

Inside the Joint Commission

Independent news and guidance to ensure rigorous compliance and accreditation excellence

April 3, 2017 | Volume 22, Issue 7

IN THIS ISSUE

Life safety

Impress upon C-suite the need for broad evacuation drills in wake of Texas fire 1

Fire doors contain flames but smoke still problem at Texas hospital fire.....5

NPSG

Enliven clinical alarm fatigue training with interactive 'name that tone' game 1

Section 1557

Injunction lifts discrimination ban — but possible consequences remain2

Infection control

What's wrong with this photo? Take a look at what's not on the transport tray.....3

Survey basics

Learn more about new Life Safety Code through online CMS surveyor training4

Survey readiness

Reviews mixed after TJC adds email to its survey notification process4

Life safety

Impress upon C-suite the need for broad evacuation drills in wake of Texas fire

Consider adding or enhancing training on how to conduct vertical evacuations into your quarterly fire drill schedule to ensure staff is prepared for how difficult such an effort can be and better understand the need for exacting coordination.

The best place to start the training review is with your hospital C-suite.

The value of staff training was clear in the aftermath of a fire at a University of Texas Medical Branch hospital in Galveston, Texas, in January in which 110 patients were evacuated safely from a 12-story building.

(see *Life safety*, p. 6)

NPSG

Enliven clinical alarm fatigue training with interactive 'name that tone' game

Don't let training fatigue add on to alarm fatigue. Look for creative ways to educate and remind clinical staff about the importance of cardiac monitors and other alarms and what their responsibilities are for the proper operation of those clinical alarms.

Concerns about clinical alarm fatigue were elevated to a National Patient Safety Goal in 2014, and education requirements became effective at the start of 2016. **NPSG.06.01.01, EP 4**, requires licensed clinical practitioners and other staff to receive training on the alarms for which they are responsible,

(see *NPSG*, p. 8)

9th annual Care Coordination Summit



Making it Work: Your Roadmap for Quality and Payment Success.

Join us May 1-3 in Baltimore to learn what works from the best care coordination programs in the health care industry. If improving quality care is your goal in

2017, this conference simply can't be missed! Full details at

carecoordinationsummit.com.

Section 1557

Injunction lifts discrimination ban — but possible consequences remain

An injunction against enforcement of certain anti-discrimination regulations seems to leave insurers and employers free to refuse certain procedures to transgender patients — but it does not necessarily protect them from legal action if they do.

The injunction “is against enforcement by the government,” says Arthur Leonard, professor of law at New York Law School in New York City. “It should not directly affect the ability of individual employees to bring lawsuits as such.”

The injunction, issued by federal judge Reed O'Connor in U.S. District Court for the Northern District of Texas on Dec. 31, 2016, in the case of *Franciscan Alliance v. Burwell*, prevents the government from enforcing certain protections in the HHS Office for Civil Rights (OCR) rule based on section 1557 of the Affordable Care Act (ACA).

OCR will enforce what it can

That rule, which went into effect on Jan. 1, prevents discrimination in health care on several bases, but the injunction bars enforcement with regard to “termination of pregnancy” and “gender identity.” So, for example, this would affect providers asked to provide hormone therapy or reassignment surgery for patients in gender transition. Reassignment surgery is not covered by a

national coverage determination — though CMS briefly considered it — but contractors may authorize it for payment at their own discretion.

HHS notes on its website that it cannot pursue civil rights cases on the grounds proscribed by the injunction (see box, p. 3).

Does this mean providers can refuse to cooperate in a Medicare patient’s gender reassignment? Providers are generally able to refuse to perform procedures on conscience grounds. Franciscan Alliance argued that it is entitled to a religious or conscience exception under Title IX, and the injunction may strengthen the case for providers at other religious institutions who wish to claim that exception in these cases, says David Johnson, counsel at Crowell & Moring LLP in San Francisco.

But Title IX cuts both ways. The Supreme Court was expected to consider whether the law prohibits discrimination on the basis of transgender status in *Gloucester County School Board v. G.G.*; the case has been sent back down to the lower courts after the Trump administration withdrew guidance issued by the Obama administration that effectively prohibited such discrimination. The U.S. Court of Appeals for the 4th Circuit relied upon that guidance in ruling against the school board and affirming Grimm’s right to use the correct bathroom.

Risk of lawsuit remains

Even without a Supreme Court ruling, “providers and plans still face risk of suit for discrimination based on a

Subscriber Information ▶ Have questions on a story? Call or email us.

Inside the Joint Commission is published 24 times each year by DecisionHealth, LLC. Copyright 2017.

Have questions on a story? Call toll-free: **1-855-CALL-DH1**

President:

Steve Greenberg, x6034
sgreenberg@decisionhealth.com

Vice President:

Tonya Nevin, x6036
tnevin@decisionhealth.com

Content Manager

Jay Kumar, 978-624-4560
jkumar@blr.com

Editor:

A.J. Plunkett, x6001
aplunkett@decisionhealth.com

Technical Advisers:

Patton Healthcare Consulting, LLC
Kurt Patton, MS, R.Ph.
Jennifer Cowel, MHA, RN
John Rosing, MHA, FACHE

Join our DecisionHealth — Medical Practice & Hospital community!

 www.facebook.com/DecisionHealthMP

 www.twitter.com/DH_MedPractice

 www.linkedin.com/groups/4048762

DecisionHealth Pledge of Independence: DecisionHealth’s *Inside the Joint Commission* works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we’ve been independently watching out for the financial health of health care providers, and we’ll be there for you and your peers for decades to come.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered and is NOT intended to be used as a substitute for legal advice. It is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the service of a competent professional should be sought.

ELECTRONIC VERSION: To get other helpful tips, news and tools you won’t find in the hardcopy version, sign up for your free e-version of *IJC*. Just email customer@decisionhealth.com and tell us to add your email address to your subscription.

SUBSCRIPTIONS: \$459/year for 24 issues. For questions about newsletter delivery and account status, call toll-free 1-855-CALL-DH1 or email customer@decisionhealth.com.

FREE LISTSERV: *JCAHO-Watch* is a free chat group where you can get advice from your peers and share your experience on daily challenges such as surveys, TJC standards, patient safety and more. To sign up, visit: www.decisionhealth.com/jcaho-watch-enroll.

MULTIPLE COPIES, SITE LICENSES AND REPRINTS: Could more than one person at your company benefit from a subscription to *Inside the Joint Commission*? To request permission to make photocopy reprints of *Inside the Joint Commission* articles, call 1-855-CALL-DH1 or email customer service at customer@decisionhealth.com. Also ask about our copyright waiver, multiple copy and site license programs by calling the same number.

WARNING: Copyright violations will be prosecuted. *Inside the Joint Commission* shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal photocopying or electronic redistribution. To report violations contact: Brad Forrister at 1-800-727-5257 x8041 or bforrister@blr.com.

Inside the Joint Commission is 100% independent and not related to, affiliated with, endorsed or sponsored by The Joint Commission. Joint Commission™ is a trademark of The Joint Commission.

person's transgender status — a risk that varies based on the jurisdiction,” notes Johnson.

Leonard notes a recent order in a separate Northern District of Texas case, *Baker v. Aetna Life Insurance Company*, in which the plaintiff claimed discrimination on section 1557, Employee Retirement Income Security Act of 1974 (ERISA) and Title VII grounds because Aetna and a plan administrator would not cover breast implants for “individuals with a male birth gender designation who are transitioning to the female gender” although the plan covers “individuals with a female birth gender designation who are transitioning to the male gender and seeking a mastectomy.” Aetna and the administrator moved to dismiss the section 1557 and Title VII claims, and Aetna to dismiss the ERISA claim.

On Jan. 13, Judge Sidney Fitzwater disallowed the section 1557 and ERISA claims but allowed the Title VII claim to stand because “Baker plausibly alleges that she was denied employment benefits based on her sex.”

“Certainly I would not feel comfortable advising employers that they can just ignore the issue for now because of the injunction,” says Leonard. —*Roy Edroso* (redroso@decisionhealth.com)

Resources:

- ▶ HHS on Section 1557 enforcement: www.hhs.gov/civil-rights/for-individuals/section-1557
- ▶ Franciscan Alliance v. Burwell: <https://www.crowell.com/files/20131231-Franciscan-Alliance-v-Burwell.pdf>

Here is what HHS had to say about the Dec. 31 injunction

“On December 31, 2016, the U.S. District Court for the Northern District of Texas issued an opinion in *Franciscan Alliance, Inc. et al v. Burwell*, enjoining the Section 1557 regulation's prohibitions against discrimination on the basis of gender identity and termination of pregnancy on a nationwide basis. Accordingly, HHS' Office for Civil Rights (HHS OCR) may not enforce these two provisions of the regulation implementing these same provisions, while the injunction remains in place. Consistent with the court's order, HHS OCR will continue to enforce important protections against discrimination on the basis of race, color, national origin, age, or disability, as well as other sex discrimination provisions that are not impacted by the court's order.”

Infection control

What's wrong with this photo? Take a look at what's not on the transport tray

Ensure that containers used to transport biohazardous devices such as soiled endoscopes are not only marked with a biohazard label, but also with the correct hazardous chemical identification. This will help you avoid RFIs under one of the top scored standards by The Joint Commission (TJC) under Infection Control.

In the March 6 issue of *Inside the Joint Commission*, we published the photograph below to illustrate the type of container that can be used to transport medical devices that need to be decontaminated or sterilized from point of use to the area where the devices will be cleaned. Careful transportation of such devices is a key concern in infection control to protect staff and patients (*IJC 3/6/17, 10/31/16*).

We also asked if readers could identify what was wrong in the photo.

The red disinfection tray has a lid and is clearly marked with biohazard labels, but there is no identification on the type of disinfectant being used in the tray and the expiration date of the solution, notes Ernest E. Allen, a former TJC surveyor and patient safety account executive with The Doctor's Company in Columbus, Ohio.

“This would be cited on a survey for lack of hazardous chemical identification for staff and for infection control as there is no label with expiration to replace with fresh disinfectant solution,” says Allen. “There should be a policy and procedure specifying the frequency of changing the solution based on the manufacturer's recommendation.”

TJC would score the RFI under IC.02.02.01, concerning IC of medical equipment, supplies and devices. — *A.J. Plunkett* (aplunkett@decisionhealth.com)



*Survey basics***Learn more about new Life Safety Code through online CMS surveyor training**

If you are new to hospital compliance or just want to know more about how the newly implemented **NFPA 101 Life Safety Code (LSC)** and **NFPA 99 Health Care Facilities Code** will impact your job overseeing surveys by The Joint Commission and CMS, there is some online training available for you.

CMS has made the course its state agency surveyors are required to take on policy and regulations related to the new NFPA codes available online publicly.

However, know that to take the full course will require a bit of your time. The “Life Safety Code Transition Course” is self-paced, and CMS estimates it will take about 20 hours to complete.

The interactive course provides a crosswalk between the old and updated K-tags, which are similar to the A-tags seen in the main CMS State Operations Manual Appendix A (SOMA) and used to identify specific LSC deficiencies on form CMS-2786R.

There will be a quiz

With “knowledge check” quizzes throughout, the course provides an overview of changes as well as new requirements and expectations for such things as means of egress, fire alarm systems, corridors and special provisions. It includes modules on health care occupancies as well as ambulatory care and residential occupancies, and on building rehabilitation requirements.

There is also one entire module just on NFPA 99-2012, including a section explaining the fundamentals behind the standard, and the K-tags associated with the requirements.

Previously only referenced by earlier adoptions of the LSC, NFPA 99 was formally adopted, with some exceptions, in the final rule published by CMS last year. The NFPA 99 section also includes an overview of those sections that were adopted.

CMS, TJC and other accrediting organizations were required to implement both new NFPA codes in surveys as of Nov. 1. All CMS state agency surveyors that conduct LSC surveys are required to complete the transitional course before conducting LSC surveys.

Find the training at <http://tinyurl.com/CMS-LSC-training-course>. — A.J. Plunkett (aplunkett@decisionhealth.com)

*Survey readiness***Reviews mixed after TJC adds email to its survey notification process**

Don't rely yet on a new email notification to be your first indication that surveyors from The Joint Commission (TJC) are about to announce themselves at your facility or health system.

TJC announced in the March issue of “The Joint Commission Perspectives” that, based on customer feedback, it was adding email notifications to its process of alerting organizations of imminent announced, short-notice and unannounced visits.

The emails were to begin as of March 6. The “Perspectives” announcement detailed what information the notifications would contain. For instance, with unannounced visits, which includes all surveys for Medicare deemed status purposes, the email would be sent after TJC posts the “letter of introduction, the survey/review agenda, and the biography and picture of each surveyor/reviewer assigned to conduct the event” on a hospital's secure Joint Commission Connect site.

That posting still serves as the official notice of survey, says TJC. The email is to be sent to “the individuals listed as chief executive officer, primary accreditation/certification contact, and corporate contact (if applicable) on the organization's extranet,” according to the article.

The email then includes instructions to check your hospital TJC Connect site for details of the visit.

While the emails have been sent, they have apparently been received at varying times of the day by hospitals, according to some reports.

The addition of the email notification is a “minor enhancement, but at this time I would not rely on it,” advises Kurt Patton, a former TJC executive director of accreditation services and founder of Patton Healthcare Consulting, which serves as technical adviser to *Inside the Joint Commission*.

“Hospitals are pretty well used to checking their TJC website daily when they are close to survey and should continue to do so,” says Patton. — A.J. Plunkett (aplunkett@decisionhealth.com)

Resource

- ▶ Joint Commission email announcement: www.jointcommission.org/assets/1/18/Changes_Survey_Review_Notification_Policy.pdf

*Life safety***Fire doors contain flames but smoke still problem at Texas hospital fire**

Just after lunch on a Wednesday, four days into the new year, someone decided to set the University of Texas Medical Branch's John Sealy Hospital in Galveston, Texas, on fire.

The 12-story hospital built in 1975 is in a complex of UTMB Health buildings that are interconnected. John Sealy is L-shaped, with a shaft of elevators sitting in the center core area that connects wings A-B on one side and wings C-D on the other.

Built before fire codes required patient care facilities to be fully equipped with fire suppression systems, the building is being retrofitted with fire sprinklers one wing at a time, one floor at a time, said Jack Tarpley, UTMB Health's associate vice president for environmental health and safety.

Alarm triggers automatic responses

The fire alarm system activated at 1:20 p.m. Jan. 4, signaling smoke and heat in a waiting area on the second floor. Designed to provide families a quiet place to wait while patients were in surgery, the open area is off the elevator core. At the time of the fire, however, the area was unused because the wing it served was closed for renovations, including the addition of sprinklers, Tarpley recalled recently.

The second-floor wing on the other side of the elevator core housed John Sealy's burn unit. On the first floor below the waiting area was the hospital entrance and lobby, which connects to other buildings, including a central food court. The floor above the fire was labor and delivery.

The fire alarm activated on the central alarm panel, which can be seen as you enter the ground-floor lobby, as well as the floor where the heat and smoke were detected, and on the floors above and below, said Tarpley.

Throughout the second floor, fire doors had closed automatically, sealing each wing from the flames. With the alarm's activation, the elevator cars, as designed, recalled to the first floor. However, the smoke from the furniture-fueled fire infiltrated the elevator shaft.

First on the scene was the hospital's fire marshal of the day, who also is an off-duty Galveston firefighter. The hospital employs the off-duty firefighters to take advantage

of their expertise and to ensure that local firefighters are familiar with the hospital as well, Tarpley observed. The marshal had entered the lobby, checked the alarm panel as he passed through to a stairwell and was on the second floor within a minute or so of the alarm's activation.

Incident command set up

As required under the hospital's fire plan, UTMB police as well as staff from environmental services, property services, safety, facilities crew and others trained as first responders met within minutes at the main fire panel. Tarpley, whose office is in another building, said he arrived just as Galveston firefighters did.

The hospital's fire marshal began coordinating his fellow firefighters and directing them to the fire as other staff throughout the building reacted according to the fire plan — all fire doors were closed and staff prepared to shelter and defend in place, as they are trained every quarter, Tarpley said.

Tarpley, meanwhile, was working with on-scene commanders and alerting hospital executives to what was happening. "It's hard to fathom, how literally in minutes, how fast everything happens," he recalled.

As firefighters began laying fire water lines from connections in the stairwells into the second floor to breach the fire area, the smell of smoke began infiltrating other floors, going through the stairwells as well as the elevator shaft.

On the second floor and the floor directly above the fire, smoke was becoming heavier but still moderate. Patients were evacuated immediately from the second floor burn unit.

While the fire was contained, the smoke smell began to intensify and some staff members "felt like they needed to be outside the building," Tarpley said, noting that drills train staff to use their own judgment.

Not unsurprisingly, the continued sound of the fire alarm and the smell of smoke quickly evoked the concern of patients as well.

Evacuation ordered

Out of "an abundance of caution," a decision was made to evacuate the entire building along with a connected annex building. Overhead communication was used to send out the order, and staff went into action. Those patients who were ambulatory were helped down the stairs. Some were strapped to evacuation sleds, while others were taken out on mattresses.

Fortunately, patients were not on every floor. Unfortunately, the care units that are in the building feature some of the most vulnerable patients.

Besides the burn unit and labor and delivery, John Sealy housed high-risk obstetric patients on the 10th floor, pediatric and pediatric intensive care units on the 9th floor, mother-baby units on the 7th and 8th floors, intermediate nursery and newborns on the 6th floor, dialysis on the 5th floor and a cardiac catheterization unit on the 4th floor.

And yes, a surgical team was in the middle of a catheterization when the alarm sounded, said David Marshall, a UTMB vice president and medical center's chief nursing officer, who responded to the fire along with other leadership from across the campus. The team finished the catheterization and evacuated the patient on his mattress.

All hands on deck

Outside the building, teams were waiting with stretchers to transport non-ambulatory patients, including the soon-to-be mother, to care units in other buildings. Several of the babies and other children were taken to the Shriners Hospital for Children about a block away.

By 2 p.m., about 110 patients had been evacuated from the building where firefighters worked to finally knock down the flames in the waiting area.

There were no injuries and no deaths as a result of the fire or evacuation. "It was scary for everybody," noted Tarpley. Yet while staff were "very attentive, they weren't panicked."

"It was great to see all hands on deck," he observed.

"The message I've been giving is, 'We did an incredible job,'" said Marshall. Everyone seemed to be working almost intuitively, responding in no small degree to training from previous drills.

The state fire marshal later ruled it arson. — *A.J. Plunkett* (aplunkett@decisionhealth.com)

Life safety

(continued from p. 1)

The mid-day blaze at the 42-year-old John Sealy Hospital was contained by fire doors. However, the building was constructed before fire codes required patient care facilities to be fully equipped with fire suppression systems. Smoke released before the doors closed and after firefighters breached the area to douse the flames spurred evacuation of the entire building. (*Details, p. 5.*)

Just how important training for vertical evacuations might be and how complicated such evacuation can be was not lost on one member of UTMB's leadership team.

Blaze prompts vertical evacuation

David Marshall, a UTMB vice president and medical center's chief nursing officer, was among staff who teamed up to carry a woman in labor down three flights because she had already been given an epidural and could not evacuate on her own.

A nurse for 34 years, Marshall said he has gone through decades of fire drills and training, including how to evacuate patients. But that training always involved a horizontal evacuation — taking patients from one wing to another, or from one building through a passageway to another building. "Never vertically," Marshall noted.

With six pairs of hands holding the evacuation sled the woman had been strapped to, the team was met in the third-floor stairwell by a physician and a patient care technician carrying an adolescent patient. The patient, who was being cared for in a 9th floor pediatric unit, was having difficulty dealing with the noise and stress of the evacuation and was so distraught he could not manage the walk down stairs.

So his doctor and the technician locked arms to form a chair and made it as far as the 3rd floor before faltering under the weight, said Marshall.

To allow the evacuation of the woman on the sled, the pediatric team stopped on the 3rd floor — which also allowed the doctor to call the patient's mother, who calmed the teen enough to finish being evacuated, and allowed the youngster's caregivers a much needed rest, said Marshall.

Both patients and their evacuation teams made it downstairs and outside safely.

Educate leadership on challenges

Yet it is just such incidents that can illustrate the complexity of a vertical evacuation and the need for the planning and training for such events to start with the hospital's leadership, says Dr. Howard Levitin, an emergency department physician and founder of DQE Inc., an Indianapolis-based disaster-readiness training and consulting company.

"Train your hospital leadership first," because they need to understand the risks and challenges of moving patients down stairs and the resources necessary to do it safely, notes Levitin.

A good fire evacuation plan begins and ends with leadership, he says, from authorizing the resources for staff training and equipment such as evacuation sleds, to planning how drills are carried out in each building and each floor and by whom, to initiating and orchestrating the incident command function, if and when it is needed.

“A successful evacuation and incident command are kissing cousins,” says Levitin. “It’s all about leadership, decision-making, prioritizing objectives and accomplishing your objectives.”

Joint Commission requires drills

As a subject matter expert in disaster planning, Levitin says he has reviewed several hospital evacuations over the years and discovered that when there have been failures, it was because there was not a clear cut process and no leadership.

In an emergency, “if staff are thinking they’re hanging out there, if there is no leadership, they’re going to do what they think is best,” Levitin says. That leads to people evacuating patients randomly or without proper equipment, which can lead to bottlenecks and other problems that can potentially injure staff or patients, or worse.

Fire drills can illuminate the process, and reinforce the leadership chain, from the overall facility command and control, to the nurse manager on the floor prioritizing patients and organizing evacuation teams, to the team leaders carrying out the controlled evacuation.

Those drills should include some aspect of what must happen should a vertical evacuation be required, Levitin says.

The Joint Commission (TJC) requires hospitals under Environment of Care standard **EC.02.03.03** to conduct fire drills with patient care staff at least once per shift per quarter, with at least half of the drills unannounced. Under Life Safety standard **LS.01.02.01**, hospitals are also required to add one additional fire drill per shift per quarter when Life Safety Code deficiencies are found that cannot be immediately corrected or during construction, as outlined in the hospital’s interim life safety measures policy.

EC.02.03.03, EP 1, notes that evacuation of patients during drills is not required. However, simulating the physical aspects of a vertical evacuation periodically is good practice, notes Levitin.

Vertical evacuations are “physically very taxing,” says Levitin, and should be done only as a last resort. Most fire plans call for horizontal evacuations, keeping patients in their rooms or moving them to other areas and using a building’s smoke and fire compartments to keep patients safe.

If a vertical evacuation becomes necessary, the best practice is to have those people who are the best trained and most capable of physically handling patients doing the literal heavy lifting — local community emergency responders, says Levitin and other experts.

Please pass this coupon to a colleague who could benefit from a subscription to *Inside the Joint Commission!*

YES! I want proven guidance and strategies on how to boost Joint Commission accreditation and ensure top-notch patient care. Please enter my subscription for one year (24 biweekly issues) of **Inside the Joint Commission** right away at \$459.

Name: _____
 Org.: _____
 Address: _____
 City/State/ZIP: _____
 Phone: _____
 Fax: _____
 Email: _____

Payment enclosed. Make checks payable to *Inside the Joint Commission*. (TIN 26-3622553)

Send me an invoice (PO _____)

Charge my:    

Card #: _____

Exp. Date: _____

Signature: _____

Mail to: *Inside the Joint Commission*

Two Washingtonian Center, 9737 Washingtonian Blvd., Ste. 502
 Gaithersburg, MD 20878-7364 | Toll-free: 1-855-CALL-DH1

www.decisionhealth.com

PAS 2017

Make drills realistic

A part of developing a good fire drill and fire evacuation plan includes assessing the response times of community emergency responders and developing a plan in conjunction with them, says Rick Nelson, the safety, security, and emergency preparedness manager for the Seattle Cancer Care Alliance, who has worked at hospitals in the Washington state area for much of his career.

“It is really somewhat situational to risk. How many horizontal safety zones are available — the preferred option by far is to move persons on the same floor rather than risk a full evacuation,” Nelson says, noting that if a nurse or other staffer is not adequately trained or not physically capable of carrying someone down stairs, you’re like to end up with two patients instead of one.

That being said, it would be good to include training on how to use evacuation sleds or chairs during your regular training schedule, says Levitin. That might include asking a volunteer or using a mannequin to simulate a patient and having staff drill on strapping in a patient, and what it would take to lift and negotiate that patient in an evacuation.

That certainly would have been acceptable for Marshall, UTMB’s vice president, who says he was proud of his staff for the job they did in the January evacuation. But training can be improved, he notes.

“We need to practice vertical evacuation, and what happens when the plan doesn’t work,” he says. And after his experience helping to move the woman in labor, he wants staff to train with the sleds.

“It’s much easier when you’ve had to use one in practice.” — *A.J. Plunkett* (aplunkett@decisionhealth.com)

NPSG

(continued from p. 1)

and experts say that training should be done at orientation and as needed throughout the year.

Consider using interactive training such as a “name that tone” game that nursing and accreditation managers at San Antonio Regional Hospital in Upland, Calif., devised a few years ago for the registered nurses, licensed vocational nurses and certified nursing assistants.

The training began with a review of what alarm fatigue is, a reminder of why alarms are used and how they are an important tool in patient safety. Clinical nurse educator Kathi Lioudakis, RN, BSN, said she reminded trainees that car alarms succeeded in deterring thieves only until people began ignoring every alarm that went off in the middle of the night.

Alarms, according to the training, are in place so that nurses can react to a problem “before there is harm to the patient.” Lioudakis also led a discussion about other environmental stimuli that humans must guard against adapting to over time — the crying baby you no longer hear or the the foul odor you no longer smell.

Include alarm equipment overview

The training included a quick overview of the alarms and their prioritization. And then comes the interactive game. People break up into groups of four or five, and are given signs with the alarms they are responsible for: IV pumps, bed alarms, pulse oximeter, bathroom call bell/light, ventilator, telemetry, Code Blue, and so forth.

All the alarm sounds should be recorded for about 30 seconds, with special emphasis on the rarely heard alarms, recommends Martin Jarzombek, San Antonio Regional’s safety officer. Your hospital’s biomed team should be able to activate alarms where they can be recorded in a controlled environment, he says.

He also recommends including a description of the equipment, where it would be located and other information about each of the alarms, including company of origin, to ensure the correct alarms are covered.

After each alarm, a team has to hold up a sign identifying the alarm. To spice it up, teams can “bid” on how fast they can “name that tone,” suggests Jarzombek — within 30, 20, 10 and 5 seconds.

Be sure to have someone with a timer. And consider offering some type of prize.

The entire training session can be done in 30-45 minutes as a refresher course, notes Lioudakis.

If you have a suggestion for a game, puzzle or other interactive training device that you’d like to share with colleagues, send suggestions to *Inside the Joint Commission* editor A.J. Plunkett at aplunkett@decisionhealth.com. — *A.J. Plunkett*

COPYRIGHT NOTICE

It is illegal to forward this electronic version of ***Inside the Joint Commission*** to anyone else. It is a free benefit only for the individual listed by name as the subscriber. It's illegal to distribute electronically ***Inside the Joint Commission*** to others in your office or other sites affiliated with your organization. If this email has been forwarded to you and you're not the named subscriber, that is a violation of federal copyright law. However, only the party that forwards a copyrighted email is at risk, not you.

To confidentially report suspected copyright violations, call our copyright attorney Brad Forrister at 1-800-727-5257 x8041 or email him at bforrister@blr.com. Copyright violations will be prosecuted. And ***Inside the Joint Commission*** shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal electronic forwarding of ***Inside the Joint Commission*** or photocopying of our newsletter.