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For most, the EOC 'tracer' breeds fear; follow these tips to be prepared

Tips and tools for a successful building safety survey

If the thought of The Joint Commission surveying you on your environment of care or building safety makes you squirm, you're not the only one. And there's good reason. Of the top five challenging requirements for hospitals in the first half of 2010, four of the five standards were related either to the environment of care or life safety code chapter, according to The Joint Commission. Those four, respectively, are:

- with a 50% noncompliance rate: LS.02.01.20 — The hospital maintains the integrity of the means of egress;
- with a 44% noncompliance rate: LS.02.01.10 — Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat;
- with a 38% noncompliance rate: EC.02.03.05 — The hospital maintains fire safety equipment and fire safety building features;
- with a 37% noncompliance rate: LS.02.01.30 — The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

According to **Glenn D. Krasker**, MHSA, FACHE, president and CEO of Critical Management Solutions, a consulting firm based in Wilmington, DE, the life safety code used to be a part of the environment of care chapter, but in 2009, The Joint Commission separated the two.

"Life safety is essentially the hospital's compliance with the National Fire Protection Association's Life Safety Code, which means whether the hospital is fire-safe, whether it is constructed and built in a way and maintained in a way that will prevent the fire from starting and the fire from spreading... The environment of care chapter is more global in that it addresses the entire physical environment of the hospital, more importantly, the interrelationship between the occupants of the building — visitors, patients, staff, and the building itself." Both life safety and environment of care fall under hospital safety standards.

Within the environment of care chapter, there are six management programs, Krasker says:

- safety;
- security;

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• hazardous materials and waste;
• emergency preparedness;
• medical equipment;
• utility systems.

For each of the six, you must have a management plan or document describing the program, says **Scott Anderson**, principal consultant with the Quality Systems Group LLC in Linn, OR.

In 2010, EOC and emergency management are a combined session for ambulatory care, behavioral health care, home care, long-term care, and office-based surgery accreditation surveys. For both critical access hospitals and hospitals, the two now are separate sessions.

The environment-of-care session itself is separated into two parts: a sit-down discussion reviewing documents and policies, as well as corrective plans that have been identified by the organization; and a tracer, Anderson says.

The life safety code specialist mainly handles building inspections, while another surveyor generally does the environment-of-care session, Anderson says. "There is overlap because your fire safety program is just one element or program under the umbrella of environment of care," he says.

Krasker says, "My intelligence tells me that starting in 2011, The Joint Commission is going to change their survey process a little bit," including increasing the number of days the life safety code specialist is on site. "I see that the life safety specialist will really be surveying all aspects of the environment of care and life safety."

What's included in an EOC session?

As part of the sit-down session, The Joint Commission will want to see a lot of documentation, Anderson says, including:

• the six required management plans, plus your emergency operations plan;
• minutes from your safety committee for the last 12 months;
• annual effectiveness evaluations from each of the six management areas;
• statement of condition documents.

In looking at the six management plans, Krasker says, The Joint Commission will look at the scope and content of the plans and also "the indicators or performance measures the hospital has identified" in each, as well as "the data they have collected and what they have done with those data, what conclusions they have drawn."

Surveyors want to see areas you have identified as needing improvement and what you have done. Krasker says surveyors will take one or two of the management programs and run them through the EOC risk management cycle, which includes planning, teaching, implementing, responding, monitoring, and improving.

Surveyors want to see the EOC risks the hospital has identified, the plan of action, and what has been done or will be done to mitigate the risk identified. As an example, Krasker says, if you find

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Editorial Questions

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the medical gas system is not functioning properly or generators are not producing enough power, surveyors are going to look for "what steps have been taken, what do you need to do in the meantime while you are implementing that plan" or while you are getting the money together to repair a system, what you are doing in the interim. If you have identified a risk, produced a plan for corrective action, but you have not done enough on that, you would certainly be cited, he says.

He says that he sees, too often, hospitals getting cited "for not following up, taking corrective actions to repair [the failing system] or making necessary repairs in a timely manner. It's almost as if they get these reports from inspections from outside companies that do a lot of testing for them and they just don't pay attention to them. They just don't jump on these issues that need to be addressed very timely... That's something The Joint Commission is keyed in on.

"Whether it's the building or any aspect of the environment of care, medical equipment or your utilities systems, if they are not functioning properly, what is your plan to fix them and to repair them?; and in the meantime, what have you done to keep the environment or keep the occupants safe while those repairs are pending?" he says.

As part of that session, Anderson says surveyors also will meet with the chairman of the safety committee and other committee members to discuss risk areas and corrective actions. "You are provided a fair amount of latitude with regard to standards and regulations about committee membership. You need to have a cross section of the organization represented. There are some state regulations, which are more specific as to committee membership," he says. He suggests a cross section of staff including clinical, nonclinical, clinical inpatient, and outpatient representatives. Many larger organizations, he says, construct sub-committees based on the six management plans.

The statement of conditions, he says, is a Joint Commission management tool that allows hospitals to "do a self-evaluation of their compliance with the life safety code. It has four sections, but the major section is where you identify, based on a very rigorous tool and inspection of the hospital, life safety code deficiencies — whether it's holes in smoke and fire barriers, whether it's doors that don't positively latch." For those deficiencies that are going to take longer than 45 days to repair, you must develop a call for improvement, or PFI, he says. That should state what you are going to do to fix that deficiency, the time frame it will take to complete, and the cost. If surveyors see something you have identified and the due date has not passed, you won't be cited, he says. If surveyors do find something that is not in the statement of conditions but violates standards, you will be cited.

Preparing for the EOC session

In preparing the documents The Joint Commission will review and to accommodate the breadth of activities required by the EOC standards, **Kurt Patton**, MS, RPh, CEO of Patton Healthcare Consulting in Glendale, AZ, and former executive director of accreditation services at The Joint Commission, says, hospitals should:

• Organize activities such as tests or drills by when evaluations are required.

There are myriad time tables in the EOC chapter, Patton says. "We have a tool that we give people. When you look in the chapter, it talks about all these things you've got to do once a month, once a week, once a year, every six months." As part of the tool, he organized those activities that you do on an infrequent basis — such as semi-annual — or on a quarterly, monthly, or weekly basis. *(See the online version of this issue for the tool.)*

• "Document every aspect of the tests that they do so that it mirrors the requirements of the elements of performance precisely."

"Think of something like generator testing. Hospitals say, 'Yes, we do generator testing.' But then when you look at The Joint Commission standards, do you do the generator testing every month? No less than every 20 days? No more than every 40 days? And, surprisingly, you look at some hospitals, and they do one test 19 days apart and they do one test 41 days apart. That's not compatible with the standard," Patton says.

• Check your documentation for the level of detail and make sure you're getting details from your vendors as well.

The standard Patton refers to above also requires that during the generator test you should ensure that when the generator goes on, that you transfer the power using automatic transfer switches and document whether those work and how many seconds it took to throw the power. "Hospitals do it by observation, but they don't check and say, 'That transfer switch, No. 1, took us eight seconds. That transfer switch, No. 2, took us five seconds.' And The Joint Commission is looking for that level of detail."

He says you must require the same level of specificity from your vendors. Echoing Krasker's sentiments, Patton says, The Joint Commission is

(Continued on page 137)

Department Walkthrough EOC Checklist

Area/Item to be checked:	Status (OK or Gap)	Action Needed & Taken
Compressed gas cylinders are secured		
Hazardous materials properly stored/labeled		
Sharps containers secured/not overfilled		
Chemicals have not passed expiration date		
Eyewash stations have water temperature regulated to prevent burning from hot water		
Under sink storage clear of patient care items		
Corridors/stairways free of clutter and storage		
Exits signs are illuminated and visible		
Fire hoses and extinguishers are accessible		
Monthly fire extinguisher checks complete		
18" clearance under sprinkler heads		
Fire doors close properly & are unobstructed		
Doors positively latch & door wedges not used		
Storage areas are clean		
Medical gas shutoff clearly marked/ accessible		
Ceiling tiles are in place and unstained		
All lights are working		
Handrails are in good repair		
HVAC vents are clean and unobstructed		
Walls, ceilings, and doors in good repair		
Area is clean and uncluttered		
Soiled equipment & linen separated from clean		
Refrigerators/freezers/microwaves clean		
Refrig/Freezer temperature logs complete		
Patient supplies kept off the floor		
Disinfectants/chemicals include manufacturer warning labels		
Doors to Biohazard areas are kept closed		
Patient care equipment is cleaned per policy		
Microwave is clean		
Access to sensitive areas is enforced		
Medications are properly secured		
Syringes/Prescription pads secured		
ID badges worn by all employees		
Patient information inaccessible to public		
Defib and crash cart checks done per policy		
Electric panel secure and unobstructed		
Electric outlets/switch plates/cords in good condition		
Quality Checks are documented for Point of Care testing (e.g. Glucose Meters)		
Solution bottles & test strips are dated when opened and are not expired		
Other:		

Source: Kurt Patton Consulting.

2010 Tracer Tool — Environment of Care Walk Around

Life Safety
- Fire exits accessible? Clearly marked?
- Exits signs are illuminated and visible
- Fire doors close and latch
- Fire door have proper gaps and undercuts
- Fire door with appropriate fire rating
- Fire alarm pull stations accessible
- Evacuation route maps posted and accurate
- Fire extinguishers inspected monthly and annually
- Fire extinguisher and hoses accessible
- Fire drills completed as required and documented
- Fire alarm system testing up to date
- Ceiling tiles are in place and clean
- 18" clearance under sprinkler heads
- Corridors/stairways free of clutter and storage
- Hallways clean and uncluttered – 8 foot unobstructed
- Fire doors close properly & are unobstructed
- Doors positively latch & door wedges not used
- Penetrations in walls or ceilings properly sealed
- Walls, ceilings, and doors in good repair

Environment, Storage, and Equipment
- Medical equipment PMs up to date
- Medical equipment is cleaned per policy
- Under sink storage clear of patient care items
- Storage areas are clean free of combustible material
- Medical gas shutoff clearly marked/ accessible
- Medical gas alarm panels working
- Handrails are in good repair
- HVAC vents are clean and unobstructed
- Soiled equipment & linen separated from clean
- Refrigerators/freezers/microwaves clean
- Refrig/Freezer temperature logs complete
- Microwave is clean
- Defib and crash cart checks done per policy
- Electric panel secure and unobstructed
- Electric outlets/switch plates/cords in good condition

Safety
- Negative pressure rooms functioning, testing complete
- Access to sensitive areas is enforced
- ID badges worn by all employees
- Required PPE available in department/area
- Safety glasses and face shield NIOSH approved (Z87.1)
- Compressed gas cylinders are secured
- No more than 12 E cylinders in a smoke compartment
- Eyewash stations have water temperature regulated to prevent burning from hot water

Hazardous Material/Waste
- Hazardous materials properly stored/labeled
- Waste receptacles emptied before overfilled
- Sharps containers secured/not overfilled
- Sharps containers mounted below 4'10"
- Doors to Biohazard areas are kept closed, labeled
- Disinfectants/chemicals include manufacturer warning labels
- Chemical containers properly stored and labeled
- Chemicals have not passed expiration date
- Material safety data sheets up-to-date and accessible

Source: Kurt Patton Consulting.

(Continued from page 135)

focusing a lot more on documentation and also looking that you've resolved any identified risks. He, too, sees hospitals that have a vendor test something and the vendor reports that a certain system, such as medical or gas alarms, isn't functioning properly. "And the hospital gets the report and doesn't act upon it. That's worse than not knowing," he says.

Working with vendors, engineers

One of the most common "flaws" he sees is when a vendor hands the hospital an invoice for $4,000 and says, "I tested your fire alarms." "But what the vendor needs to do is say, 'I tested the following fire alarms, I tested the following fire strobes, and they all worked successfully,'" Patton says. The vendor should leave a complete listing of all the devices that were tested.

Patton also says many hospitals should improve how they work with engineers. "We have in each hospital a quality department, and they make sure the doctors are doing what they are supposed to do, they make sure nurses are doing what they are supposed to do... And when it comes to engineering, for some reason, they seem to turn a blind eye to it. It's very technical. Perhaps people aren't welcoming of others looking over their shoulder, but you've got to do it. Just like you would in any other part of the hospital." And since the QI department houses "experts in knowing how The Joint Commission works," he says, they should "look for a certain degree of documentation that engineers might not automatically think of."

(Editor's note: See pages 136, 137 for EOC tracer tools.) ■

Look out for these to prepare for EOC tracer

Consultants share common problems

Clutter. It's a huge problem. "It's probably the second most scored standard," says **Kurt Patton**, MS, RPh, CEO of Patton Healthcare Consulting in Glendale, AZ, and former executive director of accreditation services at The Joint Commission. "Hospitals are crowded places, and there is a limited number of pieces of equipment that we are permitted to keep in the hallway. And what I see in hospitals are abandoned beds, stretchers, laundry carts that are left, clean linen carts, dirty linen carts. They are just not moved for hours on end. It's just a mess in hospitals."

Patton's solution is twofold. First, he suggests, there should be an "owner or department owner for a device." If you bring an X-ray machine, for instance, onto the unit, you do your work and take it back. "Transporters might bring a patient on a gurney. They place the patient in the room, and then they have to take that gurney out of there. Then you should have an oversight process, which might be rounds by a safety officer, where every time that person is making their rounds and they see something that hasn't moved in 30 minutes, they call the owner of the department to come and get rid of it," he says.

COWs, or computers on wheels, are on and off the floor. Patton says as long as they "are in use" per The Joint Commission's and Centers for Medicare & Medicaid Services' definition, you're OK. And that is, that the machine is moving at least every 30 minutes.

If a nurse is going from room to room with a medication cart, that fits the definition of "in use." If, however, you take that cart and plug it in to recharge the battery in the hallway at 10 a.m. and the nurse goes to do other things, that violates the "in use" criteria.

Patton says, most often, a nurse or physician surveyor during a clinical tracer will notice stationary equipment. If, for instance, he or she notes it and then is occupied for 45 minutes, then comes back and notes the cart is still there, "it makes it pretty obvious," he says.

Another area The Joint Commission is homing in on is fire safety. Patton says that, previously, documentation of hospitals' fire safety testing was inadequate so The Joint Commission is looking for much more. "That's getting back to the example where the vendor gives you a bill, 'You owe me $4,000. I checked your fire alarms.' But when the surveyor looks and says, 'What alarms were tested? What strobes were tested?', nobody can tell," he says. He suggests looking rigorously at your documentation and asking yourself, "Will this pass muster with The Joint Commission?" He compares it with the stringency The Joint Commission would use looking at clinical components such as the history & physical and noting whether it's dated or timed. Your documentation for environment-of-care components must be as thorough, he says.

Scott Anderson, principal consultant with the Quality Systems Group LLC in Linn, OR, also sees a huge emphasis from The Joint Commission on fire safety. He points to a violation he often sees with penetrations in fire and smoke walls. "The life safety code says you have to divide your building up into compartments, smoke compartments and then larger fire compartments, to keep a fire from spreading, and the integrity of those walls has to be maintained from floor to the deck of the floor above," he explains. "And so, it's largely in the spaces that you can't see above the ceiling." With all the electronic systems for electronic medical records, pharmacy systems, radiology systems, there are a lot of wires "to support those systems, and those wires have to go through the walls and then the patchwork has be to done to make sure that the integrity of that wall is maintained."

He says The Joint Commission will look for this, "but these are unseen dangers from a fire safety standpoint above your head that make it more difficult to track and fix."

In one facility, a Centers for Medicare & Medicaid Services surveyor found penetrations in a closet in the admitting manager's office in the back corner of the admitting department, Anderson says. "I thought, how in the world did they even find this room, let alone that there was [a violation here]?"

CMS surveyors, he says, will actually use a blueprint while inspecting your buildings. "They will take a copy of those drawings and they will highlight as they check each location, area by area. Even with that, that may take them several days, sometimes a team of two or three or even four," Anderson says. "The Joint Commission life safety code specialist surveyors will do the same thing, follow the same methodology. But often they will need to spot check in order to get through the very large buildings in a one- to two-day time frame."

Now, The Joint Commission may give you a pass if you have a penetration and documentation proving you are working on fixing it, says **Glenn D. Krasker**, MHSA, FACHE, president and CEO of Critical Management Solutions, a consulting firm based in Wilmington, DE. "CMS doesn't have that hole, doesn't have that functionality within, doesn't have that allowance that's in their survey process. So they find one hole, you get written up for it," Krasker says.

Anderson also says another huge area for noncompliance with Joint Commission standards deals with egress corridors. Hospitals should not store anything in egress corridors to allow safe exits in case of fire, Anderson says. If you do have equipment there, such as environmental services carts or EKG carts, he says, it must be on wheels and on one side of the hallway with the same 30-minute "in use" criteria. The two allowable exceptions, he says, are crash carts "because they may be needed at any particular time... and the risk of not having it accessible is considered greater than the risk of fire safety" and patient isolation carts or patient isolation materials.

Why is the egress issue a chronic one for hospitals? "Lots of hospitals were built a long time ago, before we had as much medical technology as we have now. Storage issues are just chronic problems in hospitals. You know, part is maximizing your storage and having them being as organized as you can be in storage." Some hospitals use the Lean approach to redesign and found they don't need all the supplies they have on hand, he says. "They've done better about that," he says.

As for maintenance on machines or equipment, Anderson says, it's best to first check all points of entry. "So for any new equipment, the biomedical engineering staff have to work closely with where that equipment is checked in or where it's coming into the organization, usually through purchasing materials management. That relationship in most hospitals is pretty strong; if it's not, it ought to be." Rented or privately owned equipment should be checked as well, which can be more troublesome, he says.

"The problems with it is, when it is patient-owned, then there are more and different points of entry. It might be after hours through the ED. So it's building those relationships with those points of entry and building knowledge with your nursing staff [or respiratory staff] that any equipment that the patient brings in that is electrical needs to be checked out and to alert biomedical when they see something," he says. ■

What do you do after multiple adverse events?

Seattle Children's goes on record after deaths

After one patient death in 2009, an error with an adult patient this year, followed by two patient deaths, Seattle Children's Hospital has been in a lot of discussions with not only the state's department of health and The Joint Commission, but the media and its staff as well.

Cara Bailey, BA, MBA, vice president of continuous performance improvement at Seattle Children's, says she almost felt as if she were in a reality television series as the stories kept breaking in the media in late September. In her role, Bailey is responsible for the hospital's continuous performance improvement resources. She says the organization adopted and has been using the Toyota production system/Lean methodology for 10 years. She also is responsible for patient safety, clinical quality improvement, and regulatory compliance.

"Through this crisis, my role has really been to, first of all, mobilize the right resources to both do the immediate root-cause analyses and really get in there and understand what happened and what to do and what the root causes are. But it has also been to say, 'OK, what are the things the staff are telling us that we need to go out and take a closer look at using our continuous performance improvement methodology?'" she says. In terms of mobilizing resources and people, she is working to make sure the core leadership group is managing the issues. One of those people, she says, is the organization's vice president of marketing communications. "So we're, as a group, constantly in contact with each other regarding the media and just both the internal and external communication strategy because all of this work is obviously linked," she says.

On the regulatory side, her job has been to ensure the hospital is talking to all "the right people" within all regulatory bodies — The Joint Commission, the Centers for Medicare & Medicaid Services, and the state's health department.

"One thing that I have learned, you have to be able to segment out the work and have people going out and doing it. There is just so much that comes at you all at once. The first decision we made with the first medication error was that we were going to be transparent about it. It was in keeping with our philosophy, and we did send a letter to all of our employees and our medical staff," that ulti-

mately made its way to the media, she says.

"It's really hard to imagine that you can send an e-mail or a letter to 5,000 of your employees and associates and expect that it's not going to make it's way to the media when it is dramatic," she says. Many peer hospitals, she says, have "kind of looked at us askance, [asking], 'Why are you talking about it?' Kind of like, 'You have made your own misery here because you have been out there talking about it.'" But, she adds, the hospital's policy has always been to disclose to patients, families, and staff any adverse events that happen.

However, much of the media's coverage has been confusing regarding when and why the four events occurred, she says. They also reported the hospital was suspending operations for a day to review their policies. That was really a bit of a "misnomer. We realized that we were going to need to really make sure that we were reinforcing some basic safety behaviors and so we started that right away," Bailey says.

The hospital called it a "rolling stand down," after the military's reaction to an event such as a plane crash when they "stand down" all operations for a day to review safety principles and to ensure everyone's understanding of those basic elements.

The hospital held a series of forums in which employees discussed behaviors — specifically around verbal orders, Bailey says, which was identified as a particularly risky area. The purpose? To create a standard that everyone follows. "So within about a week to 10 days, we had seen about 2,500 to 2,600 of our employees in those forums and then followed up with the ones that weren't able to be there." That was followed up with a forum on a Saturday.

At about the same time, leaders were sent into the workplace to review things they had learned from speaking intensively with staff during the forums about what employees saw as barriers, problems, or obstacles. In speaking with them, for example, about verbal orders, "they told us all sorts of things. We heard a lot about our clinical information systems and how easy they are to access or not. We heard things about interruptions in the workplace and distractions and interruptions of all kinds. We heard some specific things about equipment. A lot of themes began to emerge, and given that input, we started to work on what we could do on this patient safety day that starts to get at some of what we have heard," Bailey says.

Thirteen projects emerged from discussions with staff. One group worked on order sets for verbal orders as part of the clinical information system. "We believe that by having these order sets, it not only makes the care more consistent, it also makes it easier for the prescribers, as they are going into the information system to order the right thing. So a lot of it comes down to human factors and what's going on in the environment," Bailey says.

Another group worked on interruptions in the operating room. One used simulation to identify what the standard work involved with verbal orders should be, and another also used simulation to evaluate how staff should escalate problems. "We had one group that was working on the standard process for medication administration. We had two groups that were working on automated dispensing cabinets on the unit and looking at what's in those cabinets and how should we make that more consistent. So we had a wide variety of groups all working on specific projects around medication safety. People were so energized by it," Bailey says.

She says the work is not "rocket science," but about how to simplify a very complex environment. One thing that was brought up in discussing interruptions was the wireless phones nurses carry with them. "[T]hose things go off all the time. A nurse shouldn't be thinking about her phone when she is in a medication room preparing medications," Bailey says. Staff also discussed what the protocol should be if you couldn't locate a staff member on his or her phone.

"I think the other thing that we have discovered around that is because this technology can tend to make the environment really seem urgent all the time, and so even separating out what's truly urgent and needs to be addressed immediately versus what can wait or what things should we be anticipating so that they don't become urgent or emergent," she says.

All four cases had something to do with medication overdoses or errors in medication administration, she says. In one of the events, an infant was given an overdose of calcium chloride. Immediately following the incident, calcium chloride was removed from the automatic dispensing cabinets in all the units, she says. Other medications were also removed to make it harder to make an error.

Bailey says it's not just about root causes but the themes that emerge to make it easier to make errors.

Bailey says all the events were reported to The Joint Commission, and as of press time, the hospital had submitted its root-cause analyses and was waiting for The Joint Commission to schedule a conference call to discuss the findings. Of the four events, The Joint Commission determined three did not meet its definition of sentinel events. The calcium

chloride event did, she says.

"Any time these things catch media attention, then whether or not they meet a list of never events, it's going to bring your regulators out," she says. The state came in and has reviewed all four cases. The facility licensing review is, as of press time, complete on three of those. She says the state health department did release a statement saying "that those investigations were complete and they found no deficiencies in the hospital systems and processes on those three cases. Now, at the same time, there are also investigations going on into some of the individual people involved from the nursing committee and the medical quality assurance committee. [They] are being looked at separately for individual licensing; those investigations generally take longer," Bailey says.

"I think it's all about, ultimately, how did we really cut down the complexity of our environment? And it plays out in things that are as concrete as interruptions. It also plays out in recognizing that when patients are so complex, how we do make our system such that the staff are supported to take care of each patient one at a time and that the information systems and the other things around them make it easy for them to do the right thing — not make it more complicated to do the right thing. That's the ultimate systems challenge, I think." ■

Educating ED staff to care for psych patients

TJC issues sentinel event on suicide in EDs

In its latest sentinel event alert, issued Nov. 17, The Joint Commission calls attentions to preventing suicide risks in the emergency department and medical/surgical unit and recommends educating clinicians, noting that many of these suicides are committed by patients who had no prior psychiatric history.

Hospital Peer Review spoke with two experts about treating psychiatric patients in the ED setting: **Lauren Ball**, MSW, LCSW, BCD, administrative director, youth services and social services at Loma Linda University Behavioral Medicine Center; and **Michelle Buckman**, RN, MSN, psychiatric clinical nurse specialist working as a consultant to Loma Linda's emergency department.

Ball sees movement in the regulatory arena on standardizing and educating hospital staff about dealing with patients who have psychiatric disorders. The industry continues to "see that suicides in hospitals are still one of the top sentinel events," Ball says. "As long as those statistics are there, then we are going to be expected, as an industry, to do better, and we need to do better."

The Joint Commission's National Patient Safety Goal 15.01.01 requires hospitals caring for patients with emotional/behavioral disorders to identify those at risk of suicide. (See the alert for EPs related to the goal: http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_46.htm.)

Both Buckman and Ball note that the industry is moving away from using what was once the traditional form of de-escalation — restraints and seclusion — and using assessments and patient preferences to find better ways for stabilization; it's something they both agree with. Restraints are a "plain out physical risk for the patient, never mind the re-traumatizing of someone who is already scared," Ball says. Ultimately, she adds, you have to try everything and chart everything, with a "whole tool box of things" to de-escalate before using restraints and the rules surrounding them.

"I see a lot of indifference to psych patients" in the ED, Buckman says — in part, because staff are scared or think, "'Oh brother, here comes Joe again. He's going to act out...' They don't understand mental illness. They think he is acting out on purpose to make your day bad. " And in an ED where multiple complex situations demand priority, the thought may be to keep Joe quiet and out of the way in order to treat patients who seem more urgent, such as a car crash victim. A patient in an aggressive stance puts staff on the defensive and gets them riled up, she adds.

"I've had to do a lot of education," she says. "I think it has helped them to learn mental illness is really a disease. Joe coming in and acting out is really a symptom of all the problems that are going on or the abuse that he's had or the voices in his head." Or staff may see a kid, who may look like a gangster, in an aggressive stance and think, "We're going to have to tie this kid down," when, as Buckman says, if you sit and talk with him for a minute and validate his feelings, it can de-escalate the entire situation.

"It's very difficult, no matter your level of skill, to manage the patient in a way that's safe for them or other patients," Ball adds. For instance, with a patient who has not taken his medications and is hearing voices and thinks you are part of the CIA and trying to kill him, you may not be able to reason with him in that state. Those are challenging situations, she says.

Buckman says the priority for nurses in the ED is simply to stabilize the patient and not try to treat or gather a comprehensive history. Often, she'll tell nurses, "You just help me with vital

signs and getting the patient in the bed.

"Sometimes they could do a lot better job, though, if they had some better understanding of the psych patient. There are some days that they really don't have to ignore the patients the way they do or they don't have to get out restraints as quickly as they do... [Their role] is pure stabilization and not really any treatment or any attempt to help the patient discover their own triggers or their own coping skills."

Buckman and Ball admit they are lucky to have a psychiatrist who visits patients in the ED and note that many smaller or rural hospitals might not have the same resources internally, or the closest psychiatric unit may be 150 miles away for possible transport. Buckman says one hospital she's familiar with is training its paramedics in mental health and certifying them so they can complete mental health screening exams in patients' homes. Ball says some hospitals are thinking about tele-psychiatry or working with their state's mental health department or private psychologists in the area who can be on call if needed in the ED. Some hospitals are doing "really creative things," Buckman says.

As community resources for psychiatric patients become backlogged and financially tied, more of these patients search out the ED for help, Ball says. Sometimes, Buckman says to her ER nurse, "Who will die faster? Your patient having a heart attack or your patient who shoots himself in the head with a gun? You know, if they are going to be dead in a few seconds, either way you look at it, both of them need emergency care really, really fast. Dead is dead." And Ball concurs. She says staff must understand that patients with behavioral or mental issues in the ED are in crisis, too. "[T]hey are not something that is getting in the way of your business; that is your business," she says. ■

CNE QUESTIONS

21. Which of the following are among the six management plans in The Joint Commission's environment of care chapter?
A. safety;
B. hazardous materials and waste;
C. emergency preparedness;
D. all of the above

22. According to Kurt Patton, equipment is "in use" as long as it is moved every 45 minutes.
A. True
B. False

23. According to Lauren Ball, MSW, LCSW, BCD, and Michelle Buckman, RN, MSN, restraints and seclusion should be the last choice in calming a psych patient?
A. True
B. False

24. Vicki Searcy says privileges should match the reality of how physicians practice.
A. True
B. False

Answer Key: 21. D; 22. B; 23. A; 24. A.

CNE INSTRUCTIONS

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with **this issue**, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

Credentialing & Privileging

Establishing criteria for privileging practitioners

[In the first part of this four-part series, we introduced the four basic elements of clinical privileging:

1. Defining your organization's scope of services.

2. Defining the criteria (i.e. training, experience, behavior, skills) necessary to provide a specific service (or grouping of services). Determining how those expectations will be handled.

3. Allowing those interested to apply for privileges and identify if they meet established criteria. Make a decision on the privilege.

4. Monitoring privileged persons to ensure competence and practice.]

Before establishing criteria to qualify privileging, and to make the process more manageable, **Vicki Searcy**, president, consulting services at Morrisey Associates Inc. in Chicago, suggests grouping privileges. "If privileges are in a 'laundry list' format (with each privilege given equal weight), it would be necessary to establish criteria for each and every privilege — an overwhelming task," she says.

Grouping privileges

There are several ways to group privileges, Searcy says:

• Privileges can be bundled by residency or fellowship training.

For example, Searcy says, "privileges that an anesthesiologist would be trained for during a resident program might be one grouping, with additional groupings (sometimes referred to as clusters) related to fellowship training (such as pain medicine, cardiothoracic anesthesiology, critical care medicine)."

• Privileges can be grouped by how specialties practice.

Family physicians, for example, learn in their residency programs to treat all ages in all settings, including ambulatory and critical care, Searcy says. Today, however, she says, "many family physicians do not continue to practice in this full spectrum of care and may specialize in ambulatory/primary care and not continue to seek privileges to handle obstetrics or critical care." Others, she says, may work in the acute care environment and seek privileges for advanced obstetrics, usually following additional fellowship training.

The grouping of privileges should mirror "this reality of how family physicians practice," Searcy says. Another example she gives deals with surgeons. "Some general surgeons specialize in treatment/surgery of the breast and do not continue to exercise privileges in other surgical areas."

• Privileges for family physicians and general surgeons often relate to the location in which they practice.

"Physicians who practice in rural areas are more likely to exercise the full spectrum of privileges in a particular specialty than those in urban areas where there is access to sub-specialized care," she says.

Once you have grouped privileges, the criteria related to the group or a stand-alone privilege, "usually includes all or some of the following," Searcy says:

- education/training (residency, fellowship, etc.);
- continuing medical education;
- board certification;
- clinical activity (Searcy adds that it would be difficult to determine competency for something a physician has not done recently);
- outcome information;
- additional parameters, such as:
  - ° current certification in areas such as basic life support (BLS), advanced cardiac life support (ACLS), pediatric advanced life support (PALS), or neonatal advanced life support (NALS);
  - ° a contract with the hospital to provide a specific scope of services ("for example," Searcy

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

COMING IN FUTURE MONTHS

- Tackling hand-off communications, transitions of care
- Identifying, managing patient suicide risks
- More on credentialing, privileging
- Making core measure data abstraction more efficient

says, "the organization may contract with a radiology group and, therefore, it would be necessary to be part of the group in order to be eligible to request privileges in radiology").

Also, to be eligible to request privileges, a physician could be required to live within a specific area, have no felony convictions, or no Medicare exclusions, Searcy says.

She offers the following as an example of initial privileging criteria for interventional nephrology privileges:

- Completion of a 12-month fellowship in interventional nephrology approved by the American Society of Diagnostic and Interventional Nephrology AND
- Certification by the American Society of Diagnostic and Interventional Nephrology

Initial Request – 25 cases of each of the following during the previous 12 months OR completion of fellowship training in interventional nephrology during the previous 12 months:

Angiography of peripheral hemodialysis vascular access
Angioplasty of peripheral hemodialysis vascular access
Thrombolysis/thrombectomy of peripheral hemodialysis vascular access
Insertion of tunneled cuffed long-term catheters

The applicant also must be qualified for and obtain primary privileges in nephrology.

Searcy says it's incumbent upon your facility to establish privileging criteria and to be sure those are obtainable. "Criteria must also be reasonable and established to ensure that patients will receive high-quality care — not to protect the interests of a group of practitioners who don't want other specialties 'competing' with them to provide the same type of care [such as turf battles].

"One of the benefits to a health care organization in establishing criteria for privileges," she says, "is that when a practitioner does not meet criteria for privileges, the request does not have to be processed. The organization has not made a decision that the applicant is incompetent — just that the applicant does not meet eligibility criteria. This is not reportable to the National Practitioner Data Bank."

(Editor's note: Stay tuned for the January 2011 issue of HPR *and the third part of this series.)* ■

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PATIENT SATISFACTION PLANNER™

Use patient satisfaction data for improvement

Low scores could affect reimbursement in the future

If you're not using your patient satisfaction data to develop process improvement projects, you're missing a chance to improve patient care, says **Quint Studer**, *CEO of Studer Group, a health care consulting firm based in Gulf Breeze, FL.*

Studer particularly recommends paying close attention to your hospital's scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which he says will transform the way hospitals do business.

"To raise your HCAHPS scores, you have to identify and fix the core underlying causes of low patient satisfaction. Patients aren't going to perceive your quality any better than it actually is — you can't fake it. If you have quality issues like readmissions or high rates of hospital-acquired infections, that's where you need to focus to move both HCAHPS and quality results. HCAHPS helps you know how to focus," he says.

HCAHPS is a 27-question survey created by the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality. It is designed to measure patients' perception of the care they received while in the hospital.

HCAHPS is far superior to patient satisfaction tools of the past because of its focus on quality, Studer says.

"The HCAHPS includes questions like pain management, responsiveness of the staff, communicating the side effects of medication, and understanding home care instructions. No clinician can say those items are not important," he says.

In addition to measuring issues that affect clinical quality, HCAHPS measures the frequency of how often something happens, Studer points out.

Answers to the survey questions include "never," "sometimes," "usually," and "always."

"For instance, many other tools ask if someone explained the side effects of medication. This is different from asking if the side effects are always explained. To do well in today's health care environment, hospitals can't be content with responses of 'usually.' If they want to be a stellar performer, they should move to 'always,'" he says.

HCAHPS gives hospitals an accurate snapshot of how well they are performing in comparison to their peers, Studer says.

The drawback of patient satisfaction tools in the past was that a hospital could compare its ranking only with other hospitals that were using the same measuring tool.

"HCAHPS creates a level playing field. It allows hospitals to see how they really stack up against the competition in the eyes of patients," he adds.

The issues covered by the HCAHPS are crucial ones that hospitals must address in order to be able to produce good outcomes in a tight money situation, he adds.

The Centers for Medicare & Medicaid Services (CMS) announced its intention in 2007 to include HCAHPS scores as part of its value-based purchasing initiative, points out **Carolyn Scott**, *RN, MEd, MHA, vice president of performance improvement and quality for Premier, a health care performance improvement alliance.*

Although the details of how and when value-based purchasing will be rolled out have not yet been announced, it's clear that how patients score a hospital on the HCAHPS will affect reimbursement, she adds.

"CMS is building the voice of the consumer into the quality equation. Hospitals are paying more and more attention to HCAHPS scores," Scott says.

Scott recommends that in addition to reviewing their HCAHPS scores, hospitals dig deeper into the results for specific questions to find out where the problems lie.

"Vendors often are able to segment results by hospital unit, which helps hospitals identify the specific departments where issues may reside," she says.

That's what happens at Integris Baptist Regional Health Center in Miami, OK, according to **Alice Hunt**, *MBA, the hospital's director of service excellence.*

The hospital's patient survey integrates the HCAHPS data with the standard Press-Ganey patient satisfaction survey, she says.

"When we look at the HCAHPS data and something doesn't look right, we dig deeper using the Press-Ganey questions to see if there are any underlying issues. We can identify more specific problems and focus on areas where we can make a difference," Hunt says.

If patients give the hospital a low rating on the HCAHPS global questions that measure the overall rating of the hospital and their willingness to recommend the hospital, Hunt uses the Press-Ganey data from the same time period to see if there are specific areas where patients expressed dissatisfaction and comes up with process improvement projects to address the issue.

The hospital administration looks at HCAHPS data to determine if the percentage of "always" or "usually" answers changes in any category.

"It's difficult to meet the expectations of 'always' but some hospitals are doing it, and that is what we are working toward," Hunt says.

Newton-Wellesley Hospital in Newton, MA, uses its HCAHPS and Press-Ganey data to identify gaps in processes and procedures and to develop initiatives to correct the situation, says **Patrick Jordan**, *senior vice president, administration, and COO.*

Every month, the hospital administration produces a leader report card that goes to every manager who, in turn, takes the information to his or her staff.

The care coordination report card includes information such as staff turnover, timeliness of completion of annual evaluations and orientation, number of thank-you notes written to the staff, employee satisfaction, customer care activities, productivity, response to patient and family complaints, and budget performance.

"We track to see if there are a pattern of complaints and take this as a signal to look at opportunities to bring together a small group of people to look for solutions," says **Elaine Bridge**, *RN, MBA BSN, senior vice president patient care services and chief nursing officer.*

For instance, patient satisfaction data had shown that patients were unhappy about the length of time it takes to be discharged.

*"The scores are not troublesome, but there always is an area for improvement,"says M***onica Ferraro**, *RN, MS, manager of care coordination.*

The hospital created a work group that includes staff nurses, RN case managers, and hospitalists to analyze the discharge process for nurses, physicians, and discharge planning staff and identify improvement opportunities. The multidisciplinary team has looked at all aspects of the process from the time the physician writes the order until the patient is out the door.

"The discharge process frustrates the staff as well as patients at times. Each step of the process is dependent upon another clinician completing a part of it. The delays in discharge are not intentional delays. They are directly related to the complex processes. We have a motivated group of people on the team who are looking for rapid cycle improvements as well as long-term solutions, such as leveraging technology," Ferraro says.

Meanwhile, as part of a statewide initiative to reduce avoidable readmissions in collaboration with the Institute for Healthcare Improvement, the team on some patient care units is analyzing whether patients receive discharge education, whether the right person to receive the education is identified and involved in the teaching, and what kind of information is being communicated to the next level of care, she adds.

For instance, the orthopedic unit is looking at the key items patients should be educated about and who is the appropriate person to receive the information.

"We are trying to find ways to be sure that the patient is able to process the information using the teach-back method. We want to make sure they completely comprehend what they are supposed to do after discharge," Bridge says.

Take proactive approach to HCAHPS

Take a proactive approach to the HCAHPS questions and ask patients the questions while they are still in the hospital so you can address the issues and make changes before the patient leaves the facility, Scott suggests.

For instance, if a patient reports being confused about his or her medication or discharge destination, the nurse or case manager can spend more time making sure the patient understands, she says.

"There's not a lot a hospital can do to improve its rating once the patient leaves. But if things

aren't going well, paying attention to the gaps in information can turn the tide, especially if the patient sees that the hospital staff are interested in them as people," she says.

Some hospitals participating in Premier's QUEST: High Performing Hospitals collaborative engaged in practices to assess the patient experience prior to the time of discharge. These hospitals have reported that when they ask questions before patients leave the hospital and address the issues identified, they begin to see some improvement in patient experience statistics.

Scott suggests overlaying HCAHPS with other data such as readmission rates and clinical quality scores to identify trends that may be parallel to patient experience scores.

In addition, look at staff satisfaction and see how it trends with the patient experience, she adds.

"Typically, when staff satisfaction goes up, so does the patient experience," she says.

Studer suggests calling patients 24 hours after discharge and going over the home care instructions.

The phone calls have paid off for Integris Baptist Health Center by raising HCAHPS scores as well as potentially avoiding readmissions, Hunt says.

An analysis of the HCAHPS data determined that patients who get a post-discharge phone call usually rank the hospital in the 90th percentile or above on whether they'd recommend the facility to family and friends. Those who don't get a phone call rate the hospital much lower, Hunt says.

"The phone calls have helped us catch potential problems, such as when patients have a reaction to their medication, when they haven't gotten their prescriptions filled, and when their symptoms indicate that they should see their doctor. All of this filters back to the case managers, and we work to ensure that there are no gaps in care," adds **Linda Hollan**, *RN, BSN, CDE, ACM, director of case management.*

Make your focus improving clinical outcomes, not just raising patient satisfaction scores, Studer advises.

"People are not likely to be motivated by a project with the goal of raising scores. Instead, hospitals need to determine where they need to focus their process improvement efforts to remove the barriers that get in the way of quality care," he says.

For instance, look at your answers on the pain control measures of HCAHPS. If the patient answers include mostly "sometimes" and "never," look at what your team is doing to deal with patients' pain, he suggests.

Correcting the problem could pay dividends in a number of areas, he adds.

If a patient's pain is controlled, the patient isn't hitting the call button to ask for more medication and the family isn't rushing out to the nurse on a regular basis to say that patient is in pain. This leaves the nurse free to deal with other issues, Studer adds.

"One in every five patients discharged from the hospital have adverse events. About 60% of these are because they aren't taking their pain medications correctly and have side effects so they call in or go to the emergency department. If you're doing things right while patients are in the hospital, keeping their pain under control and teaching them about their medication, you can avoid these adverse events," Studer says.

Include all departments in the hospital in your process improvement initiatives, Scott suggests.

"It's not just doctors and nurses who affect the patient satisfaction scores. HCAHPS measures issues like cleanliness and noise are often impacted by non-clinical staff. Every employee has the potential to impact the patient experience," she says.

When the HCAHPS scores indicated that patients at Newton-Wellesley Hospital were disturbed by noises on some units, the unit staff met to brainstorm ways to reduce the noise. In some cases, the solution was to put up a glass partial partition in the nursing station. On one unit, the hospital moved the ice machine away from patient doors. On the obstetrical unit, the hospital set up a two-hour quiet period where no one but a significant other could visit in order to give the patients a chance to rest.

"We received wonderful feedback on those changes," Bridge says.

[For more information, contact: Linda Hollan RN, BSN, CDE, ACM, director of case management, Integris Baptist Regional Health Center, e-mail: HollLM@Integris-Health.com*; Patrick Jordan, senior vice president, administration and COO, Newton-Wellesley Hospital, e-mail: pjordan@partners.org; Carolyn Scott, RN, MEd, MHA, vice president of performance improvement and quality for Premier e-mail:* Carolyn_Scott@PremierInc.com*; Quint Studer, CEO of Studer Group, e-mail:* quint@studergroup.com.*]* ■

Keep patients satisfied, even if waits are long

Information is the key

While you wish that no patient ever had to wait in any registration area, that's not realistic due to patient volumes and other factors beyond the control of your department.

On the positive side, though, there is evidence suggesting that an informed patient is a happy one, even if he or she is kept waiting.

Patients who waited more than four hours in the emergency department, but received "good" or "very good" information about delays were just as satisfied as patients who spent less than one hour waiting, according to Press Ganey's 2010 Emergency Department Pulse Report.

Lisa A Cox, *CHAM, admitting manager at Maine Medical Center in Portland, says she has found this to be true.*

"We have found that customers that wait a long time for their bed, but were kept informed and checked on during their wait, were happy even thought they had to wait," says Cox.

Cox says this is the responsibility of both the access rep who admits the patient and the front desk access rep. Updates are given every 10 or 15 minutes.

"Patients like to have a contact person, so they can ask questions and let us know if they need anything," says Cox. "The access rep ensures that the patient has their name and knows where to find them."

The patient and family get meal passes, and a flower is sent to their room with a note saying, "Sorry for the wait." This approach has paid off, according to surveys by hospital volunteers.

"Volunteers go to each unit and survey the patients on their experience and how they were treated by the admitting area," says Cox. "We received positive comments about waiting for a bed if patients got to eat lunch on us, or they had a nice flower in the room when they arrived."

Informed patients are less nervous about their stay compared to those who are not told why they are waiting. "This can be seen in their body language," says Cox.

Sheri Lasater, *manager of patient access for Penrose-St. Francis Health Services in Colorado Springs, notes that patients often interact with patient access staff before interacting with members of any other department.*

"It is the responsibility of patient access associates to start the visit off on the most positive and professional note that they can," says Lasater.

Even if patients receive the best clinical care and outcomes possible, they will always remember any portion of their visit that they perceived as negative.

"It is crucial that the patient access associates give patients positive things to remember, right from the moment they enter our facility," says Lasater.

Patient access associates often need to act as the liaison between clinical departments and waiting rooms. This is a difficult role for several reasons.

"Patients arriving for scheduled procedures typically have the least amount of wait time, and present fewer challenges," says Lasater. "However, many patients are seen on a walk-in basis and are prioritized by acuity."

This can be very difficult for patients to understand, especially when they see others receiving care outside of a "first-come, first-served" system.

"It is important for patient access staff to be given accurate and appropriate scripting that they can use when explaining patient prioritization based on acuity to patients who are waiting," says Lasater.

Patients may wrongly believe that long wait times for available inpatient beds are the fault of patient access.

"In order to clear up the misconception of these patients, we explain that patients have a discharge time of 11 a.m.," says Cox. "However, that time is not enforced since patients cannot leave until their physician is able to give them the OK to go."

Physicians work to ensure patients are discharged quickly, but sometimes testing may delay the discharge. "As soon as the bed shows as dirty in the bed tracking system, environmental services will be ready to clean the bed, stat," says Cox.

Lasater says that, occasionally, scheduled patients are kept waiting because other patients presented to the emergency department for traumatic injuries. The injured patient might require procedures on the same equipment that was reserved for the scheduled procedure.

"This can be one of the most difficult waits to explain to a patient," says Lasater. "Patients with a scheduled appointment have a hard time understanding that they could be 'bumped' for an emergent patient." ■

Hospital Peer Review
2010 Index

2010 Tracer Form - EOC Document Review

Name: _____ Title: _____ Date: _____

	2010 Requirements (Check those not compliant)	Observations and Comments
Every 5 or 6 years	Every 6 years - Test and maintain all fire and smoke dampers (1 yr after install, then q6) *EC.02.03.05-18* Every 5 years after install - Conduct water flow test of standpipe systems (then Q3yr) *EC.02.03.05-12*	
Every 3 yrs	Every 3 years - Test each emergency generator for a minimum of four continuous hours. *EC.02.05.07-7* Every 3 years - *Test* occupant fire hoses *EC.02.03.05-17*	
Annually	Annually - Automatic sprinkler system: Conduct main drain tests at all system risers *EC.02.03.05-9* Annually - Conduct environmental tours where patients are not served *EC.04.01.01-13* Annually - Conduct one community-wide practice emergency management drill *EM.03.01.03-3* Annually - Conduct proactive risks assessment to evaluate the potential impact of buildings, grounds, equipment, occupants, and internal *physical* systems on the safety and health of patients, staff, and others *EC.02.01.01-1* Annually - Evaluate the objectives, scope, performance and effectiveness of the seven EOC plans (investigate problems, staff injury, damage to property) *EC.04.01.01-15* Annually - Fire drills conducted in all free-standing business occupancies *EC.02.03.03-2* Annually - For automatic sprinkler systems:Test fire pump under flow conditions *EC.02.03.05-11* Annually - Preparation / review / update of Statement of Conditions to ensure currency *EC.5.20 (EP 2)* Annually - Recommend EC improvement (based on data analysis) activity to organization leaders *EC.04.01.03-2* Annually - Review SOC Part 4 Plan for improvement to ensure appropriate progress is being made relative to identified corrective actions *EC.5.20 (EP 5)* Annually - Test all duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm boxes and smoke detectors *EC.02.03.05-3* Annually - Test gas automatic fire-extinguishing systems (no discharge) *EC.02.03.05-14* Annually - Test horizontal and vertical sliding and rolling fire doors *EC.02.03.05-20* Annually - Test smoke detection heating, ventilation, and air-conditioning (HVAC) shut-down devices *EC.02.03.05-19* Annually - Test visual and audible fire alarms, including speakers *EC.02.03.05-4* Annually - the hospital performs maintenance on portable fire extinguishers *EC.02.03.05-16*	

2010 Tracer Form - EOC Document Review

Name: _____ Title: _____ Date: _____

	2010 Requirements (Check those not compliant)	Observations and Comments
Semi-Annually	Semi-Annually - At least one drill (at each site that offers emergency services) includes influx of patients *EM.03.01.03-2* Semi-Annually - Conduct environmental tours where patients are served *EC.04.01.01-12* "Semi-Annually - Inspects any automatic fire-extinguishing systems in a kitchen" *EC.02.03.05-13* Semi-Annually - Test response phase of emergency management plan at each site of plan *EM.03.01.03-1* Semi-Annually - Test sprinkler valve tamper switches and water flow devices *EC.02.03.05-2*	
Quarterly	Quarterly - automatic sprinkler systems Inspect all fire department water supply connections *EC.02.03.05-10* Quarterly - Perform fire drills on all shifts; critique to identify deficiencies and improvement opportunities - healthcare occupancy *EC.02.03.03-1* "Quarterly - Test fire alarm "off site" fire responders" *EC.02.03.05-5* Quarterly - Test fire alarm supervisory signal devices *EC.02.03.05-1*	
Monthly	Monthly - Automatic sprinkler systems: test water-storage tank temperature alarms during cold weather *EC.02.03.05-8* Monthly - Automatic transfer switches (not less than 20 days; no more than 40 days)*EC.02.05.07-2* Monthly - Battery powered lights for egress (min. 30 seconds per month & 90 minutes per year) *EC.02.05.07-1* Monthly - Generator for 30 minutes(not less than 20 days; no more than 40 days) *EC.02.05.07-1* Monthly - the hospital inspects portable fire extinguishers *EC.02.03.05-15*	
W kl	Weekly - Test fire pump under no-flow conditions *EC.02.03.05-6*	
Other EOC Standards	The building is safe and suited to patient care old ec.8.10 (lighting, ventilation, furniture, etc) *EC.02.06.01-1* The hospital conducts performance testing of and maintains all sterilizers *EC.02.04.03-4* The hospital critiques fire drills *EC.02.03.03-5* The hospital has written procedures to follow in the event of a security incident ie infant abduction *EC.02.01.01-9* The hospital inspects, tests, and maintains all life support equipment on inventory *EC.02.04.03-2* The hospital inspects, tests, and maintains non-life support equipment *EC.02.04.03-3* The hospital inspects, tests, before initial use all medical equipment on the medical equipment inventory *EC.02.04.03-1* The hospital performs equipment maintenance and chemical and biological testing of water used in dialysis. *EC.02.04.03-5* Maintain and test medical gas. Main supply valves and area shut-off valves are clearly labeled *EC.02.05.09- 1&3*	

Source: Kurt Patton Consulting.