Joint Commission backs off of emergency prep tracers

Several developments have come to light regarding 2010 emergency management sessions that Joint Commission surveyors conduct during accreditation visits.

The biggest switch is that the formal emergency management tracer, which was part of some 2009 surveys, has been de-emphasized, said George Mills, MBA, FASHE, CEM, CHFM, CHSP, senior engineer at The Joint Commission. Mills spoke during a Joint Commission Resources, Inc., Webcast April 7.

The change in the tracer occurred as of January 2010, said Kenneth Powers, spokesperson for The Joint Commission. Although the revision appears in the accreditor’s 2010 Survey Activity Guide for Healthcare Organizations, it has not been overly publicized.

If, during the session, a surveyor finds an emergency management concern worthy of a tracer, it can be rolled into other tracers conducted by fellow surveyors. “Instead of conducting a special session on the emergency management tracer, surveyors assess the organization during regular tracers that are conducted throughout the survey,” Powers said.

Session tilts toward conversation

The emergency management session remains scheduled for 90 minutes, but you can expect more dialog between surveyors and hospital representatives regarding disaster preparation efforts and the performance of emergency exercises, Mills said.

“This interview process evaluates the organization’s preparedness to cope with emergencies identified in their hazard vulnerability assessment,” said Powers.

According to the Survey Activity Guide, the following items could be discussed during the session:

➤ The hospital’s involvement with the community and other healthcare facilities (EM.01.01.01)

➤ The inventory of assets that would be needed during an emergency response (EM.01.01.01)

➤ The hospital’s capabilities when it can’t be supported by the local community for at least 96 hours (EM.02.01.01)

➤ Planning for the six critical functions of communication; resources and assets; safety and security; staff responsibilities; utilities; and patient support activities (EM.02.02.1 through EM.02.2.11)

➤ The hospital’s processes for disaster privileging of licensed independent practitioners and verification of
other practitioners who are required to have a license or registration (EM.02.02.13 and EM.02.02.15).

➤ Improvements to the emergency operations plan or lessons learned from emergency drills (EM.03.01.03)

The preceding list aims to explore whether the emergency management efforts are appropriate and realistic for a hospital. “The emphasis is on how prepared the organization is to cope with emergencies,” said Powers.

Utility planning remains a focus

You may want to double-check your utility contingency plans, which Mills continues to note as a subject of high importance to him.

Although memorandums of understanding are great ways to prepare for utility disruptions, they are weakened if several facilities or community organizations have agreements to get the same piece of standby equipment, such as a 25,000-gal. water bladder, Mills said.

Hospital emergency management coordinators should talk to their counterparts in the community about this concern, and if, in fact, several parties lay claim to a limited resource, it is time to conduct a drill and see what happens, he said.

Surveys have been used to ask hospitals about memorandums of understanding, how to evaluate these agreements against the emergency management standards, and aspects of testing these agreements.

Memorandums are excellent pieces of an escalating emergency drill, as called for under EM.03.01.03, element of performance 13.

Other standards to review in regards to utility contingencies include:

➤ EM.02.02.09 (managing utilities during an emergency response)
➤ EC.02.05.01 (managing utility risks)

In particular, think about the provisions under those standards in terms of the hospital’s capabilities to survive without assistance from the community for up to 96 hours.

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Future changes in acute care?

**Reviewing new ambulatory EC standards reveals MRI and diagnostic imaging best practices for hospitals**

Although new elements of performance (EP) for advanced diagnostic imaging only appear in the EC chapter for ambulatory providers, these requirements may still be worth hospitals’ attention.

For starters, the disparity now between the ambulatory and hospital EC chapters when it comes to MRI and radiology safety results in a more strenuous approach for ambulatory settings, says Tobias Gilk, M.Arch, president and MRI safety director at Mednovus SAFESCAN®, based in Leucadia, CA. SAFESCAN develops ferromagnetic detection products for MRI suites.

“The Joint Commission hates disparities when they don’t need to be there between the hospital and ambulatory accreditation programs,” Gilk says.

The Joint Commission acted quickly to amend its ambulatory diagnostic imaging requirements after the Centers for Medicare & Medicaid Services (CMS) mandated that outpatient imaging providers become accredited by a federally designated organization by January 1, 2012.

“The Joint Commission has been going at a breakneck pace since December” to align with CMS’ rules, Gilk says.

CMS has designated the following organizations to provide advanced diagnostic imaging accreditation: The Joint Commission, American College of Radiology, and Intersocietal Accreditation Commission.

CMS’ 2012 deadline will affect more than 7,000 sites that utilize advanced diagnostic imaging, according to The Joint Commission. The rules apply to the technical component of MRI, PET, and CT services, but not to x-ray, ultrasound, mammography, or other imaging.

**Passing over hospitals, for now**

In some sense, The Joint Commission’s effort to revise its ambulatory accreditation standards has led to the organization bypassing similar hospital provisions. Yet inpatient facilities can take useful information from their outpatient brethren in terms of best practice and also perhaps preparing for future changes in the hospital standards for advanced diagnostic imaging.

 “[The Joint Commission] is going to be doing work on the hospital side,” Gilk says. “I’d bet my paycheck on it.”

The CMS ambulatory diagnostic imaging provisions don’t apply to hospitals that provide such services—at least not yet—because hospitals bill for this under different payment systems than ambulatory surgical centers.

**Changes within the EC standards**

Let’s look at the specific imaging provisions that The Joint Commission added to the ambulatory standards.

Under EC.02.02.01 (managing safety and security risks, similar to the hospital version of the standard), new EP 14 requires ambulatory organizations that provide advanced diagnostic imaging services to manage MRI risks associated with the following situations:

➤ Patients who experience claustrophobia, anxiety, or emotional distress in an MRI scanner

Although new elements of performance (EP) for advanced diagnostic imaging only appear in the EC chapter for ambulatory providers, these requirements may still be worth hospitals’ attention.

> continued on p. 4

**Attend the Hospital Safety Center Symposium from your facility**

If you’re reading this on or before May 6, you still have time to register as a virtual attendee of the 4th Annual Hospital Safety Center Symposium.

As a virtual participant, you will be able to view symposium sessions on your computer via a live Web broadcast. You’ll have full access to the slides and materials presented by our speakers and can even ask questions during the live presentations through our virtual network.

For more information about virtual participation in the Hospital Safety Center Symposium, go to www.hcmarketplace.com/seminars, where you’ll also be able to find details about session topics and speaker bios.
MRI

➤ Patients who may require emergency care while in the scanner room
➤ Metallic implants and devices entering the MRI suite
➤ Ferromagnetic objects entering the MRI suite

Briefings on Hospital Safety has previously detailed the risk prevention steps surrounding the latter two bulleted items, but it may not be as clear how the first two items apply to the EC.

Regarding patients who need emergency care while in an MRI scanner room, Gilk believes this provision of EP 14 ensures that there is physical space to properly handle a patient who goes into a code blue (e.g., availability of a crash cart and medical gas hookups). You don’t want a code team running into an MRI room without properly screening them for metallic objects, a precaution that, on the flip side, might delay urgent care to the distressed patient, Gilk says. Therefore, ambulatory centers should keep a space outside of the immediate MRI scanner room equipped for resuscitation efforts.

As for the first bullet about claustrophobic patients, Gilk is surprised to see it on the list, because he can’t find a compelling connection in EC.02.01.01 between patient comfort and the physical environment.

Setting frequencies for image upkeep

Meanwhile, ambulatory standards EC.02.04.01 and EC.02.04.03 address medical equipment management and testing, again similar to the hospital EC chapter.

Under EC.02.04.01, new EP 7 mandates that the ambulatory organization identify activities and frequencies for maintaining the technical quality of diagnostic images.

Also, EP 15 of EC.02.04.03 wants ambulatory sites to maintain the clarity and accuracy of images. Both EPs leave much in the hands of ambulatory centers to determine exactly how the provisions are carried out.

This approach differs from the stricter provisions of the American College of Radiology, which requires sites to use a “phantom”—an object filled with gel and a low-contrast test pattern—to test the parameters of an MRI scanner, Gilk says. He will be working with The Joint Commission to provide basic MRI education to its ambulatory surveyor roster.

The inequality of diagnostic image provisions between ambulatory and hospital settings may pressure The Joint Commission to introduce similar standards for acute care facilities. It’s not difficult to foresee affected ambulatory surgical centers decrying a double standard that hospitals need not meet, especially given that hospitals provide MRI services to patients who are more critically ill, Gilk says.

A good source of prevention steps for MRI accidents is the February 2008 Joint Commission Sentinel Event Alert (see the related story below).

Consider zoned approaches to keep people safe in MRI areas


A prominent piece of the guidelines discusses a zoned system of access restrictions into an MRI area:

➤ Zone I: General public
➤ Zone II: Unscreened MRI patients
➤ Zone III: Screened MRI patients and personnel
➤ Zone IV: Screened MRI patients under constant direct supervision of trained personnel

You can read the full guidelines at http://tinyurl.com/2m95qa.

You can also check out the Sentinel Event Alert at http://tinyurl.com/2htx47.
### Sample checklist for MRI environmental safety

The following checklist will help your hospital gauge how successful it is at preventing potential MRI environmental safety hazards. The list reflects recommendations made by The Joint Commission in a Sentinel Event Alert about MRI safety.

The alert doesn’t set any new standards or requirements but does tie into provisions under EC.02.01.01 (managing safety risks and conducting risk assessments), EC.02.04.01 (managing medical equipment risks), and EC.02.04.03 (inspecting medical equipment). Answering “no” to a question may indicate a chance to improve your MRI safety policies and procedures.

*Source: Based on recommendations and observations from The Joint Commission’s Sentinel Event Alert, “Preventing Accidents and Injuries in the MRI Suite,” Issue 38, February 14, 2008.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the hospital appointed a person to oversee MRI safety procedures?</td>
<td></td>
<td></td>
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<tr>
<td>Does the hospital have written policies and checklists about MRI safety procedures?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the hospital established zoned access levels in the MRI suite, such as those published by the American College of Radiology?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do all staff members who enter the MRI suite understand that the equipment’s magnet is always on?</td>
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</tr>
<tr>
<td>Do all staff members who enter the MRI suite understand that the equipment’s magnet can attract metallic, ferromagnetic items?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do all staff members who enter the MRI suite understand that the equipment’s magnet can cause certain devices to fail (e.g., some battery-powered monitors and infusion pumps)?</td>
<td></td>
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<tr>
<td>Do all staff members who enter the MRI suite understand what “MR safe” items are?</td>
<td></td>
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<tr>
<td>Do all staff members who enter the MRI suite understand what “MR conditional” items are?</td>
<td></td>
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<tr>
<td>Does the hospital provide a written list of typical ferromagnetic items?</td>
<td></td>
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<tr>
<td>Do housekeepers and maintenance workers enter the MRI suite only when patients are not present?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does a specially trained staff person knowledgeable about the MRI environment accompany any patients, visitors, and coworkers into the suite who aren’t familiar with this environment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do MRI staff members screen all nonemergent patients twice for metallic objects before they enter the MRI suite?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do MRI technologists have access to patient records to screen for implanted devices that may be metallic?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the hospital provide patients and family members with written materials explaining the safety risks of the MRI environment?</td>
<td></td>
<td></td>
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<tr>
<td>Do all staff members who work in the MRI suite understand the principles of safe handling and storage of the scanner’s cryogenic gases?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do all staff members who enter or work in the MRI suite understand emergency procedures should the scanner’s cryogenic gases inadvertently release?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the hospital annually provide all medical and ancillary staff members who might accompany patients into the MRI suite with safety education about the MRI environment?</td>
<td></td>
<td></td>
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</tbody>
</table>
Healthcare reform items for safety committees to review

As the initial waves of the newly passed healthcare reform law begin to ripple out, safety committee members should consider how the changes could affect EC and occupational health concerns.

“To the extent you believe the healthcare reform law will increase the demand for services, it could certainly have the effect in the near term of straining the resources of hospitals … [and] that would affect [managers] who are overseeing the safety and health of employees,” says Bradford Hammock, partner at Jackson Lewis, LLP, a law firm in Reston, VA, where he heads the workplace safety compliance practice group.

The law will provide coverage to about 32 million uninsured people and offer tax credits to about 4 million small businesses to help cover the cost of insurance for their employees.

According to experts and industry observers we talked to, the following three reform-related areas may be worth adding to your next safety committee meeting agenda:

➤ **Monitoring more patients and visitors.** When it comes to the physical security of hospital buildings and the well-being of workers, healthcare reform may bring increased traffic into the nation’s EDs.

EDs are among the top locations in medical centers for violence between patients and staff, generally because EDs act as funnels into the rest of the facility. “You have overcrowded emergency rooms right now,” says James Blair, FACHE, president and CEO at the Center for Healthcare Emergency Readiness in Nashville. “You’re going to make 30 million people eligible [for insurance]. They won’t be coming hat in hand.”

In other words, someone who is accepting charity medical care is likely to have patience while waiting in an ER.

But when people believe they have a right to medical care—“and that’s what the rhetoric has led everyone to believe, that everyone in America is covered,” Blair says—some individuals may be difficult to physically control when they find out at the ER that they have to wait until certain provisions for covering the uninsured kick in over the next four years.

That dilemma puts ER nurses, physicians, and security officers on the battleground of dealing with potentially upset, confused, or even violent patients who don’t fully understand the healthcare reform laws passed in March.

Hospital security expert Fredrick Roll, MA, CHPA-F, CPP, agrees.

“I think a greater number of folks will show up and push for their ‘entitlements,’ “ which will up the ante for workplace violence in medical centers, says Roll, president and principal consultant at Healthcare Security Consultants, Inc., in Frederick, CO.

However, others aren’t so sure about a long-term increase in ED visits.

Although there may be a spike in traffic in the near future, the long-term situation may see fewer traumatized people arrive at the ED, says Randall Snelling, CPEO, chief physical environment officer at DNV Healthcare, Inc., a hospital accrediting group based in Cincinnati.

Expanding on his point, Snelling says healthcare reform will hopefully prompt more ill people to initially seek treatment from primary care physicians instead of the ED.

“Once everyone gets their arms around it … folks won’t be coming to the ER with stomachaches,” he says.
Stemming from that, EDs may also host fewer folks who are stressed out because they can’t afford healthcare, which will lower the potential for confrontations.

➤ **Stretching your limited supplies even further.** Fears of patient surge issues in the ED because of healthcare reform mirror concerns about an influx of patients from a community emergency.

Although not a potential disaster in the traditional sense, healthcare reform, by potentially bringing more people into hospitals, will challenge facilities by depleting them of supplies more quickly, Blair says.

It’s already tricky enough determining just-in-time inventories of surgical masks, latex gloves, food, and other provisions.

Hospital planners and emergency managers will soon need to get a firmer grasp on how healthcare reform could tax the supply chain.

“It’s a matter of numbers,” Blair says.

Whenever a major regulatory change occurs that affects an industry directly, implementing the changes takes away resources from other areas, such as safety and occupational health, Hammock says.

“The reality is you have X number of people to do things,” he says. “When something major comes along, you’ll pull resources from other areas.”

An interesting note: A provision in the healthcare reform bill establishes a National Healthcare Workforce Commission, which will include among its roster healthcare workers and employers, writes John Howard, MD, director of the National Institute for Occupational Safety and Health (NIOSH), in his NIOSH Science Blog (www.cdc.gov/niosh/blog).

The workforce commission is expected to submit recommendations to federal lawmakers and agencies to improve the safety and worker protection for healthcare employees, Howard writes.

➤ **Hoping a more efficient healthcare system frees up funds.** Safety, security, and facilities departments may stand to improve their budgets in the long haul if healthcare reform does indeed save money, Snelling says.

These increased funds could better help medical centers pay for needed repairs and upgrades or staff education about safety topics.

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**It’s okay if facilities don’t have perfect EC processes**

A risk-free physical environment is a nearly impossible goal to attain, said Steven MacArthur, safety consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

“But that’s okay—and it’s okay if we do not have perfect processes,” MacArthur wrote recently on his blog, Mac’s Safety Space (http://blogs.hcpro.com/hospitalsafety).

“The management of the environment of care, as it is with most risk management undertakings, is one of continuous tweaking (in the industry this is known as process improvement),” he wrote.

“It’s all about getting better—which has a strange commonality with the purpose of healthcare, no?” he added.

MacArthur noted that The Joint Commission’s physical environment standards are full of provisions for hospitals to identify how they do things, but the standards never say activities must be done perfectly.

“It’s all about identifying improvement opportunities and then identifying strategies to make those improvements ‘real,’ ” he wrote.

“Even then, there are strategies that will fall by the wayside because they weren’t the right move or at the right time. This, ladies and gentlemen, becomes what is known as experience.”

Check out Mac’s Safety Space frequently for the latest advice and commentary about hospital safety concerns. By subscribing to the blog, you can receive updates by e-mail about new postings.
The FDA has approved a new alternative system to the Steris System 1 (SS1) processor—which came under federal fire because of alleged infection control risks with the device—but not without some confusion.

The Steris System 1E (SS1E) is a liquid chemical sterilant processing system that is used to process reusable heat-sensitive devices (e.g., endoscopes and their accessories) that cannot be processed using steam. The FDA cleared the SS1E March 16 and publicly posted an announcement April 5.

“This is good news for our [SS1] customers, and we look forward to working with them as they continue their transition to acceptable alternative technologies,” Walt Rosebrough, president and CEO of Steris Corp. in Mentor, OH, said in a statement.

The original SS1 is a popular sterilizing device used by thousands of hospitals and clinics in the United States. The FDA said Steris modified the SS1 and the agency hasn’t approved the modifications yet.

Steris has been critical of the FDA’s stance, saying there has been no documented case of infection caused by the SS1 when the equipment is used properly.

The FDA has asked hospitals to transition away from the SS1 to alternative reprocessing systems by August 2011.

“The SS1E may be considered as an alternative to the SS1 for processing compatible heat-sensitive devices, as healthcare facilities transition away from the SS1,” the FDA said.

Items reprocessed in the new SS1E are not considered sterile and should be used immediately, the agency said. This has confused some in the healthcare industry who had expected an SS1 alternative to sterilize items. We’ll update you as further information becomes available on this aspect.

Steris is hopeful the SS1E will fill the gap created by the SS1 controversy. “Steris continues dialogue with the agency to close out the remaining System 1 issues and expects to announce a transition plan in the near future,” it said.

To read the full FDA approval, go to www.fda.gov and search for K090036.

**California says low humidity raised the risk of surgical fires, leading to a $100,000 fine**

California health officials this week punished a hospital that allegedly raised the risk of fires in a labor and delivery operating room (OR).

According to records reviewed by the California Department of Public Health, three scheduled Caesarean sections were performed at Southwest Healthcare System in Murrieta October 26 and 28, 2009, despite low humidity levels noted earlier on those days in the surgical suites. Low humidity in an OR increases the risk of fire from sparking surgical instruments, much like dry days can raise the potential for brush fires.

The state said the alleged lapse constituted an immediate jeopardy to patient safety and issued a $100,000 penalty against Southwest Healthcare.

The hospital planned to dispute the findings.

**Minnesota hospital fined $7,000 for fatal fall**

A hospital and a window washing company were both fined by Minnesota’s OSHA agency stemming from the death of a window washer who fell from scaffolding at the facility in September 2009.

Park Nicollet Methodist Hospital in St. Louis Park, MN, was fined $7,000 by the state, and CID Services, LLC, of Minnesota was fined $28,750, according to records available from federal OSHA.

Minnesota OSHA cited the hospital under the state’s suspension scaffolds standard, which requires scaffolds to be installed with proper support and workers to be provided with safety belts. CID Services was also cited under the scaffold standard, as well as under a state statute requiring employers provide personnel with hazard-free workplaces.

Both the hospital and CID Services were contesting the citations, according to WCCO-TV in Minneapolis.
EC risk assessment important part of suicide prevention

Patient suicides remain one of the top sentinel events reported to The Joint Commission, so safety officers should consider how EC issues might contribute to suicide risks.

The Centers for Medicare & Medicaid Services (CMS) could also have a say in your suicide prevention efforts should its inspectors visit your hospital.

The EC will likely be a focus in 2010 for surveyors when it comes to patient suicide risks, Sharon Chaput, RN, C, CSHA, director of regulatory and quality management at the Brattleboro (VT) Retreat, said during HCPro’s recent audio conference, “Suicide Risk Assessment: Comply with The Joint Commission’s National Patient Safety Goal and Keep Your Patients Safe.”

**EC.02.01.01 sets the stage**

At the very least, suicide hazards should be part of an annual EC risk assessment. EC.02.01.01, which requires hospitals to manage safety and security risks, is often cited by surveyors, sometimes for suicide-related concerns, Chaput said. Specifically, surveyors cite element of performance (EP) 1, which requires hospitals to identify safety and security risks associated with the EC through internal sources such as ongoing monitoring and root cause analysis, as well as credible external sources, including Joint Commission Sentinel Event Alerts.

Also, watch out for EP 3, which requires hospitals to take action to eliminate or minimize any identified safety and security risks in the physical environment.

“There is no specific requirement from The Joint Commission at this time for how often to complete this risk assessment, but the key wording is ‘ongoing monitoring of the environment,’ ” said Chaput. “One easy way to accomplish this is to use an environment of care suicide risk assessment tool.” The tool can be used during hazard surveillance rounds.

**Debate swirls about risk-free environs**

There has also been a push from CMS in some Northeastern states to create a totally risk-free environment as a way to decrease inpatient suicides. It’s imperative to clearly articulate psychiatric standards of care at survey time, Chaput said. For example, parasuicidal behavior is a hot topic among CMS surveyors.

“Surveyors often have no psychiatric background,” said Chaput. “They have a really hard time differentiating between a suicide attempt and self-mutilation.”

If a CMS surveyor attempts to cite you for something like this, Chaput recommends informing the surveyor that it is not clinically therapeutic to create a clinically adverse environment.

In other words, patients are going to be discharged into a world with pens and staplers, and ridding the hospital of these items will not facilitate the hospital in helping patients identify their feelings associated with hurting themselves and teaching them how to cope. It’s helpful to have some literature on hand to back up these points, said Chaput.

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The EC will likely be a focus in 2010 for surveyors when it comes to patient suicide risks, says Sharon Chaput, RN, C, CSHA.

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**Joint Commission requirements for suicide prevention**

The Joint Commission’s National Patient Safety Goals (NPSG) set a variety of mandates to better ensure the well-being of hospital patients.

NPSG.15.01.01 requires general hospitals treating patients for emotional or behavioral disorders and psychiatric hospitals to identify patients who are suicide risks.

Elements of performance under NPSG.15.01.01 include the following:

- Performing risk assessments to identify patient or environmental characteristics that may increase or decrease suicide hazards
- Addressing patients’ immediate safety needs
- Providing suicide prevention information to at-risk patients and their families
Don’t put your lab at risk; check on proper PPE use

In your laboratories, lab coats and other personal protective equipment (PPE) keep staff members safe but too often are used improperly, reducing their value and possibly putting others at risk.

Medical technologists and pathologists frequently leave lab coats hanging open or take dirty coats into a storage area or bathroom, which can create infection control risks, says Elaine Pappamihiel, MT(ASCP), a technical specialist at Medical Laboratory Evaluation in Washington.

Every lab should have areas designated as dirty and clean. Dirty areas are work locations where blood or body fluids are present. Clean areas are those outside of the workspace, such as break rooms, says Pappamihiel.

Since contamination may be invisible, PPE is always assumed to be dirty.

When staff members leave a dirty area, they must remove their dirty lab coats and exchange them for clean, non-PPE coats. Provide lockers for lab employees in a location near where they should be exchanging garments. It will allow them to quickly switch dirty lab coats for clean ones when they head to lunch or to the hospital floors, Pappamihiel says.

To provide appropriate protection, lab coats must also be worn properly, meaning they must:

➤ Protect the individual from splashes and sprays
➤ Meet safety standards
➤ Be buttoned up
➤ Include gloves that pull over the end of the coat’s sleeves

Lab coats should be changed when they become visibly dirty. In tight economic times, hospitals might be tempted to skimp on cleaning services or neglect to purchase extra coats, but this can present safety issues for staff members, says Pappamihiel.

Remember, under OSHA, cleaning and maintenance of lab coats and PPE is the employer’s responsibility. Workers should never take lab coats home to wash them, says Pappamihiel.

A good training topic is to show staff members the proper procedures for putting on and removing lab coats, particularly when they are wearing other protective gear.

Be sure they put on and take off their coats in the proper order to reduce infection risks. The Centers for Disease Control and Prevention (CDC) provides specific information about these techniques, says Terry Jo Gile, MT(ASCP), MA Ed, owner of Safety Lady®, LLC, in North Fort Myers, FL. (For an example of such training, see the CDC’s sample slides on p. 11.)

Don’t take gloves outside the lab

The same type of rules should also govern proper glove use. “Gloves should be worn pretty much anytime in the lab [when] working with infectious materials,” says Pappamihiel.

Many of the same issues that exist with lab coats are seen with gloves, she says. Workers might leave their gloves on when they go into a storage room to retrieve supplies, or they may forget to remove them before walking down the hall or entering an elevator.

Staff members also should wash their hands or use alcohol-based sanitizer after they take off their gloves, says Pappamihiel. And, as mentioned earlier, gloves must be worn over the cuffs of lab coats. This is primarily to prevent the sleeves from dragging and becoming contaminated when individuals are working, she says.

Other types of PPE may also be needed from time to time in the lab, including face protection.

“Most people don’t like to use face protection; it’s hot, it’s uncomfortable, and it’s a hassle,” says Pappamihiel. But such precautions are important because there are times when people do get splashed in the eyes and mouth.

Like anywhere else in the hospital, gaining compliance with proper use of PPE in a lab can be a challenge, Pappamihiel says.

“Accidents are never planned,” so staff members must be trained to err on the side of caution, she says. ■
### Sample PPE Slides

**Sequence for Donning Personal Protective Equipment (PPE)**

<table>
<thead>
<tr>
<th>Task</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Gown</strong></td>
<td>Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back.</td>
</tr>
<tr>
<td><strong>2. Mask or Respirator</strong></td>
<td>Secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Check respirator.</td>
</tr>
<tr>
<td><strong>3. Goggles or Face Shield</strong></td>
<td>Place over face and eyes and adjust to fit.</td>
</tr>
<tr>
<td><strong>4. Gloves</strong></td>
<td>Extend to cover wrist of isolation gown.</td>
</tr>
</tbody>
</table>

**Use Safe Work Practices to Protect Yourself and Limit the Spread of Contamination**

- Keep hands away from face.
- Limit surfaces touched.
- Change gloves when torn or heavily contaminated.
- Perform hand hygiene.

Source: Centers for Disease Control and Prevention.

### Sequence for Removing Personal Protective Equipment (PPE)

<table>
<thead>
<tr>
<th>Task</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Gloves</strong></td>
<td>Outside of gloves is contaminated! Grasp outside of glove with opposite gloved hand; peel off. Hold removed glove in gloved hand. Slide fingers of ungloved hand under remaining glove at wrist. Peel glove off over first glove. Discard gloves in waste container.</td>
</tr>
<tr>
<td><strong>2. Goggles or Face Shield</strong></td>
<td>Outside of goggle or face shield is contaminated! To remove, handle by head band or ear pieces. Place in designated receptacle for reprocessing or in waste container.</td>
</tr>
<tr>
<td><strong>3. Gown</strong></td>
<td>Gown front and sleeves are contaminated! Unfasten ties. Pull away from neck and shoulders, touching inside of gown only. Turn gown inside out. Fold or roll into a bundle and discard.</td>
</tr>
<tr>
<td><strong>4. Mask or Respirator</strong></td>
<td>Front of mask/respirator is contaminated — <strong>DO NOT TOUCH!</strong> Grasp bottom, then top ties or elastic and remove. Discard in waste container.</td>
</tr>
</tbody>
</table>

**Perform Hand Hygiene Immediately After Removing All PPE**

Source: Centers for Disease Control and Prevention.
Tip of the month

Include water fountains on your Legionella hit list

The dangers of Legionella in hospital water systems are well known. Even decorative water fountains can be a risk with Legionella, as Aurora St. Luke’s South Shore Hospital in Cudahy, WI, found out recently.

The hospital had ties to at least six cases of Legionella in March that state and hospital investigators traced to a fountain near the main entrance. Aerosolizing water, such as mist from a fountain, can carry Legionella organisms to people.

Aurora notified more than 1,000 patients who were at St. Luke’s South Shore from February 24 through March 10, warning them that they might have been exposed to the illness and to be wary of symptoms such as fever, chills, cough, and shortness of breath.

Meanwhile, the hospital sanitized and then shut down the main entrance fountain.

“As a precaution, all water features throughout Aurora have been turned off,” the facility said in a statement.

Under EC.02.05.01, The Joint Commission requires hospitals to have a process for managing pathogenic biological agents in cooling towers, domestic hot water, and other water systems that have the potential of being aerosolized.

A study in the December 2007 Managing Infection Control outlined three ways to minimize the risk of Legionella in your water systems:

➤ Release copper and silver ions into a hot water system, which helps eradicate Legionella

➤ Inject chlorine dioxide into the water, which over the long term can reduce the presence of the bacteria

➤ Use point-of-use filtration, which removes Legionella at faucets and other outlets

A combination of the three tactics may be the most effective approach, according to the research.

The Joint Commission does not require that hospitals check for Legionella, but this process is useful in determining the possible presence of the waterborne bacteria in the facility.
Annual security assessments become California law
Noncompliance becomes a crime

California, often the forerunner in compliance standards, may be leading the pack when it comes to security assessments.

In October 2009, the state revised California Health and Safety Code 1257.7, requiring hospitals to conduct security risk assessments annually and making failure to do so a crime. It took effect in January and requires that the first annual assessments begin no later than July 1, 2010, making some California hospitals scramble to perform a security assessment. CEOs or managers responsible for failure to comply could receive a criminal complaint. The law is a revision of AB 508, which passed in 1995.

Although it’s unlikely OSHA has the resources to check each and every hospital throughout the state and charge individuals with noncompliance, it is more likely that a criminal complaint will result from an incident that is reported to state authorities, who then may decide to bring the case to the district attorney, says Mark Mooring, MS, CPP, CHPA, founder of consulting firm Proper Authorities in Ventura, CA. This threat would not only mean legal and financial troubles for the hospital, but a slew of bad press. “No one wants to be the first one to have the CEO get a criminal complaint,” says Mooring. “You can imagine if it hits the news media and becomes negative publicity.”

The law also states that hospitals should consider OSHA’s Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers. Although many hospitals consult these guidelines when developing a security plan, they still serve only as guidelines and are not required by law. The 42-page document is prescriptive and suggests performing risk assessments, creating a security plan, and training staff members on 11 content areas, says Mooring. He notes that a small handful of states have similar laws, but that California is in the forefront of compliance by making noncompliance a crime that can also result in civil penalties—a move that may be a sign of things to come.

Violence on the rise

California’s current Health and Safety Code 1257.7, previously known as AB 1083, was originally brought to California legislators by Southern California’s Registered Nurse Union, SEIU Local 121RN, which surveyed members about workplace violence in March and April 2009. The survey found that about half of respondents witnessed violence or aggression at their hospitals, and more than half said they had not received adequate safety training at their hospital. This survey was on par with another well-cited study by the Emergency Nurses Association, “Violence Against Nurses in U.S. Emergency Departments,” published in the July/August 2007 Journal of Nursing Administration. That study found that more than half of 3,465 ED nurses experienced physical violence—including being spit on, pushed, scratched, and kicked—and 67% of ED nurses rated their perception of safety at five or lower on a 10-point scale. One in three even said they had considered leaving the department or nursing because of the violence.

“Our members were reporting acts of violence and aggression by patients who were disoriented by their > continued on p. 2
California law  < continued from p. 1

medical conditions and/or under the influence of drugs or alcohol,” says Aimee Barajas, communications director for SEIU 121RN. “Many hospital security policies prevented security guards from restraining patients or helping medical staff who are dealing with an aggressive patient.” Barajas says the new law, with criminal penalties, brings to the attention of hospital leaders the importance of preventing violence in hospitals.

“No one wants to be the first one to have the CEO get a criminal complaint. You can imagine if it hits the news media and becomes negative publicity.”

—Mark Mooring, MS, CPP, CHPA

“Our members felt that hospital administration could be a bit out of touch with what really happens in the emergency room or any other department of the hospital,” Barajas says. “Many hospital security plans are out of date and don’t reflect reality. So our nurses felt it was critical to have input when safety and security plans are written. This bill accomplishes that.”

To the joy of Barajas and other SEIU Local 121RN members, the bill passed unanimously through all committees and the Senate floor. “The bill will allow registered nurses and other healthcare workers who are on the floor and at the bedside day after day to give their realistic input on whether the current security plan has been successful or not and how it can be amended to make the hospital safer for employees and visitors,” says Barajas.

Joint Commission may take notice

Mooring says the overwhelming support of the bill indicates that California just might be the first of many states to require annual assessments.

“You may see this continue to expand into other states, particularly as statistics and surveys show that violence against healthcare workers is on the rise. I think more and more legislators are going to get involved in it and want to pass something that gets [workplace violence] out in front and gets hospitals to create as safe an environment as possible,” he says.

Fredrick G. Roll, MA, CHPA-F, CPP, president and principal consultant at Healthcare Security Consultants, Inc., in Frederick, CO, also believes the new state law will help reinforce security compliance.

“I think it is going to help strengthen the OSHA guidelines somewhere down the road because similar violent events are going to happen across the country, and all of a sudden it will tighten up, and I predict that eventually, they’ll move from a guideline to standard,” says Roll.

It’s very likely The Joint Commission will take special notice, particularly because the bill makes non-compliance a crime—a sign that legislators did not believe hospitals were complying with the previous bill, AB 508, which addressed the need for hospitals
to conduct a security assessment but did not require one every year and did not have criminal penalties attached, Roll says.

The perceived noncompliance leads Mooring to think that The Joint Commission may refocus attention on security assessments, planning, and training.

“I think The Joint Commission is very aware of the requirements of California law,” he says. Although it may have looked to some as though security requirements were being watered down after they were made part of the safety management plan section under the Environment of Care standards, Mooring believes there will be a renewed focus on the area.

“Some surveyors seemed like they had a lot of things on their plate, so they were not delving deeply into security sometimes, but I fully expect this will kind of get them going again because ... this shows that the legislature was convinced that hospitals were not compliant. So that means The Joint Commission is going to look closer like they did when AB 508 passed originally,” says Mooring.

AB 508 was more open to interpretation, leaving a wide discrepancy in what constituted compliance. The new law not only requires an annual assessment, but involvement of affected employees and unions when developing the plan. California hospitals must also collaborate with local law enforcement. New focus will also be spurred by what Mooring calls a growing, nationwide problem of assault against healthcare workers.

**Striving for compliance and beyond**

Although California hospitals are required to perform a security assessment every year, Mooring recommends making the best use of each assessment.

The first assessment should be a “full-blown, door-to-door, floor-to-floor, cover-every-little-iota assessment,” he says.

After that, however, the assessment can focus on what incident reports show as high-problem areas and look at what’s changed and progressed. Mooring notes that the new state law also focuses on better incident tracking and reporting: hospitals should have on record when incidents occur, what department they occurred in, what time of day they occurred, and so on. The safety assessor can then go back and review these data and focus on problem areas.

Although the law doesn’t mandate a specific number of hours or frequency, Mooring says training should be supplied to all hospital employees. However, not everyone needs to receive the same type of training. “For example, the ED and security staff might receive all-day in-person training that includes hands-on elements, including restraint,” he says, whereas other departments would receive less in-depth training.

Mooring reminds safety and security directors that assessments are a minimal expense compared to the potential expense of noncompliance. Training can be the more expensive element of security, but staggering the levels of education is a more frugal option, he says.

Mooring also reminds safety and security directors that The Joint Commission might take a close look at documentation of training, including the original sign-in sheet for a training class, who was there, what departments attended, and whether there was a 90% or higher compliance rate.

“They do look beyond just the management plan,” says Mooring, who’s been through seven surveys. “I’ve had them look at the outline for the curriculum of the training, of the trainer’s résumé, etc.”

Place a particular focus on security assessments and have all of them well documented, Mooring says. “Nationwide, I think hospitals are going to have to amp up their compliance a little more because California tends to be the forerunner in this sort of thing,” he adds.
Hurricane season brings security challenges

Editor’s note: Hurricane season, which officially starts in June, can loom large on the minds of emergency management officials. Joe Cappiello, BSN, MA, chair of Cappiello & Associates, advises safety and security directors to remember the potential security vulnerabilities the hospital can find itself in during and after natural disasters. He says to think of the storms in three levels: pre-disaster, during the disaster, and post-disaster.

Pre-disaster

For storms that are predictable, such as hurricanes, you usually know when they’re coming and whether your facility is in their path. You can plan a couple of days out. Begin to think about how you’re going to get the right staff in, lock down the facility, protect the facility, work with community planners, etc. For these types of events, when there’s some sort of warning, security issues should be addressed as much as possible before the disaster.

During the disaster

When the storm or the earthquake occurs, there are issues during the event such as loss of power, which means loss of alarms, the ability to lock down the facility, and ensuring that critical systems work on emergency generators.

For example, disasters are opportune times for those who might want to abduct an infant from a medical center. Make sure the infancy protection programs and alarms are on emergency power. Should an emergency generator fail, you need to provide extra security for certain populations to make sure they’re protected if they are unable to protect themselves.

Trying to evacuate from one wing to another as the disaster occurs can also be a major challenge that will need extra focus from security.

Post-disaster

The post-disaster period could last months depending on the insult to the community and the medical center itself. There may be a need for heightened security for an extended period.

In my experience, following a disaster, the people in the community don’t rush to the firehouse or the police station, but rather to the hospital. And this is not just because of illness or injury, but because the hospital generally has water, food, and medicine. In many communities, the hospital is often the most fortified structure due to OSHA and Joint Commission requirements. They have emergency generators, food supplies, and so on.

A community looks at its medical center as the place to go when there is no other place to be. If the medical center has been diminished in some way, there’s a problem. There is an increased demand placed on the center and a decreased ability to serve.

During this stage, security can become a huge challenge, involving three main issues:

➤ People are trying to gain access who may not need medical care. They want food, water, and shelter.
➤ There may be a small group that tries to take advantage, so you need to be able to control access to the facility. Identify who’s coming into the facility and why. Particularly after a disaster when things are chaotic, you need to exercise greater control.
➤ If the medical facility is damaged (e.g., flooding, mold, or structural integrity), security must ensure that access is limited to the affected areas of the building, especially during any possible contracted construction or cleanup.

Security challenges are only going to become more complex as the disaster unfolds. Facilities have lots of plans—they’ve conducted hazard vulnerability analysis, they have emergency response plans, they have all of these things ready to go—but the problem is that a disaster never plays out exactly as history shows us. When a disaster strikes, it never goes according to plan.

What ensues is a “fog of war.” Much like a battle that’s being conceived by generals, who lay out the battle plans, strategies, etc., hospitals plan against natural disasters. But when the first bullet is fired, plans tend to go by the wayside. You then have to rely on the training and exercises that you did and the skills that your staff built through those training and exercises to save the day. Be prepared to redraw the plan on the fly as events unfold.