Hospital Safety Symposium coverage

Experts offer tips to meet emergency planning rules

One thing that proved crystal clear at HCPro’s Second Annual Hospital Safety Symposium is the overriding importance of emergency management to safety officers.

The Joint Commission (formerly JCAHO) continues to emphasize a scalable emergency operations plan that can flex depending on the severity of the crisis at hand, said symposium keynote speaker Dean Samet, CHSP, director of regulatory compliance at Smith Seckman & Reid, Inc., based in Nashville.

Joint Commission officials “want you to be able to handle little emergencies and ‘Oh my God’ big emergencies,” said Samet, a former associate director of standards for the accreditor.

The Hospital Safety Symposium was held May 8–9 at Caesars Palace in Las Vegas.

A simple step: Read the standards

Samet said he worries that too many safety officers and facility directors have only taken peripheral looks at the full slate of emergency management standards in the Comprehensive Accreditation Manual for Hospitals, which is a mistake, he said.

“Open the book. [The standards are] all listed very clearly in the accreditation manual,” he said. “That book is your Bible.”

Check out the following advice attendees at the Hospital Safety Symposium heard about disaster planning.

Seek outside help with prep work

One of the requirements under EC.4.15 (safety and security during emergencies) mandates that hospitals identify the roles of outside authorities. Don’t merely look at the hospital’s capabilities; ask your local police and sheriff offices about their capabilities during a catastrophe.

“Find out where the gaps are,” Samet said. Remember that your internal incident command system must gel with the community’s (refer to EC.4.12 in the manual).

He also encouraged safety professionals to contact local units of the National Guard to coordinate possible response efforts.

Dig into your HVA findings for 96-hour help

The 96-hour provision under EC.4.12 requires hospitals to evaluate their abilities to stand alone without community support for up to 96 hours. If that time frame is unrealistic, options include curtailed services or full evacuation of the building.

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Symposium

One way to stay ahead of the 96-hour rule is to look at your hazard vulnerability analysis (HVA), said Steven MacArthur, a safety consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. MacArthur also spoke at the Hospital Safety Symposium.

Explore which HVA scenarios could isolate your hospitals for 96 hours during a community disaster, MacArthur said. This research may help you comply with EC.4.12.

Use tabletop exercises to test isolation

EC.4.20 (testing emergency operations plans) requires hospitals to conduct at least two annual exercises, and one of those drills must incorporate the idea of the facility becoming isolated without community support.

Although EC.4.20 doesn’t directly mandate a drill for the 96-hour provision, it leans in that direction. A good way to evaluate your hospital’s ability to survive on its own for up to 96 hours is to hold a tabletop exercise immediately after one of your regular emergency management drills, Samet said.

During the tabletop, ask various department managers questions such as, “How long would our water supply have lasted during a prolonged emergency?” Samet said. Those answers will help you gauge your abilities in the 96-hour window. Remember that tabletop exercises can only meet limited provisions within the emergency drill requirements (refer to EC.4.20 for full details).

Outline pediatric services during responses

An idea that has been hinted at in the EC standards in the past, but is now firmly within the standards, concerns managing certain vulnerable patients, Samet said. EC.4.18 spells out the need to oversee clinical services during emergencies for pediatric, geriatric, disabled, or chronically ill patients. This may be a new concern for safety officers, even though the gist of it has been implied before, he added.

Determine who commences response actions

Verify that your emergency operations plan describes the process for initiating and terminating emergency response efforts and recovery steps, said Samet (refer to EC.4.12). “You’re going to have to determine those time frames” and who has the authority to make these decisions, he added.

When The Joint Commission debuts its overhauled standards manual in January 2009, the emergency management requirements will basically remain as is, with a few potential tweaks.
Hospital Safety Symposium notebook

Life safety surveys may be drawn out by weeks

The experts at our Second Annual Hospital Safety Symposium gave attendees plenty of information and advice to take back to their facilities. Let’s review some of the highlights.

The Joint Commission (formerly JCAHO) is hoping to shore up its life safety specialists’ schedules by summer so that these surveyors always visit hospitals at the same time as the regular survey teams. As some hospitals can attest to, life safety specialists have occasionally shown up by themselves after the regular surveyors have left. “You could be in the mix for two unannounced surveys instead of one,” said Steven MacArthur, a safety consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

The concern about a two-part survey? “Until you get that final report [after both parts are complete], you can’t be really sure what they cited you for,” MacArthur said.

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Noise is a big concern in hospital laboratories, said Terry Jo Gile, MT(ASCP), MA Ed., a lab safety expert from North Fort Myers, FL. Lab safety officers should ask their facilities staff members to use a noise monitor to evaluate decibel levels in the lab. A conversation between people in the lab is usually about 60 decibels, a power mower can be 105 decibels, and a rock concert gets to 115 decibels. “Anything over 90 decibels can harm your hearing,” Gile said. Offering ear plugs to lab techs is one solution to save their hearing.

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There is speculation that The Joint Commission’s building maintenance program may not keep its scoring benefits intact once the 2009 life safety standards are unveiled.

Regardless, “my advice to you is to continue using a building maintenance program,” said Brad Keyes, CHSP, a safety consultant at The Greeley Company and a former life safety specialist at The Joint Commission.

The program offers a great way to assess life safety compliance with certain items on a regular basis (e.g., burnt-out exit signs), added Keyes.

The statistics generated by a building maintenance program can also offer useful feedback to your efforts within the *Statement of Conditions* (SOC) and plans for improvement (PFI), he said.

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Keynote speaker Dean Samet, CHSP, director of regulatory compliance at Smith Seckman & Reid, Inc., based in Nashville, reminded attendees about new fire and smoke damper testing requirements for hospitals, which took effect January 1.

The new testing frequencies have expanded from every four years to every six years, which is consistent with the recent provisions from the National Fire Protection Association.

Also, new dampers must receive an initial test one year after installation.

Finally, The Joint Commission allows you to forgo testing for inaccessible dampers provided you note these items on your electronic PFI within the SOC. Enter a six-year completion date on the ePFI for each inaccessible damper, said Samet. If, at the end of that six years, the damper has not been made accessible (e.g., renovation of the wing), then you must submit a PFI extension request to The Joint Commission, he added.

Platinum subscribers to the Hospital Safety Center can read an expanded version of this notebook article with more tips and advice. Log on to www.hospitalsafetycenter.com, go to the Regulatory Compliance Database, and look in the What’s New box.
Emergency management standards

Joint Commission softens some enforcement until 2009

The Joint Commission has turned down the heat on certain provisions within emergency management standards EC.4.11 through EC.4.18 until 2009.

Briefings on Hospital Safety was the first to report this development nationally April 24 on our blog “Mac’s Safety Space” (www.hospitalsafetycenter.com/blog).

The Joint Commission’s (formerly JCAHO) decision affects 15 elements of performance (EP), which are outlined to the right. Until January 1, 2009, deficiencies within these EPs won’t count toward an adverse accreditation decision (e.g., conditional accreditation). However, surveyors will continue to cite noncompliance with these EPs, and hospitals will still need to provide evidence of standards for any deficiencies. The decision is posted at www.jointcommission.org/AccreditationPrograms/Hospitals.

“In essence, we’ve capped the scoring on the standards and EPs” EC.4.11–EC.4.18, said Jerry Gervais, CHFM, CHSP, an engineer with The Joint Commission’s Standards Interpretation Group. Gervais spoke during a Joint Commission Resources, Inc., audioconference on April 25.

Additionally, hospitals must be in compliance with EC.4.20, which deals with emergency planning exercises, by December 31, Gervais said. This offers medical centers more breathing room for drills. The series of moves came after hospitals surveyed in the first quarter of this year struggled to comply with the full suite of emergency management requirements, Gervais said.

Despite The Joint Commission’s decision, the University of Pittsburgh Medical Center (UPMC) is among those hospitals that will continue headstrong efforts to fully comply with the standards now, says William Smith, senior director of emergency preparedness at UPMC.

At UPMC, tracking assets under EC.4.11 has been the most sticky compliance issue, starting with which assets to track.

Although the standards require a minimum annual listing, that’s too infrequent for UPMC, says Smith. “We’re really trying to make it a realistic tool we can use during an emergency. If we did an inventory a year ago, that’s not doing us much good at this point,” he says.

Although UPMC can centrally track some items, such as N95 masks, it’s working on knowing how many respirators are in which buildings at any given time, compared to how many should be on hand.

What standards are included in this decision?

The Joint Commission’s decision about scoring for certain emergency management requirements affects the following elements of performance (EP):

- EC.4.11, EP 9 (documenting an inventory of assets and sources)
- EC.4.11, EP 10 (monitoring quantities of assets and resources)
- EC.4.12, EP 6 (meeting the 96-hour provision)
- EC.4.13, EP 7 (communicating with vendors of essential supplies and services)
- EC.4.14, EP 8 (sharing of assets and resources with healthcare facilities outside of the community)
- EC.4.14, EP 10 (transporting patients, medications, equipment, and staff members to alternate care sites)
- EC.4.15, EP 2 (coordinating security activities with outside agencies)
- EC.4.15, EP 3 (managing hazardous materials and wastes)
- EC.4.15, EP 5 (for long-term care facilities, identifying residents who might wander)
- EC.4.16, EP 2 (training staff members about their roles in emergency response)
- EC.4.16, EP 3 (communicating to licensed independent practitioners about their roles in emergency response)
- EC.4.17, EP 4 (determining alternative supplies of fuel for building operations or essential transport activities)
- EC.4.18, EP 4 (managing mental health needs of patients)
- EC.4.18, EP 5 (managing mortuary services)
- EC.4.18, EP 6 (documenting and tracking clinical information)
Sharpen safety practices around your hospital helipads

Helicopters offer efficient transportation for patients coming to and going from your hospital, and can be an important cog in quickly saving a life.

Unfortunately, chopper landings and takeoffs present intense safety risks, too.

Taking the time to assess related injury risks, review training policies, and revise safety rules can protect employees, patients, and passersby.

The No. 1 tip for making helicopter landings safer is to establish a clearance zone around the helistop; keep the public and employees not trained in helicopter safety out of it, says Tom Schuman, vice president of sales and marketing for FEC Heliports in Cincinnati. FEC is a helipad design and installation company.

For a quick review of helicopter landing site terms, see “What the heli are we talking about?” below.

**FAA recommendations provide a start**

The Federal Aviation Administration’s (FAA) heliport Advisory Circular 150/5390-2B doesn’t mandate any steps, but it offers specific safety recommendations for helicopter landing areas, devoting an entire chapter to hospital helistops. Safety managers should read this important industry publication, Schuman says.

In his experience, some hospitals “scare the heck out of you,” falling short of the FAA guidelines not only for clearance issues, but for lighting and obstructions that make even routine landings tricky, he says.

“Especially when you’re dealing with ground pads, the things that we run in to the most are people that park cars within or too close to the clearance areas,” Schuman says. “The debris that accumulates in and around the pad can shoot around, cause damage to cars, and cause damage to people.”

“We’ve even been to facilities where they’ve established a pad without knowing about the guidelines,” he adds. “They’ve put it too close to the ER entrance and they’ll be blowing the doors open.” See “Evaluate these issues to keep chopper landing zones safe” on p. 7 for specific risks to watch for in hospital helipad designs and activities.

**There are many cooks in the cockpit**

Helicopter operations at hospitals fall under several regulatory and standard bodies:

- The FAA governs flight safety and offers advice and voluntary certification of new and existing helipad construction
- OSHA covers employee safety on helipads, including ergonomics, injuries from lifting and twisting and flying debris, hearing damage, and contact with spinning rotors
- Joint Commission (formerly JCAHO) standard EC.1.10 covers general safety risks, whereas various emergency management standards (e.g., EC.4.14) discuss the idea of evacuating the facility
- National Fire Protection Association (NFPA) standard NFPA 418, *Heliports*, outlines fire safety at these sites and specifically requires helipads to be a safe distance from oxygen tanks and vents
- The Centers for Disease Control and Prevention offers recommendations about infection control in helicopters

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**What the heli are we talking about?**

If helicopters park in hangars such as at an airfield and can refuel, the location is a **heliport**. If a helicopter stops at a facility as part of a route without fueling options, the location is a **helistop**.

The heliport-helistop relationship is similar to a bus terminal/bus stop relationship. Helistops are what 80%–90% of hospitals that offer a landing spot have.

Meanwhile, a **helipad** usually refers to a special surface fabricated specifically for helicopter landings.

Sources: The Federal Aviation Administration and The Joint Commission’s October 2006 Environment of Care News.
Helipads < continued from p. 5

State rules may be tougher to meet

On top of all these regulations, it’s important to keep tabs on state laws, too, says pilot Rex Alexander, president of the Indiana Association of Air Medical Services and one of the country’s top hospital helicopter safety experts. State rules can be more stringent than federal regulations. In some locales, city fire and building code rules have a hand in helicopter issues, too, says Alexander.

Each year, more states require permits for helicopter operation, so it behooves hospital safety managers to track that issue; although you might not need it today, you may next year, Schuman says.

A good place to look for that information is with the aeronautics section of your state’s department of transportation, Alexander says.

A national canon of best practices for hospital helicopter landing safety is still under development. The Indiana Association of Air Medical Services (www.inaams.com) provides the closest thing to a national Web site for hospital-specific helicopter safety documents, research, and pointers to the various federal regulations. The Web site also provides links to associations for in-flight medical professionals and general helicopter information.

Helipad certification acts as buffer

Getting a helipad certified as compliant with FAA guidelines can help decrease injuries and will also likely reduce the hospital’s exposure to liability if an accident happens, Schuman and Alexander say. This voluntary process involves an FAA representative coming to your hospital, performing a site survey, and confirming you’ve filed the proper paperwork with the U.S. Department of Transportation.

Better yet, if your hospital is planning a helistop as part of new construction, get the FAA—or at least a helicopter-savvy consultant—to look over the architect’s plans before construction begins to prevent costly alterations.

Certification doesn’t prevent you from being sued. However, if you’re not certified, it can be used as evidence that your hospital didn’t do everything it could to prevent an accident.

“Not only do you expose the hospital to safety concerns, but all the liabilities that go with it—when it’s so simple to get your helipad to meet the [FAA] criteria,” Schuman says. “It may cost you a couple thousand dollars to move a light pole out of the way, but in the big picture, that’s nothing compared to someone getting hurt” and taking legal action.

If you have a difficult time getting the attention of administrators when it comes to helipad safety, you have an ally in your risk managers, Alexander says.

“A lot of time, you talk to the CEO and it goes in one ear and out the other,” Alexander says. “The risk managers know what the liabilities are and pay really close attention,” and they can dissect this information into financial effects that interest administrators.

Find this month’s Healthcare Security Alert online

In this month’s Healthcare Security Alert—now available exclusively online at the Hospital Safety Center—we talk to a former Joint Commission official about how security and safety tie into emergency management efforts.

All subscribers can read this article by logging in at www.hospitalsafetycenter.com and choosing “Healthcare Security Alert” in the left column.

If you don’t have a user name or password yet, call our customer service department at 800/650-6787.

Platinum subscribers to the Hospital Safety Center can view the Federal Aviation Administration’s heliport design advisory, which devotes an entire chapter to hospital helistops. Log on to www.hospitalsafetycenter.com, go to the Regulatory Compliance Database, and look in the What’s New box.
Evaluate these issues to keep chopper landing zones safe

Hospital safety officers interested in making their helipads safer should consider the following points, as noted by Rex Alexander, president of the Indiana Association of Air Medical Services and one of the country’s top hospital helicopter safety experts:

✓ Make sure the helicopter landing zone displays adequate warning placards. A typical sign might say, “Danger: Helicopter landing area, please stand clear.” Also establish a marked clearance area around the landing zone, as determined by the size of helicopters you allow to land and the power of their “rotor wash” (i.e., the wind created by the rotors).

✓ Staff member education is a prime safety measure. Verify that everyone who is allowed inside the clearance area is aware of the noise, rotor risks, debris danger, and other hazards. Reviewing the main points can take as little as 15 minutes annually and can make a huge difference in preventing injury, says Alexander.

✓ For ground-level landing areas, monitor the landing angles created by trees, signs, power lines, and lamp posts. In particular, watch for tree growth. When they’re planted, trees and hedges may pose no problems, but as they grow, they can become dangerous to incoming flights.

✓ Although there are typically fewer hazards to a rooftop helipad than there are on the ground, most rooftop landing zones require ramps, which have their own set of concerns (e.g., drainage systems that can separate fuel from water in the event of a spill on the roof).

✓ Make sure the lids of Dumpsters latch securely or that the bins are far enough away that helicopter landings won’t kick up debris.

✓ Review your exterior light layout per Federal Aviation Administration guidelines to ensure that the glare doesn’t blind pilots making night landings.

✓ During cold weather, chemical- or electrical-based ice removal systems help make landings safer, avoid slippery conditions for patient transport, and, in the case of rooftop helipads, prevent chunks of ice from being thrown off the roof in the rotor wash.

✓ If an MRI scanner operates too close to a helipad, it could cause false instrument readings in the helicopter, especially with the compass. In bad weather, this could prohibit instrument-only landings. In the best of weather, pilots must be aware that their instruments are not giving accurate readings when near an MRI scanner.

✓ Helicopter exhaust on rooftop helipads sometimes gets into hospital intake vents. Facilities can address this by installing air intake filters.

✓ Be wary of medical gas storage or cylinders near a landing zone. Oxygen could cause further burning if a chopper crashes near it. Also, the out-gassing of oxygen-rich air into a helicopter’s engine intakes could cause the engine to rev up. Consult National Fire Protection Association standards and local fire codes to determine how far a helipad needs to be from medical gas systems.

✓ If your helipad is near a street or parking lot, make sure there’s a way to alert passersby that a helicopter is coming in. A chopper’s rotor wash can create hurricanelike bursts at varying distances around the aircraft, depending on its size. Imagine the potential injuries for someone opening a car door and stepping out just as a helicopter lands nearby.

✓ Keep ground helipads clean and have landing zones cleared of debris.

Regarding the last bullet, “one of the biggest injury-makers and causes of personal property damage in aviation is what we call FOD,” which stands for “foreign object damage,” Alexander says.

“Given that most helicopters create a downwash of air with at least 75–100 m.p.h. winds, it can propel an object with enough force to injure someone within about 100 ft.,” he adds. Finally, watch weather reports if a storm is forecast to ensure landing safety.
Survey monitor

Corridor clutter stings, but 96-hour prep impresses

Editor’s note: This survey occurred in two segments in February and March at Midland (TX) Memorial Hospital, a 320-bed acute care facility.

A growing number of hospitals have reported that the life safety specialists are coming later than the main survey team—sometimes two or three weeks after. The Joint Commission has confirmed this scheduling problem occurs in some cases.

That can make a survey feel like double jeopardy and force staff members to gear up for two unannounced surveys for the price of one. But for Deric Hebert, CHFM, director of facility services at Midland Memorial Hospital, having the life safety surveyor come about three weeks later was a godsend.

“It made us all a little nervous,” Hebert says of the hang time between the two Joint Commission (formerly JCAHO) visits. “But it gave us a little more time to keep pounding away at some of the things we thought we were weak on ... If you’ve got a couple extra weeks, that’s just good for you.”

The chief EC problem for which surveyors handed out a requirement for improvement is difficult to address: There were too many objects in the corridors blocking egress. This common mistake falls under EC.5.20, which requires compliance with the Life Safety Code®.

Linen carts were the main culprit, but rolling computer workstations and medication carts worked into the mix, too.

Some wings of the hospital were built in the 1950s and use 7-ft. corridor widths; these days, newly built hospitals would be required to have 8-ft. widths.

“You look down the corridor and see all that stuff, it looks pretty bad,” Hebert says of the clutter. “Even though I believe we do a pretty good job of keeping it clear as possible, [surveyors] didn’t seem to like it.”

Later, the life safety specialist—whom Hebert says did a thorough job of checking ceilings and doors for deficiencies—found unprotected smoke barrier penetrations, which resulted in another RFI under EC.5.20.

96-hour prep work survives scrutiny

On a more positive note, Midland Memorial’s emergency preparedness session was a success, Hebert says. It went so well, in fact, that Hebert was a “little disappointed” that The Joint Commission revised its scoring for the emergency management standards after his survey, he says. (See “Joint Commission softens some enforcement until 2009” on p. 4.)

Even under the more stringent scoring rules for the standards, there were no citations, Hebert adds.

Surveyors reviewed the emergency management policies and procedures in detail and were complimentary, saying the hospital had covered all of its bases.

There was a lot of discussion and questioning about the 96-hour provision under EC.4.12, which requires hospitals to assess their ability to stand alone without community support for at least 96 hours during a catastrophe.

A committee at the hospital had written a plan determining how the hospital would attempt to keep running...
for three days during various disaster scenarios, Hebert says. The committee gathered detailed information on how to acquire supplies if local vendors were knocked out of commission. For example, if respiratory therapy ran out of liquid oxygen, Midland Memorial has a back-up vendor 400 miles away in Albuquerque, NM, that could supply more oxygen within 24 hours.

Planned tornado tracer doesn’t happen

Time ran out before the surveyors could do a tracer during the emergency management meeting. What’s interesting for hospitals that might have Joint Commission visits coming up is that surveyors tipped their hand about what was up their sleeve for Midland Memorial if time had permitted: a tabletop exercise in which a tornado hit the hospital.

After discussing what would happen with the emergency preparedness committee, surveyors planned to stop talking and summon in certain key players in the disaster scenario. For example, surveyors would have quizzed the head of nursing at Midland Memorial about what she’d do if a tornado occurred, Hebert recalled the surveyors telling him. Had the tabletop happened, Hebert and his colleagues would have had to sit silently and watch, surveyors told him. The nurse manager’s knowledge of the plan would have affected the survey results.

More life safety tidbits to note

One area that Hebert was most proud of during the survey was fire alarm testing and documentation thereof as mandated in EC.5.40, and the facility’s overall utilities management program under EC.7.10.

However, surveyors gave Midland Memorial a supplemental recommendation that came out of the review of the construction management program. Although the hospital did invoke interim life safety measures (ILSM) during construction—and documented its use in detail—that wasn’t quite enough for a surveyor when assessing compliance with EC.5.50. “He wanted it spelled out that we would [consider] ILSMs no matter when we found a Life Safety Code deficiency,” Hebert says. The hospital should look at ILSMs if a deficiency comes up during construction or normal maintenance.

Don’t be surprised if surveyors don’t ask for your Statement of Conditions (SOC). Because you already have to file your SOC electronically, surveyors will likely have looked at it as part of their preparation, Herbert says.

In fact, at Midland Memorial, the life safety specialist spoke with Hebert about the SOC in detail from memory, without referring to notes. That level of awareness impressed Hebert.

Another little compliance windfall the hospital enjoyed occurred because the survey occurred within a few days of its self-graded periodic performance review (PPR) and ensuing phone conversation with representatives from The Joint Commission. During the call, both sides discussed Midland Memorial’s plans for rectifying five compliance issues, none of which involved EC standards.

Surveyors arriving at the facility noticed two of the five problems, so Hebert “played the PPR card,” as he puts it. He pointed out to surveyors that hospital managers already had a plan in place for improving compliance and they’d gone on record with The Joint Commission to address them, which satisfied surveyors.

Survey at a glance

Hot spots: Emergency management, smoke penetrations, hallway clutter, fire alarm testing.

Life safety surveyor on-site: Yes; this part of the survey lasted one day, and happened several weeks after the other surveyors completed their work.

EC citations: Items blocking egress corridors under EC.5.20, two unprotected penetrations in smoke barriers under EC.5.20, and deficiencies for interim life safety measures (ILSM) under EC.5.50.

Quote of note: The surveyor “wanted it spelled out that we would [consider] ILSMs no matter when we found a Life Safety Code deficiency,” says Deric Hebert, CHFM, director of facility services at Midland (TX) Memorial Hospital.
Talk to the IT team about emergency planning steps

As part of disaster planning, particularly the 96-hour provision under EC.4.12, you need to plan for Internet communication and network server failures.

Interfacing with your hospital’s information technology (IT) team will help you get a grip on how well the computer system will stand during a disaster, enabling communications, access to medical records, and even security clearance. Remember, EC.4.12 requires hospitals to evaluate their ability to remain in operation if the community can’t support them for at least 96 hours.

A critical look at your contingency plan for computer servers will help put you on the road to better Joint Commission (formerly JCAHO) compliance.

It can also meet rules governing grants from the U.S. Health Resources and Services Administration if your hospital is receiving federal disaster preparedness funding, says Steve Ennis, CHSP, CFPS, president of SME Consulting in Fredericksburg, VA.

Connect the dots to your grant funding

Federal authorities are pushing hospitals and other disaster responders to develop closer relationships with each other, Ennis says. Agencies increase their expectations each year and tie these goals to eligibility for funds. “One of the primary issues has been interoperable communications, especially in FY ’07,” Ennis says, referring to how local, regional, state, and national agencies work together in a disaster.

“As we understand it, in the FY ’08 grants that are coming out, interoperable communications is going to [again] be a major issue—with radios and telephones and cell phones and ham radio,” he adds.

Another critical piece is that most states have established incident management IT systems to share data in a large-scale disaster, Ennis says.

Thankfully, hospital IT teams have been battling network crashes and breakdowns for years, starting with Y2K preparations when the calendar switched from December 31, 1999, to January 1, 2000.

In addition, because of various Wall Street financial scandals in the new millennium, IT departments must comply with regulations for electronic records—so they’ve probably done a detailed risk assessment and, from it, built a fairly solid disaster and backup plan.

Reach out to vendors

When refining your disaster plan and determining where network and Internet issues fit into the 96-hour puzzle, Ennis suggests discussing the following issues with IT staff members:

► Determine whether internal communications on the intranet network within the hospital will continue if the Internet goes down.
► Find out who your Internet service provider (ISP) is and whether IT has discussed with the ISP restoration of service in the case of an outage. Call the ISP if there’s not enough information.
► The same approach applies to network hardware. Call the hospital’s computer equipment vendors to find out how detailed their disaster plans are. If your

Illustration by David Harbaugh

“He was asked to do a four-hour generator test every 36 months. He didn’t ask for a repeat of the verbal order and ended up running the generator every four hours for 36 months.”
facility has a service plan for the network, call plan representatives, too.

➤ When it comes to equipment protection, analyze the network servers and conduct a risk assessment of their physical location. Are they vulnerable to flooding or other damage? Can they be relocated to a safer location?

➤ Some disaster service vendors offer complete backup Web sites that give hospitals a means to communicate among staff members and the public. At a minimum, the IT team should already be backing up data regularly and storing it away from the hospital.

➤ Try to have a mechanism in place to honor privacy rules in a disaster setting that may involve quickly handing off patients and their electronic records to other facilities.

Hospitals that want to go the extra mile can stress the computer and ISP vendor network by conducting a disaster drill in cooperation with other hospitals.

Although vendors may say they can restore Internet service in a certain number of hours, what if 10 of their hospital clients called at once with similar catastrophic issues that needed to be fixed? You’ll learn a lot about your local resources with an exercise like that, Ennis says.

For a snapshot of guidelines that apply to recovery after a catastrophe, see “Journal outlines rules and standards covering healthcare disaster continuity” below.

Stress the computer and ISP vendor network by conducting a disaster drill in cooperation with other hospitals, says Steve Ennis, CHSP, CFPS.

Journal outlines rules and standards covering healthcare disaster continuity

Ever wonder what regulations you may be subject to when it comes to business continuity and recordkeeping in a disaster beyond The Joint Commission’s emergency preparedness standards in the EC chapter? The following is a partial list of the standards that cover electronic information, compiled by the Disaster Recovery Journal:

➤ Joint Commission standard IM.2.30—Provisions outline plans for scheduled and unscheduled interruptions, which includes end-user training with the downtime procedures, as well as contingency plans for operational interruptions (e.g., hardware, software, or other system failure)

➤ Federal Information Security Management Act of 2002—Details requirements to assess risk, determine levels of security necessary to protect such information, periodically test and evaluate information security controls and techniques, and develop plans and procedures to ensure continuity of operations


➤ American National Standards Institute (ANSI) and ARMA International standards—ANSI/ARMA 5-2003, Vital Records Programs, requires assessing what records are essential to survival in a disaster scenario and what would happen if they were lost

➤ USA Patriot Act of 2001—Includes requirements for record retention

➤ Health Insurance Portability and Accountability Act of 1996—Requires a data backup plan, disaster recovery plan, emergency mode operation plan, and procedures for testing and backing up thereof

➤ Sarbanes-Oxley Act of 2002—Mandates the ability to identify and rebuild lost transactions and source documentation, as well as vital records creation

For the complete overview of more regulations that the Disaster Recovery Journal outlines, download the magazine’s Excel spreadsheet, loaded with links, detailed explanations, and potential consequences for noncompliance. Go to www.drj.com, click on the Tools tab, and then scroll down to “DR rules and regulations.”
**Tip of the month**

**Build OSHA eTool visits into your safety plans**

Most hospital safety managers know about OSHA's Hospital eTool (www.osha.gov/SLTC/etools/hospital), which offers a glimpse of what employee safety regulators consider hot spots in the medical workplace.

But it’s sometimes hard to figure out what’s going on at that wing of the OSHA site and when new information gets posted.

Safety officers should review the eTool at least annually as they make mandated reviews and updates to their occupational safety plans, says Dionne Williams, senior industrial hygienist at OSHA.

**Hotter topics receive more updates**

Consider making time for more frequent reviews to the eTool, too, as there often are updates several times per year, especially in enforcement focus areas (e.g., bloodborne pathogens), Williams says.

“[OSHA officials] try to update the eTools on an annual basis, but for some programs, safety and health managers should really look at the page more regularly than that,” she adds. In order to update a policy at your hospital, it helps to be familiar with the most recent information, regulations, and standards.

OSHA’s Hospital eTool also offers links to standards from outside groups such as the American National Standards Institute and the Association of PeriOperative Registered Nurses (AORN) in the “Additional information” sections after text on a particular topic.

Compliance issues for which hospitals get cited the most—again, bloodborne pathogens is one example for healthcare settings—are likely to be updated more frequently on the eTool than others, Williams says.

**Collaborations result in revised content**

A Salt Lake City office of OSHA’s technical division maintains the various eTools and industry-specific topic pages for the agency, Williams says. OSHA staff members develop the content, sometimes in conjunction with specialists for a particular discipline. For example, a collaboration between OSHA and AORN representatives resulted in a recent update to the Hospital eTool's surgical smoke page (see the June Briefings on Hospital Safety for more details about surgical smoke dangers).

Thoroughly reviewing the different pages of the eTool is important, because it’s not always obvious what’s new by looking at the main page, Williams says. For example, updated information about laser plumes and hazards is halfway down the surgical suite module link off the eTool home page, she adds.