Joint Commission revises requirements for fire alarm and protection systems
Alignment with CMS requirements

Starting July 1, hospitals will need to meet some new Joint Commission requirements for their fire alarm and protection systems.

In January, The Joint Commission announced revisions to standard EC.02.03.05 from the Environment of Care chapter of the Comprehensive Accreditation Manual for Hospitals. The reason for the changes to two of the standard’s elements of performance (EP) is to comply with the Centers for Medicare & Medicaid Services’ (CMS) Conditions of Participation (CoP).

The accreditor made the changes in order to maintain CMS deeming authority, according to the January 12 Joint Commission Online. The Joint Commission must ensure that its standards and EPs are equivalent to the requirements in the CoP.

EC.02.03.05 requires hospitals to maintain fire safety equipment and fire safety building features.

Here’s what’s changing:
➤ EP 2 will require quarterly testing of a hospital’s valve tamper switches and water flow devices, instead of the current testing every six months.
➤ The new EP 25 requires documentation of the maintenance, testing, and inspection activities for fire alarm and water-based fire protection systems. Documentation must include the following:
   – Name of the activity
   – Date of the activity
   – Required frequency
   – Name and contact information, including affiliation, of the person who performed the activity
   – National Fire Protection Association (NFPA) standards referenced for the activity
   – Results of the activity

Making life easier

The changes should actually help hospitals, says MacArthur. Before the revision, The Joint Commission required less frequent testing under EP 2 than CMS. “So the change brings them in line with CMS requirements,” says MacArthur.

Now, hospitals have a very specific checklist when it comes to required documentation, says Steven MacArthur.

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Joint Commission  < continued from p. 1

As for EP 25, the change to documentation requirements brings the Joint Commission process and expectations into line with CMS requirements and NFPA codes, MacArthur says.

Too often, documentation supplied by vendors who come in to test and maintain fire alarms systems is not as complete as it should be, he notes. The result is that hospitals get cited during survey.

Poor documentation has resulted in numerous findings under EC.02.03.05 over the past couple of years and is a key factor in why the standard is so frequently cited, MacArthur says.

Now, hospitals have a very specific checklist when it comes to required documentation that they can share with their vendors, he says. The new EP may finally mean hospitals can retire EC.02.03.05 from the ranks of most frequently cited standards, he adds.

The change is effective July 1, according to Joint Commission Online, which you can find at www.jointcommission.org/assets/1/18/jconline_Jan_12_11.pdf.

Stay tuned: EPA formulating new emission standards for boilers and some incinerators

The Environmental Protection Agency (EPA) is under a court-ordered deadline to sign a final rule on emission standards for boilers and some incinerators.

The agency had until February 21 to set a final rule on emissions for large and small boilers and solid waste and sewage sludge incinerators. At pretime, the rule had not been published.

An EPA spokesperson said that until the final rule is published, she could not say what the agency will require and how it will impact hospitals.

In April 2010, the EPA proposed a set of regulatory rules under the Clean Air Act that address emissions from boilers, process heaters, and certain solid waste incinerators. The rules would significantly cut emissions of pollutants—including mercury and lead—that are of particular concern for children, according to the EPA website.

Observers expect the final standards to be significantly different than what the EPA proposed last April. The new standards will not take effect until six months after the final rule is published in the Federal Register.

You can follow this issue on the EPA website at www.epa.gov/airquality/combustion.
Other changes in Joint Commission standards for 2011

Although they didn’t get much fanfare, hospital safety officers should take note of some other changes to safety-related standards that The Joint Commission made in its 2011 Comprehensive Accreditation Manual for Hospitals (CAMH).

The Joint Commission gave no real notice of the changes, but Steven MacArthur, safety consultant at The Greeley Company, a division of HCPro, Inc., in Danvers, MA, picked up on them in his review of the 2011 CAMH.

Environment of Care (EC)

Take note of the following changes in the EC chapter:

➤ EC.02.06.01, EP 20, which requires hospitals to keep areas used by patients clean and free of offensive odors, was elevated to a direct impact finding. It had been listed as an indirect impact EP. “This change makes sense to me,” says MacArthur, noting that an unclean room certainly has a direct impact on a patient. The change could be a harbinger of an increased focus by surveyors on ensuring a clean environment, he adds, so you may want to make ensuring cleanliness in patient areas a higher priority.

➤ EC.02.03.05, EP 4, which requires the provision of emergency power for elevators (at least one for nonambulatory patients), changed from a direct impact to an indirect impact finding.

➤ EC.02.06.01, EPs 4, 5, 6, and 18, were all removed from the hospital accreditation standards. The Joint Commission made reference to this change last year, MacArthur says. The applicable EPs were all focused on long-term care environments as opposed to the acute care setting, he says.

➤ EC.02.06.05, EP 1, was updated in terms of one of the design criteria to reflect the 2010 edition of the Guidelines for Design and Construction of Health Care Facilities. The change applies primarily to new construction.

Emergency Management (EM)

Take note of the following change in the EM chapter:

➤ EM.02.02.13, EP 7, which speaks to the continuation of disaster privileges to volunteer licensed independent practitioners during an emergency, and EP 8, which requires primary source verification of licensure, both went from an “A” EP to a “C.” Scoring for a “C” EP is based on the number of times an organization fails to meet a particular requirement. This means that if for some reason one practitioner gets lost in the emergency credentialing process, it will not be enough for a survey finding, MacArthur says. If surveyors find two practitioners not properly credentialed (which would be enough for a finding), the hospital could use an audit of all the practitioner volunteers used in a disaster to show a 90% compliance rate. This would apply only if a hospital used many practitioners during an emergency, since in order to have a 90% score, a hospital would have to use at least 20 volunteers, he says.

Use your risk assessments to your advantage during surveys

When it comes to frequently cited Joint Commission standards, many are not as clear-cut in directing hospital compliance as safety officers would like.

Some of those standards are grayer than gray, said Steven MacArthur, safety consultant at The Greeley Company, a division of HCPro, Inc., in Danvers, MA.

However, one of the general principles of risk assessment is to rely on your best judgment for what is right for your organization rather than surveyor preference, said Bud Pate, REHS, Greeley’s vice president for content and development. “You do these risk assessments whether you think you are doing them or not,” Pate said.

MacArthur and Pate spoke during the HCPro audio conference “Risk Assessments: Focus on Weak Spots and Meet Joint Commission Requirements.”

Make your own judgments

Many of the standards leave room for interpretation because they don’t specify exact requirements, Pate

> continued on p. 4
Risk assessments < continued from p. 3

said. For instance, what is the requirement for blanket warmer temperatures? How about the requirement for flash sterilization? For specific measures to prevent suicides? For the outdating of open multidose vials of medications?

Joint Commission surveyors often cite these issues under general standards based on their own preference for how hospitals operate because there is no specific requirement, MacArthur said.

Hospital safety officers, however, should beware of blindly following surveyor wisdom, he advised. Surveyors are not experts in all areas or in all of the accreditor's standards. If you’ve done a risk assessment and decided what works best for you, don’t adopt surveyor suggestions or findings unless the suggestion makes absolute sense to you, MacArthur said.

Hospitals are often being cited not for failure to follow the regulations, but for not having a clear thought process and an understanding of why they do something a particular way, Pate noted.

“A lot of us are pulled around by the nose by surveyors. All we really need to do is take a step back and do a thoughtful risk assessment,” he said.

Take, for example, the issue of supply storage, MacArthur said. Do you allow boxes to be stored on the floor? Do you have solid shelves or open shelves in your supply closets? What do you allow staff to store under sinks?

Four steps to risk assessment

All of these decisions have a risk, and you need to determine what works best for your organization, MacArthur said.

A risk assessment requires the following steps:

➤ Step 1: Review the requirements. Are there specific requirements or regulations you need to follow?

➤ Step 2: Review other literature. The Internet can help with your research. Do professional organizations have guidelines or recommendations you might want to follow? What are other hospitals doing?

➤ Step 3: Review your own experience. “This is probably the most important step of all,” MacArthur said. “These risks do not occur in a vacuum.” Has your hospital had any adverse events or collected any data that suggest a problem?

➤ Step 4: Make your decision. Be sure it’s the result of a thoughtful process, MacArthur said.

You will want to document how you arrived at that decision. Use your committee minutes and annual summaries and evaluations to document the decision process, MacArthur said.

Hospitals use a risk assessment process to make decisions not just about environment of care, but also in clinical areas, said Pate.

Hospital leaders are always considering the pros and cons of taking a particular action. Ultimately, decisions made through your risk assessment process should be convincing to The Joint Commission, the state department of health, and the Centers for Medicare & Medicaid Services, Pate said.

A sample risk assessment

Sample risk assessments can help you understand the process, Pate said.

For example, take the issue of blanket warming cabinets. (See the sample risk assessment on p. 6.) Joint Commission surveyors frequently issue requirements for improvement regarding their use. However, there are no specific requirements in the standards, and surveyors cite hospitals relying on general requirements covering safe practices.

The risk is that if blanket warming cabinets are not set at a safe temperature, a patient could be burned. As a result, some hospitals have determined a maximum safe temperature for these warming cabinets and posted...
a log to keep track of these temperatures, Pate said. The problem is the logs frequently have blanks where staff failed to record the temperature, or the temperature is higher or lower than it should be.

The current literature on the topic is inconclusive. One study concluded that blankets taken from a warmer operated at temperatures up to 200°F can be used safely by both patients and staff.

In the sample risk assessment on p. 6, the hospital determined the maximum achievable temperature for blanket warmers is 200°F but set a recommended temperature of 150°F. It determined that no temperature monitoring is required and no action is needed for warmers found to be less than 200°F.

With a good risk assessment process, a hospital will be able to defend whatever decision it makes, including to external regulators, Pate said.

**Document your approval**

An important step to include in your risk assessment is the approval and adoption by your leadership. You want to note who approved it and when, said Pate. Include the data presented to your safety committee or other hospital committee so you can trace how you arrived at the decision.

“Ultimately, you want to be able to present your case,” said MacArthur, so include a brief summary of the decision-making process.

If the decision generated some controversy within your organization, that is a good indicator that someone from the outside may also question your procedure, he noted.

**FAQs provide guidance**

Hospitals can find some guidance from The Joint Commission in the accredditor’s FAQs, MacArthur said. You can find the FAQs at [www.jointcommission.org/standards_information/jcfaq.aspx](http://www.jointcommission.org/standards_information/jcfaq.aspx).

The Joint Commission updates many safety concepts through these FAQs, he said. Topics the FAQs have addressed include:

- Under-sink storage
- Refrigerator temperature management
- Food and drink in patient care areas
- Utility systems and hospital-acquired illness
- Use of fans
- Patient-owned equipment
- The 96-hour “requirement”

However, keep in mind that “what is compliant for you is not necessarily going to be compliant for another organization, and vice versa,” MacArthur said. “Ultimately, you know what works best in your house. Conversely, you also know what doesn’t work. You can stay out of so much trouble if you embrace the philosophy of the risk assessment process.”

**Convincing surveyors**

What if a surveyor won’t accept your risk assessment? Ninety percent of surveyors are trying to do a good job and protect patients, said Pate. “They don’t all have the same background. They come in with their own set of expectations,” he said.

A surveyor may be used to seeing hospitals do things a certain way. It may take some convincing that your way is also acceptable, said Pate. But a thorough risk assessment provides you with the ammunition to do so.

Pate recommends that you sit down and privately discuss the issue with the surveyor. A good approach is to ask the surveyor to help you understand what the regulations say. You can ask the surveyor to show you where the requirement is in the regulations.

Present your risk assessment and the reason why you have adopted a certain procedure. Remember, if you cannot convince that individual surveyor that your risk assessment is correct, many findings are removed in the clarification process with The Joint Commission, Pate said.

“Ninety-nine percent of the time, if you have a good solid risk assessment, the finding will ultimately get overturned,” he said.
Sample risk assessment excerpt

**Blanket Warming Cabinets**

**Issue**

Joint Commission surveyors frequently issue requirements for improvement related to blanket warming cabinets. However, the citations lack consistency and are unsupported by specific regulatory expectations. This raises a number of questions:
- What is a safe maximum temperature for patient blankets?
- What is a safe maximum temperature for warming cabinets?
- Should intravenous fluids be warmed in blanket warming cabinets? If so:
  - What is the safe maximum temperature for intravenous fluids?
  - What effect does warming have on the expiration date of intravenous fluids?
- If a maximum temperature is adopted, should hospital personnel monitor blanket warmer temperatures? If so:
  - How frequently should temperatures be monitored?
  - Who should perform the monitoring?
  - What actions should be taken when the cabinet is above the maximum temperature?
  - How should the this monitoring be documented?

**Regulatory Analysis**

**Joint Commission**

There are no Joint Commission standards that directly relate to this issue. Surveyors rely on general requirements covering safe practices. For example:
- EC.02.01.01 EP.1: *The hospital identifies safety and security risks … [including information from] credible external resources …*
- EC.02.01.01 EP.2: *The hospital takes steps to eliminate or reduce identified risks.*

**CMS Conditions of Participation**

There are no CMS regulations that address the appropriate temperature for blanket warmers. General regulations pertain. For example:
- A-0724 § 482.41(c)(2) - *Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.*

**State and Local Laws and Regulations**

[State and local laws and regulations that pertain and what they say.]
Literature Review

Current literature is not conclusive.

ECRI recommends that:

- The temperature setting on blanket warming cabinets be limited to 130°F;
- Intravenous solutions not be warmed in the same cabinets as blankets;
- Cabinets used for heating intravenous solutions be limited to 110°F;
- Warming cabinets be monitored “periodically” to assure proper functioning.

These ECRI recommendations are based on consensus and suffer from a lack of data.

Moon, however, demonstrates that blankets taken from warmer operated at temperatures up to 200°F have “almost no effect on skin temperature so are safe for both the patient and hospital staff.”

Moon and Bujdosó demonstrate potential patient benefits from blankets warmed above 150°F.

Review of Quality and Risk Management Data

Patient satisfaction is tied to comfort which, in turn, is tied to warm blankets and intravenous fluids. Warm blankets also play a role in heating patients undergoing general anesthesia and at risk for hypothermia.

No adverse events or other data suggest a problem with warmed blankets or intravenous fluids.

Operational Considerations and Analysis

Blanket warmers are in use in all inpatient units, the operating room and the emergency department. The emergency department also uses blanket warming cabinets to warm intravenous fluids. The warmed fluids are not dated.

The maximum temperature to which any current warming cabinet may be set is 200°F.

It is the general feeling among staff that there is virtually no risk that a care giver will apply a blanket that is so hot as to burn the patient: 1) blankets cool very rapidly after removal from the warming cabinet; and 2) the care giver will feel discomfort from an overheated blanket before it ever reaches the patient.

Organizational Position

After due consideration, the hospital has adopted the following position:

- Blanket warmers will not be used for warming intravenous fluids.
- The maximum achievable temperature for blanket warmers through the hospital shall be 200°F.

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Many hospitals jumping on social media bandwagon

*Safety officers have opportunities, too*

With people across the globe increasingly using social media websites—blogs and social networking sites such as Facebook, Twitter, and YouTube—for business and personal communications, more and more hospitals are joining the revolution.

“Social media is impacting every single business. It’s where we are communicating these days,” says Peter Ericson, president of The Complete Website, LLC, a Grantham, NH, company.

With more hospitals using social media, there’s an opportunity for safety officers and facility managers to get involved, says Ericson.

Ericson gave an overview of the social media landscape when he spoke at a joint meeting of the Vermont and New Hampshire Healthcare Engineers Societies last year.

So just what is social media? Whereas e-mail is a way to communicate one-on-one, social media is a way for users to participate in many-to-many communications, Ericson says. And several of the tools to do so are free.

“Social media is a big change in the way we communicate,” says Ericson, who believes that once people understand what it can do, they will take advantage of its benefits.

At one New Hampshire hospital, leaders in the patient safety arena are setting up an internal blog for facility staff.

**At a glance**

**U.S. hospitals’ use of social networking tools**

As of mid-January, 906 of the more than 5,000 hospitals in the United States were using social networking tools. To demonstrate how quickly the number is growing, 81 hospitals have begun using social networking since August 2010.

This includes:

- 448 YouTube channels
- 719 Facebook pages
- 674 Twitter accounts
- 439 LinkedIn accounts
- 106 blogs
- 693 Foursquare users

Source: Ed Bennett, director of Web strategy at the University of Maryland Medical Center. You can access his blog, *Found in Cache*, which includes his Hospital Social Networking List, at http://ebennett.org.

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*Sample risk assessment excerpt (cont.)*

- Signs shall be posted on blanket warmers warning that they may not be used for warming intravenous fluids and that the recommended temperature is 150°F. (No action is necessary for blanket warmers found to be 200°F or less.)
- Warming cabinets will be subject to preventive maintenance according to the hospital’s plan (consistent with manufacturer guidelines).
- Ongoing temperature monitoring of blanket warmers is not required.
- Cabinets used to warm intravenous fluids shall be subject to a separate risk assessment and organizational position.

employees, he says. The blog will let staff know what is going on at the hospital, from educational opportunities to links to articles that might interest them. It will provide a way for different departments in the hospital to communicate about what they are doing, Ericson says.

A growing phenomenon

As of mid-January, 906 of the more than 5,000 hospitals in the United States were using social networking tools, according to Ed Bennett, director of Web strategy at the University of Maryland Medical Center. Bennett tracks the growth of hospitals using social media on his blog, Found in Cache, available at http://ebennett.org.

The number of hospitals jumping on board has increased dramatically in the past couple of years.

“This is changing even faster than I expected,” Bennett admits, noting some hospitals still didn’t have their own websites until about 2004–2005.

Although hospitals are conservative by nature, social media is increasingly difficult to ignore, says Ericson. “The conversation is happening,” he says, and healthcare organizations have to decide whether to participate. “This is going to happen whether you are there or not.”

The need to protect patient privacy

Social media is now the No. 1 use of the Internet. Of the largest 11 websites in the world, seven are social networking sites, Ericson says.

A complication for healthcare organizations, however, is the need to keep medical information confidential, says Angel Hoffman, RN, MSN, consultant with the AP Health Care Compliance Group in Pittsburgh.

Healthcare organizations worry about patients’ health information or pictures being posted on the Internet or staff members blogging about a patient they took care of, Hoffman says.

Despite concerns, healthcare organizations are using social media for marketing, including advertising, patient relations, and connecting with consumers.

Social media is also used for human resources, including recruiting new employees and even conducting informal background checks on job candidates by checking sources such as Facebook.

If you or your staff members use social media, be sure to follow your hospital’s policies and become educated about any restrictions on its use.

Mayo Clinic, based in Rochester, MN, which has been a leader in the use of social media, recently established its Center for Social Media.

The center was set up to help drive adoption and exploration of social media tools to benefit Mayo Clinic patients and the healthcare system, and also to help other healthcare organizations, says Lee Aase, director of the new center.

Some healthcare organizations are so scared of privacy concerns that they have closed the door on social media.

“We hope to open some of those doors,” Aase says. “You already have the risks; why not get some of the rewards, too? It’s important to recognize this is a big communication trend out there, that it matters. You need to be dealing with it. Blocking [access] and just sticking your head in the sand is not an option. Well, it is an option; it’s just not a good one.”

Bennett says worries about social media are no different than the concerns people had when inventions such as telephones and fax machines were introduced. And there’s no turning back the tide on this technology.

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Social media

he says. “It’s inevitable. It’s over,” says Bennett. Worldwide, 500 million people are on Facebook, and 100 million use the site in the United States alone. “Half of that 100 million go on every day and are on there for an hour a day.”

But to many people, social networking is a whole new world.

“People are a little scared of it,” admits Ericson. “Nobody knows exactly what to do with it.”

But just as people learned to use e-mail and to access the Internet, they can learn to use social media. “The tools are very easy to use,” he says.

How to get started

So how can hospital safety officers interested in social media get started? Here’s what Ericson advised the group of healthcare engineers:

➤ Start a blog. You can create a blog for your own department and write informal articles that would be of interest to your staff members. Or perhaps you have a particular specialty—such as your knowledge of new construction—that you want to blog about. You can find tools online to set up a blog for free.

➤ Start a Facebook page. You can use the social networking site to create a page for your department or on a topic such as patient or facility safety. Use it to communicate news that is happening in your department or hospital.

➤ Join LinkedIn. This site provides a way to network with other professionals. You can search for groups, such as facility management professionals, or you can start a new group on a particular subject that others might join.

What’s what when it comes to social media

Different social networking tools provide different roles when it comes to social media. Whether it’s your blog, Facebook, Twitter, YouTube, or LinkedIn, they all have a distinct purpose, says Peter Ericson, president of The Complete Website, LLC, a Grantham, NH, company.

According to Ericson, each of the major social networking types has carved out a niche:

➤ Personal blogs were the start of social media and still form its foundation, Ericson says. A blog can build trust and, if it is public, attracts Google searches. There are both internal blogs that are private for your own group and external blogs that share your expertise or a businesses’ products and services with the world.

➤ Facebook is the site for participation. This is the place to discuss an issue and allow participants to leave their feedback.

➤ YouTube is where you can post or watch videos. It is the educator/convincer, Ericson says, adding that video is an incredible way to sell something.

➤ Twitter is the tool to convey what’s happening now. It’s for notifying people and driving traffic. It’s the news feed. For instance, when an airplane crashed into the Hudson River, it was a nearby ferry boat operator who was the first to report the news on Twitter. Eighty percent of Twitter users don’t post much, Ericson says, but they do receive Tweets to keep them up to date. Posts are limited to 140 characters, so these are short, quick news flashes.

➤ LinkedIn is a business networking site. It is the world’s largest business network, which is now being used in the hiring of employees, Ericson says. “This is really the new résumé,” he says. You can find out who is networked with your future hire. Or if you’re looking for a new job, you can find out who is networked with your desired position and can provide information on the company.

There’s no limit to the social media tools you use. “You can use one or more. You don’t have to use them all,” Ericson says.
Hospitals go green, save money with free recycling program

Before Mark A. Wehner, CHSP, ARM, learned about Call2Recycle, one of his jobs was to collect the heavy metal–containing waste batteries generated by the healthcare system where he worked and personally transport them to a local metal recycling facility.

It was no easy task, as the Seton Family of Hospitals in central Texas generated approximately 1.5 tons of batteries each year. Since then, Seton has grown to 11 hospitals with even more waste batteries generated annually.

So Wehner, the network hazmat safety officer who manages environmental compliance for Seton, was pleased to discover Call2Recycle’s free rechargeable battery and cell phone recycling program.

In 2010, Seton recycled 2,300 pounds of rechargeable batteries through the program—shipping them off in postage-paid boxes—plus another 800 pounds of larger batteries on a pallet ready to ship, Wehner says. “All at no cost to us.

“As a not-for-profit healthcare organization struggling in these tough financial times, that’s a tremendous asset to have,” he says. “I would enthusiastically recommend this program to other hospitals or to any business that generates waste rechargeable batteries as a no-cost, environmentally responsible alternative.”

Hospitals generate a large number of waste batteries, both single use and rechargeable, Wehner says. Sealed

Five steps to get started recycling rechargeable batteries

How can you get started launching a rechargeable battery recycling program?

Call2Recycle, the only free rechargeable battery and cell phone collection program in North America, recommends the following five steps:

➤ Step 1: Select a rechargeable battery recycling partner that meets your needs. Items to consider include:
  - Overall cost of the program
  - Ease of enrollment
  - Shipping process and costs
  - Compliance with the U.S. Department of Transportation’s regulations on battery transport

➤ Step 2: Identify which departments in your hospital use the most rechargeable batteries. Rechargeable batteries are used to power many items in a hospital, including crash carts, vital sign analyzers, radiology equipment, infusion pumps, cordless surgical equipment, electric wheelchairs, cordless power tools, laptops, personal digital assistants, two-way radios, and cell phones. Identifying departments that use the most batteries will help you in the next two steps.

➤ Step 3: Determine the locations in your facility that are the most visible to your employees who are likely to have rechargeable batteries to recycle. You want to place your rechargeable battery collection boxes in the departments that use the most batteries. Likely departments to consider include radiology, biomedicine/clinical engineering, emergency medical services, environmental health and safety, housekeeping, information technology, waste management, and security.

➤ Step 4: Create an internal communications strategy to introduce the program to your employees and encourage recycling. Consider the ways that all of your employees, and specifically those in the departments that use the most rechargeable batteries, receive important information. Develop a strategy that uses those communication vehicles to launch your program. Ways to build support for your program include displaying signs promoting the program and explaining how to participate and meeting with key contacts in each department.

➤ Step 5: Enroll in a rechargeable battery recycling program. You will begin saving money and reducing your facility’s carbon footprint.
Recycling program  < continued from p. 11

lead acid, nickel cadmium, and nickel metal hydride make up the bulk of these and, pound for pound, constitute the majority of Seton’s hazardous waste generation.

A growing program for hospitals

Call2Recycle, a national nonprofit organization based in Atlanta, has seen increasing interest from hospitals, from 25-bed facilities to 1,000-bed facilities, says Tim Warren, the account manager who serves the healthcare industry.

Currently, more than 1,000 of the country’s 5,800 hospitals participate in the program, he says. Last year, Call2Recycle recycled about 188,000 pounds of rechargeable batteries from hospital and healthcare organizations.

Rechargeable battery recycling efforts increased about 120% in United States hospitals in 2010 over 2009.

Call2Recycle is run by the Rechargeable Battery Recycling Corporation, and the battery manufacturing industry pays for the cost of the program.

The program is attractive to hospitals because of the increasing volume of rechargeable batteries used in medical equipment, communication systems, and information systems, Warren says. Batteries are used in everything from infusion pumps and patient lifts to computers on wheels. Typically, bioengineering and biomedical departments generate the largest quantity of rechargeable batteries, he says.

“Hospitals are telling us they are saving thousands of dollars per year,” says Warren.

Before joining Call2Recycle, Seton took its rechargeable batteries to a local recycling facility. Although the facility didn’t charge the healthcare system to take the batteries, there were a number of types it wouldn’t accept, forcing Seton to dispose of them through its hazardous waste vendor at considerable cost, Wehner says.

Call2Recycle provides Seton with postage-paid boxes to ship a variety of sealed rechargeable batteries to its facility for environmentally responsible recycling, he says. The boxes will hold a total of 45 pounds and individual batteries up to 11 pounds. For larger batteries, the program accepts shipments of pallets of 500 pounds or more, also shipped for free.

Most of Seton’s battery waste is generated in the biomed department, although maintenance also generates some waste from its operations, Wehner says.

Once Call2Recycle receives a box, it automatically sends out an empty replacement box. At the end of the year, the organization sends each hospital a computerized accounting of how many pounds of batteries were recycled, which “is a great way to demonstrate how green your facility is,” Wehner says.

Visit www.call2recycle.org for more information about Call2Recycle.
Studying the aftermath of the Tucson shooting

Security department at Arizona hospital deals with media onslaught

On Saturday, January 9, U.S. Rep. Gabrielle Giffords (D-AZ) appeared at a local event called “Congress on Your Corner,” held at a supermarket parking lot in Tucson, AZ.

The event was similar to many other past appearances until things took a drastic turn for the worse when a gunman stepped forward, opening fire on Giffords and the crowd, leaving six dead and 12 wounded.

Miraculously, Giffords—who was shot in the head at point-blank range—was among the survivors, albeit in critical condition.

She was immediately sent to University Medical Center (UMC), an independent nonprofit 365-bed hospital in Tucson. As surgeons and doctors at the facility cared for the wounded congresswoman, the security department was quickly thrown into a unique situation. Many urban hospitals have to deal with the potential aftermath of a shooting, but the involvement of a government official escalated the circumstances to another level.

In the days and weeks that followed, the security department teamed with the local police department, federal agents, and the Secret Service to ensure that no further incidents occurred, control the media storm that followed, and keep the hospital running smoothly.

Initiating an immediate lockdown

When the security department received word that Giffords would be arriving at the hospital, it initiated an immediate lockdown to establish access control, says Harry Kirlin, director of security services at UMC. “What we did was immediately put the hospital on kind of a lockdown situation,” Kirlin says. “In other words, we funneled everyone who comes in and out through one entrance, with security officers there to make sure that they needed to be there and belonged there.”

This procedure is essential during any potential security threat, says Fredrick G. Roll, MA, CHPA-F, CPP, president and principal consultant at Healthcare Security Consultants, Inc., and Roll Enterprises, Inc., in Frederick, CO.

“If they went to their emergency lockdown and their campus lockdown—which they should have as part of their emergency management plan—certainly things should have fallen into place,” Roll says. “If they went to their emergency lockdown and their campus lockdown—which they should have as part of their emergency management plan—certainly things should have fallen into place,” Roll says.

However, a situation like this presents extra complications, wherein security is not just concerned with visitors in the hospital. Because the shooting quickly became a national news story, news outlets from all over the country descended upon UMC.

“When something of that magnitude happens, you are totally overwhelmed by media from all around the world, and they’re going to do their damnedest to get in there and get a story,” Roll says. “So that’s why access control is so important to the campus and particularly to the building, and then on the inside what we call ‘security-sensitive areas.’ And in Giffords’ case, that would have been surgery and ICU.”

Dealing with a national media storm

Once the news broke, national media outlets quickly jumped on the story, sending correspondents and reporters to Tucson to cover the story on-site.

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“The news media were probably the single biggest thing to deal with because we had so much for such a long period of time, but they were very cooperative,” Kirlin says.

UMC set up an area outside of the hospital to house the media and hold daily press conferences to update the press without bringing them into the hospital.

“What a lot of places will do as part of their [emergency management] plan is to identify a certain parking area where they will allow the media to set up their trucks and put up their towers,” Roll says. “And if you don’t identify it, they will go wherever they feel is appropriate.”

UMC used a building adjacent to the hospital for media reports every morning at 10 a.m., delivered by Peter Reid, MD, the attending trauma surgeon for Giffords. The security department also arranged to have portable toilets brought in and worked with the hospital cafeteria to provide food and coffee, which went a long way in gaining media cooperation.

“The comment we got from a lot of the media people was that they had been treated better here than they had anywhere else,” Kirlin says.

The other important aspect of dealing with the media was providing regular updates to keep them apprised of the situation. Neglecting the media, especially in a situation with such a high level of interest, can only cause more access control and security problems.

“If you have a spokesperson that goes back and forth on a regular basis to keep them informed, then they will work with you,” Roll says. “But if you’re not doing that, they will definitely work against you.”

Checking in patients and visitors

Once the emergency plan was activated and the facility went into a lockdown, UMC security’s primary responsibility was checking visitors at the door, Kirlin says. All security officers were immediately put on 12-hour rotating shifts. The medical center canceled days off and maintained that schedule for the first week that Giffords was receiving care.

Check-ins were handled by security officers as well as admission transition management, with support from the Tucson Police Department.

“For the first few days, everyone that came in through the hospital came in through one entrance and checked in and we would verify them,” Kirlin says. “If it was someone coming for a clinic appointment, we had to verify that.”

Visitors and patients were very understanding of the situation and the added time it took to check in for appointments, partly because security also focused on customer service.

“I would go out and talk to the people waiting in a line for five to 10 minutes; just stop by and say, ‘Sorry to hold you up, hope you understand,’ ” Kirlin says. “Everybody was very cooperative, saying, ‘We understand, we’re glad to see it.’ ”

The medical center also had local police, Secret Service, and U.S. Capitol Police guarding Giffords’ room and the ICU during her first week at UMC to provide further access control.

Security created a specific procedure for people who had a legitimate reason to be in the ICU, particularly other patients, visitors of those patients, and Giffords’
they can come and go with relative ease, without having to potentially confront the media.

“If her husband were to walk up and there’s this media mob there, they are going to attack him to get a comment or get his picture,” Roll says. “So you might want to look at a back door or separate way, or at least friends and family. “We set them up with a specific badge that identified them as being appropriate to be in that unit,” Kirlin says. “So it was a shortcut for them to get in and out. We had a lot of things like that just trying to make it work for everybody.”

Roll says it is a best practice in a situation like this to develop a separate entrance for friends and family so

Developing an emergency plan for ‘VIPs’

Just as hospitals develop plans for emergency situations that impact security—such as hostage situations, gang-related crime, or armed visitors—facilities should develop some sort of plan that involves the arrival of high-profile patients, says Fredrick G. Roll, MA, CHPA-F, CPP, president and principal consultant at Healthcare Security Consultants, Inc., and Roll Enterprises, Inc., in Frederick, CO.

Under EM.02.02.05, The Joint Commission calls for hospitals to develop plans for events that affect internal safety and security, including the following requirements:

➤ Define the roles of the community security agencies
➤ Coordinate security activities with community agencies
➤ Consider how access will be controlled in and out of the facility
➤ Determine how internal movement and individuals will be controlled during emergencies
➤ Control vehicle access to healthcare facilities during emergencies

In 2008, The Joint Commission removed specific requirements to plan for “VIP” patients, requiring hospitals to bundle those plans into their overall policy.

Fortunately, the Secret Service identifies hospitals that will be used during an emergency involving a federal official and conducts an annual walk-through at those facilities to familiarize themselves with the hospital’s layout and resources.

Further, the hospital is able to develop an appropriate plan for this type of situation so it can appropriately identify the first few steps during this kind of incident.

“It’s something we’ve talked about in the past,” says Harry Kirlin, director of security services at University Medical Center in Tucson, AZ. “It’s difficult to write a plan for that kind of individuality. A lot of it is a general idea of what we will do and then we’ll tailor it to meet the needs at the moment of the event. Based on that, you make decisions on who needs access and how to provide that access in the most effective manner.”

The very first part of your facilities plan should address how to shut down the campus or the hospital to establish access control.

“One easy way to do that quickly and initially is you go to your after-hours lockdown,” Roll says. “Sometimes you can do that electronically; if it’s a newer building and has the right equipment, you can flip a switch and those doors just lock. Other times we need to have staffing do that or we need to have facilities management help us do that.”

Kirlin cautions that you also want your plan to incorporate some flexibility to adapt to any situation. “You have a basic idea of what you are going to do, but you also need to be flexible enough to change that as situation and circumstances change in the middle,” he says.

These plans should also highlight the importance of a close relationship with local police and Secret Service, Roll says. Belonging to the local police community groups and associations and asking local police departments to do a walk-through of your facility, or even practice emergency exercises, helps build that relationship.

“[Administration] gets really nervous if it’s a SWAT team exercise and they are running through the psych unit, but if you have a building that’s under renovation, for example, you can call the cops and say, ‘Hey, we have this building under renovation, there are no patients in there right now, are there any exercises you have in mind?’” Roll says. “The more you build those relationships, then all of this stuff seems to work out a little bit better.”

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a way to escort him through that crowd as quickly as possible.”

Outpouring of public support

UMC also had to deal with an outpouring of public support from the local community. Residents traveled to the hospital to set up a huge memorial on UMC’s front lawn.

Kirlin stationed two hospital security officers outside to direct traffic and control the front of the building because there were so many people.

“We had literally a couple hundred people at a time almost 24 hours a day for the first week or two, out on the front lawn lighting candles, putting up posters, and delivering teddy bears,” he says.

Working with local PD and Secret Service

Once Giffords arrived at the hospital, UMC security took a backseat role in favor of the jurisdiction of local police and federal agents. Its primary responsibilities quickly transformed to a supporting role to help the police and Secret Service.

“The security people are really only going to have control over these major situations for the first few minutes because when higher-ranking cops get there, they are going to take over,” Roll says. “It’s like a hostage situation. If there is a hostage situation, we expect the security people to do some initial stuff, but when the cops get there, the security people better get the hell out of the way.”

Secret Service and local police took over the hospital fairly quickly when Giffords arrived, Kirlin says. From there, the security department dealt with lockdown and check-in procedures and assisted the local police department with internal security.

“Probably the best thing that made it work here was that there was a lot of cooperation from all the various agencies and jurisdictions that were involved,” Kirlin says.

It also helped that UMC maintains a close relationship with the local police department as well as national security agencies. The hospital was already designated by the Secret Service as the facility in Tucson that would treat elected officials during an emergency.

“The Secret Service designates a hospital whenever one of their protective parties is going to be in the area, and they come in and do a check of that particular facility ahead of time to make sure [they understand] how things work should the need arise,” Kirlin says.

Once the local and national authorities establish themselves, security’s role should continue with core competencies, says Roll. For example, some hospitals assign security people to a hazardous spill team to deal with emergencies, without considering who will provide security support during a simultaneous event.

Managing a visit from the president

There’s no higher-profile visitor than the President of the United States, and University Medical Center (UMC) in Tucson, AZ, had to deal with a visit from President Obama and the first lady during the first week that U.S. Rep. Gabrielle Giffords (D-AZ) was undergoing treatment at the facility.

Although federal agents and the Secret Service handled a lot of the preparation and security measures, security provided support for the much-anticipated visit, says Harry Kirlin, director of security services at UMC.

“It was somewhat of a last-minute announcement that they were coming,” Kirlin says. “So the Secret Service was here the day before the visit, and then [Obama] came in the next day and actually came into the hospital and visited the representative and some of the other patients, and then had a big inspirational service at the university a mile or so south of us at the main campus.”

Security helped plan the president’s arrival to the facility and where he would enter, but the ultimate plan was determined by Secret Service staff members.

“Even then it’s kind of a last-minute thing,” Kirlin says. “The final decision-maker isn’t here until Air Force One touches down.”