The Joint Commission may be just now eyeing obstructive sleep apnea (OSA) as a potential National Patient Safety Goal, but anesthesiologists in the ambulatory arena have been aware of the disorder’s dangers for years.

Even though the levels of anesthesia are lighter in ASCs than in hospitals, and the patients go home awake and alert, the danger is with pain medications. OSA patients normally can rouse themselves from sleep when they stop breathing, but if they’ve taken a narcotic for pain, they may be unable to do so and slip into respiratory arrest. And if they’re at home with no one monitoring them, the results can be deadly.

“The narcotics are the real problem,” says Beverly K. Philip, MD, an anesthesiologist at Brigham and Women’s Hospital in Boston. Philip, who specializes in ambulatory anesthesia, has treated patients in both the inpatient and outpatient settings. Under The Joint Commission’s proposed goal, hospitals would have to
- screen patients who show signs that they may have sleep apnea
- consider OSA when developing the anesthesia plan of care
- develop a protocol to deal with OSA based on evidence-based best practices
- use the developed protocol for patients who are diagnosed with OSA and for patients who are not diagnosed but show signs that they may have apnea

OSA patients have gone into respiratory arrest and died following surgery, although only a few cases of this type have been documented in The Joint Commission’s Sentinel Event Database, according to Elizabeth Zhani, media relations specialist for the agency.

Philip has also heard accounts of OSA patients dying after surgery.

**Most OSA cases not diagnosed**

One of the problems is that 80%–90% of sleep apnea cases are undiagnosed. That’s why it’s critical for surgeons to have suspected OSA patients evaluated at a sleep lab before they come in for surgery, Philip says.

“If it’s not practical and they can’t go to a sleep lab, then you have to assume they have sleep apnea,” Philip says. “That’s really the core answer.”

Edward Grandi, executive director of the American Sleep Apnea Association in Washington, DC, strongly agrees. Anesthesiologists are driving the push toward better OSA monitoring, he adds.
Apnea  < continued from p. 1

“Go back into the operating room, and, in terms of all of the characters in that room, the ones who stand to lose the most are the anesthesiologists,” he says.

Risk factors

Patients with risk factors for sleep apnea include those who snore loudly, suffer from excessive daytime sleepiness, have a body mass index of over 30, and have a neck circumference of more than 17 in. for men or 16 in. for women.

“One of these risk factors is apparent,” Philip says. “You see the person sitting in the chair across from you, and you know that there might be trouble.”

Apnea < continued from p. 1

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Resources

For more information about sleep apnea or the JCAHO proposal, go to

- [www.jointcommission.org](http://www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/FieldReview/08_hap_npsg_fr.htm)
- [www.sleepapnea.org](http://www.sleepapnea.org)
- [www.sleepapneainfo.com](http://www.sleepapneainfo.com)

An estimated 2%–4% of the population—about 18 million people—suffers from OSA, says Kevin Finkel, MD, an anesthesiologist at Barnes-Jewish Hospital in St. Louis, who has performed extensive research on the issue. However, Finkel suspects that those figures are low. Approximately 20% of surgical patients have sleep apnea, he says.

Both Finkel and Philip advise that OSA or suspected apnea patients be put on continuous positive airway pressure machines.

Dangerous procedures

Certain procedures just shouldn’t be done in an ambulatory setting, Philip adds. She cites a 2005 practice guidelines paper by the American Society of Anesthesiologists that details experts’ opinions on what surgeries should and shouldn’t be performed in ambulatory centers. They include the following:

- Superficial surgery/local or regional anesthesia—safe
- Airway surgery (adult)—unsafe
- Tonsillectomy in children under three years old—unsafe
- Minor orthopedic surgery/local or regional anesthesia—safe
- Laparoscopic surgery, upper abdomen—unsafe
- Lithotripsy—safe

Doctors had mixed opinions on whether the following procedures were safe in ambulatory settings: Superficial
surgery/general anesthesia, tonsillectomy in children over three years old, minor orthopedic surgery/general anesthesia, and gynecological laparoscopy.

Most experts agree that the obesity epidemic, which shows no signs of waning, is causing more people to develop OSA.

**Feedback from the field**

Anesthesiologist **Ann Lofsky, MD**, a governor emeritus at the insurance firm The Doctors Company in Napa, CA, says after her company issued a bulletin on the eight claims it had for narcotics deaths and indicated that sleep apnea may have played a role, the feedback was overwhelming.

“The response from the community was, ‘Oh my God, I’ve had a case like that’, or ‘I’ve had three of them,’” Lofsky says. “They were being classified sort of as mysterious deaths.”

Lofsky and clinical pharmacist Shelly Collins, PharmD, of Chesapeake (VA) General Hospital, agree that facilities may be treating pain too aggressively with opioids.

“We’ve made the expectation of [pain] zero,” Lofsky says. “We’ve erred too much on the side of overly aggressively treating pain.” She adds that doctors need to tell patients with OSA, “We’re going to control your pain, but we’re not going to entirely eliminate it, because that would be risky.”

**Tool helps ambulatory centers assess patient safety**

A new tool aims to help ambulatory healthcare centers in assessing and beefing up patient safety.

The Physician Practice Patient Safety Assessment tool, created by the Health Research & Educational Trust in partnership with the American Hospital Association, Institute for Safe Medication Practices, and Medical Group Management Association (MGMA), came out about six months ago.

“It’s very positive in that it makes sense,” says **Terry Hammons, MD**, senior fellow at MGMA. “These items are good.”

The groups that produced the tool used their own knowledge of patient safety, looked at the latest literature, and solicited input from 10 experts in the field. Parts of the tool can be downloaded for free. For $200, organizations can input their data on a longer form and send it in for analysis and benchmarking (see the sample form on p. 5).

Only a handful of organizations have opted to do that, a number that Hammons hopes will rise in the future for better benchmarking.

He says there’s no telling how many people have downloaded the free portion of the tool.

“What we also don’t know is, does it lead someone to do something?” Hammons asks. “In my opinion, that’s where it gains value.”

**Offering advice on patient safety**

Down the road, Hammons envisions partnering with an insurance company so risk managers can visit the facility, look at the data from the tool, and offer advice on how to improve patient safety.

“It’s not in the physician’s office where patients are at great risk, Hammons says. It’s where they go and what they do once they leave—most notably at home—that puts them in danger.

For example, patients may receive correct diagnoses, recommendations, and prescriptions from their physicians, but once they’re home, it’s up to them to comply.

Another safety issue that falls through the cracks, Hammons adds, is getting the lab results back to the patient in a timely manner.

“In ambulatory care, that’s a huge problem,” he says.

A woman might go in for a mammogram or a Pap smear and assume that she’s fine if she doesn’t hear back from her physician—but that’s not always the case.

> continued on p. 4
“That happens not just in my office, but between the office and the lab,” Hammons says. “We know that’s a huge source of dissatisfaction and stress.” It’s also a huge liability issue.

Although some of the items on the assessment tool parallel the standards of The Joint Commission and AAAHC, Hammons says the intent was not to line the measures up one to one.

“We didn’t want to make it seem like it was an accreditation thing or an OSHA thing,” Hammons says. “We thought that that information was already out there. We were trying for a more positive form.”

**Standard of the month**

**Allied healthcare professionals must be credentialed**

**Editor’s note:** The AAAHC Standard of the month is a monthly series offered in BOAA. Our AAAHC experts dissect a specific standard each month to bring attention to the compliance challenges organizations face. If you have a specific standard you’d like us to tackle, please contact Senior Managing Editor Lisa Buckley at 781/639-1872, Ext. 3715, or e-mail lbuckley@hcpro.com.

Ambulatory centers may keep on top of clinician credentialing, but they sometimes forget about privileging of allied healthcare professionals.

Standard F in Chapter 2, Subchapter 2 of the 2006 Accreditation Handbook for Ambulatory Healthcare says:

**The governing body provides a process (in a manner consistent with state law and based on evidence of education, training, experience, and current competence) for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for allied healthcare professionals.**

Because this requirement is contained in the credentialing and privileging standards, many facilities are not sure how to comply, says Michon Villanueva, assistant director of accreditation services for AAAHC.

“Typically, organizations struggle with this because they’re not quite sure what is required of them,” says Villanueva. “They may understand credentialing and privileging of physicians, but they’re not sure of their responsibility about allied healthcare professionals.”

Allied healthcare professionals are usually licensed individuals such as nurses, certified registered nurse anesthetists (CRNA), medical assistants, and x-ray technicians.

“There is a whole list of requirements that organizations have to go through to ensure the education and training of physicians,” Villanueva says. “It’s the same with allied professionals.” Facilities can master this standard in one of two ways. First, they can utilize relevant items contained in standards 2.II.B-3 for allied health professionals.

They also can make sure those professionals are appropriate for the services they provide by instituting job descriptions, policies, and procedures, including method of supervision and periodic performance evaluations. AAAHC surveyors will be looking to see whether the facility has clearly outlined the role of those workers, Villanueva says.

“One other thing is that the organizations should be monitoring any relevant professional licensure and certifications,” Villanueva says. “Organizations often forget to do this on an ongoing basis, so what happens is there’s a two-year cycle and the professional’s license and/or certifications have lapsed in the interim.” Again, surveyors will be checking to make sure allied health workers’ licensures are up to date.

“One of the things organizations should consider, especially with CRNAs, is to outline what levels of anesthesia the CRNA is privileged to provide,” Villanueva says. “Be very specific about that.”
Sample physician practice patient safety assessment

The following choices can be used to answer the questions below.

| A. Unaware or aware but no activity to implement | B. Discussed but not implemented | C. Implemented partially for some areas, patients, drugs, etc. | D. Fully implemented for some areas, patients, drugs, staff, etc. | E. Fully implemented everywhere |

Sample assessment questions from each domain

**Medications:**
1. A complete medication history, including over-the-counter medications, vitamins, and herbal products, is obtained and documented on every patient during each office visit.
2. Patients are provided with an up-to-date list of all medications they are receiving upon leaving the practice or other encounter (e.g., on a convenient wallet reference card).

**Handoffs and transitions:**
1. The results of laboratory, pathology, and imaging tests are communicated to the patient in a timely manner (24–48 hours), and the practice confirms and documents that the patient received the results. Patients are notified of all laboratory, pathology, and imaging test results, including those that are negative, regardless of whether they require further clinical action.
2. When a patient for which the practice has responsibility is discharged from a hospital or other facility, the practice has a system that confirms the discharge information and enters it into the patient record.

**Surgery/anesthesia and sedation/invasive procedures:**
1. The practice has identified and communicated surgical and other invasive procedures that could be performed on site to all clinicians.
2. The site of any surgical or invasive procedure is confirmed and documented by two staff members and the patient before the procedure is begun.

**Personnel/qualifications:**
1. The practice maintains a system to periodically (at least annually) assess nursing and support staff competency that is appropriate for the services and procedures they perform.
2. The practice maintains a system to periodically (at least annually) assess physician competency that is appropriate for the services and procedures they perform.

**Patient education/communication:**
1. Patients are assessed for their financial and physical ability to obtain prescriptions and medical supplies at the time of their office visit or when provided a prescription over the phone.
2. Patients are routinely asked to repeat back what they hear to help the clinician clarify any instructions.

Source: © 2006–2007 Health Research & Educational Trust, in partnership with the American Hospital Association, the Institute for Safe Medication Practices, and Medical Group Management Association and its certifying body, the American College of Medical Practice Executives. All rights reserved. May not be redistributed except as set forth in the terms of use.
Focus on poor-performing areas to truly boost safety

Don’t ignore the dirty laundry. All too often, ambulatory centers avoid the areas in which they have quality problems and instead choose less troublesome topics for performance improvement projects, according to Naomi Kuznets, PhD, managing director of AAAHC’s Institute for Quality Improvement.

“When AAAHC comes in, if you’ve got an issue with a problem of care or a near-miss, you should be dealing with that before you work on other areas,” Kuznets says. “In terms of quality issues, the thing that ambulatory centers struggle with most is choosing a [quality improvement] topic. People either avoid the areas where they have problems or, if there are no apparent problems, they pick these areas that are sort of esoteric, instead of their core business.”

The paramount patient safety issues at ambulatory centers are similar to those at hospitals—wrong-site surgeries, infection control, anesthesia monitoring, prescribing/administering a medication to a patient with a known allergy to the medication, and failing to notify patients of abnormal test results. “Failure to diagnose and treat are the biggest insurance liability issues,” Kuznets says.

Focus on clinical issues

Ambulatory centers, she adds, sometimes focus too much on financial and administrative issues and not enough on the clinical ones, which have significant financial implications as well. For those organizations fortunate enough not to have safety troubles, Kuznets advises starting a medical event prevention program if one is not already in place. Facilities should focus on the procedures they perform the most. Data processing and analyses, she says, are other things that often trip up quality improvement (QI) directors in smaller ambulatory centers.

“The majority of AAAHC organizations are small, and they are organizations where people multitask, and that includes multitasking for quality improvement,” Kuznets says. “[QI directors] may or may not have had training in data processing and analysis.”

Many QI directors are nurses or nurse managers who are not necessarily comfortable in the world of statistics, benchmarking, and data. “They’re overwhelmed and they need someone to help them either on the basic how-tos, or if they’re already [conducting studies], they need to know how to move up to the next level,” Kuznets says.

Support from the top

The first thing rookies should do is determine whether they have organizational support for performance improvement initiatives—something the AAAHC handbook requires in Chapter 5, Subchapter 2, she says. “Does the organization offer them the time, resources and cooperation to do their job?” Kuznets asks. “You can’t do data collection by yourself for the most part. You have to have the backing of management.”

QI directors also need to appreciate the importance of process measures, not just outcome ones, she says. Process measures include asking questions such as, “What are you doing to prevent wrong-site surgery?” Outcomes could be how many wrong-site surgeries you have had.

If she were judging an ASC, Kuznets says she would rather know that the organization consistently follows recommendations to prevent wrong-site surgery than know how many wrong-site surgeries it has had.

Emphasis on quality growing

Kuznets has been director of the Institute from the time it began in 1999. The Institute has since gone on to do more than 30 studies for the AAAHC’s accredited organizations and others. The AAAHC currently accredits approximately 3,500 organizations.

The emphasis on quality and patient safety also has grown over the years, with no signs of abating.

Indeed, a healthcare finance and tax law signed by President Bush in late 2006 establishes a quality reporting program for ASCs in 2009 that will reduce payments to facilities that don’t participate.
Communication root cause of medical errors

What we have here is a failure to communicate. "Nurses and, I think, doctors are reluctant to challenge each other," says Beth Kohsin, MS, RN, CPHQ, a retired lieutenant colonel in the U.S. Air Force. "People do not feel they have the stature to be able to say, 'Hang on a second, I'm really concerned about this.'"

The results of this can be disastrous. Kohsin points to data from The Joint Commission that found that between 1995 and 2004, communication problems were the leading root causes of the following:

- Sentinel events (75%)
- Delays in treatment (85%)
- Medication errors (nearly 65%)
- Wrong site surgery (nearly 80%)

During that same time period, communication only played a role in 5% of infection-associated events. But by 2005, communication was the leading cause of infections and accounted for 75% of them, according to The Joint Commission.

Kohsin knows whereof she speaks. In 2001, she was selected to work for the Air Force surgeon general to develop the Air Force Patient Safety Program. In that role, she worked with her Navy and Army counterparts to develop safety initiatives for the U.S. Department of Defense. Before her recent retirement from active duty, she served in the Air Force for more than two decades as a nurse working in various clinical areas, primarily the intensive care unit (ICU).

Two-challenge rule

“I grew up as an ICU nurse and one of the things they instilled in us is that the doctor is depending on you,” she says. “You have to be the eyes and ears for that patient. You have to speak up for them.”

When Kohsin started teaching medical team management in the Air Force, she had to train staff in something called the two-challenge rule. That rule requires that anyone—be it a nurse, technician, or doctor—speak up and tell the team if they believe that something has gone awry. If no one heeds that first warning, the person must bring it up a second time, possibly rephrasing it.

“We did pretty well,” Kohsin says. “What we didn’t do was teach the people on the receiving end that you will stop and you will listen. We didn’t really teach them how to effectively listen.”

Lagging behind aviation industry

Kohsin says she doesn’t think communication is any more difficult in the healthcare industry than in other high-risk fields, “but, for some reason, we’ve been a little slower on the uptake,” she says. She likens the current state of healthcare to the aviation industry in the 1970s, when communication problems hampered safety.

“They started instituting things such as the two-challenge rule and dynamic skepticism,” she says. “It’s not that you don’t trust others, but you’re always questioning what you think is real.”

Critical elements of safety

Kohsin cites the following factors as crucial to improving safety:

- **Strong leadership.** “Patient safety professionals need to help [leaders] understand this and show them the data from reported events. [CEOs] have to make a proclamation that ‘We’re going to take this on. And we’re going to change it,’” she says.

- **An action plan.** “I truly believe adopting a consistent method of communication . . . is probably a critical success factor. Not probably, it is,” she says. “You need to be able to tap each other on the shoulder and tell a colleague, ‘We’re supposed to discuss this piece of critical information, and I didn’t hear that.’"

- **Patient involvement.** “We’re starting to get there, but we’ve got a long way to go,” she says. “[Patients] are a contributor, and we want them to contribute. No more, ‘You’re the doctor, I accept what you say and just tell me what to do.’”
**Disruptive doctors pose threat to patient safety**

Todd Sagin, MD, JD, national medical director for The Greeley Company, has advised medical staffs throughout the country on a multitude of issues, but he’s forever surprised by the prevalence of “disruptive behavior” plaguing healthcare facilities.

“It ranges from things like abusive and off-color language to sexual harassment to throwing instruments in the operating room,” Sagin says. “We’ve even read accounts of physicians locking a nurse in a storage closet.”

Sagin and Richard A. Sheff, MD, are the authors of A Practical Guide to Preventing and Solving Disruptive Physician Behavior. The Greeley Company is a division of HCPro, Inc., in Marblehead, MA, the publisher of this newsletter.

“It certainly is an extremely widespread problem, largely because we historically rarely addressed it,” Sagin says. “As a result, unprofessional physician conduct has manifested itself on most medical staffs in the country at one time or another.”

Ambulatory health centers may want to start paying attention to the issue.

The Joint Commission is once again considering as a National Patient Safety Goal discouraging disruptive clinician behavior.

The measure was sent out for field review in December 2006, with comments due back by January 24.

The Joint Commission’s proposed Standard LD.3.15. requires organizations to set behavioral expectations in order to improve patient safety. The elements of performance for the proposed goal, according to The Joint Commission Web site, require the following:

- The organization’s leaders set a code of conduct for everyone
- The code clearly lays out what is desirable and disruptive behavior
- All staff are educated about desirable and disruptive behavior
- Leaders create processes to manage disruptive behavior
- Leaders set the roles of individual leaders for managing behavior

Leaders come up with a fair hearing process for disruptive clinicians

**Inappropriate conduct**

“Inappropriate conduct can affect patient safety by making people reluctant to contact the physician in a timely manner,” Sagin says. For example, nurses concerned about their patients’ deteriorating conditions may hold off on calling their doctors, fearing a verbal assault.

Although physicians berating nurses is the most common type of disruptive behavior, doctors also square off against other physicians, administrators, and patients. Such behavior can vary from the demeaning of a colleague’s clinical abilities in front of patients, to fisticuffs, and even stalking. Sagin recalls his visit to a medical staff in Florida where one physician had actually shot a bullet through the kitchen window of a colleague with whom he was unhappy.

**Specific policies needed**

Most institutions have general policies about employee conduct, but Sagin says they need to be more specific about physician behavior.

For example, an organization might want to set a strict rule prohibiting doctors from writing disparaging comments about colleagues in medical records. According to Sagin, the best practice is to have a specific physician conduct policy which is adopted by the medical staff.

Once the expectations for behavior have been established and communicated, Sagin suggests facilities conduct collegial interventions for disruptive physicians.

Such intercessions may involve reminding doctors what types of behavior are unacceptable and pointing out what actions cross the line.
“Disruptive individuals often don’t perceive their behavior as problematic,” Sagin says. Counseling also may be in order for physicians who are acting out because of a personal crisis at home, Sagin says. Doctors also may be referred to therapists who can teach them how to better manage their interpersonal skills.

“There are certainly are physicians who won’t respond to those kinds of interventions,” Sagin says. “And those people, quite frankly, are dangerous and inappropriate for a clinical setting.”

**Corrective action against physicians**

When significant efforts at collegial intervention have failed, it’s time for leadership to consider corrective action against the physician. Ultimately, continuing unprofessional behavior may require termination of medical staff membership. Such an action is a reportable event to the National Practitioner Databank.

Sagin suggests that when quality improvement directors are faced with disruptive physician behavior they alert their medical staff leadership and the hospital CEO. They also should encourage staff to carefully document instances of verbal or physical abuse.

“A lot of times, people just complain to their friends, or simmer but don’t formally document their complaints,” Sagin says. “It is difficult to manage a problem that isn’t formally brought to leadership’s attention. And the paper trail is critically important to track and trend the magnitude of the behavioral problem being faced.” Organizations should adopt nonretaliation policies, says Sagin, so that staff will be less intimidated in bringing forth their concerns about physician behavior. He notes that he has facilitated ‘nurse-doctor’ summits at some institutions to allow a complete airing of mutual concerns about professional conduct.

Consistent efforts to address disruptive conduct ultimately lead to changes in an institution’s culture and climate, which reduce the incidence of new occurrences of unprofessional behavior. This is the goal for which everyone should strive, says Sagin. ■
Keep up with fire door inspections and tests

If you are responsible for the maintenance of a healthcare facility, managing door upkeep can seem overwhelming. It is one thing to keep doors operational; it is another to keep them operational and meet fire and Life Safety Code (LSC) requirements.

Because of the unique characteristics of healthcare occupancies, the requirements for doors in these settings have many exceptions to standard fire protection and life safety rules and requirements.

With all of the exceptions, there does not appear to be any consistent or standard way of applying requirements. For example, a smoke barrier door requires a fire rating but, unlike any other fire-rated door, does not need to latch. In contrast, a corridor door in a nonsprinkler protected zone must have a fire rating, but does not need to self-close. Many of the traditional fire protection features found in fire doors have been modified to address specific needs (e.g., the operational need to move bed-ridden patients or remain in the facility during a “defend-in-place strategy,” etc.).

Fire doors are considered a passive means of controlling fire and smoke spread. They are intended to protect the openings in the barriers in which they are located. You will find the requirements dictating the fire and life safety requirements for doors in National Fire Protection Association (NFPA) standard 101, the LSC, 2000 Edition, and NFPA 80, Standard for Fire Doors and Fire Windows, 1999 Edition. It is only fair to warn those who attempt to read NFPA 80 that this, in itself, will be quite an education, and that the applicable building code requirements may be different. This article only covers the requirements of the LSC.

As a general rule, labeled fire doors are required to self-close and positive latch. A self-closing door closes without intervention from a person. You can accomplish this with a self-closing device attached to the door or by automatic door equipment. A standard latch set generally provides positive latching. The latch does not allow someone to push or pull the door open without an action such as the turning of a handle or knob. Note that not all doors in healthcare occupancies that require a fire rating need to be labeled or meet all aspects of NFPA 80 (e.g., smoke barrier and corridor doors). To begin, you need to classify the wall types in your facility. The regulations dictate door requirements based on the requirements for the wall within which they are located. The wall types typically found in healthcare occupancies may include:

- corridor walls
- smoke partitions and barriers
- fire barriers
- fire walls

Classification can be as easy as color-coding a floor plan of your facility to indicate wall types. In most cases, healthcare facilities that are Joint Commission–accredited should already have this documentation because the Statement of Conditions, Part 2, Basic Building Information, requires it.

Remember that a single wall can fall under several types of wall classifications. For example, a wall can be both a corridor wall and a smoke barrier, or a smoke barrier and a two-hour fire wall. If classified as more than one type of wall, the most restrictive requirements of both wall types apply. Once the classification is complete, the door requirements are much easier to apply.

Much of the confusion about fire door requirements is based on the rating of the wall versus the rating of the door. The chart on p. 11 summarizes the requirements for walls and doors in healthcare occupancies. In healthcare occupancies, corridor doors must latch and smoke barrier doors must self-close. So, a wall that is both a corridor wall and a smoke barrier would have a door that both self-closes and positively latches.

Editor’s note: This column was written by fire protection consultants Sharon S. Gilyeat, PE, Jennifer Frecker, and Lennon Peake of Koffel Associates, Inc., in Elkridge, MD, for BOAA’s sister publication Healthcare Life Safety Compliance.
## Requirements for walls and doors in healthcare occupancies

<table>
<thead>
<tr>
<th>Wall application</th>
<th>Wall requirements</th>
<th>Door requirements</th>
<th>Hardware required</th>
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</table>
| Corridor wall—sprinkler-protected zone | Smoke resistive to slab above or to underside of smoke-resistant suspended ceiling | ▶ Smoke-resistant, no minimum rating or thickness  
▶ Door undercuts up to 1 in. permitted  
▶ Gasketing is not required if relatively tight-fitting (limit excessive gaps) | Positive latch              |
| Existing corridor wall—nonsprinkler-protected zone | Half-hour                                        | ▶ Equivalent to 20-minute rating (1.75-in. solid bonded core wood)  
▶ Door undercuts up to 1 in. permitted  
▶ Gasketing is not required if relatively tight-fitting (limit excessive gaps) | Positive latch              |
| Smoke barrier                          | Half-hour                                        | ▶ Equivalent to 20-minute rating (1.75-in. solid bonded core wood)  
▶ Door undercuts up to 0.75 in. considered acceptable  
▶ Up to 1/8-in. gap permitted            | Self-closer, astragal, and stops at head and sides of frame |
| Smoke barrier                          | One-hour                                         | ▶ Equivalent to 20-minute rating (1.75-in. solid bonded core wood)  
▶ Door clearances must meet NFPA 80 (requirements change for conditions but generally limit to 0.75-in. undercut and 1/8-in. gap) | Self-closer, astragal, and stops at head and sides of frame |
| Smoke partition enclosure of hazardous areas | Smoke resistive to slab above or to underside of smoke-resistant suspended ceiling | ▶ Smoke-resistant, no minimum rating or thickness  
▶ Door clearances must meet NFPA 80 (requirements change for conditions but generally limit to 0.75-in. undercut and 1/8-in. gap) | Self-closer |
| Fire barrier                           | Half-hour                                        | 20-minute                                                                         | Self-closer and positive latch |
| Fire barrier                           | One-hour                                         | 0.75-hour                                                                         | Self-closer and positive latch |
| Fire barrier                           | Two-hour                                         | 1.5-hour                                                                          | Self-closer and positive latch |
| Fire barrier                           | Three-hour                                       | Three-hour                                                                        | Self-closer, positive latch, and astragal |
| Vertical shaft enclosure               | One-hour (existing 45-minute doors may remain)   | One-hour                                                                          | Self-closer and positive latch |
| Vertical shaft enclosure               | Two-hour                                         | 1.5-hour                                                                          | Self-closer and positive latch |

Set the bar carefully when benchmarking

Benchmarking is a delicate balancing act. Set goals too high and staff become demoralized. Set them too low? Performance won’t improve, and precious resources will be wasted, says Cindy Barnard, MBA, MSJS, CPHQ, director of quality strategies at Northwestern Memorial Hospital in Chicago, and the author of the book Benchmarking Basics.

“You’re balancing speed against quality of information, you’re balancing aggressive goals against insufficiently ambitious goals, and you’re balancing a bias toward action—which is a good thing—against making the mistake of chasing the wrong objective and wasting resources,” Barnard says.

Benchmarking is also key to AAAHC accreditation. Chapter 5, Subchapter 2, of the AAAHC handbook, says:

“The organization’s quality improvement program must include participation in performance benchmarking activities that will allow for the comparison of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals.”

What should you benchmark?

Barnard says the first thing you need to do is to sit down with senior leaders and answer the following questions:

► What do we want to look at?
► Who are we going to compare ourselves to?
► What do we want to get out of all this?

“One level of benchmarking is just to ask, ‘Do we have the right quality priorities this year,’ ” Barnard says. “Are there areas where we’re not performing very well?”

The next step is to find organizations that are comparable to your facility with which you want to benchmark.

“You want to pick a relevant group and find out details about their processes,” Barnard says. “Frequently, we talk just about outcomes—what’s our mortality rate, what’s our complication rate. Good benchmarking involves looking at the processes.”

One limitation, she says, is that local competitors may not want to share their information. Even if they do, they may be reluctant to share detailed privileged quality improvement process data.

Internal benchmarking

Organizations also can benchmark internally. For example, you may want to determine your best unit and ask other units to try to achieve the same goal.

“The big risk there is that your best unit might not be performing at the potential best, so, at that point, you’ve almost limited yourself,” Barnard says. Nonetheless, internal benchmarking can work quite well in larger facilities.

After deciding what you’re going to measure and to whom you’re going to compare yourself, move into the analysis phase.

“Once you go into the analysis phase, you want to be extra careful about the quality of the data,” Barnard says. In the analysis process, you want to focus on understanding the relationship of process to results to figure out how to improve, she adds.

“It’s a lot harder to start an improvement project than it is to move up once you’ve gotten going,” says Barnard.

“We have a number of projects where we had a goal and we said, ‘Over the first few months, we’re going to get one-third of the way to our goal. Once we’ve gotten there, we’re going to sweep the next two-thirds quickly.’ ”

Know your limits

Barnard offers the following three tips for those considering benchmarking:

1. Choose something that really matters.
2. Balance precision with usefulness. “You want a relevant peer group, but you don’t want to spend three years getting the data,” Barnard says.
3. Be careful in the analysis and know your processes. “You can’t just draw a line and say ‘We’re going to meet that,’ ” she says.
As Joint Commission eyes dangerous disorder

Disruptive doctors
Standard of the month

The Joint Commission may be just now eyeing obstructive sleep apnea (OSA) as a potential National Standard of the month, aiming to address a dangerous disorder that has been overlooked. The Joint Commission's proposed goal, hospitals would have to develop a protocol for patients who are considered OSA when developing the anesthesia plan and screen patients who show signs that they may have OSA based on evidence-based best practices.

One of the problems is that 80%–90% of sleep apnea cases are undiagnosed. That’s why it’s critical for surgeons to have suspected OSA patients evaluated at a sleep lab before they come in for surgery, says Beverly K. Philip, MD, president of the American Society of Anesthesiologists. "If it’s not practical and they can’t go to a sleep lab, then you have to assume they have sleep apnea," Philip says. "That’s really the core answer."

Most OSA cases not diagnosed after surgery, although only a few cases of this type have been documented in The Joint Commission’s Sentinel Event Database, according to Edward Grandi, media relations specialist for the agency. Grandi agrees. Anesthesiologists are driving the push toward better OSA monitoring, he adds. "The narcotics are the real problem," says Philip, executive director of the American Sleep Apnea Association in Washington, DC, strongly supporting the push.

The narcotics are the real problem.
— Beverly K. Philip, MD

Set the bar carefully when you start benchmarking, advises this quality expert. The Joint Commission sends out for field review its proposed National Patient Safety Goal to discourage disruptive behavior.

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