Prepare for the worst with repetition

What The Joint Commission expects from your emergency exercises

There’s a good reason why The Joint Commission expects hospitals to regularly conduct emergency drills or exercises, says Joseph L. Cappiello, MA, BSN.

“We do best what we do often,” says Cappiello, chair of Cappiello & Associates in Elmhurst, IL.

“Why do we do drills? We’re trying to ingrain in our staff an automatic response,” he says. In an emergency—a hurricane, an ice storm that wipes out power, or a terrorist attack—you want your staff prepared to operate in a crisis.

Cappiello compares emergency preparation to the five weeks of airborne training he once went through. In two or three hours, instructors can train soldiers to jump out of an airplane and land safely on the ground. But repeating this training for five weeks means if soldiers have to jump from a plane in a stressful combat situation, they’ll be able to do so without hesitation.

Exercises build competence and confidence in staff when they have to do things they don’t ordinarily do, Cappiello says. Staff need to develop skills and be exposed to experiences that are uncommon in their work routines, he told the audience at the 4th annual Hospital Safety Center Symposium in Las Vegas in May.

Joint Commission requirements

Exercises are also important to The Joint Commission, says Cappiello, the former vice president for accreditation field operations at the organization. Cappiello helped develop The Joint Commission’s emergency management (EM) standards.

In 2008, The Joint Commission moved the EM standards into their own chapter within the Comprehensive Accreditation Manual for Hospitals. “That was a shot across the bow,” Cappiello says. “The Joint Commission was saying to leadership, ‘The emergency management standards are important. We’re putting you on notice that you better be doing these things.’ ”

The EM standards require that hospitals have an emergency operations plan (EOP) that outlines how the facility will deal with a disaster, whether it’s a sewer line backup or a flood. The standards also require hospitals to activate the EOP at least twice each year, Cappiello says.

If you activate the plan in response to an actual emergency, that counts as one of your required exercises. If you are in doubt whether a particular event counts, call The Joint Commission and describe the event; officials will give you a ruling, Cappiello says.

The standards also require that at least one of the two exercises includes:
EM exercises  < continued from p. 1

➤ An escalating event in which the community is unable to support the hospital
➤ An influx of patients
➤ Participation in a communitywide exercise

These requirements are based on the debriefing of hundreds of facilities that experienced emergencies, Cappiello says.

In many disasters, events escalated and hospitals found themselves without any community support. Patients flooded local medical centers, and the hospitals’ best chance of surviving the disasters was to be closely connected to their communities, he says.

Exercises have real benefits and value to hospitals, Cappiello says. The emergency exercises you perform make for a prepared organization. However, it is not enough to conduct an exercise that ends in an exchange of high-fives and the CEO saying everyone did a terrific job. A successful exercise demonstrates how, when, and why the critical systems needed for survival or recovery break down. The value of the exercise comes from learning how to improve those systems and extend their functionality.

Another benefit of exercises is that they increase staff and leadership’s sense of competency. Exercises don’t just help prepare staff; they also help ensure that hospital leadership is ready to cope in a disaster. “The last thing we want is a leadership team not sure what to do,” says Cappiello. “Leaders need to understand how to manage escalating and complex events.”

Cappiello outlines the following tips to get the most out of your emergency exercises:

➤ Make sure your exercises mirror reality. Significant disasters, such as a major hurricane or flood, are sustained events that can last for multiple days or weeks, Cappiello says. A large-scale disaster can affect multiple communities, both near and far. Disasters often affect or debilitate public services, and they can overwhelm state and federal response teams. If your response to a disaster is to rely on outsiders for support, you have created an unrealistic and potentially harmful plan, he says.

In one case, four large hurricanes hit Florida back to back, Cappiello says. In a disaster of that magnitude, help may not get to you very fast.

In fact, major disasters can threaten the entire health-care infrastructure, he says. Many facilities must begin
providing services they normally don’t provide. Hospitals can expect the chronically ill to arrive seeking medical support, such as dialysis patients who get their care from freestanding centers that may have been forced to shut down.

Patients who normally receive home care may be left without services if nurses cannot reach them. Ventilator-dependent patients who live at home may come to your hospital if the community loses power.

Well-run exercises keep returning to the point where a facility’s systems begin to break down and fail, Cappiello says. The goal is to improve the performance of responders.

“It’s not about having a great exercise, it’s about having a realistic exercise that challenges us, that strains our systems, where learning takes place and we make improvements. That is where exercises need to go,” he explains.

➤ **Design your exercises to prepare for the real challenges you may face.** In a disaster, a hospital is likely to see increased admissions along with decreased discharges. Citizens may come to your hospital seeking non-healthcare-related services and shelter, especially if you are the only place in the community with power and water.

You can count on the fact that not everything you usually depend on will work. Staff that you need may not be on hand and may not be able to get to the hospital if roads are blocked by downed trees or clogged with snow.

Escalating pressures will continue to be applied to your limited resources, Cappiello says. Your facility itself will face challenges when it comes to space, safety, and power. You should address how you will take care of these needs in your EOP, and you should exercise those plans.

“One of the issues we’ve seen time and time again is that exercises don’t reflect reality,” Cappiello says. Instead, hospitals run the same old exercise every time, such as a pile-up of cars on the interstate. “They don’t put a lot of time into their exercises,” he says. “It’s a ho-hum event that’s not challenging to the staff and not stressing your systems."

However, be sure your exercises are practical. Cappiello recalls a hospital in the Midwest that based its exercise around a volcanic eruption. Hospital officials said they wanted to make the exercise entertaining to staff by doing something unusual.

The problem with such a scenario is that you learn nothing, he says. “It’s a waste of time and energy.”

Good exercises can also be expensive and disruptive, Cappiello says. If a scenario calls for a hospital to close down one of its operating rooms, that will cost revenue. So you have to balance a realistic plan with the disruption to your facility.

➤ **Take threats and the exercise process seriously.** In July 2004, emergency planners at the Federal

Upcoming webcast

**Achieve Life Safety Code® compliance—with help from frontline staff and senior leadership**

As the life safety officer, you may be the expert in your facility on code compliance—always on the lookout for violations involving fire walls, integrity of egress, and fire safety management.

Some of these issues may escape the everyday scrutiny of frontline staff members, but corridor clutter, one of the top five Life Safety Code violations, is an area where nurses and hospital leadership can play a significant role in compliance.

On Monday, September 20, Greeley consultants Brad Keyes and Ken Rohde will host a 90-minute webcast discussing the top life safety violations and how to change the culture in your facility to maintain compliance. Keyes, a life safety expert, will focus on strategies to eliminate corridor clutter. Rohde, a process improvement expert, will support this approach with tools to change behavior among staff members and provide effective solutions going forward.

For ordering information, visit www.hcmarketplace.com.
Emergency Management Agency created a simulated hurricane exercise called “Hurricane Pam.” The five-day exercise was held at the State Emergency Operations Center in Baton Rouge, LA, involving emergency officials from 50 parish, state, federal, and volunteer organizations. In the scenario, a slow-moving Category 3 hurricane carrying 20 inches of rain hit New Orleans. Levees overflowed, the city flooded, and 100,000 “low-mobility” people could not evacuate the area. In the scenario, an estimated 25,000 people died.

Yet the government didn’t take it seriously, Cappiello says, adding that state and federal groups thought the exercise was a joke. They did not think the scenario was plausible. The participants didn’t engage in the exercise, and leaps of faith and assumptions were rampant.

“A year later there was a real hurricane named Katrina,” Cappiello says, referring to the storm that devastated New Orleans. If people had taken the lessons of Pam seriously, “we could have prepared that city so much better.”

➤ Construct your emergency exercise by taking eight steps. Start constructing your exercise by assessing the needs of your hospital. Your hospital vulnerability assessment tool will show you the types of disasters that are likely to occur. Follow these steps:

1. Assess your needs
2. Define the scope of the exercise
3. Write a statement of purpose
4. Record the objectives of your exercise
5. Compose a narrative of what will occur
6. Write and detail the events
7. List the expected actions
8. Prepare messages

The last step on the list is to prepare messages. This means you start with a given scenario, but as the exercise progresses the leaders continually send messages that develop the situation, Cappiello says. For example, you may start with a scenario in which a tornado hits the south wing of your building. Then leaders send a message: The tornado has hit the local power plant—you no longer have power. Another message follows: Dozens of injured people are now making their way to your ER.

“It’s these messages that add complexity and challenges,” Cappiello says.


➤ Start thinking about your exercise with the end in mind. Determine exactly what you want to test, says Cappiello. Is it your communication systems? Your technology? Existing resources? Knowledge? Skills? Adaptability?

➤ Create a more effective exercise. Choose the right type of exercise for your facility. The scenario you pick makes a big difference, Cappiello says. Choose an event that is realistic and poses a real threat to your hospital.

Develop a role for the general medical staff, including your physicians. What happens when you can’t get the supplies you need? What happens if you suddenly have patients of a type or quantity that you are not used to? For instance, if you are a children’s hospital and adults are arriving at your facility, which patients will...
be prioritized if resources run short? Say there are only 75 ventilators in your entire state. Are you prepared to move to an altered standard of care if there are too many casualties for your staff to treat? Are physicians and nurses prepared to turn their backs on patients if they simply can’t treat them?

You should engage nongovernment organizations whenever possible. Remember that surprises are good when it comes to emergency exercises.

Get the media involved. Leadership will take an interest and it is a good chance to demonstrate your role in the community, Cappiello says.

➤ Recognize why exercises fail. Exercise design often fails to include breakdowns in communication, Cappiello says. In reality, communication failure is the single biggest problem in an actual disaster. How will you communicate when normal channels are disrupted? What happens when cell phones and landlines don’t function?

It’s often effective to write messages on a notepad and have someone deliver them from your command center to staff, Cappiello says. “The written word is clearer than messages relayed verbally and provides a record of actions taken.”

Another reason for failure is the after-action review, which is seldom as honest as it needs to be for lessons to emerge, Cappiello says. Nobody wants to be very critical. Everyone worked hard on the exercise, making it difficult to say something failed. Bringing in an objective party to evaluate your exercise is a worthwhile step, he says. One possibility is to get your community’s fire chief to look over the exercise. Fire chiefs are involved in exercises all the time and are not tied to your facility. Tell the evaluator to be blunt with his or her criticism. The point of the review is to be aware of your limitations and build a better response.

An additional problem is that the exercise evaluation is not documented or circulated to the offices and agencies that need it the most. Too often this valuable report sits on someone’s desk, Cappiello says, or the person with authority to respond to the issues raised fails to read it. Create some urgency for your hospital leadership to read the evaluation.

➤ Escalate your exercise scenarios. Running an exercise is an art form, Cappiello says. The basic scenario must allow for feasible and realistic escalation to keep all parties engaged.

The messages you add into your scenario need to take specific groups out of their comfort zone, he says. Don’t allow anything to run smoothly for very long, especially communication.

When a solution is developed, ask “How?” three to five times to explore its feasibility, says Cappiello. For instance, you decide you can prevent flooding by sandbagging the levees around your community. How are you going to accomplish this? Where will you get the trucks? Who is going to fill the sandbags? Where will you get the sand?

Stress the goal during exercises, but remember that you are not setting out to find fault or embarrass anyone. You are trying to discover where your systems are vulnerable.

“Why do we do fire drills? We want to prepare staff to react instinctively to protect themselves and the patients they serve,” Cappiello says. “Exercises are no different.”

What emergency exercises can do for your hospital

Emergency exercises help hospitals do the following:

➤ Teach automatic responses that are less easily eroded by stress
➤ Increase staff and leadership’s sense of competency
➤ Identify gaps in response planning
➤ Highlight organizational system failures
➤ Reduce dependency on outside agencies
➤ Validate the usefulness of tools
➤ Reduce uncertainty and help control anxiety

Source: Joseph L. Cappiello, MA, BSN, chair of Cappiello & Associates in Elmhurst, IL.
Children pose special challenges for emergency planners

When you plan for how your hospital will handle emergencies, don’t forget to think about how you will deal with children who may come to your facility.

Pediatric populations bring a whole new set of issues to the table when it comes to emergency planning, says Joseph L. Cappiello, MA, BSN, chair of Cappiello & Associates in Elmhurst, IL.

Unless your hospital specializes in pediatrics, many facilities don’t typically deal with a large number of children, says Cappiello.

If you decide to conduct an emergency exercise and include a large number of pediatric patients, they will need to be treated in a different manner and will add complexity to your emergency scenario, he says.

Different needs

Triage guidelines differ for children, Cappiello says. The developmental and cognitive levels of children may impede their ability to escape danger. Very young children caught in a fire or explosion may not realize they should run from the scene. They may suffer extensive injuries.

Also, think about your medical supplies. You will need appropriately sized equipment and supplies, as well as age- and weight-appropriate medications, including antibiotics and antidotes.

Different physiology

Children have a higher respiratory rate than adults, which means they will potentially have greater exposure to aerosolized agents. In the case of a chemical leak in your community, children may become much more affected than adults. More permeable skin and a larger ratio of skin surface to mass increases children’s exposure risk to some agents. Children are also especially susceptible to dehydration and shock.

“It’s not a small version of an adult,” Cappiello cautions.

Children are more vulnerable to the effects of radiation exposure and require a more vigorous medical response than adults, he says. Adult decontamination units are not ideal for children, who are also more vulnerable to hypothermia during the decontamination process.

Additionally, children with special healthcare needs are particularly at risk if their survival depends on medications or technology such as respirators.

Communication issues

Depending on their age and cognitive development, children may not be capable of readily conveying their medical history or conditions. Be cognizant of the kind of information children may be able to convey. Can they tell you whether they are allergic to any medications, or whether they have a medical condition such as asthma or diabetes?

Children also have unique psychological vulnerabilities, Cappiello says. They do not typically carry identification and may become separated from parents and caregivers in an emergency situation.

No effort spared to save a child’s life

Few emergency exercises focus on pediatric patients, Cappiello says, but he warns that in a real disaster, pediatric victims will require significant resources, and this can bring medical response to its knees.

You can expect emergency personnel and your medical staff to do everything they can to save a child’s life—including heroic acts, he says. It is not in our culture to deny care to a child regardless of the hopelessness of the clinical presentation. This can drain your resources. Consider ways to handle this issue during the emergency planning process.
How to address Life Safety Code® survey deficiencies
Create a Plan of Corrections for CMS that will meet requirements and ensure safety

Editor’s note: Last month, BHS looked at what you can expect during a CMS Life Safety Code inspection. This month, we look at how to create a Plan of Corrections to address survey deficiencies.

The surveyors are gone, and you are ready to breathe a sigh of relief. You’ve just had a team of surveyors from your state health department comb your hospital to review your compliance with the Life Safety Code® (LSC) as part of a validation survey on behalf of the Centers for Medicare & Medicaid Services (CMS).

The LSC surveyor looked above ceiling panels at smoke dampers and fire walls. He tested your sprinkler system and fire alarms. He reviewed all your documentation, from fire drill critiques to your fire emergency policies and procedures. And at the end of that grueling day, he had a list of deficiencies.

So while you may be tempted to sigh with relief, your work has only begun, says Henry Kowalenko, supervisor of the Design Standards Unit in the Division of Health Care Regulation at the Illinois Department of Public Health in Springfield, who has been conducting and overseeing LSC surveys for the past 17 years.

Before they leave your organization, the state survey team will identify any deficiencies they have cited, which will appear on a Statement of Deficiencies (SoD). It will be up to you to formulate a Plan of Corrections (PoC) in response, Kowalenko says.

Get started right away on your PoC

The LSC surveyor will list all the deficiencies he or she found during your survey using the CMS-2567 form (see p. 8), along with the relevant sections of the LSC, says Kowalenko. The state sends the form to CMS.

In Illinois, the state agency also sends a copy to the healthcare provider as a courtesy so the facility can begin addressing any deficiencies, he says. However, the only official copy of the SoD is the one that arrives from CMS.

CMS reviews the SoD and can override some of the deficiencies from the state, although typically it will not do this, Kowalenko says.

He advises hospitals to put together their corrective action plan right away. Keep in mind that you may need to hire a contractor or architect, and once CMS sends a letter informing you your hospital is out of compliance, you only have 10 days to respond. Remember that correcting some deficiencies, such as installing fireproofing or smoke dampers, will take time.

Develop an acceptable PoC

Although the state survey agency works on behalf of CMS, officials there can help you, Kowalenko says. CMS will review your plan for correcting deficiencies if the state is not sure about your proposal.

Send all correspondence directly to CMS, providing a copy to your state survey agency, he advises. CMS will set a termination deadline to make all corrections; however, your PoC can extend that date.

You must use the original PoC form from CMS; it cannot be reproduced. Re-creating the PoC form will lead to an automatic rejection, Kowalenko warns.

Be sure the form is signed by hospital officials, he says. Although the survey team has electronic access to the form, hospitals cannot fill it out electronically.

Be specific on how you will correct deficiencies

CMS expects to see a very prescriptive method of corrections when it comes to construction, Kowalenko says. The CMS form will identify the deficient practice in the left-hand column. You must indicate the corrective action in the right-hand column. “Indicate what will be done,” Kowalenko says. “Be specific.”

Set priorities identifying which items are the most critical and which are the easiest to correct. For example, a nonfunctioning fire alarm system is a major deficiency

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that should be addressed right away, Kowalenko says. Fixing doors that don’t latch should be done within a couple of days of your survey. Look at what is most critical and affects patient or staff safety. Doing this can help determine what needs to be addressed quickly.

Be realistic and reasonable, Kowalenko advises. Fixing a door closer should not take a year. Indicate the date you will complete a corrective action—including the month, day, and year—and who will be responsible, such as your CEO, facilities director, or supervisor. Use the title of the person, not his or her name.

State specifically how you have fixed or will fix a deficiency. Don’t just say “completed” or “will correct.” If you are patching holes, for example, state whether you will use drywall compound or insulation. Be sure your corrective action is appropriate to the deficiency, says Kowalenko. If you have a penetration through a wall and you stuffed it with mineral wool, you’d be using the wrong type of material. Save yourself headaches down the road by making sure you list an appropriate corrective action, he says.

Show your progress in correcting deficiencies

If a corrective action is going to take a long time to finish, such as installing a sprinkler system in part of your building, describe milestones along the way and when you expect to meet them, Kowalenko says. Describe the extended corrective action, including the dates when you obtain a consultant, review your solution, bid the work, start construction, and complete the project.

CMS will accept revisions to the PoC, he says. Use the CMS-2567 form and indicate why you need to revise
Use caution if you opt for the FSES

There is also an equivalent method of compliance known as the Fire Safety Evaluation System (FSES), which is described in National Fire Protection Association 101A, 2002 edition. The FSES shows an equivalent level of safety without prescriptive action and relies on other safety features, Kowalenko says. It considers factors such as:

➤ Fire alarm and suppression systems (sprinklers, smoke detection, exit locations, etc.)
➤ Patient acuity (ICU, medical-surgical floors, pediatrics) and patient-staff ratio
➤ Patient location within the building (lower floors are better than upper floors)

The FSES is acceptable to CMS, Kowalenko says, but he cautions hospitals about using it. Your hospital will need to complete the CMS-2786T form, which you can find at www.cms.hhs.gov/cmsforms/downloads/CMS2786T.pdf.

Keep in mind that the FSES must be acceptable to the authority having jurisdiction over your facility. It also must be renewed periodically. For hospitals, this takes place at the next LSC survey or when changes occur. If there is a complaint survey, the facility needs to renew the FSES.

The FSES is not typically accepted for new construction, Kowalenko says. It is a complex form and should be completed by an individual who is very knowledgeable about the LSC for healthcare occupancies.

“It is very interpretational,” he says. “I do not recommend you do this form yourself.”

The FSES provides a method of compliance in situations that are difficult or impossible to correct, Kowalenko says. For instance, if a hospital has a stairwell that is not wide enough, it may not be able to correct the problem without spending millions of dollars.

Know and follow the correction process

You must submit the PoC to CMS and the state survey agency within 10 days of receiving notice from CMS. Timely submissions will result in timely requests for extensions, Kowalenko says.

The state reviews and recommends acceptance or rejection of your PoC. If your plan is rejected, a revised SoD/PoC must be submitted, and the state recommends an extension of your termination date as necessary. CMS makes the final decision and notifies the provider.

Be prepared for LSC monitoring surveys

LSC monitoring surveys are “mini-surveys” based on your PoC, Kowalenko says. These surveys are unannounced and focus on the deficiencies cited in your original survey and whether you have corrected them. They are done to verify your progress and compliance with the PoC.

Although the survey will focus on cited deficiencies, surveyors can add new ones. If they see further problems, they can cite you, warns Kowalenko, and your ILSM documentation will be reviewed.

After a monitoring survey, surveyors will then revise your SoD, deleting deficiencies you have corrected and adding any new deficiencies that were discovered. Monitoring surveys will continue until you complete the PoC, Kowalenko says.
**Common Life Safety Code® deficiencies in CMS surveys**

There are some Life Safety Code® (LSC) deficiencies commonly cited in Centers for Medicare & Medicaid Services (CMS) surveys that hospitals need to be aware of.

Surveyors base their citations on the CMS-2786R form, a lengthy form that identifies many of the LSC requirements, says Henry Kowalenko, supervisor of the Design Standards Unit in the Division of Health Care Regulation at the Illinois Department of Public Health in Springfield. Kowalenko has been conducting and overseeing LSC surveys for the past 17 years.

Although it is not an all-inclusive list, the form includes most of the requirements found in the LSC. You can find it at www.cms.hhs.gov/cmsforms/downloads/CMS2786R.pdf.

CMS and state survey agencies do not send the form to providers, but it provides references to code requirements, so surveyors use it as a tool, Kowalenko says. The form allows surveyors to identify deficiencies as well as compliant items. It can also serve as a checklist for healthcare organizations regarding LSC compliance.

There are a number of deficiencies commonly cited by state survey agencies performing CMS validation surveys, including the following:

- K-011: Fire barriers (fire resistance rating and doors that self-close and latch)
- K-012: Construction type (construction material and areas that need sprinkler systems)
- K-014/K-015: Interior finish (specifications for interior finish and flame-retardant agents)
- K-017: Corridor walls (requirements for monolithic ceilings and openings in walls)
- K-018: Corridor doors (considerations for door frames and door wedges or foot stops)
- K-020: Vertical shafts (fire rating specifications for vertical shafts)
- K-023/K-024: Smoke compartments (required square footage and fire resistance ratings)
- K-029: Hazardous areas (sprinkler considerations for storage rooms, boiler rooms, etc.)
- K-033: Exit stairways (no enclosed spaces)
- K-038: Means of egress (locked doors; special locking arrangements and delayed egress locks)
- K-047: Exit signs (illumination and size requirements)
- K-050: Fire drills (minimum frequency and staff involvement)
- K-051: Fire alarm installation (installation and alarm code requirements)
- K-056: Sprinkler system installation (system requirements per setting and common errors)
- K-104: Smoke dampers (dampers must be tested every four years, but testing every two years is recommended)
- K-211: Alcohol-based hand rubs (maximum capacity and minimum corridor width)

Editor’s note: For a complete list of issues associated with each deficiency, visit the Hospital Safety Center and download the free tool that includes specific issues under each requirement.
Time for facility safety officers to get on board with performance improvement

If you’re asking yourself what performance improvement has to do with facility management, consider this. If a nurse gives out one wrong medication dose, that jeopardizes the safety of one patient. If you have one bad surgeon at your hospital, all the patients on which he or she performs are affected. But if you have major facilities issues—a fire, electrical outage, water failure, or facility damage—everyone in the hospital is affected, says Ken Rohde, a senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, who has more than 25 years of experience in quality management.

That’s why it’s important for patient safety officers, risk managers, facility managers, and safety officers to be on the same page, Rohde says.

Safety-related adverse events don’t only affect facility management operations; they can also have consequences for overall patient care, he says.

Performance improvement strategies, which have long been the domain of patient safety and risk management, can help hospital safety officers tackle adverse events, Rohde says. Traditional performance improvement tools, such as root cause analyses and tabletop exercises, can help improve your hospital’s physical environment processes across the board, he adds.

Facility and clinical safety go hand in hand

There should be a crossover between facility safety and clinical safety.

“I’m seeing a lot more cross-functional work between the two worlds,” Rohde says, but notes, “It’s still not seamless. There are still some big divides.”

Facility managers can supply vital contributions to patient safety efforts, he says. Your patient safety, employee safety, and facility safety programs should work in conjunction to create a safe environment for everyone.

Encourage safe behaviors

It’s important for hospitals to build a culture of safety and reliability, Rohde says. Culture—the shared values and beliefs of individuals within a group or organization—is important because it drives behavior and outcomes.

The culture of safety framework originally came from efforts to improve employee safety, particularly in the nuclear power, submarine, and aviation industries, he explains.

To be the safest facility in your area, you need to have all physicians, staff, and leaders practicing safe behaviors, says Rohde. To build safe behaviors, you must set clear expectations for safety and reliability, and those expectations must be clearly communicated.

Six expectations

Hospitals need to share expectations for safe behavior with all employees. You want to communicate what you expect regarding typical behavior. Expect every employee, leader, and physician to demonstrate the following behaviors:

1. Pay attention to details
2. Communicate clearly and directly
3. Have a questioning attitude
4. Perform effective handoffs
5. Work together with your team
6. Follow the rules

“It comes down to these six things—these six expectations for safety,” Rohde says. “We’re starting to see hospitals now set these as behavioral expectations.”

For instance, having a questioning attitude means that rather than reacting passively to a potential problem, thinking “I’m sure someone will call,” employees will realize something isn’t right, get in touch with the appropriate department, and report the issue themselves.
Performance improvement

Handoffs occur any time there is a change in responsibility for a task or activity. On the patient safety side, it may mean moving a patient from radiology back up to the hospital floor where a nurse takes over care. On the facility side, it could be when a contractor takes over the work to maintain an elevator.

Get staff members to work together as a team by using tools such as peer checking and peer coaching. This encourages staff members to help each other improve performance. Some of the tools used to protect patient safety also apply to facility safety, Rohde notes.

Look closely at the following tools:

➤ **Self-check using STAR.** STAR stands for:
  - **Stop:** Pause for 1–2 seconds to focus on what you’re about to do.
  - **Think:** Think about what you’re about to do. Is it the correct course of action?
  - **Act:** Concentrate and perform the task.
  - **Review:** Check whether the task was done right.

It’s important to use STAR and force yourself to pay attention to details rather than acting on autopilot, Rohde says. For instance, you are about to go into a patient’s room; there is a contact precautions sign on the door. You stop and think, and remember to put on personal protective equipment.

➤ **Structured communication.** Expect everyone to communicate clearly. Good communication requires including all the important parts of the message, ensuring that you hear everything correctly, and making sure you understand what is being communicated.

How can you make sure you don’t forget to convey important parts of a message? Remember the acronym **SBAR** when you need to communicate a problem:
  - **Situation:** Describe what you are calling about, the immediate problem, and your concerns.
  - **Background:** Review pertinent information, such as location, recent work, procedures, mental status, skin condition, or oxygenation level.
  - **Assessment:** Give your view of the situation, such as “I think this is the problem,” or “I’m not sure what the problem is.” Convey the urgency of action: “We need to do something now.”
  - **Recommendation:** Provide your recommendation or request.

For example, a person comes into the ED, and a staff member is concerned he or she may become violent. The staff member calls the security department and describes the situation, providing the background (the person was previously in the facility but had no reason to return), the assessment (the person is starting to get out of control), and the recommendation (security should send officers right away).

➤ **Three-part repeat-back communication.** When information is transferred:
  - The sender initiates communication using the receiver’s name. The sender provides the request or information in a clear and concise format.
  - The receiver acknowledges receipt by repeating back the request or information.
  - The sender acknowledges the accuracy of the repeat-back by saying “That’s correct.” If it’s not correct, the sender repeats the communication.

➤ **Phonetic and numeric clarifications.** For sound-alike letters, say the letter followed by a word that begins with the letter (e.g., “That’s D as in dog”). Numbers often sound alike as well, especially the teens, and mixing up sound-alike numbers can create a safety risk in certain situations. To ensure clear communication, say the number, then say each digit (e.g., “The number 13—that’s one-three”).

Facility safety officers have a lot to contribute to the patient safety world, says Rohde. “They know stuff that patient safety folks don’t know,” he says, noting that facility managers have a wealth of knowledge, are good at project management, and bring other tools to the table, such as the use of checklists. “Don’t undervalue what you have to offer.”
Patient surge and security planning
What Israel can teach us

When planning for an emergency, most hospital emergency management, safety, and security directors want to gain knowledge on best practices. They talk to neighboring hospitals and local law enforcement and connect with hundreds of hospitals throughout the nation.

It’s important to understand each hospital’s community and the potential hazards that lie within it to create the best emergency management and security plan. But Erin Downey, MPH, ScD, former director of emergency preparedness for the Louisiana Hospital Association, who studies environmental health sciences at Tulane University School of Public Health and Tropical Medicine in New Orleans, and Anjanette Hebert, CHPA, director of security and safety at Lafayette (LA) General Medical Center, recently traveled a little further for best practices, to a country that has much more experience in emergency planning: Israel.

Downey and Hebert took a trip to Israel to examine healthcare security systems as they relate to patient surge. They wrote about their observations in their report, Best Practices of Hospital Security Planning for Patient Surge: A Comparative Analysis of Three National Systems, which was funded by the International Healthcare Security and Safety Foundation. In addition to security systems in Israel, they studied Canadian and U.S. systems, seeking to find best practices that may transcend national boundaries.

Patient flow for lower security risk

Although each country has different healthcare systems and cultures, Downey and Hebert had some interesting insights when examining how Israel handles a patient surge.

“I think one of the most important findings is that their system is reflective of a one-way movement of patients through a facility, whereas Canada and the U.S. kind of tend to [have patients] go in and out of departments depending upon what services they are needing within the facility,” Downey says. “I think that’s the most important finding from my perspective in terms of managing a surge effectively.”

The Israeli hospitals Downey and Hebert visited had a strict one-way flow of patients. Once seen, they never returned to the ED. They also ran a two-level triage system: non-ambulatory patients were first priority and ambulatory patients were second. It should be noted that most physician offices in Israel are located within hospitals, so physicians can arrive to triage and treat during a surge much more quickly and easily than in the United States. But no matter where the hospital is, patient flow undoubtedly helps keep a hospital safe and prevent possible security threats.

“When you’re experiencing a disaster situation, you have people who are afraid,” Hebert says. Many who are afraid or looking for loved ones—also known as the worried well—wind up at the hospital, adding to the number of people at the facility.

“When you have that many people, you’re going to have problems,” she says. “You’re going to have outside traffic problems, you’re going to have internal pedestrian problems, and you’re going to have people who are upset. The wait will take too long and the anxiety is going to grow, and the more people you have and the more anxiety they exhibit and feed off each other, eventually there will be a growing aggressiveness within this crowd of people—and the longer they wait, the more difficult it is to manage.”

The simplest way to fix this type of problem is to treat patients quickly and efficiently so there is less opportunity

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Patient surge  < continued from p. 1

for a large number of people waiting together in the same area to grow anxious and create an unruly atmosphere. Hebert notes that it’s also good customer service practice to keep patients and families accurately informed.

To create an efficient patient flow, hospitals in Israel enforce strict access control and give patients a clinical care team, which ensures that once a patient is seen, he or she continues through the process until the decision is made to admit or discharge. At no point does the patient return to the ED—unlike in the United States, where it is common to return to the ED after lab tests or scans.

“[In the United States], we keep stacking people up in the waiting room,” Downey says.

Educate staff for better security

During a surge brought on by an emergency, Downey says it’s critical to ensure that staff know and understand the security policies.

“All of the staff needs to be educated on security. Even if security policies are in place, people just don’t know them, especially when they go into an elevated situation. They need to know what the security measures are,” Downey says.

Hebert adds that teaching policies may also include setting expectations.

“You have to determine who is going to be emergency security. Staff must understand there is always the possibility that during an emergency, their roles might change from their day-to-day roles, that they may be asked to be part of security for the day where they help direct traffic or make sure a certain entrance is not used,” Hebert says.

Not all practices transcend nations

There are some implicit differences between Israeli and U.S. healthcare that may keep certain practices out of the reach of U.S. hospital emergency planners. For example, the general Israeli population is acclimated to undergoing screening and security checks upon entering many buildings, including hospitals.

“Israel has a culture of security that is not matched here in the U.S. or in Canada,” Downey says. “The U.S. culture is an overall sense of freedom and not wanting to give up any of the convenience of being able to walk in and out of hospitals without being screened for any type of potential weapon.”

The report also attributes the absence of security checks in the United States to the country’s competitive healthcare system, in which hospital leadership must also be concerned with customer satisfaction. Patients and families may see greater security presence as a nuisance and a sign that the hospital is not safe, and they may choose to be treated elsewhere. Downey and Hebert agree that installing security checkpoints will not work for the U.S. culture, in which such measures are left to airports and, to a lesser degree, courts and federal buildings.

Physical design changes can help

Although a cultural change may take time, Hebert says there are physical design aspects of Israeli hospitals that could be more quickly adopted in the United States if hospitals take advantage of them when renovating or building new structures. She discusses a type of “dual design” in which a space is designed to function for normal, day-to-day activities, but also can be easily
transformed in a patient surge to hold twice as many patients if necessary. This type of design includes ensuring that common areas, such as cafeterias, are equipped to handle patient care if need be.

In Israel, ER patient surge capacity is achieved through a design that provides easy access to diagnostic equipment—for example, x-ray lights on swinging arms—so two patients can be treated in the same amount of space that one usually is. Israeli hospitals feature walls or ceilings in the cafeteria or in hallways that are equipped with medical gas strategically placed behind easily removable panels. Unfortunately, running these oxygen lines in such areas is against the National Fire Protection Association fire code in the United States.

Hebert does acknowledge such designs are part of a very long-term strategy. “I have been working in a hospital for 23 years and we’ve done a lot of renovation and building since I’ve been here, and we tend to focus on how we are going to move patients on a normal day, but we haven’t given a lot of thought into the massive surge situation,” she says. “The point is to hide it in plain view, so I can use it day to day, but I can quickly put a few things in place or pull this wall or lock this door, and that will give me the ability to better manage patient flow and security.”

A dual-concept design creates a cost-effective way to ensure preparedness in the case of an emergency. Hebert notes how many hospitals set up tents outside during the H1N1 pandemic. She says that although this was a practical, workable solution, the United States could instead design hospitals with pandemic and decontamination procedures in mind, which would make such a measure unnecessary.

Questions of the month

What do we have to consider before deciding whether security should carry stun guns?

Editor’s note: Healthcare Security Alert provides expert 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 queries. If you have a security question for one of our experts, e-mail Managing Editor Tami Swartz at tswartz@hcpro.com.

What are your thoughts on stun gun use? What are some factors we should look at before considering giving them to our officers?

A When considering putting weapons into the hands of security officers, you need to establish a process for educating the officers on their appropriate use. You must clearly define the instances in which the weapons can be used (the Centers for Medicare & Medicaid Services says they can only be used for forensic encounters, not patient encounters). You must establish clear competencies for the use of the weapons and an ongoing process for evaluating those competencies. It would be difficult to convince any surveyor to accept anything less frequent than an annual cycle for evaluation.

You would also need to consider what municipal ordinances might come into play—it may be that only police or special police officers are authorized to carry. In general, you’d want to work closely with community law enforcement in adopting any kind of strategy like this. You’d probably need to consult your legal department and be able to present a strong case in support of such an action. I know that there is, and will likely continue to be, a focus on workplace violence prevention and response, but one would have

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to consider that equipping the security staff with any kind of weapon is, if not a last resort, certainly way down on the list of potential interventions.

What are some overlooked hospital security measures that might need our focus?

One big one that springs to mind is the delicate balance of appropriately controlling access to both the hospital facility and the various departments within the facility and ensuring that compliance with the Life Safety Code® (LSC) has not been compromised.

The LSC has some very specific requirements relative to the securing of egress doors, etc. Other experts and I have found that hospitals frequently “abuse” the requirements of the LSC in securing areas. Security systems are often the cause for the greatest LSC compliance gaps. At any rate, this concept also comes into play with regards to locking down a facility during an emergency. It’s one thing to lock all the doors so no one gets in, but a whole other thing when considering (once again) appropriate egress from a life safety/emergency perspective.

You also have to ensure that someone monitors all those doors to guarantee that breaches do not occur. A clever person might take advantage of someone leaving the facility as a means of entry. Locking down is the first and simplest step. Maintaining the perimeter—that’s the challenge.

Recently, we’ve been experiencing theft of patient belongings. What are some tips for prevention?

The single most effective means of preventing the loss or theft of patient belongings is to ensure that patients don’t bring belongings with them that can be stolen. In its simplicity, this is probably one of the biggest pains for security folks because it is all downside. Security doesn’t have the resources to chase every admission to make sure that the front end of the process is appropriately managed (in which valuables would either be sent home or locked up), but if something happens, it’s the security folks who have the target painted on their backs.

Some organizations have unit-based accounting for lost/stolen items, but that process is only as good as the valuables list prepared during the admission process. Some hospitals have even considered having safes for valuables in each room (much like you have in some hotels), controlled by the patient, but if the patient is confused or disoriented, that is a much less foolproof process.

If you look at it purely from a numbers perspective, how many thefts might an organization experience in one year? Even three or four dozen, when compared to the number of patient days, is a pretty small percentage, and more often than not there are no commonalities through which one might identify a perpetrator; sometimes it happens, but not very often. Although I absolutely understand that one theft is one too many, we can’t really say at what point something was stolen, making it virtually impossible to invoke a root cause analysis to see whether there are lessons to be learned. Valuables go out with the laundry (especially false teeth); sometimes they come back and sometimes they don’t. It’s impossible to say whether a criminal act occurred.

And then there’s the organizational reticence to tell people to take valuables home because those concerned with patient satisfaction or public relations will worry that asking patients to do so gives the hospital a bad reputation for being unsafe or untrustworthy. However, the bottom line takes us back to the beginning—if you don’t have it with you, it can’t be lost or stolen.