MAINTENANCE A-N-X-I-E-T-Y

No one ever said being a hospital administrator was easy. Few jobs involve managing as many disparate types of employees, operating in such a fiercely competitive yet highly regulated market, and making as many decisions with literally life-or-death consequences. Furthermore, both our economy and the nature of the American healthcare delivery system are going through a period of such tremendous change that long-range planning has become quite chancy. Yet every administrator constantly is prodded and expected to improve his or her hospital's performance—not merely maintain the status quo. Unfortunately, many administrators are forced to meet these pressuring demands while suffering from a severe and debilitating handicap—Maintenance Anxiety.

Maintenance Anxiety (MA) is our name for a chronic managerial nervous disorder which we find afflicts the majority of hospital administrators to at least some degree. MA is characterized by a chronic, irrational aversion to dealing with the hospital's maintenance department. In mild cases, the victim's administrative abilities are only moderately afflicted and the hospital can still function, albeit at a reduced level of efficiency. In more advanced stages, however, MA has such a negative effect that the hospital's operational viability is gravely threatened.

Unfortunately, an administrator with MA is often misdiagnosed as not. The symptomology is such that some other administrative ailment is often blamed—e.g., inflationary fever, inflammation of the labor force, or hardening of the financial arteries. Currently, the career prognosis for an administrator suffering from an advanced case of MA is very bleak. Indeed, an administrator's upward career usually has gone terminal long before the characteristic "maintenance anxiety attacks" begin to manifest themselves.

Hence the purpose of this article. The battle against MA is an educational one, because MA is virtually 100 percent curable if diagnosed and treated early enough. But, first, what causes MA?

- There are several identifiable causes. One is simple snobbery. In a world full of surgeons, microbiologists, accountants, management

1985 FALL SEMINAR
OCTOBER 29- NOVEMBER 1
NEWPORT, RHODE ISLAND

This fall's seminar promises to deliver a wide range of professional development sessions coupled with an exhibition featuring over forty vendors. An active program is planned for both the engineer and spouse.

As the cut-off date for registration has passed, late sign-up may be made by immediately contacting:

Mrs. Diane R. Frey
Buildings & Grounds Department
Rhode Island Hospital
593 Eddy Street
Providence, Rhode Island 02903
(401) 277-8000
SEE YOU THERE!

HISTORY

It is of interest to all of us that Jim Lawson, Administrative Engineer, Medical Center Hospital, Burlington, VT, is a candidate for President of ASHE. But, did you know that Jim is a Past President (1977) of NEHES and that he served on the Board of ASHE? Our historical records show this and also show that Vinny Gardner, Past President (1964) of NEHES, is the only NEHES member who served as President of ASHE.

The above information is a part of our growing historical data base which we are asking each of you to contribute to. Our most recent contribution to the data base was from Warren Marble of Danbury Hospital. Warren's package included all the historical data gathered and prepared by he, Al Bender, and Vinny Gardner for a presentation by Warren to the Annual Banquet on our Silver Anniversary.

The first draft of "Our History—1958 to Present" has been presented to the Board of Directors for their review. It is expected that a final draft, with additional information, will be presented to the Board's September Meeting with the intention of getting the first issue printed and distributed to each member at the Annual Meeting in October at Newport.

Richard Popham, Director
Facilities Management & Operation
UConn Health Center

BY-LAW COMMITTEE REPORT

The following proposed changes to the By-Laws of the New England Hospital Engineers' Society were discussed, amended and approved at the Board of Directors meeting held on June 7, 1985 in Tewksbury, MA.

The proposed changes will be presented to the membership at the Annual Meeting on October 31, 1985 in Newport, RI.

It is proposed that the Following Sections of Article V be changed to read as follows:

Section 5-5: Delete; move to Section 9-2
Section 5-6: becomes Section 5-5
Section 5-7: becomes Section 5-6 and is proposed to read as follows:

The president-elect shall, in the absence of, or because of incapacity of the president, perform all duties and assume all responsibilities of the president. He shall also act as planning and program coordinator for the spring and fall seminars. The position of president will automatically be filled by the president-elect.

Section 5-8: becomes Section 5-7 and is proposed to read as follows:

The vice president shall assist the president and president-elect as directed by the president. The vice president shall also maintain the Society's Historical Records and periodically report to the Board of Directors and to each annual meeting on the status of the Society's history.

Section 5-9: becomes Section 5-8 and all remaining paragraphs shall move up one number to reflect the changes in the total article. The change in numerical sequence will show Article V containing Sections 5-1 through 5-23.

It is proposed that Article IX be changed to read as follows:

Article IX Committees
The Standing Committees shall be as follows and it shall be the responsibility of the committee chairman to see that minutes of all meetings are properly recorded and filed with the secretary.

Nomination Committee
Section 9-1 (Formerly 9-3)
This committee shall consist of at least five past presidents and be chaired by the president. The committee shall present a slate of officers to the membership for their consideration at the Annual Meeting.

Continued on Page 2
Maintenance Anxiety - Continued

specialists, government planners, and the like, not a few administrators have come to think that communicating with maintenance people is somehow beneath their dignity. Never mind the fact that maintenance personnel may hold advanced degrees in engineering, or that they have daily encounters with some of the most sophisticated machinery ever devised: the stereotype of the grease-smeared Neanderthal janitor, shuffling along wrench-in-hand, dies hard.

Strangely enough, snobbery's converse — fear — is another cause of MA. In some administrators' minds, the bowels of their hospital are inhabited by strange and evil gnomes who somehow minister to a mystifying array of even stranger and more evil machines. Administrators have only the vaguest idea of how these machines are kept running, but they can all too vividly imagine what horrors would ensue if they were to break the magic spell by interfering with the maintenance department's arcane rituals.

MA produced by fear or snobbery is, we are sad to say, almost impossible to cure. A negative feedback loop usually develops. The more an administrator fears or disdains the maintenance department, the less communication takes place. Poor communication leads to further isolation which breeds still more fear and loathing, etc., etc., etc. Unless the administrator can change his or her attitudes — a difficult task — the eventual result is hospital service disaster at worst, hospital financial deterioration at next.

Fortunately, most cases of MA are caused neither by fear nor by snobbery, but by something more readily treatable: a misplaced sense of complacency. With all the major and minor crises they must face each day, few administrators have the inclination to go looking for problems. They tend to reason that as long as the hospital is not actively collapsing around their ears, the maintenance department must be doing its job. To avoid uncovering yet another area of their hospital's operations that needs improving, they unconsciously ignore the many warning signs of a maintenance department running inefficiently. Such signs as growing amounts of maintenance crew overtime, frequent interruptions of patient care due to equipment breakdowns, and increasingly shortened equipment life spans.

How to treat the hospital administrator whose ostrich-like attitude has brought on MA? Simple: sit down with most current Profit and Loss statement. A fresh look at that document, with an eye to maintenance-related expenses, will prove that just because the boilers aren't exploding doesn't mean there aren't substantial profit erosions due to poor maintenance department performance.

The efficiency of the maintenance department affects a hospital's operational costs both directly and indirectly. The most obvious direct effect is seen in such maintenance-related expenses as tools, supplies, parts and salaries. For most hospitals these are sizeable outlays. A better-managed maintenance department should mean significant savings in these areas, plus improved service.

There are many other operational expenses, however, that oftentimes are not associated with maintenance but do depend on its quality. Energy costs are an example. Most energy conservation measures are really maintenance procedures. Keeping equipment operating at peak efficiency, regularly changing filters, checking up on temperature gauges — these are all simple tasks that can add up to big savings via less energy wastage.

Capital expenditures for the replacement of worn-out equipment are also influenced by the maintenance department's performance. Given the proper care, most automobiles theoretically can last 150,000 miles — yet the average car barely lasts half that many miles because of owner neglect in following the prescribed maintenance procedures. Likewise, the hospital maintenance department that fails to follow a preventive maintenance schedule can be assured of unnecessarily short equipment life — with consequent excess costs for capital repairs and replacement.

Insurance and legal costs are two other expenses that are influenced by maintenance quality. Risk management is a hot topic in hospital circles today — and one of the most important tools for risk management is good preventative maintenance. A loose tile in a stairway, a faulty electrical outlet, poorly maintained medical equipment, a broken wheelchair — these are accidents waiting to happen. (Thorough preventative maintenance can also take some of the hassle out of a JCAH review!)

In addition, there are other benefits to an efficient maintenance department that are not tangible enough to show up on a P&L statement, but just as important. One is the contribution made to the hospital's overall image. Well-kept buildings and grounds go a long way towards reassuring patients and their families, as well as impressing physicians. Another is the boost given employee morale. Employees are happier and work more efficiently in clean, safe surroundings using reliable equipment. Having to wait an unreasonable amount of time for repair work to be done or finding work suddenly interrupted can be a frequent-reported hospital employee complaint. Happy employees are less likely to consider a union.

Once "Maintenance Anxiety" has been replaced by "Maintenance Awareness," the typical administrator begins to improve the maintenance department's level of efficiency. Assuming the maintenance department is adequately staffed and funded, the first thing that should be examined is the hospital's work-order system.

Work order procedures are a maintenance department's nervous system, bringing undistorted input in from all over the hospital and carrying orders and directions out to the engineers. Many hospitals, however, have either inadequate work-order systems or none at all.

Instituting a comprehensive work-order system, or revamping an inadequate one, can be difficult enough, but there are even more ambitious methods of improving a maintenance department's efficiency. One of the most popular moves right now is the adoption of a Schedule Preventative Maintenance Program.

Preventative maintenance is taking care of equipment before it breaks down. Theoretically, most hospitals practice some limited form of "preventative maintenance" on a catch-as-catch-can basis. But until the development of computers, the clerical work needed to keep track of the literally thousands of monthly tasks necessary in even an average-sized hospital, made administering a truly adequate scheduled preventative maintenance program impractical. Now, however, as the cost of computer time decreases, it has become demonstrably cost-effective to use computers for preventative maintenance.

Of course there still will be equipment malfunctions but, if the system is effective, they should be greatly reduced.

While a "home-made" computerized scheduled preventative maintenance system can be custom-tailored to a particular hospital's needs, it requires much time, expertise, and planning. The hospital must have sufficient computer capacity to include such a system, and it can take as long as two years to become operational. However, software packages can eliminate designing a custom program and often come with expert consultation to help "personalize" the system.

Some hospitals turn to contract maintenance firms, and dispense with trying to handle their own preventative maintenance program altogether. This approach is especially suitable for the maintenance of delicate technical lab equipment.

Preventative maintenance administration firms are a relatively new phenomenon. Usually, they send their own engineers to do the inventorying and then put the data into their own computers. They then send the hospital regular work-orders — and sometimes performance reports — for a monthly fee. The degree of sophistication varies considerably between firms. So do their fees. In many instances, however, these specialized firms can be very cost-effective because they are experts at what they do. They are also faster (a system usually is operational in a few months) and a few include consultation as part of the package.
A happy by-product of a scheduled preventative maintenance program is the increased communication fostered between the maintenance department and the hospital’s administration. The administrator can see what the maintenance department’s goals are, what their resource needs will be, and how well they have been performing. This increased level of understanding will help prevent MA relapse.

By Stanley G. House
Executive Director
Healthcare Interaction Consultants

NEWS FROM THE STATES
Rhode Island
During the past month in construction and building renovation projects in the State have developed into full bloom. This is probably true for most of you throughout your respective hospitals.
Memorial Hospital of Pawtucket, Rhode Island has just got off the ground with their $14,000,000.00, 68,000 SF addition. The new addition will be used primarily for Clinic In-Patient care and Administrative Offices. Project is scheduled for completion early 1987.

For more information, contact:
T.J. Shubbuck
Conn. State Representative

By Law Committee Report — Continued

Audit Committee
Section 9-2 (Former 5-5)
The president shall appoint an Audit Committee to review the treasurer’s records annually and prior to transferring them to the new treasurer.

Membership Committee
Section 9-3 (New)
The president shall appoint a Membership Committee whose primary function shall be to publicize the activities of the Society and solicit appropriate and qualified members to the Society from the health care industry.

Scholarship Committee
Section 9-4 (New)
The president shall appoint a scholarship committee whose duties will include fund raising and disbursement of funds with prior approval of the Board of Directors.

Research Committee
Section 9-5 (Formerly 9-2)
The president shall appoint a chair and any additional members he feels are required. The duties shall be to conduct research and gather information that will contribute to the advancement of the Society.

Steering and By-Laws Committee
Section 9-6 (New)
The president shall appoint a Steering and By-Laws committee which should consist of past presidents and be chaired by the most immediate past president.

The Steering and By-Laws committee shall provide guidance and consulting to the Board of Directors in the every-day activities of the Society.

The Steering and By-Laws committee shall review the By-Laws annually for adequacy and appropriateness and propose changes to the Board of Directors for approval and then submit approved, proposed changes to the annual meeting for action.

Special Committees
Section 9-7 (Formerly 9-4)
special committees may be appointed by the president from time to time as authorized by the Board of Directors.

Certification Committee Update
Now that vacation time is over, Certification Committee Action shall be resumed at full speed. During the summer months, meetings were held to further refine the definitions for the sub-topics of the Management and Technical Sections of the Certification Exams.

In early September, a Preliminary Exam Package will be forwarded to NICET (National Institute for Certification in Engineering Technologies) for their review and critique. Based on the results of that review, further discussions will be conducted with ICS (International Correspondence Schools) for Exam Tutorial Courses.

The Certification Committee intends to provide a status report of progress at the New England Hospital Engineers Society Fall Seminar, at Newport R.I., to update the Society Members on our progress. See you there.

Roderick A. Cameron
Research Committee Chairman
Lawrence & Memorial Hospital

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