Making HAZWOPER work for you
Part two: What’s in your emergency hazmat plan?

A large solvent spill has been cleaned up. Patients have been returned to their care rooms safely. Employees knew what to do.

So what helped things go so smoothly?

If your workers have some level of hazardous materials (hazmat) response as part of their duties, then there are certain things you want to have in place to keep government investigators happy.

Having these hazmat provisions in writing will help ensure your compliance with them. Here are three areas to look at:

1. Keep things simple
   Make changes that will keep confusion down among employees during a stressful incident, says Michael Callan, president of Callan & Company Ltd., a hazmat training company in Middlefield, CT.

   For example, if you have a yellow book that contains material safety data sheets, then don’t also have a yellow book for your written emergency hazmat plan.

Do you announce new births?
Tips on weighing the risks and alternatives

Hospital safety managers who have yet to address issues concerning the release of birth announcements to their local media might want to revisit those concerns soon.

Policies on birth announcements vary widely throughout the country. But overall, the trend is leaning toward ending the tradition of releasing the information to community news outlets in favor of posting the information on password-protected Web sites, if at all.

Some hospitals worry that it is too easy for would-be infant abductors to access information about newborns. They are also concerned about the security of newborn children in their buildings.

According to a report released in March 2000 by the National Center for Missing and Exploited Children (NCMEC), 104 children were abducted from hospitals in the period from 1983 through 1999. While these statistics do not indicate a national crisis, the gravity of this crime warrants serious consideration from safety officers—and surveyors from the Joint...
Consider the financial aspects of using safety needles
While their effectiveness sounds good, you must debate the costs

Like many safety officers, you’ve probably had a financial tussle or two with administration about obtaining safer equipment for your nurses, phlebotomists, and doctors to work with.

If having happier, more efficient employees doesn’t convince your chief executive officer to drop some dough, maybe it’s time to bring out the pie charts and show some dollar signs.

Case in point: safety needles.

Though such devices cost more to purchase than traditional needles, they could potentially save your hospital money through decreased injuries and related treatments.

Safety costs you plenty
Safety needles save money even though they usually cost at least three to five times the price of standard needles and syringes, says Erika McGovern, director of marketing for safety injection systems at Becton Dickinson in Franklin Lakes, NJ. Becton Dickinson manufactures traditional and safety needles.

“The cost varies dramatically,” says McGovern. “But when you start looking at the cost of needlestick injuries—such as treatment, testing, and lost work—you see how the balance goes toward savings.”

McGovern stresses that since Congress passed the Needlestick Safety and Prevention Act late last year, there is an increased federal emphasis on safety needles.

The legislation aims to protect health care workers from accidental needlesticks by requiring hospitals to review and make available safety-engineered sharps.

“The bottom line is that when you consider both the direct and indirect cost of needlestick injuries, providing safer devices is simply the right thing to do for health care workers, it makes good business sense, and it is now essentially the law,” says Steven Weinstein, MT (ASAP), MPH, CIC, HEM, an environmental, health, and safety specialist for Abbott Laboratories in Bedford, MA.

However, at least one government group—the General Accounting Office (GAO)—may disagree with a full-fledged endorsement of safety needles solely based on finances.

Finding middle ground
A report by the GAO, which is a federal watchdog agency, offers an interesting debate on supply-spending and long-term savings: While the use of more expensive safety needles would cost hospitals anywhere from $70 million to $352 million per year, the related savings in terms of reduced postexposure treatment expenses to injured health care workers could be from $37 million to $173 million annually.

“This analysis shows that the use of needles with safety features is cost-efficient when the costs of postexposure treatment are moderate or high and the added costs per [safety needle] feature are low,” states the GAO report, which came out in December.

The report does, however, support the effectiveness of safety needles in terms of worker well-being. It says an estimated 189 needlesticks from hollow-bore needles could be avoided each day in hospitals across the country if health care professionals used more safety devices.

The Centers for Disease Control and Prevention commended the report as objective within the limits of the study. The GAO researched the topic at the request of safety needle proponent Representative
Pete Stark (D-CA), who wanted to see an analysis of the benefits of using safety devices.

How much could you save?
The GAO estimates that using needles with safety features could prevent about 69,000 needlesticks per year.

Weinstein estimates the direct costs of a needlestick at between $500 and $3,000, with the higher end occurring when treatment is needed for exposure to HIV. However, the indirect costs are four to 12 times the direct cost, he says.

Confused by this? To put it simply, direct costs are known costs, such as medical expenses or indemnities for injured workers. Indirect costs are things such as overhead, administrative expenses, and coverage of lost work time. Indirect costs are a multiplied factor of direct costs.

You need to consider the overall hit a needlestick could give your hospital’s coffers over a period of time.

Postexposure activities such as clinical treatment following a needlestick can often be expensive, especially if the injury involves exposure from a patient with HIV or hepatitis.

“Many drugs used for HIV postexposure treatment are expensive and have unpleasant side effects,” says the GAO report. “Even when a serious disease is not transmitted, the emotional distress of a needlestick injury can be severe and long-lasting, often requiring counseling.”

Focus on the highest risk
Although hospitals should work to reduce all needlesticks and puncture injuries, they should also concentrate their efforts on the job activities that have the greatest risk for bloodborne infections, Weinstein says.

For example, he believes that phlebotomists have a disproportionately high rate of occupationally acquired HIV infection compared to others in the health care work force.

He also estimates that although 50% to 70% of health care facilities have implemented safer devices for intravenous line manipulations, only 20% to 30% have provided safer blood collection devices for their staff.

“Infection control practitioners, and safety and occupational health staff, should team up with supervisors and employees to identify the most hazardous jobs through job safety analysis and identify which safer devices are user-friendly and cost-effective,” Weinstein said.

Editor’s note: To read an online version of the GAO report—titled Occupational Safety: Selected Cost and Benefit Implications of Needlestick Prevention Devices for Hospitals—go to www.healthsafetyinfo.com/pdf/gao.pdf.

How the use of safety needles affects hospital budgets

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<th>Increased needle costs</th>
<th>Decreased treatment costs</th>
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<td>$70m–$352m</td>
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Conclusion: Use of safety needles is cost-efficient when the costs of postexposure treatment are moderate or high and the added costs per safety needle are low.

Source: General Accounting Office
Birth announcements

Commission on Accreditation of Healthcare Organizations (JCAHO) will probably take a good hard look at your policies.

View from the heartland
In February, seven hospitals in Iowa announced that at the urging of the JCAHO they would stop releasing new birth information to newspapers due to abduction concerns, according to stories from the Des Moines Register and the Telegraph Herald of Dubuque. The hospitals are in locations throughout the state and from several different health care systems.

However, five other hospitals, including three in Des Moines, decided not to change their policies and to continue to release information as they have in the past. A main reason for not changing the policies was the parents, who felt newspaper birth announcements were an excellent way to inform long-distance friends and relatives of the happy event.

For other health care facilities, the issue has been moot for years. Northside Hospital Director of Safety and Security John McDonald reports that the Atlanta facility has not released birth information in more than eight years, citing concern about giving potential abductors critical information. The hospital now uses a password-protected Web site to announce births.

What can you do?
Educate parents on safety issues pertaining to print and Web birth announcements during prenatal training classes so they will be well versed on the hazards of both electronic and newspaper announcements, says Cathy Nahirny, supervisor for the case analysis and support division of the NCMEC.

The Joint Commission, however, recommended in a 1999 Sentinel Event Alert that hospitals stop releasing birth information to local media. (For a look at the JCAHO’s recommendations on preventing infant abductions, see the related story on p. 5.)

If this step is not an option at your hospital, consid-

Tips for staying safe with birth announcements

In its handbook, Guidelines on Prevention of and Response to Infant Abductions, the National Center for Missing and Exploited Children (NCMEC) has the following suggestions for hospitals that choose to release birth announcement information.

**For print media**
- Make sure birth announcement releases do not contain home addresses or other unique information that would put the infant or the family in jeopardy after discharge
- Make sure the parents understand the risk involved in using yard signs at their homes to publicize births

**For Web-based nurseries**
- Internet birth announcements should contain only the first name and last initial of the baby and parents and should not contain any references to the baby’s home address
- Don’t post any information until the mother and baby have been discharged and full written consent has been given
- Web sites that provide information other than the baby’s first name and last initial should be password-protected so that only family members and friends can access the site
- Hospitals should remove Web photos of babies after a short time, recommends Cathy Nahirny of NCMEC

Editor’s note: To read an online version of the NCMEC’s guidelines as a PDF document, go to www.ncmec.org.
Hospitals should discontinue sending birth announcements to newspapers as part of an overall plan to prevent infant abductions, says the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

In its Sentinel Event Alert on infant abductions, the JCAHO examined eight infant abductions and concluded that the root causes of these incidents included information-related factors, such as birth information published in the newspaper, a delay in notifying security officers of a possible abduction, and a lack of communication among caregivers.

Other root causes were insufficient security equipment, physical factors such as no line-of-sight to entrances and unmonitored elevators and stairs, and reluctance of staff members to confront unidentified people in the hospital.

In its environment of care (EC) standards, the JCAHO expects you to address baby security through EC.1.2, which requires that hospitals plan for a secure environment.

The Joint Commission recommends the following steps:

- Discontinue publication of birth announcements in local papers
- Increase education for parents about abduction risks and their responsibility for reducing this threat
- Attach identical numbered bands to the baby, mother, and father immediately after birth
- Take a footprint and a color photo of the child, and record the infant’s physical examination within two hours of birth
- Require maternity and other relevant staff to wear up-to-date, conspicuous identification badges with color photos
- Consider a swipe-card or keypad entry into a nursery and an infant abduction alarm system

Editor’s note: To read the JCAHO’s Sentinel Event Alert online, go to www.jcaho.org/sentinel/sentevnt_frm.html, scroll down to the “Sentinel Event Alert” link near the bottom of the list, and then scroll down to the April 9, 1999, entry.
Look beyond thermometers for mercury sources

An aide put a meal on a warming tray and brought it from the hospital kitchen to a patient’s room. The tray contained a mercury thermostat. Before the patient got the food, the thermostat leaked, spilling mercury all over the tray.

“Luckily, someone noticed [the] problem,” says Todd Dresser, CHMM, TURP, recalling the story. “Imagine if [the mercury] had just sprinkled out. It would have been ingested.”

An important lesson for hospitals is that mercury is not just in old-fashioned thermometers and blood pressure cuffs. For instance, common batteries are a source of mercury.

“The use of batteries is widespread in medical devices,” says Dresser, an environmental engineer with the Burlington, MA, Board of Health, who spoke at a mercury workshop in March in Lowell, MA.

Watch what you throw out
Did you know that thermostat controls for heating systems or microwaves, reed switches in some security systems, commercial heating and cooling equipment, and older fire alarm pull stations also contain mercury?

Such items should not be routinely thrown in the Dumpster or trash compactor. When burned off or otherwise released into the environment, mercury can make its way into water and contaminate fish. The toxic element then makes its way up the food chain to humans.

The Environmental Protection Agency (EPA) recommends that pregnant women and nursing mothers limit their consumption of freshwater fish to one meal per week due to mercury pollution concerns. Local authorities may encourage people to observe even stricter limits.

Many state and local departments of health offer advice on mercury collection and recycling. You can also ask your waste haulers and contractors whether they have programs to help your hospital safely dispose of the element.

Maintenance workers and contractors are often responsible for mercury pollution in hospitals because they simply don’t recognize the risks, Dresser said. A sealed item containing mercury isn’t a problem, but once the mercury leaks out, you must take precautions and clean up any spill.

Some helpful pointers
Here are some practical tips when dealing with mercury, as provided by Dresser and Denise Abell, a facility inspector for the Massachusetts Department of Environmental Protection:

• Don’t store mercury items near floor drains

• Map out your hospital and note the location of

Online help with mercury

[www.epa.gov/mercury/index.html](http://www.epa.gov/mercury/index.html)— This site has strategies and facts about mercury from the Environmental Protection Agency (EPA).

[www.epa.gov/epaoswer/hazwaste/id/univwast.htm](http://www.epa.gov/epaoswer/hazwaste/id/univwast.htm)— This link provides information on the EPA’s universal waste regulations.

[www.state.ma.us/dep/files/mercury/](http://www.state.ma.us/dep/files/mercury/)— This page features information on mercury from the Massachusetts Department of Health.

[www.sustainablehospitals.org](http://www.sustainablehospitals.org)— This page presents a variety of advice on mercury products from the Sustainable Hospitals Project, a Massachusetts group that helps health care facilities reduce occupational and environmental hazards.

[www.sustain.org/hcwh/](http://www.sustain.org/hcwh/)— This link is by Health Care Without Harm, a group that promotes environmentally sensitive policies for the health care industry.
mercury-containing items

- Make sure contractors are aware of the risks and check for the presence of mercury-containing products during construction or renovations at your hospital

- Don’t assume a contractor will dispose of mercury properly—instead, insist on knowing where the mercury will end up after it leaves your site

- Develop a mercury spill plan and decide who will be responsible for it

Along those lines, your hospital should have mercury spill kits on hand to deal with cleanups. Health care facilities usually have a good handle on personal protective equipment—such as gloves and goggles—when it comes to the basic necessities of mercury cleanup, says Ted Morang Sr., a sales manager for Spillkit.com, an environmental response company in Wilmington, MA.

Morang also recommends that you have an absorbent powder to soak up the mercury, a vapor suppressor (such as activated carbon), and an indicating powder that you shake over a contaminated area and let sit for a day in order to find any wayward mercury droplets.

Light bulb blues
You’ve probably heard the dilemma on fluorescent bulbs: They contain mercury, but they’re more energy-efficient than regular light bulbs.

There won’t be an end to using fluorescent lights, Dresser says. But you must be careful when disposing of burned-out or broken fluorescent tubes. It’s reasonable to expect occasional accidental bulb breaks and that does not require special cleanup. But you should not store or stockpile broken fluorescent tubes in a container or indoors, he adds.

Chucking dozens of used fluorescent lights is not considered incidental, and laws govern their disposal. Mercury products such as fluorescent bulbs fall under the EPA’s universal waste rules, which help to curb the amount of everyday hazardous waste thrown into the trash by encouraging recycling and lowering compliance costs. (For more information on universal waste, see the related story below.)

Some states also classify mercury thermometers as universal waste.

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### How does mercury fit into universal waste?

The universal waste rule aims to reduce the amount of common hazardous waste items in everyday trash.

The Environmental Protection Agency’s (EPA) rule encourages recycling and proper disposal of these items by reducing regulatory and administrative requirements for parties that generate the waste. Universal wastes include the following items:

- Batteries, such as nickel-cadmium and small sealed lead-acid batteries, which are found in many common items including electronic equipment, mobile telephones, portable computers, and emergency backup lighting

- Mercury-containing thermostats such as those found in almost any building or house

- Lamps, which typically contain mercury and sometimes lead, including fluorescent, high-intensity discharge, neon, mercury vapor, high-pressure sodium, and metal halide lamps

The rule eases the requirements of businesses—including hospitals—related to notification, labeling, marking, prohibitions, accumulation of time limits, employee training, response to releases, off-site shipments, tracking, exports, and transportation of this waste, according to the EPA. For example, the rule extends the amount of time that businesses can accumulate these materials on-site. States can adopt the entire rule or portions of it.
Callan says. Instead, make the emergency book red.

“You think that’s simplistic?” he asked an audience at a joint conference with the National Fire Protection Association and the Occupational Safety and Health Administration (OSHA) held in St. Louis in December.

“Trust me . . . when it’s simple, it can be done. When it can be done, it can be functional. If it can be functional, it can be in compliance,” Callan adds.

2. Use a checklist
OSHA wants to see particular compliance with its hazardous waste site operations and emergency response standard (1910.120)—commonly called HAZWOPER.

Section Q of that standard addresses responses to hazmat spills, which hospitals should pay attention to.

Coming up with a checklist based on the OSHA requirements in section Q(2) is a way to ascertain compliance with HAZWOPER, says Callan. (We’ve included a sample of such a checklist with this issue of BHS.)

OSHA wants to see that your plan has such things as lines of authority, places of refuge, site security, decontamination, and follow-up critiques (for more on critiques, see the related story to the left).

“For each one of these elements, you’ve got to go in and find it in your plan,” Callan says of the checklist. It will save you a lot of money in terms of developing future plans. It will also save you in potential fines, which OSHA can assess you for each missing piece of the plan if the agency visits you after a hazmat incident.

He warns hospitals not to use the checklist as a table of contents for a hazmat response plan because emergencies don’t flow so logically. But if your plan has these elements and you can identify them, then you’re on your way to compliance.

3. Form an incident command system
Also follow section Q(3) in the HAZWOPER standard, which addresses procedures for handling emergency responses. At the core of this requirement is having a chain of authority through an incident command system (ICS).

Many of you should already be familiar with the ICS because of requirements for emergency management
from the Joint Commission on Accreditation of Healthcare Organizations.

The ICS assigns specific duties and job titles for everyone in advance, so that people know their role during an emergency, says disaster planning consultant Russell Phillips, president of Russell Phillips & Associates/Medsafe in Rochester, NY.

“These positions are to have job action sheets, so in the disaster the incident manager does not have to keep telling everyone what to do,” Phillips adds.

Don’t be afraid to use elements of an ICS you may already have in place to satisfy OSHA’s mandates.

Other considerations
OSHA wants the incident commander to designate a safety officer for any given response as another part of Q(3). Callan says the safety officer in this case should have responsibility for watching those response workers who are at the greatest risk.

As you may recall from part one of this series in the last issue, there are a variety of training levels for hazmat response. One of the duties of the hazmat specialist level is to develop a site safety plan.

Unlike the checklist we mentioned earlier—which you should complete ahead of time as part of your permanent hazmat plan—the site safety plan is written at the time of an incident, with lots of blanks to fill in as things progress, Callan says. Hospitals could start a site safety plan for incoming hazmat teams responding to a spill.

OSHA does not have specific requirements for what a site safety plan includes, but in nonmandatory appendix material to the HAZWOPER standard, the agency suggests that such a plan have a summary of the risks on-site, a sketch of the area, locations of decontamination and clean zones, methods of communication, locations of command post and triage areas, and other relevant factors.

“This plan should be a part of the employer’s emergency response plan or an extension of it to the specific site,” says the OSHA standard.

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Requiem or revival for ergonomics? No one knows yet

Oh no, not another ergonomics story. Didn’t President Bush sign the repeal of that law?

Yes, he did. But that doesn’t mean the political brouhaha surrounding musculoskeletal disorders (MSDs) won’t someday affect your hospital.

And don’t forget, the Occupational Safety and Health Administration (OSHA) can still look for ergonomics problems under its general duty clause, says Jim Fetters, a trainer specializing in OSHA regulations who spoke at a Padgett-Thompson seminar in Danvers, MA, in March. The clause states that employers must provide their workers with jobs “free from recognized hazards that are causing or likely to cause death or physical harm.”

For now, OSHA isn’t saying what the future of ergonomics is, other than to push Labor Secretary Elaine Chao’s intent to revisit the issue.

Recent figures from the Bureau of Labor Statistics show that while ergonomic injuries declined over a one-year period, MSDs still accounted for one-third of all workplace injuries in 1999.

“This finding demonstrates the need for a solid, comprehensive approach to ergonomics,” Chao said in a statement on March 28.

The law that Congress used to knock down the ergonomics regulations prohibits any substantially similar rule from being issued. But already, Senator John Breaux (D-LA) has introduced a new bill to address ergonomic injuries, which would also discourage any MSD solutions that expand existing state workers’ compensation laws.

A hotly contested portion of OSHA’s defeated ergonomics standard required employers to maintain 100% of an injured worker’s earnings and benefits if that employee had to limit current job activities or be transferred to a temporary alternative job. In some cases this provision went beyond what worker’s comp laws allowed.

“In exchange for uncertain benefits, the ergonomics rule would have cost both large and small employers billions of dollars and presented employers with overwhelming compliance challenges,” Bush said in a statement.

There are some early indications that support may not be great for Breaux’s effort. Regardless, you should still embrace the spirit of the former law, says Steven Bryant, practice director of accreditation services for The Greeley Company, a division of HCPro, in Marblehead, MA.

“OSHA’s primary objective is to ensure workplace safety for employees,” Bryant says. “With or without the ergonomics rule, OSHA will still meet its objective of reducing workplace injuries. If an organization feels OSHA will close its eyes if someone comes in and sees injuries for musculoskeletal disorders because there’s no standard in place, that organization [could be cited].”
OSHA proposes $79,000 safety fine

The Occupational Safety and Health Administration (OSHA) has proposed penalties of $79,000 against a hospital for a series of alleged violations, though the facility says it has worked to correct the problems.

Many of OSHA’s alleged findings at Long Island College Hospital in Brooklyn, NY, were related to fire safety. On March 8, 2001, the agency cited the hospital for two repeat violations for low headroom in a fire exit access hallway and door, and for exposed electrical connections. OSHA says it cited the facility for the same alleged violations in March 2000.

Among the other problems at the hospital were alleged failures to

- keep an 18-in clearance between storage and sprinklers
- correct a fire door with a hole in it
- keep all fire exits unobstructed
- block abandoned shaftways that could carry smoke from floor to floor during a fire
- maintain fire extinguishers in fully charged conditions and visible locations
- remove extension cords used as permanent wiring

The hospital says that staff members corrected several deficiencies at the time of OSHA’s inspection in November. Those items not immediately addressed were put into a plan of correction that the facility submitted to OSHA, and since then the hospital has implemented the necessary fixes, according to a hospital spokesperson.

The hospital was expected to meet with OSHA to discuss the proposed fines.

Hospital dispels CJD fears

Trying to allay fears from the public, Exempla Saint Joseph Hospital in Denver says the community is not at risk after the Denver Post reported that two patients died at the hospital this year from Creutzfeldt-Jakob Disease (CJD).

Six others may have been exposed to CJD from tainted surgical instruments used while treating the infected patients, though doctors say the chances of these people getting the disease is slim.

The instruments were sterilized, but there is no evidence that this procedure kills the agent that causes CJD, hospital officials told the Post.

Exempla Saint Joseph assured the public in the Denver metro area that the rare brain illness is not spreading.

The original source patients had what is known as “classic” CJD—not the form that is caused by eating meat from a cow that had bovine spongiform encephalopathy, or “mad cow disease.”

CA facilities get break from blackouts

Hospitals in California have suffered because of widespread power blackouts that the state has instituted as a way to deal with a nosedive in energy supplies.

However, the state’s Public Utilities Commission recently ruled that all hospitals were exempt from rotating outages regardless of the status of backup or standby generation.

The commission had previously defined hospitals with 100 beds or more as “essential customers” that could not lose electricity unless they had backup generators, the Associated Press reported.

The move to expand the benefits to even those sites with generators, as well as small hospitals, is a way to protect all essential hospital services and not just those that generators would cover.

For more information on the commission’s full ruling online, go to www.cpuc.ca.gov.
Tip of the month

One hospital’s preparation pays off when it loses heat

Do you conduct emergency drills or otherwise have plans in place in case you lose heat in your hospital? If you don’t, you should think about it. As one hospital discovered, preparation can save you a lot of hassle during an unexpected problem.

At about 4:30 a.m. on February 5, Sinai Samaritan Medical Center in Milwaukee found out from the local power company that a boiler was down and that the hospital would lose its steam heat.

But Sinai Samaritan wasn’t paralyzed by the five-hour utility loss because it has worked around scheduled steam outages in the past, says spokesperson Jennifer Gross. Because of that preparation, officials did not activate the site’s disaster plan.

Milwaukee has harsh winters. And though it wasn’t particularly cold the day of the outage—temperatures were in the 20s rather than the typical 4-degree morning—staff members were prepared for the worst, Gross says.

When word got out about the steam heat problem, the staff members

- moved patients to the upper floors, which retain heat longer than lower levels
- brought out extra blankets for people
- closed window blinds in areas where drafts were a concern

Gross says she spoke hourly with the plant manager, who made frequent walk-throughs to make sure things were okay.

Sinai Samaritan has its employees go through in-house seminars that test their knowledge of safety measures. Further, the Joint Commission on Accreditation of Healthcare Organizations will want to see that your hospital has a plan in place in case one or more utilities go down.

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