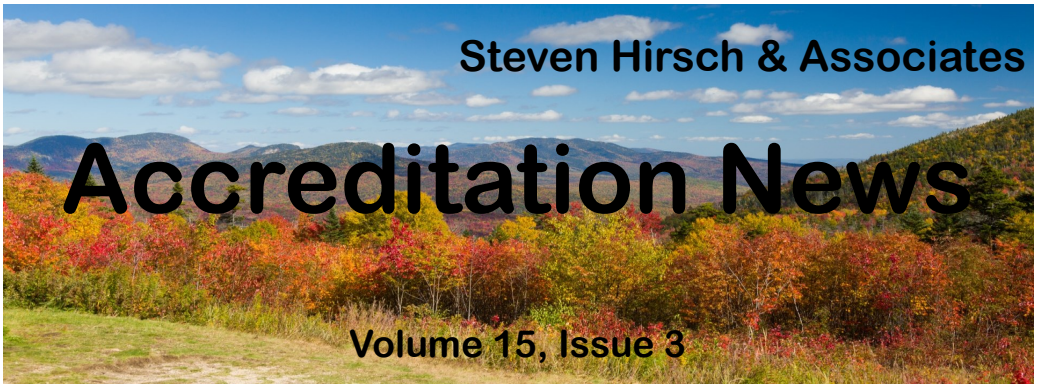

Fall 2023

Update for Compliant Use of Power Strips in Patient Care Areas

By Steven Hirsch, MPA, FACHE

The Centers for Medicare and Medicaid Services (CMS) issued S&C Letter 14-46-LSC on September 26, 2014, Guidelines for Utilizing the Categorical Waiver Process for Power Strips or Relocatable Power Taps (RPT), in Patient Care Areas. This is, in part, based on guidance published by the Occupational Health and Safety Administration (OSHA). Until that time, surveyors were citing hospitals for use of RPTs anywhere in the hospital, not only with patient care equipment, but in patient care areas. The guidance issued by CMS acknowledges that healthcare organizations, many of which have been built some time ago, do not have adequate numbers of electrical receptacles in patient care areas particularly, to support all of the new technology that is being utilized. CMS is aware that a prohibition against the use of RPTs may create "an unreasonable hardship." Notwithstanding, it is expected that redesigned or renovated facilities will provide enough electrical receptacles in patient care areas in order to avoid the use of RPTs.

The CMS Categorical Waiver acknowledges in part, revisions to NFPA 99 – 2012 Edition of the Health Facilities Code, which requires that enough electrical receptacles be located in all patient care areas to avoid the need for relocatable power taps or power strips. Provisions in NFPA 99, 2012 Edition Section 6.3.2.2.6.2 include an increase in the required number of receptacles in newly constructed patient care areas.

A number of definitions are identified in the CMS Survey and Certification Letter as contained within NFPA 99, 2012 Edition as follows:

- "Patient bed location" is defined in Section 3.3.136 as the location of a patient sleeping bed, or the bed or procedure table of a critical care area.
- "Patient-care-related electrical equipment" is defined in Section 3.3.137 as the electrical equipment that is intended to be used for diagnostic, therapeutic, or monitoring purposes in the patient care vicinity.
- "Patient care room" is defined in Section 3.3.138 as any room of a health care facility wherein patients are intended to be examined or treated. It should be noted that this term replaces the term "patient care area" previously used in the 1999 Edition of NFPA 99, however, the definition itself has not changed.
- "Patient care vicinity" is defined in Section 3.3.139 as a space, within a location intended for the examination and treatment of patients (i.e., patient care room) extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extends vertically 7 feet 6 inches above the floor.

Under the CMS Categorical Waiver guidelines, any patient bed locations in new healthcare facilities, or in existing facilities that have been renovated, or located in a change of occupancy, the minimum number of electrical receptacles needs to be provided as defined within Section 6.3.2.2.6.2 of NFPA 99, 2012 Edition.

Power strips or relocatable power taps may be used in a patient care vicinity as defined above, to power rack-, table-, pedestal-, or cart-mounted portable patient-care-related

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electrical equipment assemblies, provided that all the following conditions are met, in accordance with Section 10.2.3.6. of NFPA 99, 2012 Edition:

- The receptacles are permanently attached to the equipment assembly.
- The sum of the ampacity of all appliances connected to the receptacles does not exceed 75% of the ampacity of the flexible cord supplying the receptacles.
- The ampacity of the flexible cord is suitable in accordance with the current Edition of NFPA 70, the National Electrical Code.
- The electrical and mechanical integrity of the assembly is regularly verified and documented through an ongoing preventative maintenance program.
- Means are employed to ensure that additional devices or nonmedical equipment cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe.

The CMS Survey and Certification Letter addresses several additional issues that must be considered prior to use of RPTs. Specifically, power strips or relocatable power taps may not be used in a patient care vicinity to power non-patient care-related electrical equipment.

Power strips or relocatable power taps may be used outside of the patient care vicinity for both patient-care-related electrical equipment and for non-patient-care-related electrical equipment. Power strips outside of the patient care vicinity providing power to rack-, table-, pedestal-, or cart-mounted patient-care-related electrical equipment assemblies are not required to be an integral component of manufacturer tested equipment. Power strips may be permanently attached to mounted equipment assemblies by personnel who are qualified to ensure compliance with NFPA 99, 2012 Edition, Section 10.2.3.6.

It should be noted that relocatable power taps or power strips may not to be mounted directly to the wall. This is interpreted by the regulatory and accrediting agencies as circumventing the need for additional electrical receptacles, which should be installed based on an evaluation of the building's power distribution system. Use of relocatable power taps or power strips without proper evaluation of the electrical distribution system can result in electrical system overload and increase the risk of electrical system failure and potentially, fire.

The Joint Commission published in "Environment of Care News" that nurse's stations are considered a "patient care vicinity." This is in part due to their, in smaller units, potential proximity to patients. Further, in some facilities, patients may sit near or even in the nurse's station so they do not feel isolated. The healthcare organization needs to keep this in mind when utilizing relocatable power taps at the nurse's station.

At long-term care or residential care facilities, where line-operated patient-care-related electrical equipment is not being utilized, the more restrictive requirements contained in NFPA 99 regarding the use of power strips in patient care areas/ rooms are not applicable. Resident rooms using line-operated patient-care-related electrical equipment in the patient-care vicinity must be in compliance with the above requirements pertaining to the use of RPTs, and the organization may elect to utilize the CMS Categorical Waiver process.

Power strips providing power to patient-care-related electrical equipment must be "Special-Purpose Relocatable Power Taps (SPRPT)" as listed in UL 1363A or UL 60601-1. Power strips providing power to non-patient-care-related electrical equipment must be Relocatable Power Taps as listed in UL 1363. It should be noted that OSHA recognizes a number of testing laboratories that may test and list to UL criteria, relocatable power taps. A list of these approved testing laboratories can be found at https://www.osha.gov/dts/otpca/nrtl/nrtllist.html

Power strips used in any manner are subject to precautions as noted in the Life Safety Code and other related reference documents, including, but not limited to:

- Installing internal ground fault and over-current protection devices;
- Preventing cords from becoming tripping hazards; connecting devices so that tension is not transmitted to joints or terminals;
- That there is no "daisy chaining" of power strips;
- Power strips are adequate for the number and types of devices connected;
- There is no overloading of power strips with high-load devices; and
- Use of Ground Fault Circuit Interruption (GFCIs) devices may be required in locations that are within six feet of water sources.

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Update for Compliant Use of Power Strips in Patient Care Areas

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In the event the organization desires to utilize the CMS Categorical Waiver relating to the use of RPTs, there must be evidence that the organization has formally elected to do so, and such is documented. This includes a risk assessment completed relating to the use of RPTs in patient care locations and with patient care equipment and it must be presented to the Environment of Care or Safety Committee. An approval must be obtained and documented.

Adoption of the Categorical Waiver must be disclosed to CMS and accrediting body surveyors at the entrance conference whenever compliance with the Life Safety Code is being assessed. It can be expected that the surveyors will review the hospital's documentation supporting the use of the Categorical Waiver for the use of Relocatable Power Taps or power strips inclusive of documentation of initial and periodic inspection of power strips, assuring that all provisions of the Categorical Waiver are being met.

Since this article was initially published, there are additional accreditation standards that relate to the use of automated drug dispensing equipment and medication refrigerators and the expectation that they are connected to an emergency power source. To ensure that these medication distribution and storage devices have a reliable power source, it is suggested that they be directly connected to a designated emergency power source without the use of a relocatable power tap. A power tap creates additional potential disconnect points as well as can result in overload of the emergency power distribution system if used to connect multiple devices. These medication distribution and storage devices should be connected directly to an emergency power source.

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Lice and Scabies Outbreaks in the Behavioral Health Setting

By Marietta Hickman, BSN, CIC, and David Woodard, MSc, MT(AMT), CLS, CIC, FSHEA

Congregate settings such as behavioral health facilities pose unique challenges in the management of infestations, whether lice or scabies. While they do not spread disease, they are still highly transmissible from one patient to the next and disruptive to the facility.

Screening and Evaluation of Patients:

Preventing outbreaks requires quick diagnosis and appropriate mitigation strategies. All patients entering the facility must be screened for possible infestation. This screening should be conducted regardless of the source of the admission. Health history can be difficult to obtain in patients with mental illness. Screening for infestation will need to focus on physical assessment and close examination of patient belongings.

Staff should be sufficiently trained and competent to perform thorough hair and skin assessments at the time of initial assignment and then reinforced annually or as needed. It may be useful to refresh this training if there is an outbreak or increased incidence of patients with infestations present on admission.

Sarcoptes Scabii:

Scabies rashes can often lead to secondary skin infections. This is especially true for patients experiencing mental illness. Patients in this unique population may not recognize symptoms. It is critical that the intake nurse and the physician do a careful and complete examination of the skin. The patient may also be resistant to receiving treatment. Rapid recognition, isolation, and treatment of infested patients is pivotal to controlling outbreaks in behavioral health settings.

Typical infestation is best diagnosed by the identification of signs and symptoms associated with the infestation. These include but are not necessarily limited to a papular rash and intense itching, especially at night. The itching and rash may affect much of the body or be limited to common sites such as the wrist, elbow, armpit, webbing between the fingers, nipple, penis, waist, belt-line, and buttocks. The rash may include tiny blisters or scales.

A third manifestation, and unique to a scabies infestation is “Norweigean Scabes”. This is a crusted scabies characterized by thick crusts of skin that contain large numbers of scabies mites and eggs. These patients are very contagious and can spread the infestation easily, both by direct skin-to-skin contact and by contamination of items such as clothing, bedding, and furniture. It should be noted that persons with crusted scabies may not show the usual signs and symptoms of rash or itching.

If a person is naïve to scabies exposure it may take 4-8 weeks before symptoms manifest themselves. In a person with a past exposure history, the symptoms usually appear 1-4 days after exposure.

Symptoms may last for weeks or months, can be hard to recognize, and are often mistakenly attributed to other skin conditions.

Contact Tracing:

Before initiating treatment of single cases, all residents and staff should be checked for symptoms and signs of scabies. Assessing clinicians should be aware of the potential for asymptomatic infection, particularly in the elderly. Contact tracing should identify contacts within the 8 weeks before the case’s diagnosis. Contacts should be identified who meet the definition of close contact. These may include all residents of the setting unless there is a clear rationale for more limited tracing (see bullet points below).

- Residents on a single affected floor or wing if there is no mixing or movement of staff or residents between floors or wings.
- All members of staff (including agency staff) exposed to the index case without wearing appropriate PPE.
- Visitors to the setting who have had prolonged or frequent skin-to-skin contact with an infested individual.
- Ancillary staff, for example, hairdressers, podiatrists, community health professionals and agency staff.

It is recommended that all contacts receive treatment at the same time as identified cases.

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Bedding and clothing worn or used next to the skin anytime during the 3 days before treatment should be machine washed and dried using hot water and hot dryer cycles. Items that cannot be laundered can be disinfested in the same manner as lice infestations.

Long-term surveillance will be necessary to eradicate scabies from the facility. All new patients and staff with conditions indicative of scabies should be treated. An outbreak can signify that transmission has been occurring in the facility for weeks to months. Local health departments should be notified of an outbreak.

New admissions to settings experiencing a scabies outbreak may be possible with appropriate risk assessments, which should include:

- How new admissions can be separated from affected individuals or staff.
- Whether new admissions have any pre-existing conditions that may make them more vulnerable to scabies infection or at risk of more severe sequelae.
- Whether admissions can be delayed until at least the first 24-hour treatment has been completed by all cases and contacts.
- Whether the outbreak is proving challenging to control, for example, difficulties in coordinating mass treatment, which may increase risk to others entering the setting.

Treatment:

Use an approved scabicide. Options include:

1. Permethrin cream 5% is approved by the US Food and Drug Administration (FDA) for the treatment of scabies in persons who are at least 2 months of age. Permethrin kills the scabies mite and eggs and is the drug of choice for the treatment of scabies. Two (or more) applications, each about a week apart, may be necessary to eliminate all mites. Children aged 2 months or older can be treated with Permethrin.
2. Crotamiton lotion or cream 10% is approved by the US Food and Drug Administration (FDA) for the treatment of scabies in adults, but not for use in children. Frequent treatment failure has been reported with Crotamiton.
3. Sulfur ointment in 5% or 10% strength. Sulfur in an ointment base (petrolatum) is safe for topical use in children, including infants under 2 months of age. The odor and cosmetic quality may make it unpleasant to use.
4. Lindane lotion 1%. Lindane is an organochloride. Although FDA-approved for the treatment of scabies, Lindane is not recommended as a first-line therapy. Overuse, misuse, or accidentally swallowing Lindane can be toxic to the brain and other parts of the nervous system; its use should be restricted to patients who have failed treatment with or cannot tolerate other medications that pose less risk. Lindane should not be used to treat premature infants, persons with a seizure disorder, women who are pregnant or breast-feeding, infants, children, the elderly, or persons who weigh less than 110 pounds.
5. Ivermectin is an oral antiparasitic agent approved for the treatment of worm infestations. There is a recommended dosing schedule for Ivermectin below.

Prevention:

Because it is so highly transmissible, crusted scabies requires rapid and aggressive treatment and infection control measures. Unrecognized crusted scabies can cause institutional outbreaks. Dedicated staff and equipment should be provided. Staff will need to adhere to appropriate personal protective equipment including gowns, gloves, and shoe covers. Infested persons can transmit scabies even without symptoms.

All equipment, furniture or clothing used by the patient should be identified and treated. All suspected and confirmed exposed staff, visitors, patients and family members should be treated at the same time to prevent re-exposure. Healthcare personnel, family members, and visitors who may have been exposed to the infected patient should be identified and treated. All patients who have had exposure to the patient, or contact with any shared equipment or furniture should be treated for Crusted Scabies using both oral and topical treatments:

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1. Ivermectin should be administered together with a topical agent. Oral Ivermectin (200µg/kg/dose) should be taken with food. Depending on infection severity, Ivermectin should be taken in three doses (approximately days 1, 2, and 8), five doses (approximately days 1, 2, 8, 9, and 15), or seven doses (approximately days 1, 2, 8, 9, 15, 22, and 29.
2. Permethrin cream 5% Topical should be administered every 2-3 days for 1-2 weeks to treat crusted scabies.
3. Benzyl Benzoate 25% (with or without tea tree oil) may be used as an alternative topical agent to Permethrin. However, this agent may cause immediate skin irritation. Lower concentrations may be used in children (10% or 12.5%).
4. Keratolytic cream. A topical Keratolytic cream may also be used to help reduce the crusting of the skin and aid in the absorption of the topical Permethrin or Benzyl Benzoate.

Declaring the Outbreak Over:

For the purposes of reporting and determining the provision of ongoing support, an outbreak can be considered over when all cases and contacts have received the full recommended treatment regimen (for example, 2 doses of topical cream application). However, ongoing monitoring and a period of heightened surveillance after all cases and contacts have completed treatment is advised to reduce the risk of outbreaks continuing unchecked.

This period of heightened surveillance should include regular re-assessment of staff and residents for any new symptoms, and to ensure symptoms are resolving as expected following treatment, and should last for 12 weeks (that is, 2 mite incubation cycles) after the onset date of symptoms in the last known case.

A scabies outbreak can be declared over if no new cases are identified within 12 weeks the of symptom onset date of the last known case. Nodules can take several months to resolve after successful treatment.

Pediculosis:

Head lice (Pediculus Humanus Capitis) diagnosis is determined by finding live nymphs, adult lice, and eggs. They are most commonly found behind the ears and at the nape of the neck. Body lice (Pediculus Humanus Corporis) diagnosis is determined by finding eggs and crawling lice in the seams of clothing. Sometimes a body louse can be seen crawling or feeding on the skin. Pubic lice (Pthirus Pubis) [also known as the crab louse] diagnosis is determined by finding a louse or eggs on hair in the pubic region or, less commonly, elsewhere on the body (eyebrows, eyelashes, beard, mustache, armpit, perianal area, groin, trunk, scalp).

Head Lice:

Head lice infestation is spread most commonly by close person-to-person contact. Head lice have a life cycle completed in approximately 30 days. When not in contact with the human body, they do not survive on fomites (inanimate objects) beyond 1-2 days. It is necessary to ensure that patients are immediately isolated in the intake unit when head lice are observed. All infested patients should begin treatment as soon as possible. If possible, a patient should complete treatment prior to entering the inpatient units. Isolate patients with active infection until 24 hours after completion of initial treatment.

Prevention:

Avoid head-to-head (hair-to-hair) contact during activities. Patients with long or matted hair should be encouraged to have a haircut. Clean the combs and brushes used by an infested person by soaking them in hot water (at least 130°F) for 5–10 minutes to kill the nits.

Machine wash and dry clothing, bed linens, and other items that an infested person wore or used during the 2 days before treatment using the hot water (130°F) laundry cycle and the high heat drying cycle. Clothing and items that are not washable can be dry-cleaned or sealed in a plastic bag and stored for 2 weeks.

Storage rooms for patient belongings are usually communal in congregate living and behavioral health facilities. Educate staff to properly bag all items utilizing the “goose-neck” technique to ensure an airtight seal. Routine facility inspections for infestations should include patient belongings storage areas. All belongings brought in by family members must be carefully checked for infestation prior to being given to the patient.

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In the congregate settings, consistent surveillance is a critical component in the prevention of an outbreak. One strategy is to assess all inpatients weekly for any signs of infestation. All inpatients should be assessed on the same day and shift.

One alternative when a patient is refusing assessment is to thoroughly assess the patient's clothing and bedding.

Treatment of Head Lice:

Shampoo with 1% Permethrin or pyrethrins as the preferred product. In rare cases, Lindane, 1% may be preferred, due to known resistance to Permethrin. Apply to the patient's scalp or skin depending on where the lice were seen. It is critical to follow the instructions for use of these treatments. Patients should be re-treated per product recommendations, usually within 7 to 9 days, as no treatment is completely ovicidal. Removal of nits after successful treatment is not necessary to prevent spread. Prophylactic treatment of uninfected patients is not recommended.

Treatment of Body Lice:

A body lice infestation is treated by improving the personal hygiene of the infested person, including assuring a regular (at least weekly) change of clean clothes. Clothing, bedding, and towels used by the infested person should be laundered using hot water (at least 130°F) and machine-dried using the hot cycle.

Sometimes the infested person also is treated with a pediculicide. However, a pediculicide generally is not necessary if hygiene is maintained and items are laundered appropriately at least once a week. A pediculicide should be applied exactly as directed on the bottle or by the attending physician.

Treatment of pubic lice infestations: https://www.cdc.gov/parasites/lice/pubic/treatment.html

- Wash the infested area and towel dry.
- Carefully follow the instructions in the package or on the label. Thoroughly saturate the pubic hair and other infested areas with lice medication. Leave the medication on the hair for the time recommended in the instructions.

After waiting the recommended time:

- Following treatment, most nits will still be attached to hair shafts. Nits may be removed with fingernails or by using a fine-toothed comb.
- Put on clean underwear and clothing after treatment.
- To kill any lice or nits remaining on clothing, towels, or bedding, machine-wash and machine-dry those items that the infested person used during the 2–3 days before treatment. Use hot water (at least 130°F) for the wash and the hot dryer cycle.
- Items that cannot be laundered can be dry-cleaned or stored in a sealed plastic bag for 2 weeks.
- Persons with pubic lice should be evaluated for other sexually transmitted diseases (STDs).

Special instructions for treatment of lice and nits found on eyebrows or eyelashes:

- If only a few live lice and nits are present, it may be possible to remove these with fingernails or a nit comb.
- If additional treatment is needed for lice or nits on the eyelashes, careful application of ophthalmic-grade petrolatum ointment (only available by prescription) to the eyelid margins 2–4 times a day for 10 days is effective. Regular petrolatum (for example Vaseline)* should not be used because it can irritate the eyes if applied.

Careful assessment of new admits and routine surveillance of inpatients can mitigate outbreaks of scabies and lice infestation. Staff training should be provided to assist personnel in recognizing potential infestation. Patients identified with lice or scabies should be isolated and treated to help to control facility outbreaks and protect patients and staff from exposure.

For more complete and timely information on the treatment of these infestations, see the CDC guidance for the specific organism: CDC - Scabies - Prevention & Control at https://www.cdc.gov/parasites/scabies/prevent.html