact: info@tsigconaulting.com

TSIG CONSULTING | facilities management | condition assessment | systems development |
| 740 Broadway | New York, NY 10003 | [t] 212.420.8724 | [f] 212.420.4792 | www.tsigconsulting.com |
Suite 1001

CRITICAL ENVIRONMENT OF CARE INFORMATION ENCLOSED



NOT ALL CONSULTANTS LEAD YOU IN THE RIGHT DIRECTION!