COMPLIANCE news

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ECRI's TOP 10 HEALTH TECHNOLOGY HAZARDS FOR 2011

By David Stymiest, PE, FASHE, CHFM *dstymiest@ssr-Inc.com*

Emergency Care Research Institute (ECRI) recently published a Health Devices guidance article entitled "Top 10 Technology Hazards For 2011" listing ten sources of potential danger that ECRI believes warrant the greatest attention in 2011 for protecting patients and staff. The article, available on www.ecri.org, provides detailed guidance for each of the following issues.

1. **Radiation Overdose and Other Dose Errors during Radiation Therapy* -** Stating that this can take the form of delivering the wrong dose, treating the wrong site on the patient, or treating the wrong patient, ECRI included specific recommendations for support, training, installation, commissioning, maintenance, procedures, oversight, and implementation of corrective actions.
2. **Alarm Hazards* -** Discussing alarm-related adverse incidents typically involving staff being overwhelmed by the number of alarms, alarm settings not being restored, and alarms not being properly relayed to ancillary notification systems, ECRI made specific recommendations for examining the entire alarm environment, establishing protocols for settings and response, implementing and monitoring policies to control alarm silencing, modification, and disabling.
3. **Cross-Contamination from Flexible Endoscopes* -** Stating that patient cross-contamination from improperly reprocessed flexible endoscopes has affected large groups of patients at both large and small hospitals and can lead to life-threatening infections, ECRI recommended using, periodically reviewing, training staff on, and monitoring compliance with detailed model-specific reprocessing protocols.
4. **The High Radiation Dose of CT Scans* -** Stating that the high radiation doses generated during computed tomography (CT) are believed to increase the patient's risk of cancer, ECRI recommended educating referring physicians, monitoring and auditing radiation levels used in routine CT exams, ensuring adequate staff training, optimizing and controlling x-ray parameters (protocols), and investigating applicability of technologies designed to reduce x-ray dose.
5. **Data Loss, System Incompatibilities, and Other Health IT Complications* -** ECRI stated that the convergence of medical technology and health information technology (HIT) is becoming more commonplace and presents many benefits as well as many risks. ECRI also discussed FDA information that adverse events largely can be grouped into the following four categories: 1) errors of commission; 2) errors of omission or transmission; 3) errors in data analysis; 4) incompatibility between multivendor software applications and systems.

> *"Read the entire ECRI article at www.ecri.org to obtain full details . . ."*

   Based upon this, ECRI recommended carefully planning convergence-based projects with initial input from all involved parties, carefully wording contracts, using good project management, change management, and risk management processes, educating staff on recognizing, reporting and documenting HIT-related problems, with appropriate software management, cybersecurity, testing, and the increased importance of help desk calls.
6. **Luer Misconnections* -** ECRI stated that tubing and catheter misconnections can be harmful to patients because they can allow gases or liquids to be introduced *(continued on page 2)*

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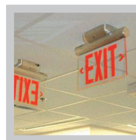


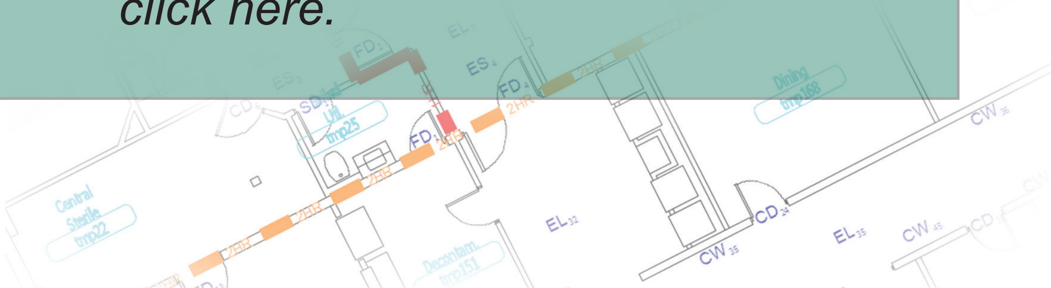
ECRI'S TOP 10 HEALTH TECHNOLOGY HAZARDS FOR 2011 *(Continued from page 1)*

into the wrong lines or by unintended routes of administration, with the risk of such misconnections heightened when two functionally dissimilar devices each use Luer connectors. ECRI recommended periodic training about misconnection prevention, prohibiting the use of adaptors, ensuring that only products incorporating misconnection safeguards be used, identifying and managing conditions and practices that may contribute to healthcare worker fatigue, requiring tracing of all lines by clinical staff at specific times, and finally labeling certain high-risk catheters so that staff can clearly see that they are making a connection to one of these devices.

7. **Oversedation during Use of PCA Infusion Pumps* -** Stating that the most significant danger when using patient-controlled analgesic (PCA) pumps is potentially life-threatening over-sedation, ECRI recommended developing an action plan to implement effective physiologic monitoring of patients on PCA therapy, reviewing how patients on PCA therapy are assessed by clinicians, considering implementing a policy on independent double-checking, and considering implementing other forms of pain management, instead of PCA, where appropriate.
8. **Needlesticks and Other Sharps Injuries* -** Stating that the number of needlesticks and other sharps injuries that occur each year remains staggering, ECRI recommended assessing injuries and current practices, defining specific objectives, establishing an action plan, implementing a full program, and periodically assessing the program's effectiveness.
9. **Surgical Fires* -** Stating that ECRI's research indicates that there are approximately 600 surgical fires per year in the United States, close to the same amount as wrong-site surgery, ECRI referenced its ECRI Health Devices October 2009 Guidance Article and recommended implementing a surgical fire prevention and management program, including training and implementing new clinical recommendations on oxygen delivery.
10. **Defibrillator Failures in Emergency Resuscitation Attempts* -** ECRI stated that failure of defibrillators to perform effectively may result in the death of a patient who could have been saved, and recommended ensuring that those responsible for using a defibrillator perform the supplier's recommended check list at least daily; verify that the installed battery is charged and that a spare battery is kept with the unit; verify that between uses the unit (or charger) is plugged in and batteries are charging. ECRI also provided detailed recommendations on actions to be taken if there are self-test failures, performance failures or error codes.

*Note: Read the entire ECRI article at www.ecri.org to obtain full details and recommendations on each topic listed above, including problem descriptions with numerous detailed recommendations supplemented by a list of resources that can be used by organizations to address the issues effectively.

If you would like to see past issues of Compliance News*,*
click here.



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EMERGENCY MANAGEMENT: EXERCISES

By Susan McLaughlin, MBA, FASHE, CHSP *smclaughlin@mslhealthcare.com*

The Joint Commission requirements for emergency exercises have been relatively static over the past several years. But there have been several minor changes, primarily in the notes to elements of performance in EC.03.01.03, that merit taking a closer look at what is needed.

First the schedule, which hasn't changed in and of itself. Hospitals must do two "live" exercises per year (as opposed to tabletops) to include the following three scenarios: Influx of patients (EP 2), Sustainability (EP 3), and Community integration (EP 4).

The twice a year requirement comes out of EM.03.01.03, EP 1, which contains Note 2, "Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code®) that do not offer emergency services nor are community designated as disaster receiving stations need to conduct only one emergency exercise annually." Conversely, if there are business occupancies that DO offer emergency services and/or ARE disaster receiving stations, the implication is that these facilities are under same exercise requirements as a hospital.

This makes it essential that the role(s) of business occupancies be defined within the Emergency Operations Plan. Typically the business occupancy roles in an emergency are one of the following:

- Close and staff goes home
- Continue to offer routine service
- Close and staff goes to the hospital to assist
- Offer emergency services and/or serve as a disaster receiving station

Once this is understood and defined, the business occupancies must be exercised according to that role.

A new Note 4 was recently added to EM.03.01.03 EP 1. "In order to satisfy the twice a year requirement, the hospital must first evaluate the performance of the previous exercise and make any needed modifications to its EOP before conducting the subsequent exercise in accordance with EPs 13-17." This will be effective July 1, 2011.

The change was in response to CMS requirements, and will likely be difficult to comply with. The good news is that it encourages prompt post-exercise evaluation. The bad news is that it will frequently be difficult to complete all identified changes prior to the subsequent exercises. Hospitals should develop action plans as soon as possible following an exercise or event. The plans should include ownership of the action and expected completion dates. Progress should be documented through to completion, whether or not that takes place prior to the next exercise. Assessment of this in practice will need to be seen.

Susan McLaughlin is Managing Director of MSL Healthcare Consulting, Inc.

DISINFECTION NOTE REVISION FOR TJC INFECTION PREVENTION AND CONTROL STANDARD

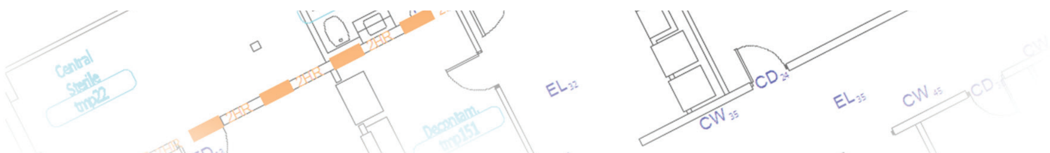
By Dean Samet, CHSP *dsamet@ssr-Inc.com*

Effective April 1, 2011, The Joint Commission made a slight revision to the Note for Standard IC.02.02.01, EP 2. The following language has been deleted: "Intermediate level disinfection is used for items such as specula."

The standard and note now read as follows: "The [organization] implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.* (See also EC.02.04.03, EP 4.)

Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.

* For further information regarding performing immediate and high-level disinfection of medical equipment, devices, and supplies, refer to the web site of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (*Guide for Disinfection and Sterilization in Healthcare Facilities, 2008*).



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FIRE PROTECTION SYSTEMS TESTING REVISIONS BY TJC

By Dean Samet, CHSP *dsamet@ssr-Inc.com*

In the May 2011 edition of *The Joint Commission Perspectives*, TJC announced a change effective July 1, 2011 for Environment of Care Standard EC.02.03.05, EP 2 and introduced a new EP 25. The standard, "the hospital maintains fire safety equipment and fire safety building features" remains unchanged.

EP 2 has been changed and will require quarterly testing of water-flow devices. TJC standards previously required testing every six months or semi-annually in accordance with NFPA 72, 1999 edition. EP 2 will read as follows: "For hospitals that use Joint Commission accreditation for deemed status purposes: At least quarterly, the hospital tests water-flow devices. Every six months, the hospital tests valve tamper switches. The completion date of the tests is documented. Note: For additional guidance on performing tests, see NFPA 25, 1998 edition (Sections 2-3.3 and 3-3.3) and NFPA 25, 1999 edition (Table 7-3.2). For hospitals that do not use accreditation for deemed status purposes: Every six months, the hospital tests valve tamper switches and water-flow devices. The completion date of these tests is documented."

New EP 25 will read as follows: "For hospitals that use accreditation for deemed status purposes: Documentation of maintenance, testing, and inspection activities for fire alarm and water-based fire protection systems includes the following:

- Name of activity
- Date of the activity
- Required frequency of the activity
- Name and contact information, including affiliation of the person who performed the activity
- NFPA standard(s) referenced for the activity
- Results of the activity

Note: For additional guidance on documenting activities, see NFPA 25, 1998 edition (Section 2-1.3) and NFPA 72, 1999 edition (Section 7-5.2).

PUBLICATIONS AND SEMINARS

Publications

"Continuous Compliance - Maintaining a constant state of regulatory readiness," *Health Facilities Management*, May 2011

Seminars

May 27 — East Tennessee THEA Meeting, Knoxville, TN, "Life Safety Accreditation Hotspots"
June 12-15 — NFPA Conference & Expo, Boston, MA, "NFPA 110/111: Proposals for the Next Editions"
July 18-20 — ASHE Annual Conference, Seattle, WA, "NFPA 110/111 Update"
August 25 — Healthcare Facilities Management Society of New Jersy All-Day Seminar, Union, NJ, "Life Safety Accreditation Challenges," "Transitioning from Construction to Operations and Regulatory Compliance," "Preparing for Surveys and Continous Compliance," and "NFPA 110/111 Update"
September 28 — Florida Healthcare Engineering Association Annual Meeting, Orlando, FL, "Life Safety Accreditation and EC Hot Spots"
October 24 — Decision Health EC Summit, Las Vegas, NV, "Overcoming Environment of Care and Life Safety Accreditation Challenges"

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Compliance News is a newsletter dedicated to accreditation, regulatory compliance and facility management issues for healthcare executives and facility managers.

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