N.E.H.E.S. HISTORY

Your Vice President's office has been charged with establishing and maintaining a chronological record of significant events affecting our Society. A history of the Society is important for many reasons. Some intangible, but interesting benefits are a list of charter members, past presidents, etc. Other more important reasons with tangible benefits are when we were founded, incorporated, and established an IRS number.

History can help to avoid reinventing the wheel in our Society. For those who know nothing of our past, can and know nothing of our past, can and do present old ideas, thinking they are new. A good history can help us to build on old ideas, while developing new ones for our Society.

In this regard, we need help developing the Historical Record of Events, especially for the early years of the Society. We have identified a list of items which should be a part of this record as follows:

- List of Officers
- List of Board Members
- Membership List
- Annual Report - Officers
- Annual Report - Board Members
- Newsletters Published
- Stationery
- Spring Seminar - Brochure
- Fall Seminar - Brochure
- Society Awards, Certificates, etc.
- By-Laws (Constitution)
- Charter Members
- Past Presidents
- Emblems and Banners
- Unusual or Special Correspondence

Will each of you (especially the old timers) search your files for the above items for the period from 1958 to 1968 (the first ten years of the Society). You may only find correspondence in the early years, which could be of significant value if listed documents are not available. In any event, please send me whatever you may have.

We expect to have a first publication of our history available to each of you at the Fall Seminar. Your help now will undoubtedly make this document more valuable. Thank you for your cooperation and help in this important matter.

Richard E. Popham, Director
Facilities Management and Operation
University of Connecticut Health Center
263 Farmington Ave. Farmington, CT 06032

ENERGY NEWS FROM MAINE

A recent federal DEPP report narrows in on hospital energy costs and their contribution to ballooning health care expenditures; the key concept being that energy costs impact hospital costs. The indisputable fact is shown that health care facilities consume 60% more energy per square foot than the average of all commercial buildings and 10% of all the energy consumed in the commercial sector. And what else might one expect of a building having 24-hour occupancy, code requirements, and an energy intensive environment? On the other hand, energy costs were only — on the average — about 3% of the hospital operating budget in 1980 and on the basis of a 17% average annual increase this means, perhaps, less than 5% of the budget in 1984.

It is erroneous to expect and claim that hospitals can reduce costs by managing energy. We may have reduced energy costs in 1984 because of more favorable oil prices, but chances are that a well-managed hospital energy program has only avoided cost.

This report, published in 1984 using statistics representative of energy activities in 1979-1981, with some data from 1982, is outdated. It really is baseline data. The impact from Cycle 1 and 2 projects under the federal energy program were not felt until '81-'82 and certainly the full momentum of energy conservation of later cycles and self-imposed programs is, even today, yet to be recorded. And, therefore, the data accumulated by AHA, DOE, and others cannot be representative of 1984. 1980 data shows New England hospitals were above average in BTU per square foot and BTU per bed which average for BTU per Inpatient day. Maine hospitals did come in below average for all categories. Well, take credit when you can!

With health care costs increasing at 12% annually, the closing of over 500 hospitals is imminent in the next decade. High energy costs will not be the reason for closing. One only has to recall the Electric Institute's TV ad which attributes $4.60 worth of electricity to a $20,000 surgery. The real concern relating to energy should be acceptance by the hospital administrators and bureaucrats of energy as a critical health resource which may be short at anytime, regardless of price, depending on the whim of any number of outside influences. This means regular allocation of capital money to energy related projects and the development of contingency plans for possible outages/crises.

The hospital engineer has a role to play as a guiding, influential and informative source. All of this will make for an energy team which will influence energy utilization factors and the next time, AHA, DOE, and HHS publishes reports, New England hospitals will be better than the national average.

Donald Ball
Maine Hospital Association

N.E.H.E.S. FALL SEMINAR

The N.E.H.E.S. Fall Seminar will be held in Newport, Rhode Island on October 30, 31 and November 1, 1985 at the Sheraton Islander.

Any comments or recommendations in reference to program planning, etc. should be forwarded to Ken Janzekovich, Seminar Chairman, at Rhode Island Hospital.

SOUTH SHORE HOSPITAL ENGINEERS' SOCIETY OF MASS. 30th Anniversary

The South Shore Hospital Engineers' Society of Massachusetts will be celebrating their 30th Anniversary of founding on April 12, 1985.

The occasion will be celebrated with a dinner and entertainment at Lombardo's Restaurant (formerly "Chateau DeVille") Junction Routes 128 and 28 Randolph, Mass.

Cocktails will be served from 8:30 - 7:30 p.m. and dinner will be served at 7:30 p.m.

As one of the oldest Hospital Engineering Societies in the country, we hope many of you will join us to celebrate and mingle with old friends.

Tickets are $15.00 per person and may be obtained from Thomas J. Galligan, Anthony Formigletti, Thomas F. Galligan (Father) and Edward Boyer.
MASSACHUSETTS ELECTRIC PROPOSES
MANDATORY TIME-OF-USE RATES

During the month of March 1985, Massa-
chusetts Electric, at the direction of the
Massachusetts Department of Public Utility-
es, will be filing a Time-of-Use Rate (H 30).
This new Time-of-Use Rate will be mandatory
for all large use rate customers (H Rate). This
could mean a substantial increase in month-
ly electric utility bills.

In June of 1984, a similar “Time-of-Use”
Rate was mandated by the D.P.U. for Boston
Edison. This rate went into effect with very
little forewarning and has resulted, in at least
one instance, in an 8 to 9% increase in the
facility’s electric bill.

Massachusetts Electric has scheduled at
least one informational meeting on this new
Time-of-Use Rate and more may be forth-
coming. Hospitals are urged to contact their
Massachusetts Electric Account Representa-
tive to determine if and when such
informational meetings will be held in their
area. Close attention should also be paid to
announcements of Public Hearings which
may be occurring over the next six months to
solicit input on the impact of these rates.

John J. Crowley
Administrative Engineer
St. John’s Hospital
Lowell, MA

HEALTH CARE FACILITIES HANDBOOK
Edited by Burton R. Klein,
National Fire Protection Association, 1984
442 Pages

This book is a handbook in the true sense.
It is written about NFPA-99, Standards for
Health Care Facilities, which is reprinted in
full in the handbook. NFPA-99 combined and
integrated 12 previous, separate health care
documents developed over the past 45 years.
For several years these standards have been
the source for criticism, controversy and
confusion, mainly because of their over-
lapping coverage and staggered revision
dates.

The evolutionary process which led to the
integration of these documents was intent on
restoring credibility to this very
valuable collection of standards and guide-
lines and reinstating the degree of safety
called for in this most critical field of health
care.

Burton Klein, both editor and author of
the handbook is a natural selection to have
written a book of this sort. He has written several
books in the health care field before and has
worked very diligently in this field for most of
his working career. During the last seven
years, Mr. Klein has served as the Executive
Secretary for the Health Care Section of the
National Fire Protection Association and as
the staff liaison for the Health Care Facilities
Technical Committee. This puts him in touch
with everything that’s happening in health
care safety.

What the author has done in the Health
Care Facilities Handbook is to provide, in
easy-to-understand language, interpreta-
tions, background information, simplifica-
tions and opinions on a large collection of
interrelated material. As he very pointedly
states in the beginning of his book, “With so
much material in one document, assistance,
in the form of commentary, seemed the best
method of sharing some of the history of this
material as well as providing additional infor-
mation and guidance in applying the standard
to present conditions”.

The Health Care Facilities Handbook
should prove to be a most significant publica-
tion because it is written and directed
towards those individuals, whose
responsibility it is, to comply with the stan-
ard. The experienced Hospital Engineer as
well as those just entering the field will find
the prologue and preface at the start of each
chapter informative, fact filling and interest-
ing.

This handbook serving the health care
safety field can be expected to find use as
a textbook as well as a handbook for years to
come.

Reviewed by Jack Berger
NFPA Liaison

NO SMOKING POLICY

No offense to those of you who smoke.
However, I cannot say too much about what
smoking does negatively to hospitals. First
of all, it is the cause of most of the fires I
have seen in our hospital in the past ten
years. Second, the ceiling tiles in all those
spaces where it has been allowed are
stained. Third, it creates a constant
housekeeping problem. Fourth, a lenient atti-

dude by the hospital makes it difficult to in-
fluence physicians and staff who smoke in
corridors, etc. Lastly, and almost the most
important, it gives the public the idea that
the hospital cannot be too worried about
what smoking does to one’s lungs if it takes
no forceful position on the subject — and it
doesn’t mean just not putting cigarette vend-
ing machines in the hospital.

Let’s face it, what patient is going to
accept an obsolet doctor’s warning to lose
weight? Thus — what public is going to get
serious about not smoking when they go to a
health care facility and see so much of it?
Well, one hospital has the guts to put its
money where its heart is — they have
recently instituted a policy of not hiring
smokers. So you think that’s unfair hiring
practice? Well, what physical fitness organi-
zation is going to hire an “out of shape”
person to advertise their business?

I heard this news on National Public Radio
recently and tracked it down to identify the
hospital. Maybe your organization would
be interested in taking the cue. Write to the
Westlake Community Hospital, 1225
Superior Street, Me Irene, IL 60160, to
find out how it is working. This 229-bed hos-
pital is in a suburb of Chicago and maybe
AHA will also have something to say about
this. I think the public would recognize the
institutions that take the “No Smoking”
approach really mean to help people with
a positive example rather than hiding in the
bush hoping for monetary gain from helping
all those victims of lung problems caused by
smoking.

David B. Hathaway, Director of Engineering
Lawrence Memorial Hospital of Medford, MA

INDIA ACCIDENT PROMPTS NEW
HOSPITAL DISASTER PLANS

Executives at hospitals located near
Union Carbide Corp.’s Institute, WV, plant
are beginning to rethink their disaster plans
in the wake of December’s chemical leak in
Bhopal, India, that killed more than 2,000
people.

“We have a disaster plan for multiple
traumas, but it falls far short of caring for
2,000 people,” said James C. Crews, presi-
dent of the 934-bed Charleston (WV) Area
Medical Center, the area’s largest hospital.

“We may update the gas leak aspect of the
plan.”

Many of the medical center’s 3,500 em-
ployees have been assigned specific roles in
case of disaster.

Six hospitals serve the institute area,
which contains six chemical plants, includ-
ing two operated by Union Carbide. Manu-
ufacturers have provided hospitals a list of
their chemical products, along with the drug
antidotes, Mr. Crews said.

J. Darrell Richmond, administrator of the
170-bed Kanawha Valley Memorial Hospital,
Charleston, said executives at his facility are
devising evacuation plans. “Previsously, the
hospital’s thinking was to stay put and
treat patients,” he said. A disaster of the
magnitude of what happened in India “bog-
gles the mind,” Mr. Richmond said. “That
number of people overwhelms any system.”

The Union Carbide plant in Institute is the
only one in the United States that makes
methyl isocyanate, the gas that caused
1,500 deaths in India. Manufacture of the chemi-
cal at Institute has been halted, pending an
investigation of the cause of the disaster in
India. But its stocks of methyl isocyanate
still are being used to make pesticides.

Modern Healthcare Jan. 15, 1985
C.H.E.S. CERTIFICATION COMMITTEE UPDATE

The following report is submitted concerning the Connecticut Hospital Engineers' Society, Inc. (CHES) Certification Committee Progress:

1. The committee is continuing to define and expand the definitions for subtopics of the Management and Technical Sections of the Certification Exams, and preparing appropriate exam questions.

2. Further discussions have been conducted relative to education programs to assist certification applicants in their preparation for the exams. Discussions are being set up with outside agencies to further investigate the options available.

3. In response to their request, Mr. Jim Piro will present an update to the Western Massachusetts Hospital Engineers' Society on the Certification Program.

4. The Rhode Island Hospital Engineers' Society has volunteered to participate in any way possible for the continued development of the Certification Program. Their eight-man delegation was represented by two members at our March 19, 1985 committee meeting.

Roderick A. Cameron

PROTOTYPE PATIENT ROOM PROVIDES PRIVACY & AMENITIES

Something new under the hospital sun is a prototypical double occupancy room that is no bigger than the usual double room configuration, but which provides more privacy and amenities. Developed by Eve Frankl, ASID, Eve Frankl Interiors, Greenwich, Conn., the roughly trapezoidal-shaped room evolved in Frankl's mind during 12 years of consultative work on several phases of construction and expansion for a nonprofit healthcare facility.

Conserving space, the trapezoidal shape permits placement of beds on opposite walls. And, provided rooms are paired to properly utilize space, they fit well along a corridor, according to Frankl. When the rooms are placed in pods or groups, they provide extra storage and utility spaces long public hallways.

"That configuration," says Frankl, "provides a layout that offers patients equal facility -- I call it 'equal turf' -- and much more convenience than the stereotypical hospital room. The latter, with which we all are so familiar, tends to be cramped and uncomfortable for patients using it."

...In the prototype layout illustrated on this page, patients enjoy the benefit of separate wardrobes and storage units. Yet all units are identical and can be easily supplied as production millwork, adds Frankl.

Offers cost-effective benefits

As for cost effectiveness, Frankl compares the required footage for this configuration to the standard double- and single-patient rooms. A double-patient room configured in the new design, including bathroom, requires 330 sq. ft. of space. A double room in a conventional scheme is estimated to require 320 sq. ft. In a conventional plan, a single-patient room is estimated to need approximately 215 sq. ft.

Frankl also points out that the double room she develops is structured to provide greater privacy than the standard plan and, therefore, can be compared to two single patient rooms, thus accomplishing a substantial savings in overall footage: 330 sq. ft. for a double versus two x 215 sq. ft., or 430 sq. ft., for two singles. At the same time, she says, the new design absorbs a negligible additional amount of space than does the conventional double room and so can be substituted for the conventional with little extra cost.

Nurse, too, stand the benefit from the plan, since nursing care becomes more central when double rooms are more prevalent than singles. The smaller number of single rooms that are required as a result," adds Frankl, "should constitute a significant cost savings in overall planning of a new institution."

Frankl concludes with the observation that increasing competition between hospitals for paying patients is another reason for providing such amenities, particularly when early planning would permit substantial cost savings.

Contract/Feb., 1985

REMINDER

As with any professional society, an active membership is critical to the ongoing success and growth of the group as a whole.

One key responsibility is the need for timely material submitted for publication in our newsletter. This responsibility rests with all members and is the society's most effective means of communicating information of interest to our general membership.

I urge you to feel obligated to contribute articles of your own as well as pertinent material from other sources. It should be noted that contributing to the newsletter provides valuable shared ideas and information, as well as professional exposure to the author and facility.

Please review the following cutoff dates for 1985 editions:

June 7 - September 6 - November 15

I look forward to your participation.

Jack Gosselin, Newsletter Editor
NEW ENGLAND HOSPITAL ENGINEERS' SOCIETY, INC.

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