Department of Homeland Security rule

**Hospitals may need to report certain chemical quantities**

In the August 2007 Briefings on Hospital Safety, we told you about a proposed federal initiative that aimed to provide better security of chemicals that could become terrorist weapons. Now, the U.S. Department of Homeland Security (DHS) has finalized its rules on this matter.

As of January 19, facilities may need to submit online questionnaires to the agency about on-site chemicals that exceed designated quantities.

In an original list that DHS released in April 2007, possessing any quantity of many chemicals subjected hospitals to tighter security rules. Among the substances on that initial list was ethylene oxide, which caught medical centers off guard.

But the final list, published in November 2007, stepped back a bit by assigning baseline quantities to the chemicals and even removing some materials from the list.

> continued on p. 2

**For further information**

To fill out the “top-screen” questionnaire for chemicals of interest, see a full breakdown of the U.S. Department of Homeland Security’s final rule, and review a host of supporting materials, go to www.dhs.gov/chemicalsecurity.

The changes in the final rule are welcome to safety officers. “We are pleased with the final list of chemicals and their threshold limits,” says Charles Workman, CHFM, director of environment of care at Texas Health Resources in Arlington. (See the chart on p. 3 for a comparison of common healthcare chemical limits in the old and final rules.)

“We do utilize a great deal of these chemicals,” adds Workman.

**Mark January 19 on your calendar**

With the final regulations—formally known as the Chemical Facility Antiterrorism Standards—in place, DHS is now conducting a nationwide risk assessment to figure out where the chemicals in question reside, a DHS spokesperson says.

Hospital safety managers can simply jump to Appendix A of the rule—the chemicals of interest list—to see whether their sites are affected. If your facility has
chemicals on the list in amounts greater than the specified quantities, it needs to fill out a “top-screen” questionnaire, the results of which DHS will parse. From there, the agency will notify any organizations that need to make security changes.

The top-screen is just the first part of the greater risk assessment, the spokesperson adds.

“From what I understand from DHS, the goal of the top-screen is to figure out what people have and to rank each facility to determine what steps are needed,” says Webber.

You can find DHS’ chemicals of interest in many areas of a hospital, including pharmacies, research laboratories, facilities departments, HVAC systems, and water treatment realms. “At the end of the day, hospitals will probably fall in a lower category [of risk],” Webber says. “But the challenge right now for everyone, including hospitals, is to understand what you have on-site from an inventory standpoint.”

### Begin by sifting through MSDSs

You may already have a good handle on chemicals of interest through your material safety data sheets (MSDS), Webber says. If you’ve got your MSDSs in order according to OSHA standards, you’re partway to DHS compliance.

“It’s a matter of leveraging what you know about your products—and what’s in them—and comparing them to a new list,” Webber says, likening the process to Environmental Protection Agency (EPA) reporting.

In fact, some of DHS’ chemicals of interest came from the EPA’s risk management program regulation, which you may be familiar with.

### Note changes from proposed to final rules

After publishing the proposed rule, DHS received feedback from many industries. Of the 4,300 public comments about the chemicals of interest list, 4,000 of them concerned propane, which originally triggered DHS review if an organization possessed 7,500 lb of the gas, according to the agency.

DHS has now upped the propane baseline quantity to 60,000 lb. Propane in tanks smaller than 10,000 lb doesn’t even count toward that 60,000-lb threshold.

Other major changes between the proposed and final rules include the following:

- Chemicals now are classified by the danger they pose (e.g., toxicity or potential for theft)
- DHS removed from the list several chemicals used in healthcare settings or the maintenance of grounds (e.g., acetone and urea)
Final federal chemical list offers relief to hospitals

The U.S. Department of Homeland Security (DHS) has changed some “threshold quantities”—the amount of a given chemical that will trigger a potential DHS security review—in a final security rule.

The preliminary chemicals of interest list affected hospitals because several of the substances on the list would have required DHS review if they were on hospital grounds in any quantity. The final list, however, increases threshold amounts.

The chart below covers a short list of chemicals many hospitals have on hand. It reflects threshold quantity changes between the proposed list from April 2007 versus the final rule released on November 20, 2007.

<table>
<thead>
<tr>
<th>Chemical of interest</th>
<th>Proposed threshold quantity</th>
<th>Final threshold quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetone</td>
<td>2,000 lb</td>
<td>Removed from list</td>
</tr>
<tr>
<td>Anhydrous ammonia</td>
<td>7,500 lb</td>
<td>10,000 lb</td>
</tr>
<tr>
<td>Ammonia (20% or greater concentration)</td>
<td>15,000 lb</td>
<td>20,000 lb</td>
</tr>
<tr>
<td>Carbon monoxide</td>
<td>Any amount</td>
<td>Removed from list</td>
</tr>
<tr>
<td>Chlorine</td>
<td>1,875 lb</td>
<td>2,500 lb</td>
</tr>
<tr>
<td>Chlorine dioxide</td>
<td>2,000 lb</td>
<td>1,000 lb</td>
</tr>
<tr>
<td>Ethylene oxide</td>
<td>Any amount</td>
<td>10,000 lb</td>
</tr>
<tr>
<td>Nitric oxide</td>
<td>Any amount</td>
<td>10,000 lb</td>
</tr>
<tr>
<td>Propane</td>
<td>7,500 lb</td>
<td>60,000 lb</td>
</tr>
<tr>
<td>Urea</td>
<td>2,000 lb</td>
<td>Removed from list</td>
</tr>
</tbody>
</table>

Source: DHS.

Life safety chapter field review open until January 22

There still may be time to comment on a field review of The Joint Commission’s (formerly JCAHO) proposed life safety standards. The final version of the standards will take effect in January 2009. The field review will close January 22, 2008. To read the full proposal, go to www.jointcommission.org/Standards/FieldReviews.

The life safety chapter will extract EC.5.20, which mandates compliance with the Life Safety Code® (LSC), and more clearly delineate associated requirements. The proposal includes the following new standards for hospitals:

- **LS.2.35**—The hospital provides and maintains its fire extinguishing systems
- **LS.2.40**—The hospital provides and maintains its special fire protection features (i.e., requirements for windowless and high-rise buildings)
- **LS.2.50**—The hospital provides and maintains its building services
- **LS.2.70**—The hospital provides and maintains operating features

There are also similar requirements for ambulatory healthcare facilities that hospitals may own.

Currently, EC.5.20—one of the top-cited standards during surveys—has four EPs for hospitals. The field review shows about 100 EPs.

The Joint Commission indicates that there is a new process under development to ensure that scoring for all of these new EPs will not result in a sudden spike in bad accreditation decisions at hospitals.
**OSHA’s top violations in hospitals**

**Hazcom citations inch up, bloodborne remains at the top**

In new data OSHA released on its Web site covering federal hospital inspections from October 2006 to September 2007, a few points changed from the previous year:

- Formaldehyde citations (1910.1048) increased sharply, moving into the number two cited standard overall—although this statistic may be an aberration, OSHA says.
- Hazard communication citations (1910.1200) increased slightly, as did wiring methods and components (1910.305).
- Confined spaces citations (1910.146) dropped from the third-most cited standard down to a tie for 10th.

Not surprisingly, hospitals once again received citations for bloodborne pathogens (1910.1030) more than any other OSHA violation, which has been a pattern for many years. (For a look at the top 10 violated standards, see the chart on p. 5.)

Total federal OSHA fines in hospitals for the year was $140,220. The average fine per citation was $410, down from past years (see Figure 1 below).

Overall, the agency saw a slight decrease in hospital inspections from the last reporting period—from 79 visits down to 75. The drop in inspections happened for several reasons, primarily because the agency received fewer employee complaints to investigate, says Dionne Williams, senior industrial hygienist at OSHA.

**Watch your ORs for needlesticks**

OSHA inspectors find bloodborne pathogen exposures highest in surgical suites and ORs despite industrywide efforts to get the message out about safety needles and similar devices, Williams says. Although many areas in hospitals are reducing sharps injuries, needlestick numbers remain stagnant in ORs. The lack of safety devices is the biggest cause of bloodborne pathogen exposures.

“A lot of facilities are using safety devices, but we still get certain segments where problems aren’t necessarily going away,” such as ORs, Williams says.

On the surface, violations in the formaldehyde standard took a noticeable uptick, but because the 20 citations came from only five inspections, it’s likely that a few sites had problems with multiple aspects of the standard, Williams says.

“It’s not necessarily that there’s something huge going on with formaldehyde,” Williams says of the past year’s jump. “It’s just that we probably ended up in a few places where there were some serious concerns.”

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**Figure 1**

Average federal OSHA fines per citation, 2001–2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Fine (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$527</td>
</tr>
<tr>
<td>2002</td>
<td>$553</td>
</tr>
<tr>
<td>2003</td>
<td>$734</td>
</tr>
<tr>
<td>2004</td>
<td>$516</td>
</tr>
<tr>
<td>2005</td>
<td>$618</td>
</tr>
<tr>
<td>2006</td>
<td>$734**</td>
</tr>
<tr>
<td>2007</td>
<td>$410</td>
</tr>
</tbody>
</table>

**This figure is skewed by a $112,500 citation at one hospital.**

Source: OSHA.
## Top OSHA citations in medical and surgical hospitals

Violations in the bloodborne pathogens standard top the list of citations by OSHA in general medical and surgical hospitals. The statistics do not cover psychiatric and specialty hospitals (e.g., children’s or cancer hospitals). This information covers hospitals only under federal OSHA requirements, not state OSHA plans, so the chart represents data from 25 states.

OSHA issued the following citations from October 2006 through September 2007.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Number of citations/inspections</th>
<th>Penalties*</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 1910.1030 (bloodborne pathogens)</td>
<td>85/31</td>
<td>$51,468</td>
<td>Controlling exposure to blood or other potentially infectious materials</td>
</tr>
<tr>
<td>2. 1910.1048 (formaldehyde)</td>
<td>20/5</td>
<td>$17,730</td>
<td>Controlling exposure to formaldehyde gas, its solutions, and materials that release formaldehyde</td>
</tr>
<tr>
<td>3. 1910.1200 (hazard communication)</td>
<td>20/13</td>
<td>$700</td>
<td>Reporting risks of chemicals to employers and employees (including labeling and training)</td>
</tr>
<tr>
<td>4. 1910.305 (wiring methods and components)</td>
<td>17/12</td>
<td>$5,438</td>
<td>Protecting workers from hazards from electrical cords and cables</td>
</tr>
<tr>
<td>5. (tie) 1910.147 (lockout/tagout)</td>
<td>15/10</td>
<td>$6,350</td>
<td>Avoiding exposure to hazardous energy (e.g., electricity, steam, or chemicals)</td>
</tr>
<tr>
<td>5. (tie) 1910.303 (electrical systems design)</td>
<td>15/10</td>
<td>$6,336</td>
<td>Protecting workers from electrical equipment hazards</td>
</tr>
<tr>
<td>7. 1910.132 (personal protective equipment)</td>
<td>13/11</td>
<td>$4,313</td>
<td>Choosing and using appropriate personal protective equipment</td>
</tr>
<tr>
<td>8. 1910.23 (guarding floor and wall openings)</td>
<td>11/8</td>
<td>$1,681</td>
<td>Protecting workers from falling into or through holes in floors and walls</td>
</tr>
<tr>
<td>9. 1910.37 (maintenance of exit routes)</td>
<td>10/8</td>
<td>$2,275</td>
<td>Protecting and maintaining exit routes</td>
</tr>
<tr>
<td>10. (tie) 1910.146 (confined spaces)</td>
<td>9/5</td>
<td>$3,288</td>
<td>Protecting employees entering confined spaces (i.e., areas having limited entrances and exits)</td>
</tr>
<tr>
<td>10. (tie) 1910.134 (respiratory protection)</td>
<td>9/4</td>
<td>0</td>
<td>Protecting employees from insufficient oxygen environments, harmful airborne substances, and diseases</td>
</tr>
</tbody>
</table>

* The penalties column reflects any settlement actions that took place after OSHA issued a citation.

The last period ranked was October 2005 through September 2006.

Source: OSHA.
**Joint Commission compliance**

Sharpen your emergency response plans with these tips

Still crossing those Ts to comply with the new 2008 emergency management standards? Then check out these tips to better prepare your hospital for a Joint Commission (formerly JCAHO) survey.

The suggestions come from Kevin Kiely, CHSP, CPSO, HEM, senior healthcare compliance advisor at Triumvirate Environmental, a chemical and hazardous waste firm in Somerville, MA. Kiely spoke during a Triumvirate roundtable in New Haven, CT, on November 29, 2007.

> **Replace “JCAHO” with “Joint Commission” in policies and documents.** By now the presence of the term “JCAHO” in policies signals to surveyors that you probably haven’t recently updated your documents. This could invite deeper scrutiny of your EC efforts.

> **Beef up evacuation plans by reaching out to the community.** The new emergency management standards put an emphasis on community outreach, and surveyors are going to examine how you interact with local agencies.

> **Don’t count on 911 to respond.** Assume in your planning that local responders will be busy when you call during a regional emergency. Some hospitals still have “call 911” as the first step in their disaster plan, which might lead to a citation, Kiely says.

During a disaster, community responders probably won’t be able to respond right away, and possibly not at all.

> **Get memorandums of understanding in writing.** As part of your community outreach, get down on paper or in electronic files the agreements you make with other sites. Some hospitals just write baseline assumptions into their emergency evacuation plans, such as “evacuate patients to a school around the block,” when in fact the Red Cross already has a memorandum of understanding with the school to act as a shelter, Kiely says.

> **Examine school facilities.** Before committing to using a school for an alternate care site, conduct a risk assessment to see what potential problems might lurk, Kiely says. For example, if you plan to relocate adult patients to an elementary school, does the school have enough adult-sized toilets? Document your findings.

> **Test your plan by treating construction as a “little disaster.”** Need to move some patients because of a construction project? That’s a “planned disaster” that you can use to drill policies and procedures, Kiely says. During such a drill, you’ll learn about shortcomings in your communications and patient tracking system, each an aspect that the 2008 standards note.

> **Remove EC standard numbers from policies.** This step won’t make your facility more compliant with Joint Commission standards, but it will save a lot of work with the coming 2009 renumbering and get you better focused on your emergency management plan instead of numbers.

> **Look to the fire department and military for examples.** You don’t have to create anew when it comes to disaster response, Kiely says. As part of your Joint Commission-mandated community outreach, talk to local fire departments and military posts about their best practices and how they quickly mobilize their personnel for a response.

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**All hail safety . . .**

Togas are optional when Caesars Palace in Las Vegas hosts the Second Annual Hospital Safety Symposium on May 8–9.

For the full agenda, go to [www.greeley.com/seminars](http://www.greeley.com/seminars).

Save $100 with early-bird registration by March 6. Plan to be part of this exciting event.
Some hospitals may need to amend their nuclear licenses

*Nuclear Regulatory Commission expands definition of byproduct material*

An expanded definition by the Nuclear Regulatory Commission (NRC) may change licensing arrangements for hospitals in some states.

The definition further outlines “radioactive byproduct material,” but the revisions won’t substantially change how a hospital conducts its nuclear medicine program, says Duane White, a health physicist at the NRC.

“The day-to-day operation is going to stay the same,” White says.

Seek out your radiation safety officer

Under NRC regulations, healthcare facilities need licenses to use certain radioactive substances, called byproduct material, for medical therapy or diagnosis. Hospitals must meet a variety of requirements to be licensed, including designation of a radiation safety officer.

Hospitals may need to amend their NRC licenses to include the material covered under the expanded definition. Safety committee members should double-check that their facility’s radiation safety officer, nuclear pharmacists, and nuclear physicians are aware of the changes.

The changes may require action from licensees in the 16 so-called nonagreement states, says David McIntyre, a spokesperson for the NRC (see the list of states on p. 8).

There are 34 agreement states in the country, which regulate byproduct material under agreements with the NRC. The NRC regulates this material in nonagreement states.

Note the following changes

The expanded definition of byproduct material now includes any:

- Discrete source of radium-226 that is produced for commercial, medical, or research activity. Radium-226 is an abundant form of radium, which is a radioactive element generally used in industrial products.

- Radioactive material produced by a particle accelerator for medical treatment, and the energy beams from some accelerators also have medical uses. Hospitals use both applications.

- Some hospitals operate accelerators that produce positron emission tomography radionuclides, which fall under the new definition, White says.

The NRC will not regulate the incidental radioactive material produced by accelerators (e.g., linear accelerators) that facilities operate to produce particle beams only and not radioactive material.

Determine your license’s status

Agreement states already recognize the new definition of byproduct material, so the NRC’s amendments simply become part of the agreements with these states, McIntyre says.

For nonagreement states, the new rules have more implications due to possible license amendments, White says. Material produced by accelerators fell to state oversight rather than the NRC as was previously the case.

The revisions won’t substantially change how a hospital conducts its nuclear medicine program.

> continued on p. 8
Have you signed up for ’Safety Talk’?

If you’re already a member of our “Safety Talk” online discussion forum, then you probably read an interesting string in December about who conducts tuberculosis respirator fit-testing in hospitals.

If you aren’t a part of “Safety Talk,” you’re missing out on a free subscriber benefit and a great forum to give your opinions, share experiences, and network with fellow facility directors and safety officers across the country.

Other topics recently discussed among members include the following:

➤ Strategies for enforcing tobacco-free zones on hospital property
➤ How and where to discard radiology aprons
➤ Time frames for computers on wheels to remain in corridors

Signing up for “Safety Talk” is easy. Just send an e-mail to owner-safety_talk@hcpro.com and include in the message that you want to participate in “Safety Talk”—it’s important to mention the chat group by name.

If you have any trouble signing up, contact Senior Managing Editor Scott Wallask at swallask@hcpro.com for help.

New rule affects certain states

Licensees in the following nonagreement states and other areas may need to amend their licenses to reflect the Nuclear Regulatory Commission’s (NRC) expanded definition of byproduct material:

➤ Alaska
➤ Connecticut
➤ Delaware
➤ Hawaii
➤ Idaho
➤ Indian tribes
➤ Indiana
➤ Michigan
➤ Missouri
➤ Montana
➤ New Jersey
➤ Pennsylvania
➤ Puerto Rico
➤ South Dakota
➤ Vermont
➤ Virginia
➤ Washington, DC
➤ West Virginia
➤ Wyoming

Source: NRC.
Second Annual Hospital Safety Symposium preview

Tune up—and trim down—your ILSMs with phasing

Interim life safety measures (ILSM) fall under standard EC.5.50.

The rationale statement for the standard indicates that hospitals should use ILSMs to compensate for deficiencies that:

➤ Occur during renovation or construction activities
➤ Staff can’t immediately correct

The Joint Commission (formerly JCAHO) has made this standard a compliance hot spot, says Steven MacArthur, safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

MacArthur will be a featured presenter at HCPro’s Second Annual Hospital Safety Symposium in Las Vegas on May 8–9 (go to www.greeley.com/seminars for more details).

View ILSMs as extensions of protection

Surveyors, including life safety specialists, will examine ILSM policies and note how well hospitals stick to them. Life Safety Code® (LSC) compliance is a big factor in these reviews.

“Any time the life safety features or equipment of a building or organization are compromised, there is a greater risk of catastrophe relative to fire,” MacArthur says. “The hospital environment, based on the LSC, is designed and constructed with certain features—smoke- and fire-resistant construction, fire detection, automatic sprinkler systems, etc.—to provide . . . the utmost protection from a fire.”

Adjust ILSMs to the situation

Building flexibility into ILSM compliance policies allows you to make midcourse corrections when project conditions indicate the need, MacArthur says. Consider the following scenarios:

➤ Different periods of construction (i.e., planning, mobilizing, demolition, construction, and finishing), during which exit routes might be blocked or debris could increase
➤ A painting project in a wing, during which contractors might cover up smoke alarms

In both scenarios, ILSM use might ebb and flow depending on the nature of the deficiencies. “As conditions change, risk increases or decreases,” MacArthur says. “The appropriate way to deal with those changes in risk would be to reevaluate and respond accordingly.”

During periods of greater risk, hospitals might institute extra fire drills, added surveillance rounds, and other ILSMs your policy dictates. When there is less risk, your ILSM approach might be less aggressive.

“You don’t want to lock yourself into something that is not necessary or appropriate for the entire duration,” MacArthur says.

As always, document your efforts

Sharpening your ILSM process is one thing; demonstrating it to surveyors is another. Stay on top of record-keeping for the following:

➤ The assessment process, including the rationale behind what ILSMs you use
➤ All ILSMs undertaken
➤ Interaction and education of staff members and contractors about ILSMs

Education levels can vary. “A lot of times, the amount of education is going to be driven by the scope and duration of the project,” MacArthur says.

Platinum subscribers to the Hospital Safety Center have an interim life safety measures assessment tool at their fingertips. Log on to www.hospitalsafetycenter.com and go to Risk Assessment Workstations in the left column.
Bits & briefs

NIOSH reviews kitchen noise at Veterans Affairs hospital

In response to a management request at a hospital concerning noise exposures, the National Institute for Occupational Safety and Health (NIOSH) issued a report that other facilities can review in regard to their own cooking areas.

Officials update face-fitting respirator guidance

NIOSH has also updated its guidance for filtering facepiece respirators. The guidance includes the following:

- More respirator choices
- New manufacturer guidelines for donning each particular type
- NIOSH approval status of respirators

Read the full guidance online at http://tinyurl.com/2maqlfn.

Leaked report details patient deaths after Katrina

The threatened legal proceedings against three clinicians accused of mercy killings after Hurricane Katrina may be over now.

On December 5, 2007, CNN published a story revealing alleged details that investigators from the Louisiana attorney general’s office found during a probe of patient deaths at Memorial Medical Center in New Orleans following Katrina.

In the report, forensic pathologists determined of the 45 patient deaths at the hospital in the aftermath of the storm, eight patients—and a possible ninth—allegedly died of homicide.

The state attorney general’s office later arrested a doctor and two nurses and charged them with second-degree murder. However, a grand jury was not convinced by the evidence in the report, and district attorneys were unable to secure any indictments in the case.

Someone leaked the report to CNN, which caused a political windstorm in New Orleans. Critics claimed the leak was retribution for the lack of indictments and damaged reputations in the attorney general’s office.

Power outage forces three facilities to run on generators

On December 10, 2007, a blackout caused three hospitals in Tulsa, OK—St. John Medical Center, Hillcrest Medical Center, and St. Francis Hospital South—to run all day on emergency generator power, according to a story in the Tulsa World.

A nursing home in nearby Collinsville, OK, evacuated 90 residents via ambulance, van, and family members’ vehicles.

St. John stopped accepting new patients and closed two satellite urgent care facilities, but was able to maintain care for patients who had been previously admitted.

Hillcrest and St. Francis continued to accept patients, but canceled all elective surgeries while under generator power, the World reported.

An explosion at a utility substation caused the blackout and may have been tied to an ice storm.

This type of power outage scenario may be a good one to evaluate during a disaster drill.
OSHA issues final rule on employer-paid PPE

OSHA has made it explicit that employers generally must pay for personal protective equipment (PPE) needed to safeguard workers. The agency published a final rule on employer-paid PPE, which appeared in the November 15, 2007, Federal Register.

“Under the rule, all PPE, with a few exceptions, will be provided at no cost to the employee,” OSHA said.

Many OSHA standards that hospitals deal with already mandate that employers pay for PPE (e.g., the bloodborne pathogens and formaldehyde standards). To read more about this final rule, go to www.osha.gov and search for the term “PPE paid.”

Hospital evacuates 200 staff members after coolant leak

A coolant leak in a mechanical room at Children’s Hospital in Denver caused a 45-minute evacuation of the lower floor, according to Fox 31 television news. About 25 local fire department responders cleaned up the spill on November 17, 2007, and vented the smoke as staff members waited outside.

Although no patients were evacuated, 200 employees left the building as coolant spilled onto hot machinery and created smoke and fumes, but no fire. Glycol coolant solution created the smoke, responders told Fox 31.

Journal: Emergency prep is tough with nursing shortage

If your hospital has a hard time developing patient surge plans, then you’re not alone.

Medical centers have found it tough to increase surge capacity and adequately prepare for disasters, according to an editorial published in the November 14, 2007, Journal of the American Medical Association.

Meanwhile, an article in the Journal indicates that the national nursing shortage is a barrier to disaster preparedness. Other hurdles include closure of hospitals and EDs and the lack of access to both primary and specialty care. Combined, these problems run counter to surge capacity planning, according to the article.

Patient escapes restraints and allegedly attacks workers

An attack at a hospital saw the assailant allegedly whip workers in the back of their heads with an electrical cable from a piece of medical equipment.

The suspect, who had been restrained because he was intoxicated, allegedly broke free and started punching and kicking ER employees at Sound Shore Medical Center in New Rochelle, NY, according to the Associated Press. Six people suffered minor injuries in the attack, which occurred on November 26, 2007.

The suspect also allegedly threw a heart monitor at a nursing station.

Hospitals may not have practical staffing plans for alternate sites

In a weird dichotomy, poll results indicate that 76% of hospitals have developed plans for alternate care sites during an emergency, but only 20% of those facilities have realistic staffing plans for those alternate sites.

Trust for America’s Health reported these results, which the Association for Professionals in Infection Control and Epidemiology collected from 630 of its members.

The statistics are part of a larger Trust for America’s Health report titled, “Ready or Not? Protecting the Public’s Health from Diseases, Disasters, and Bioterrorism 2007.”

The full report, which digs into many other topics, is available at http://healthyamericans.org/reports/bioterror07/.

Check out your free special report

Enclosed with your issue is a free eight-page special report about Joint Commission compliance.

“The EC standards in 2008: Emergency management changes and more” reviews the new EC.4.11 through EC.4.18, and also offers advice about life safety surveys.

Additionally, the special report details the top-cited EC standards in 2007, as named by respondents to an online poll HCPro, Inc., conducted.

We hope you enjoy this subscriber benefit, and please let us know what you think of the report.
Tip of the month
Review Y2K plans for ideas about EC.4.12

Are you the keeper of ancient history at your healthcare facility? One hospital consultant thinks that distinction might come in handy to figure out compliance strategies for Joint Commission (formerly JCAHO) emergency management changes in 2008.

Zach Goldfarb, EMT-P, CHSP, CEM, president of Incident Management Solutions, Inc., in East Meadow, NY, has a theory: Some of the legwork in getting your hospital into compliance with the new EC.4.12, EP 6, might possibly have been done eight years ago.

EP 6 requires emergency planners to gauge a hospital’s ability to survive on its own without community support for up to 96 hours. Evacuating the building is an option should the 96-hour threshold be too difficult to attain.

No community support? Think 1999

Those of you who were around hospitals in 1999 can remember the Y2K preparations. Before the dawn of the 21st century, many folks worried that computers would crash on January 1, 2000, because old programs would think the date was instead January 1, 1900.

Many industries spent months, if not years, preparing for the millennium turnover, hoping to avert failures in power, water, and sewer systems. Thankfully, almost nothing happened on January 1, 2000, but work leading up to that date gave rise to extensive disaster planning, including at hospitals.

Revisit old planning efforts

Now, back to 2008. If you can lay hands on your hospital’s Y2K plans, they might offer a path—or at least inspiration—to help come into compliance with the 96-hour stand-alone piece of the 2008 emergency management standards, Goldfarb says. Some areas that you’re planning for now are similar to past situations, he adds.

“Go back to 1999 when you developed your Y2K planning, and if you weren’t there, talk to someone who has the institutional memory,” Goldfarb says. People worried that hospitals and community services would shut down on January 1—a scenario that could fit into EC.4.12’s provisions.

“In the days leading up to [year 2000], you typically did a comprehensive set of plans that—in many hospitals—went unit by unit,” Goldfarb says.

If you choose to review your Y2K plans, make sure to document any items that you find useful. Not only will this help your hospital’s emergency planning efforts, but it will be a nice side note to show Joint Commission surveyors when they arrive at your hospital.
Survey says: Some hospitals lag behind on workplace violence prevention

Preventing workplace violence is one of the hottest issues facing hospital security directors.

A fall 2007 HCPro survey about the topic revealed that although a majority of hospitals have taken steps to address workplace violence, others still have work to do to make their facilities and staff members safer.

According to the survey, 68% of respondents say their hospital has a written policy or program for workplace violence prevention. However, 9% answered no to the question, and 22% said they were unsure whether their facility has a policy or program to help prevent violence. One percent did not respond to the question.

“It is a significant issue for hospitals,” says Fredrick G. Roll, CHPA-F, CPP, president of Healthcare Security Consultants, Inc., in Frederick, CO. “That [yes answer] should be 100%.” The fact that 22% of respondents were unsure about their hospital’s policy means those facilities aren’t promoting their policy or program if they have one, Roll says. And what good is a policy if no one knows what it says?

Hospitals need to address workplace violence prevention to satisfy OSHA guidelines and Joint Commission (formerly JCAHO) surveyors, Roll says. “[The] Joint Commission is very much looking at workplace violence.”

“It’s one of the major issues in healthcare today,” agrees Russ Colling, CHPA, CPP, security consultant with Colling and Kramer in Salida, CO. Increased violence in society, drug and alcohol abuse, and patients with mental health problems are some of the factors that have caused the issue to become a greater concern for hospitals, he says.

Violence on the increase?

Most hospitals have no mandatory crime reporting requirements, with the exception of medical facilities that are on a campus or part of a university, Roll says. Until hospitals outside that sphere have to report statistics, “we will never have a sound handle on what is happening,” he adds. “But we can say that crime happens in hospitals.”

Survey says . . .

<table>
<thead>
<tr>
<th>Does your hospital have a written policy or program for workplace violence prevention?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes—68%</td>
</tr>
<tr>
<td>No—9%</td>
</tr>
<tr>
<td>Unsure—22%</td>
</tr>
</tbody>
</table>

Source: HCPro, Inc., survey on workplace violence.

Based on news reports, hospital crime appears to be a growing problem, leading Colling to conclude that “we have increased violence in healthcare.” But Colling says he wasn’t surprised that almost one-third of survey respondents say their hospital either doesn’t have a violence prevention program or they’re not sure whether it does. Attention to the issue likely varies with the size and location of the hospital, he says. For example, a small rural hospital won’t have the same problems as a large inner-city hospital.

A look at the respondents

A total of 172 people responded to the survey conducted by HCPro, Inc., publisher of Healthcare Security.
Workplace violence

Alert. Keep in mind that is a small sampling, as there are thousands of hospitals nationwide. The majority of respondents (87%) work in general medical/surgical hospitals, 7% in psychiatric/behavioral health facilities, and 7% in specialty hospitals, such as those for children or cancer treatment.

Respondents work in hospitals of all sizes, ranging from small hospitals that have 50 or fewer beds or employ fewer than 100 employees to hospitals that have more than 1,000 beds or employ more than 10,000 personnel.

Programs vary from place to place

The programs hospitals have in place to prevent workplace violence vary significantly.

Some respondents’ facilities have a zero-tolerance policy for violent behavior but little in the way of actual prevention. Others have well-developed prevention programs.

“[We have a] very weak policy,” says one respondent. Another says his hospital provides one page of general information about the topic, which the respondent admits is “not very useful.”

Contrast that with other hospitals. “We have an excellent program,” says one respondent whose hospital has a zero-tolerance policy that is supported by its HR department. The facility provides education to teach staff members to recognize a patient whose behavior may escalate into violence, training on violence interventions, reporting systems for incidents, creation of a threat assessment team to review incidents, employee assistance programs for victims, domestic violence support for staff, and support for staff when criminal prosecution is warranted.

“Our security policy covers a broad spectrum of preventive actions and protective reactions,” says another respondent. The facility uses technology such as panic alarms and closed-circuit television coverage and offers training in how to handle disruptive patients.

Hospitals are a magnet for workplace violence, says Roll. Emergency departments (ED) are a particularly
volatile environment and are the place where many hospitals focus violence prevention efforts, say Roll and Colling. “We have no idea who is coming through the door,” says Roll about the potential for ED violence.

**Other survey results**

Most respondents say their hospital’s safety officer (28%), security director (25%), or HR director (17%) are responsible for overseeing workplace violence prevention.

Hospitals typically rely on traditional security features such as surveillance cameras and unarmed security officers to keep people safe (see the chart on p. 2). Only 12% of respondents say their hospital arms its security officers, 8% use metal detectors or inspect visitors’ bags as they enter the facility, and 1% use security dogs.

According to the survey, the most common step that staff members, including security officers, take to help prevent workplace violence is to verify that employees are wearing ID badges (94%). Hospitals should ensure the identification of all staff members, says Roll, as that is an expectation of The Joint Commission.

More sophisticated technology, such as using photos to screen visitors, is rarer (28%). Few hospitals (12%) allow staff members to use weapons to subdue disruptive people. (See the chart above for more steps staff members can take to prevent workplace violence.)

Only 44% of respondents say their hospital checks visitors before they enter the facility, a number Roll says he would like to see higher.

Hospitals continue to struggle to provide more security and to keep their facilities patient-friendly. “We’re buttoning down hospitals slowly,” says Colling, with tighter security happening most often during nighttime hours, when more facilities are limiting access.

When it comes to training workers in workplace violence prevention, hospitals again run the gamut.

In survey comments, some respondents say their facility provides little or nothing in the way of training. Other respondents describe mandatory and extensive training.

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**What steps can staff members, including security officers, take?**

<table>
<thead>
<tr>
<th>Step</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify that employees are wearing ID badges</td>
<td>94%</td>
</tr>
<tr>
<td>Stop someone’s entry due to a restraining order</td>
<td>56%</td>
</tr>
<tr>
<td>Use physical force to subdue disruptive people</td>
<td>49%</td>
</tr>
<tr>
<td>Check visitors before they enter the hospital</td>
<td>44%</td>
</tr>
<tr>
<td>Detain people for police</td>
<td>40%</td>
</tr>
<tr>
<td>Seize weapons from a person</td>
<td>36%</td>
</tr>
<tr>
<td>Seize illegal drugs from a person</td>
<td>31%</td>
</tr>
<tr>
<td>Use photos to screen visitors</td>
<td>28%</td>
</tr>
<tr>
<td>Use weapons to subdue disruptive people</td>
<td>12%</td>
</tr>
</tbody>
</table>

**Source:** HCPro, Inc., survey on workplace violence.

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**Violence touches close to home**

Thirty-five percent of respondents say they have been the victim of workplace violence. Several respondents say they have been hit or verbally abused. One respondent says he terminated an employee who had an explosive temper. When he went to his car that evening, he found all four tires slashed. Another employee in the department, who had been the most recent recipient of verbal abuse from the fired employee, also had his tires slashed.

One respondent paints a picture of staff-to-staff abuse. The respondent describes a doctor who, while working in the OR, verbally abused staff members and threw items when things did not go right on a case.

In 67% of hospitals, employees work alone, potentially putting them at higher risk to become a victim of violence.

Fifty-five percent of respondents say their hospital does not have a process to identify visitors and patients with a history of violence. Forty-four percent of hospitals have a process to identify employees with a history of violence.
Editor’s note: Each issue of Healthcare Security Alert features an expert’s answers to your security questions. Steven MacArthur, safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, answers this month’s questions. If you have a security question for one of our experts, e-mail Senior Managing Editor Joanne Finnegan at jfinnegan@hcpro.com.

We have a code team that responds to patients who are out of control. Some of these patients are violent and spit, kick, scratch, or bite. Should we require responders to wear personal protective equipment (PPE), such as gloves, gowns, or masks, when responding to these calls? If so, what type? We are also concerned about Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and what we can tell the responders about a patient’s medical condition, such as whether a person is HIV-positive or has hepatitis.

I think the best way to manage this is to adopt the same philosophy or strategy as with any other patient management activity: universal precautions. [Universal precautions are the basic precautions that healthcare workers should use at all times to prevent the transmission of diseases and include proper hand hygiene, use of PPE, and proper disposal of sharp items such as needles.] If you treat everyone equally, then you don’t have to get into questions about protected health information under HIPAA.

If you are not including consideration of PPE in your response plan, you’ve got a bigger risk of violating OSHA’s bloodborne pathogens standard. You have what would be characterized as a pretty clear exposure risk. If you are not ensuring appropriate protection for your responding staff members, then you could be considered in violation of the bloodborne pathogens standard.

That said, it’s really about doing the right thing. Preparing your response team for any potential risk is definitely the way to go.

My hospital is planning to purchase a new infant protection system for our maternity unit. Do you have any advice about what to look for in a new system?

That’s not an easy topic to cover in a short space. However, you want a system that is:

- Proven to be reliable; check client references
- Difficult to defeat; for example, sensor bands that signal an alarm if they are cut or removed without authorization
- Easily integrated with your other systems; consider elevator lockdown, fire alarm systems, security cameras, etc.

Try to ascertain whether the system is flexible enough to expand into other hospital departments if you have an overflow of patients. You also want the system to be easy for staff to use. If a system is too complicated, it can lead to failure when staff members figure out ways to short-circuit the process.

Look carefully at the physical space you are trying to secure. Ask whether there are any unique building features, such as linen or trash chutes, access panels into mechanical spaces, etc.

It is certainly appropriate to ask the sales representative for a system you are considering to demonstrate why the system is the right fit for your organization. Purchasing the right system is all about due diligence.
# The EC standards in 2008:

Emergency management changes and more

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**A supplement to Briefings on Hospital Safety**

*Visit the Hospital Safety Center at www.hospitalsafetycenter.com.*
New emergency plan standards pivot on six key points

By sheer numbers, The Joint Commission’s (formerly JCAHO) 2008 revisions to its emergency management standards are impressive. What was once 37 scored EPs has more than doubled to 85 EPs.

EC.4.10, which for years has been home to most of the emergency management mandates, has splintered into EC.4.11 through EC.4.18 as of January 1, 2008. EC.4.20 remains as the emergency drill standard.

The Joint Commission reshaped many of the new emergency management standards from prior emergency management provisions in EC.4.10. However, there are some notable additions, and those “are going to require some level of . . . effort on everyone’s part,” says William Smith, senior director of emergency preparedness at the University of Pittsburgh Medical Center.

Surveyors ready to roll them out

Expect an increased focus from surveyors regarding the new emergency management standards, says Joseph Cappiello, former vice president of accreditation field operations at The Joint Commission, who left the accreditor in November 2007.

Cappiello, who is now president of Simulation Education Services in Oakbrook Terrace, IL, was one of The Joint Commission’s experts in emergency management. He predicts the attention that the new emergency management standards will receive will be similar to the interest that Life Safety Code® (LSC) issues garnered from life safety specialists over the past two years, he says.

The 2008 standards revolve around six critical areas that The Joint Commission now emphasizes, Smith says. Those critical areas include the following:

1. Communication
2. Resources and assets
3. Safety and security
4. Staff member responsibilities
5. Utilities management
6. Clinical and support activities

In its preamble to EC.4.12, The Joint Commission indicates that regardless of a particular hospital’s nuances, all emergency operations plans “must address these six critical areas” as a blueprint for handling emergencies.

These six critical areas also figure into emergency exercises under EC.4.20, which has been revised to specifically mention the six points. Another new requirement under EC.4.20 requires hospitals to conduct at least one annual test that escalates to a point at which community resources can’t help the hospital. The Joint Commission

Illustration by David Harbaugh

It all starts with EC.4.11

New standard EC.4.11 requires hospitals to plan for managing the consequences of emergencies.

Provisions for the hazard vulnerability analysis are now part of EC.4.11, and the standard also makes specific mention of hospital leaders being involved in emergency planning.

New requirements include communicating needs and vulnerabilities to outside agencies and monitoring emergency resources and assets.
Commission permits tabletop exercises in meeting the community portion of the drill.

Let’s take a brief look at each of these six areas.

✔ **Communication**

EC.4.13 calls for hospitals to develop emergency communication strategies. “It’s more than technological capabilities,” Smith says. New provisions include plans for communicating to staff members, external authorities, patients and their families, and vendors.

Pay special attention to how your hospital “talks to” the surrounding community about its status during an emergency, Smith says. “There’s quite an emphasis on community involvement” throughout the 2008 emergency management standards, he adds.

✔ **Resources and assets**

EC.4.14 sets requirements for handling resources, pharmaceuticals, and medical supplies during disasters. A new provision asks about sharing resources with healthcare facilities beyond the area of a regional disaster.

Memorandums of understanding between hospitals and vendors are an important aspect of EC.4.14, but additionally, watch for vendors who may overextend themselves to several hospitals. In May 2007, the state of Pennsylvania conducted a regional tabletop drill for pandemic flu, and organizers found multiple medical centers relying on the same vendors, Smith says.

In-house supplies can be tricky to track, he adds. For example, do you know how many doses of Cipro are on hand in your building should an anthrax scare occur?

Check out stockpile expiration dates, too, says Steven MacArthur, safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Rolling stock, in which staff members or vendors regularly switch out expired drugs, is an important consideration, he adds.

(For a sample critique of emergency resources and assets, see the checklist on p. 5.)

✔ **Safety and security**

Under EC.4.15, hospitals must prepare for safety and security actions during emergencies. Although many of

> continued on p. 4

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‘**Know what the breaking point is** for the new 96-hour assessment’

Perhaps no aspect of The Joint Commission’s (formerly JCAHO) new emergency management standards has generated more initial buzz than a provision of EC.4.12. EP 6 of that standard states the following:

The emergency operation plan identifies the organization’s capabilities and establishes response efforts when the organization cannot be supported by the local community for at least 96 hours in six critical areas.

The EP reflects the dire circumstances that New Orleans hospitals faced in the aftermath of Hurricane Katrina in 2005.

The standard doesn’t require hospitals to stand on their own for 96 hours. Rather, it expects facilities to determine whether they can survive for that period, and if they can’t, what steps they’ll take in a catastrophe, says Steven MacArthur, safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Emergency planning organizers must ask themselves what 96 hours of isolation means in stark terms, he says. “You want to know what the breaking point is for your organization,” MacArthur adds.

A note to EP 6 mentions that evacuations are an acceptable response if the 96-hour threshold is unattainable. So, your hospital could determine that it has the stockpiles and staffing to survive 48 hours without external assistance, but after that point, it will evacuate patients.

Supplies are an important piece of this discussion, as many hospitals use just-in-time inventories.

It may fall to a hospital’s corporate parent, if it has one, to step in should inventories drop during a prolonged, regional disaster.

Whatever your decision, be prepared to defend your thinking to surveyors, MacArthur says.
the requirements under EC.5.15 are new (e.g., managing hazardous materials during disasters and controlling crowd movement within the building), the core of the standard’s provisions stem from other EC standards.

Hospitals must identify the roles that outside authorities, including police, will play during responses. Remember that in some cases, police may not be able to help a facility.

Emergency lockdown policies are another important area to consider particularly if they conflict with LSC egress requirements, Smith says.

✔ **Staff member responsibilities**

EC.4.16 requires hospitals to define employee roles during an emergency response. “This is something we’ve known about for a long time, but it’s under a different wrapper” in the new revisions, Smith says.

Outline staff member responsibilities in your emergency operations plans and verify that workers know how their roles will change during a disaster response, he says.

Training and education are essential aspects of EC.4.16 that the standard specifically now spells out. Licensed independent practitioners fall under these requirements, too.

✔ **Utilities management**

Under EC.4.17, facilities must develop ways to handle utility needs during an emergency. Pay special attention to power, potable water, ventilation, and fuel, which Joint Commission surveyors may focus on, says Smith. A new EP in EC.4.17 discusses fuel required for building operations and essential transport activities. This could include gasoline and diesel for transporting patients. Ultimately, it is up to hospitals to assess their needs for fuel supplies.

✔ **Clinical and support activities**

EC.4.18 requires hospitals to create strategies to oversee clinical and support activities for patient care during a disaster.

New provisions address vulnerable populations (e.g., geriatrics and pediatrics), patients’ hygiene and sanitation needs, patients’ mental health needs, mortuary services, and tracking patients’ information.

The latter consideration is a big issue to grasp in the event of an emergency, particularly when patients relocate to alternative care sites or power losses cripple electronic records systems, Smith says. Both scenarios may be good points to address in emergency drills.

EC.4.18’s wording implies the need to plan for patients showing up at your hospital during a disaster whom you may not necessarily deal with on a regular basis, according to The Joint Commission. For example, a children’s hospital might find itself treating elderly patients.

“It is especially important to identify and triage patients whose clinical needs are outside the usual scope of service of the organization,” according to the rationale statement for EC.4.18.

Surveyors may ask about your familiarity with a Joint Commission (formerly JCAHO) *Sentinel Event Alert* that discusses emergency power failures.

Surveyors will gauge whether facilities managers, and perhaps even hospital leaders, understand the capacity of their generators and how reliable the equipment is.

To read the full Alert, go to www.jointcommission.org/sentinelevents and click the Sentinel Event Alert link under the Resources heading.

Source: William Smith, senior director of emergency preparedness at the University of Pittsburgh Medical Center.
### Anytown Medical Center

**Disaster critique**

<table>
<thead>
<tr>
<th>Resources &amp; assets management:</th>
<th>Score: _____ of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were emergency supplies (including equipment) readily available at onset of emergency?</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Were emergency supplies (including equipment) adequate for the duration of the emergency?</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Were arrangements made to replenish medical supplies and equipment needed for response/recovery from external source(s)?</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Were arrangements made to replenish pharmaceutical supplies needed for response/recovery from external source(s)?</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Were arrangements made to replenish nonmedical supplies (e.g., food, linen, water, fuel) needed for response/recovery from external source(s)?</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Did all emergency systems function correctly?</td>
<td>Yes</td>
</tr>
<tr>
<td>7. Was it necessary to bring in outside vendors/contractors?</td>
<td>Yes</td>
</tr>
<tr>
<td>8. Were staff support activities (e.g., housing, transportation, incident stress debriefing) appropriate and effective?</td>
<td>Yes</td>
</tr>
<tr>
<td>9. Were staff family support activities (e.g., child care, elder care, communication) appropriate and effective?</td>
<td>Yes</td>
</tr>
<tr>
<td>10. Were resource sharing activities with local healthcare entities appropriate and effective?</td>
<td>Yes</td>
</tr>
<tr>
<td>11. Were resource sharing activities with regional healthcare entities appropriate and effective?</td>
<td>Yes</td>
</tr>
<tr>
<td>12. Was evacuation (horizontal or vertical) required?</td>
<td>Yes</td>
</tr>
<tr>
<td>13. Was evacuation appropriate and effective?</td>
<td>Yes</td>
</tr>
<tr>
<td>14. Were alternative care sites, either inside or outside of the hospital, established?</td>
<td>Yes</td>
</tr>
<tr>
<td>15. Was transportation of patients, their medications and equipment, and staff to alternative care sites appropriate and effective?</td>
<td>Yes</td>
</tr>
<tr>
<td>16. Was transportation of pertinent patient information appropriate and effective?</td>
<td>Yes</td>
</tr>
<tr>
<td>17. Was equipment damaged or loaned out during the event appropriately identified and reported?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Comments: ______________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

*Source: Steven MacArthur, safety consultant for The Greeley Company, a division of HCPro, Inc., Marblehead, MA.*
Life safety tours will dissect PFI and ILSM compliance

January 1, 2008, was a turning point for The Joint Commission’s (formerly JCAHO) life safety surveys. As of that date:

➤ All hospitals, regardless of size, will host a life safety specialist for one day
➤ Hospitals with more than 750,000 square feet of healthcare occupancy area will host a life safety specialist for two days

Although it’s reasonable to expect various interpretations of the Life Safety Code® (LSC) on a surveyor-by-surveyor basis, two points will receive near-universal scrutiny: electronic plans for improvement (PFI) and interim life safety measures (ILSM). EC citations are high in these two areas (see “Bulk of 2007 citations came from fire safety problems” on p. 7).

Monitor impending PFI deadlines

Review outstanding PFIs that your facility filed after your last Joint Commission survey and track their status, says Steven MacArthur, a safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. PFIs receive an automatic six-month grace period beyond their stated completion dates, but anything past six months needs an extension request approved by The Joint Commission.

If a PFI passes the six-month grace period without an extension, the deficiency can result in a hospital’s conditional accreditation.

Also, take a common sense approach to your PFI completion dates, because some surveyors are “very fastidious” about realistic project timelines, says William Smith, senior director of emergency preparedness at the University of Pittsburgh Medical Center.

For example, don’t write in a blanket completion date of December 31 for various PFI projects; instead, judge each project on its own merit, Smith says.

Avoid all-or-nothing ILSM policy

Poorly crafted or enforced ILSM policies have also landed hospitals in conditional accreditation status. Remember, you need not institute all 11 ILSMs if there is an LSC deficiency, MacArthur says.

Strive for a policy that requires staff members to assess a deficiency and implement ILSMs as necessary. Don’t word your policy to mandate ILSM use—such wording could attract surveyor attention if you subsequently don’t carry out ILSMs for every deficiency.

Further, if you choose not to use ILSMs for a life safety deficiency, be prepared to defend your rationale and seek approval from administrators and your safety committee, MacArthur says.

Recordkeeping will prove vital for ILSM success. During a survey in 2006, a surveyor asked Smith for ILSM documentation connected to a project that had been completed one year earlier, Smith says.

Finally, if ILSMs relate to repair work or a construction project, halt those activities if staff members or contractors don’t adhere to the assigned ILSMs. “It’s Draconian to the ‘nth degree,’ but we have to protect the safety of our patients,” MacArthur says.

Three life safety tips to note

➤ Be careful about converting space to storage. For example, converting a patient room into a storage closet could trigger hazardous-area rules under the Life Safety Code® (LSC) if the room in question is larger than 50 square feet.
➤ Part 3 of the Statement of Conditions (SOC) is not mandatory. However, despite Part 3 being optional, many surveyors are familiar with the checklist used in this section. If you don’t use Part 3, in order to accurately complete the SOC, you need to perform some sort of LSC compliance assessment of your building.
➤ Ensure that staff members understand corridor storage concerns. Employees must be able to articulate to surveyors how and when to clear corridors if a fire alarm goes off.

Sources: Steven MacArthur, safety consultant for The Greeley Company, a division of HCPro, Inc., Marblehead, MA.
**Poll results of surveyed hospitals**

**Bulk of 2007 citations came from fire safety problems**

When it comes to Joint Commission (formerly JCAHO) surveys, 2007 proved that fire protection deficiencies continue to be a big problem in hospitals. HCPro asked hospitals surveyed in 2007 to respond to an anonymous poll about their EC citations. Among the results are the following:

- 58% of respondents received a citation under EC.5.20, which mandates *Life Safety Code*® (*LSC*) compliance
- 30% received a citation under EC.5.50, which discusses the interim life safety measures (ILSM)
- 25% received a citation under EC.5.40, which sets a variety of inspection, testing, and maintenance requirements for fire protection equipment

All three of the above standards fall under the review of The Joint Commission’s life safety specialists, who will visit all hospitals regardless of size in 2008 and beyond.

Our chart on p. 8 (“Poll: EC standards that received citations during 2007”) outlines how all of the EC standards fared during our respondents’ surveys. Our poll analyzed survey data from 50 hospitals.

**Code details trip many up**

The citations under EC.5.20 come from many angles, including nitty-gritty *LSC* concerns and plan for improvement (PFI) deficiencies. Some examples of citations noted by respondents:

- Fire doors that didn’t close properly
- Doors that exceeded 1 inch average undercut clearance
- Means of egress that weren’t properly illuminated
- Unprotected penetrations in rated barriers
- Conduit running through, but not servicing, a stairwell

Smaller hospitals that host life safety specialists for the first time should be aware of these and other frequently reported *LSC* deficiencies.

Safety managers at smaller facilities may not be used to the in-depth review that the life safety surveyors will provide. In past visits, regular survey teams handled *LSC* reviews, which meant document discussions and building tours weren’t as detailed as they will be now.

Staff member knowledge will set the tone for the life safety specialists, whose visits smaller hospitals must prepare for. Meanwhile, ILSM policies—in particular, evaluating when to use ILSMs if *LSC* deficiencies exist—have become a well-established area of surveyor review.

As for EC.5.40, problems often result from lax paperwork. Examples mentioned by respondents include no records for fire pump testing, kitchen hood inspections, and emergency forces notification for fire alarms.

**Risk assessments present challenges**

Beyond fire safety, EC.1.10 remains a hot spot for surveyors, with 15% of respondents to our poll receiving citations.

This standard in part requires hospitals to conduct risk assessments on safety-related hazards and make improvements based on the results of the assessments.

It is a wide-open provision that surveyors can take in many directions—ranging from corridor storage to eyewash stations.

Well-documented risk assessments can also help you deal with requirements for improvement during the post-survey process.

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**Other EC-related deficiencies that surveyors cited**

The following problems received citations by Joint Commission (formerly JCAHO) surveyors, as noted by respondents to our online poll:

- Inadequate space in a laboratory
- Failure of nurses to conduct defibrillator checks three times weekly
- Smokestacks not labeled on the roof
- Inadequate preventive maintenance for rented medical equipment
- Unsecured medical gas cylinders
- Staff members not assessed on their fire drill performance
Poll: EC standards that received citations during 2007

Our e-mail newsletter, Hospital Safety Connection, asked readers who went through a Joint Commission (formerly JCAHO) survey in 2007 which EC standards, if any, they received citations in. The results are below.

<table>
<thead>
<tr>
<th>EC standard</th>
<th>Percentage of respondents who received a citation in this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC.1.10—Hospitals must manage safety risks</td>
<td>15%</td>
</tr>
<tr>
<td>EC.1.20—Hospitals must maintain safe environments</td>
<td>0%</td>
</tr>
<tr>
<td>EC.1.30—Hospitals must develop and carry out no-smoking policies except in specified cases</td>
<td>5%</td>
</tr>
<tr>
<td>EC.2.10—Hospitals must identify and manage security risks</td>
<td>10%</td>
</tr>
<tr>
<td>EC.3.10—Hospitals must manage hazardous materials and waste risks</td>
<td>5%</td>
</tr>
<tr>
<td>EC.4.10—Hospitals must develop emergency management plans</td>
<td>5%</td>
</tr>
<tr>
<td>EC.4.20—Hospitals must conduct emergency management tests</td>
<td>8%</td>
</tr>
<tr>
<td>EC.5.10—Hospitals must manage fire safety risks</td>
<td>5%</td>
</tr>
<tr>
<td>EC.5.20—Hospitals must comply with the Life Safety Code® and the Statement of Conditions</td>
<td>58%</td>
</tr>
<tr>
<td>EC.5.30—Hospitals must conduct fire drills</td>
<td>2%</td>
</tr>
<tr>
<td>EC.5.40—Hospitals must maintain their fire safety equipment and related building features</td>
<td>25%</td>
</tr>
<tr>
<td>EC.5.50—Hospitals must develop and carry out interim life safety measures when life safety deficiencies warrant them</td>
<td>30%</td>
</tr>
<tr>
<td>EC.6.10—Hospitals must manage medical equipment risks</td>
<td>2%</td>
</tr>
<tr>
<td>EC.6.20—Hospitals must inspect, test, and maintain their medical equipment</td>
<td>8%</td>
</tr>
<tr>
<td>EC.7.10—Hospitals must manage utility risks</td>
<td>2%</td>
</tr>
<tr>
<td>EC.7.20—Hospitals must provide emergency electrical power</td>
<td>0%</td>
</tr>
<tr>
<td>EC.7.30—Hospitals must inspect, test, and maintain utilities</td>
<td>2%</td>
</tr>
<tr>
<td>EC.7.40—Hospitals must inspect, test, and maintain emergency power systems</td>
<td>8%</td>
</tr>
<tr>
<td>EC.7.50—Hospitals must inspect, test, and maintain medical gas and vacuum systems</td>
<td>8%</td>
</tr>
<tr>
<td>EC.8.10—Hospitals must establish and maintain an appropriate physical environment</td>
<td>8%</td>
</tr>
<tr>
<td>EC.8.20—Organizations must establish and maintain appropriate dining environments as required</td>
<td>Not applicable in hospitals</td>
</tr>
<tr>
<td>EC.8.30—Hospitals must oversee the design of the physical environment during renovations, alterations, and new construction</td>
<td>0%</td>
</tr>
<tr>
<td>EC.9.10—Hospitals must monitor conditions in the physical environment</td>
<td>5%</td>
</tr>
<tr>
<td>EC.9.20—Hospitals must analyze identified issues in the physical environment and develop ways to resolve them</td>
<td>0%</td>
</tr>
<tr>
<td>EC.9.30—Hospitals must improve the physical environment</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Based on results of an informal online poll conducted by HCPro, Inc., December 2007.