



*Utah Chapter
Issue #15 Summer, 2006*

The Utah Society For Health Care Engineering is committed to developing long-range plans and programs that meet the needs of members and the future challenges of the health care facilities management profession.

USHE Chapter Calendar

◆ July 9-12 43rd Annual Conf and Technical Exhibition

Future Events to be announced later....

Check out our USHE Website!!! <http://www.Ushe.org>



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Society For Health Care Engineering.



Chapter President’s Message – Scott Anderson, IHC, Strategic Purchasing

Dear Healthcare Colleagues,

Wow is the year flying by or what? We are now officially into summer, the year is half gone, and we just finished our Summer Conference and are looking ahead to the fall conference. Speaking of the Fall Conference we just received conformation that Dale Woodin, Deputy Executive Director American Society for Healthcare Engineering (ASHE) has accepted our invitation to speak. He will be our keynote speaker; Dale is a nationally recognized expert on codes and standards, regulatory issues and advocacy. His background and understanding of meeting the day-to-day needs of running a facility and also adhering to the many codes and regulatory requirements will provide us will an exceptional opportunity to learn and improve on our capabilities. Please mark your calendar for September 22, 2006 for the Fall Conference.

If you are not a member of ASHE we would encourage you join or renew, the benefits received far outweigh the cost. If you have never joined ASHE but have interest in doing so please give me a call as we have some limited complimentary memberships. I can be reached at 801-442-3711.

Included in this newsletter are three ASHE Regulatory Advisories. If you are not familiar with these please take a minute read them. The advisories are as follows:

- 1) JCAHO Announce Their Official Stances on Alcohol Based Hand Rub Dispensers in Perspectives.
- 2) JCAHO Announces Triennial Extended Run Test for Emergency Generators.
- 3) FDA Guidance Document: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment.

Have a great summer hope to see each and every one of you at the Fall Conference.

Sincerely,

Scott G. Anderson

Scott G. Anderson, President
<mailto:mksander@ihc.com>

RU PLANNING ON BECOMING A CERTIFIED HEALTH FACILITY MANAGER?



The CHFM certification recognizes the mastery of a well-defined body of knowledge within Healthcare Facilities Management. To help you prepare a Self-Assessment Examination (SAE) is available.

The SAE provides a way to check your understanding of key concepts of healthcare facility management. The SAE was designed to help healthcare facility managers prepare for the CHFM Examination. Specifications that define coverage of the CHFM Examination, both in terms of topics and levels of testing, were used for the 100-item SAE. Further, the same rigorous standards used for the CHFM Examination were employed in developing

the SAE. The SAE is convenient to take; all you need is a credit card and valid e-mail address.

*You may take the SAE at home or in your office all at once or over 90 days.

*When you select an answer to a test item on the SAE, you receive immediate feedback that not only identifies the correct answer but also provides a rationale.

*When you complete the SAE, you receive diagnostic reports of your relative strengths and weaknesses.

For more information go to:
www.aha.org/certification.



JCAHO Announces Their Official Stance on Alcohol-Based Hand Rub Dispensers in Perspectives

A Message to ASHE Members:

On March 7, 2006, the Joint Commission (JCAHO) announced their official stance on the use of Alcohol-Based Hand Rubs (ABHR) dispensers in egress corridors in their article *Using Alcohol-Based Hand Rubs to Meet National Patient Safety Goal 7* published in the March 2006 edition of *Joint Commission Perspectives*.

The article specifically distinguishes between gel products and foam products. Joint Commission allows ABHR **gel dispensers** in corridors provided the following conditions are met:

- The corridor width is 6 feet or greater and dispensers are at least 4 feet apart.
- The dispensers are not installed over or directly adjacent to an ignition source such as an electrical outlet or switch. *Adjacent* is defined as being at least 6 inches from the center of the dispenser to an ignition source.
- In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces are permitted only in sprinklered smoke compartments.

These conditions are consistent with the ABHR amendments to the 2000 and 2003 editions of the *Life Safety Code* (NFPA 101) and the requirements of the 2006 edition of the *Life Safety Code*. This article further

clarifies the term “adjacent” (which was not defined in the *Life Safety Code*), reducing it from the 12 inches (from the center of the dispenser) previously reported in the January 2006 edition of *EC News*.

Joint Commission will allow the installation of ABHR foam dispensers provided that they meet the location criteria for ABHR gel stating: “Industry experts have indicated that small-quantity ABHR foam dispensers may be equivalent to ABHR gel. Therefore, pending further review, the Joint Commission will allow any ABHR foam installation that meets the location criteria stated above for ABHR gel. Volumes of ABHR foam are based on suppliers’ recommendations and in no case exceed the permissible volumes for ABHR gel as defined above. In the event that subsequent testing demonstrates a safety concern relating to foam dispensers in egress corridors, the Joint Commission reserves the right to modify its position on the acceptability of such installations. In that event, previously installed dispensers would be subject to the newer restrictions; that is, they would not be “grandfathered,” and noncompliant installations would have to be removed.

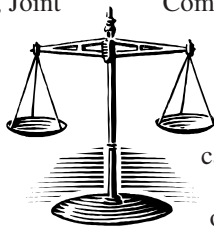
Assuring an Equivalent Level of Safety through Risk Assessment

In this article, Joint readers of the achieve an safety, if all

ABHR use completely. JCAHO

is based on the *Life Safety Code (LSC)*, the concept of performing a risk assessment to determine alternative methods to achieve an equivalent level of safety is valid and appropriate. JCAHO states: “As with other areas of the *LSC*, organizations may not meet all the requirements completely but may still provide an equivalent level of safety through assessing and managing the specific construction, systems, or operation of an area. Likewise, an organization that cannot meet all the requirements outlined in this article may perform a product-specific risk assessment of the ABHR product using product literature and determine alternative methods to achieve an equivalent level of safety.”

The article also discusses permissible volumes of ABHR and the use of ABHR to meet the requirements of National Patient Safety Goal 7.



Commission reminds opportunity to equivalent level of of the requirements for cannot be met Because the official stance is

ASHE members are encouraged to **obtain a copy of the entire article through their organization’s JCAHO liaison**. Likewise, ASHE members are encouraged to discuss this article within their organization’s Safety Committee to further refine their organizational policy and procedures regarding the use of ABHR products in improving hand hygiene and reducing healthcare-associated infection.

Since ASHE first collaborated with AHA, CDC, APIC, SHEA and others to address the potential fire safety challenges presented by the use of ABHR, ASHE has maintained a webpage devoted to ABHR at <http://www.ashe.org/ashe/codes/handrub/index.html> This webpage will continue to be updated to reflect the most current knowledge and guidance on this subject.

For questions or comments contact Dale Woodin, ASHE Deputy Executive Director, at dwoodin@aha.org or 312-422-3812

Regulatory Advisory

JCAHO Announces Triennial Extended Run Test For Emergency Generators

A Message to ASHE Members:

On May 31, 2006, the Joint Commission (JCAHO) announced the revision of Standard EC.7.40 in the June 2006 edition of *Joint Commission Perspectives*. The revision, which is **effective July 1, 2007**, requires hospital and other accredited organizations to test their emergency generators every 36 months for four continuous hours. This extended run tests, and additional requirements if the test fails, are stated in three new elements of performance.

Element of Performance #5 – Category A

Facilities that have a generator providing emergency power for the services listed in elements of performance 5 through 18 of standard EC.7.20: The organization tests each emergency generator at least once every 36 months for a minimum of four continuous hours. This test shall be conducted under a load (dynamic or static) that is at least 30% of the nameplate rating of the generator.

Element of Performance #6 – Category B

If a test(s) required by EC.7.40 fails, the organization implements interim measures to compensate for the risk to [patients/residents/ clients], visitors, and staff until necessary repairs or corrections are completed.

Element of Performance #7 – Category A

If a test(s) required by EC.7.40 fails, the organization performs a retest after making the necessary repairs or corrections.

In addition EP 1 has been revised to reference the 2005 edition of NFPA 110 - *Standard for Emergency and Standby Power Systems*, while deleting reference to NFPA 99.

Two descriptive notes are included in the revision. The first note allows organizations that have successfully operated their generator(s), to the stated criteria, since July 1, 2004 can count that occurrence as the initial compliance with retesting to occur before the three year anniversary of the occurrence. The second note allows organizations to assess the prime movers' exhaust gas temperature to meet manufacturer recommendations if they cannot achieve the minimum load of 30%.

Many ASHE members and industry experts took advantage of the opportunity to provide comments to JCAHO during the field review period earlier this year. Those comments helped to shape the final revisions – most notably resetting the proposed testing cycle from annual to triennial. The issue of providing reliable emergency power is a complex

Regulatory Advisory

Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment.

A Message to ASHE Members:

The document includes nonbinding recommendations intended to reduce life-threatening entrapments associated with hospital bed systems. It characterizes the body parts at risk for entrapment, identifies the locations of hospital bed openings that are potential entrapment areas, and recommends dimensional criteria for these devices. The Introduction states that “Manufacturers may use this guidance when designing new beds to ensure compliance with applicable FDA regulations...and to assist in ensuring that their devices are safe when used as labeled.” The document does not limit its scope to new beds only; as it states: “In addition, the recommendations in this guidance may be useful in evaluating and reducing the entrapment risk presented by hospital beds that have been placed in use, also known as legacy beds.”

The FDA Dimensional Guidance document is one more piece in the evolving body of knowledge on bed rail entrapment. In September 2002, the Joint Commission (JCAHO) issued Sentinel Event Alert #27 – Bed Rail-Related Entrapment Deaths. The alert reported that over a ten-year period JCAHO had

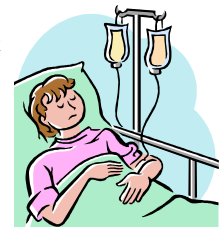
received reports of seven deaths or injuries related to bed rails; three of these reports were from hospitals. This alert identified root causes from these reports and offered risk reduction strategies. As a result of this alert many hospitals have examined the issue of bed rail entrapment within their patient safety or risk management programs focusing on training of clinical staff to assess patients for the risk of entrapment and, for those patients vulnerable to entrapment, implementing appropriate changes to the beds using bed rail netting, clear padding, etc. to close gaps and reduce the risk of entrapment. Although JCAHO recommended re-evaluation of beds for entrapment potential, no guidance existed at that time regarding gap measurement or appropriate sizing of mattresses. With the release of the FDA Dimensional Guidance document, which has now established critical dimensions and a measurement procedure, healthcare providers' focus on entrapment prevention may now inappropriately shift to proactive measurement of hospitals beds. The FDA document does not suggest that measurement of each bed is necessary, rather a representative bed from each type of bed system, which includes the bed frame, side rails and mattress. However many hospitals may not be able to easily identify a limited number of bed systems given the interchange of components, particularly mattresses. FDA Guidance Document:

Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment

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FDA points out that: “Not all patients are at risk for entrapment, and not all hospital beds pose a risk of entrapment” and that “Evaluating the dimensional limits of the gaps in hospital beds is one component of an overall assessment and mitigation strategy to reduce entrapment.” What it does not say is that new beds, manufactured in accordance to FDA Dimensional Guidance, are “safe” i.e. eliminate the potential for entrapment. FDA introduces the term “hospital bed system” to describe the bed frame and its components including the bed side rails, head and foot board, any accessories, and most notably – the mattress. To deem a “hospital bed system” as “safe” requires testing all of these components as a matched set.

In order to build a system based on bed measurement, rather than patient assessment, it is important to understand that any change in or replacement of a mattress or other component will require retesting of the entire bed system. This will necessitate a system of labeling, tracking, and recordkeeping to assure that a hospital





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