Joint Commission focuses on suicide prevention rules during surveys

A new focus on preventing patient deaths results in high scrutiny. Here’s what to expect and what to do.

Patient injuries caused by self-harm and suicides have long been a problem with hospitals. With behavioral health patients becoming a more prevalent population in healthcare facilities, preventing suicides through thoughtful design has become a priority in most facilities.

It also is about to become more of a concern when it comes to meeting accreditation requirements, and you can expect Joint Commission surveyors to pay more attention to the way your facility helps to prevent suicides.

What will change?

Effective as of March 1, The Joint Commission has ordered its surveyors to immediately start placing more emphasis on the prevention of suicides in hospitals, and will start paying close attention especially to the assessment
of potential ligature (hanging) injuries, suicide, and self-harm monitoring, especially in psychiatric hospitals and inpatient psychiatric patient areas in general hospitals.

According to Joint Commission literature, the added emphasis on suicide comes at a time of national concern about suicides in the nation’s hospitals, and is meant to be in coordination with the “Zero Suicide” campaign, an effort by several national outreach groups trying to eliminate suicide in healthcare facilities nationwide.

Suicide prevention is also second on the list of The Joint Commission’s Sentinel Event Alerts (SEA), and was the basis for SEA #56, which was issued in February 2016 as a way of bringing attention to the problem. According to that alert, suicide is the 10th leading cause of death, and claims more lives than traffic accidents and more than twice as many as homicides.

Furthermore, The Joint Commission says that care providers often do not detect the suicidal thoughts (i.e., suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them received healthcare services in the year prior to death, usually for reasons unrelated to suicide or mental health.

What can you expect?

Hospitals will, of course, have to adhere to the usual Environment of Care (EC) and Life Safety (LS) standards that they’ve always had to when it comes to preparing for surveys, but you can also expect increased scrutiny on standards that were introduced from last February’s Sentinel Alert, including the following:

- **EC.02.06.01**, which requires facilities to establish and maintain a safe, functional environment.
- **National Patient Safety Goals (NPSG)**
  - **NPSG.15.01.01**, element of performance (EP) 1, which requires a risk assessment be conducted that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
- **EP 2**: Addressing immediate safety needs for patients and determining the most appropriate setting for treatment.
- **EP 3**: When a patient at risk for suicide leaves
the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

- **Provision of Care, Treatment, and Services (PC) PC.01.01.01, EP 24**, which requires that if a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse (think about where you house patients that come in under the influence to sleep it off), the hospital does the following:
  - Provides a location for the patient that is safe, monitored, and clear of items that the patient could use to harm himself or herself or others.
  - Provides orientation and training to any clinical and nonclinical staff caring for such patients in effective and safe care, treatment, and services (e.g., medication protocols, de-escalation techniques).
  - Conducts assessments and reassessments, and provides care consistent with the patient’s identified needs.

- **PC.01.02.0**, which requires hospitals to assess and reassess patients.

- **PC.01.02.13**, which requires hospitals to assess the need of patients who receive treatment for emotional and behavioral disorders.

- **PC.04.01.01**, which addresses patient needs for continuing care, treatment, and services after discharge or transfer.

- **Provision of Care, Treatment, and Services (PC) PC.04.01.01**, which governs the hospital’s process that addresses the patient needs for continuing care, treatment, or services after discharge or transfer.

- **Care, Treatment, and Services (CTS) CTS.02.01.01**, which addresses screening procedures for the early detection of risk of imminent harm to self or others.

- **Environment of Care (EC) EC.02.01.01**, which addresses the organization’s management of general safety and security risks.

In addition, The Joint Commission has indicated in written literature that during surveys, observations of ligature or self-harm risks will be documented, and may issue an Immediate Threat to Life citation in the worst-case scenarios while on-site (Hospital leadership would be notified immediately). Any violations would be written up by surveyors as a Requirement for Improvement (RFI). You and your staff should be able to show evidence or proof of the following to a surveyor that can answer the following questions:

- Has your facility previously identified these risks?
- What is your facility’s plans for removing these risks?
- What’s your organization’s environmental risk assessment process?

In addition, you can expect that surveyors will assess and scrutinize the following situations in your hospital:

- Any plans or policies on mitigation of harm posed by risks while removal of any violations found takes place
- Adequate staffing to support these mitigation plans
- Patient suicide risk assessment processes
- Action plans, as well as policies and practices related to patients identified at risk
- Ensuring staff awareness of a patient’s level of risk
- The organization’s internal processes for improvement, including:
  - History of patient safety events and the process for root cause analysis of these events
  - Process for monitoring compliance with its policies
  - Actions taken when noncompliance was identified

**What can you do?**

You’re probably asking yourself, “What can I do to make my facility safer?” and you wouldn’t be alone. While many newer facilities are being built with patient treatment areas outfitted to handle the intricate needs of behavioral health patients and other at-risk patients considered high suicide risks, older facilities
are struggling to retrofit their existing buildings at lower cost, while trying to remain in compliance with accreditation standards.

Fortunately, there is plenty of advice out there. The Joint Commission recommends the Design Guide for the Built Environment of Behavioral Health Facilities, published by the Facilities Guidelines Institute (FGI), and there are also the design guidelines, published by the International Association of Healthcare Safety and Security (IAHSS), that has lots of information regarding helping prevent patient suicides and harm.

In the meantime, there are things you can do now to assess your facility, and take measure with your staff to help cut down on the risk. Experts say you should consider the following:

Decrease boarding times. Many safety experts say that long waits are major precursors to violence and anxiety among patients, especially to behavioral health patients, forensic patients, or any others prone to harming themselves or others. Anything you can do to cut current waiting times and keep boarding times down will help to decrease the risk of violence or suicidal behaviors.

“Sometimes at least half our ED psychiatric patients are being boarded, often for eight hours or more or even several days,” says Peter Charvat, MD, an ED physician at St. Cloud (Minnesota) Hospital. “We often get these patients transferred to us from outlying cities, psychiatrists in the community, and law enforcement. Many of the hospitals in our area don’t have the resources to handle these patients, so they are sent here.”

Make the environment friendly. Many hospitals are creating behavioral health units—and more patient treatment areas in general—that boast high ceilings, open areas, and large windows that allow more natural light to come in. The result? Friendly, therapeutic places that calm patients and give a greater overall feeling.

What you do will depend on your space and budget, but picture behavioral health units with “wander space,” to a group area to hang out and walk off their energy as opposed to sitting around. Some hospital waiting rooms are being designed with a living room feel, with even comfy furniture and fireplaces in some cases, as well as showers and video game areas to create a less-threatening environment for those who may be subjected to longer stays.

Design through the eyes of the suicidal. In 2013, Minnesota hospitals began redesigning patient rooms, when it was found that facilities there were seeing some of the highest national rates of suicides since the 1990s. As a result, facilities began floor-to-ceiling reviews of room designs, eliminating any features that patients could use to potentially harm themselves.

“Patients who are determined to harm themselves can do so by self-strangulation or by banging their heads on the floor or on a wall,” said Kathy Knight, vice president of behavioral services at University of Minnesota Medical Center-Fairview, in a report in the Star-Tribune of Minneapolis. “It’s very challenging to prevent suicide when there is a deep determination to die.”

In its psychiatric units, the hospital concentrated on patient bathrooms, which is where many suicide attempts take place (here’s your documentation as to your plan of attack, for the surveyors).

“There are no pinch points in the doors anymore,” Knight said in the Star-Tribune report. “We have breakaway shower heads. The handles on the faucets are modified. We don’t have door knobs. There really isn’t anything that we don’t constantly look at.”

Think about flexibility. If you have a behavioral health patient who needs a special room—and all your rooms are filled with equipment that they could potentially harm themselves with—they’ll have to wait until you can accommodate them, and that can lead to other problems. Why not redesign your rooms so that they can accommodate anyone?

To cut down on hazards, some facilities have begun designing “multi-modal rooms” that can be transformed depending on the needs of the patient being treated. Need a safe room for a behavioral health patient? Regular rooms are designed with medical equipment, oxygen tanks, IV pole, and other potentially harmful items behind a sliding “garage door” that can be pulled down and secured.
Lower surfaces. Although it can be pricey and difficult for older hospitals to renovate current spaces, newer construction is focusing on design elements that provide fewer opportunities for patients to harm themselves. “You want to design it in such a way that it makes it difficult to jump off higher areas,” says Thomas A. Smith, CHPA, CPP, president of Healthcare Security Consultants, Inc., in Chapel Hill, N.C. Smith has served on a task force for construction and renovation for the IAHSS, which focuses on recommendations ranging from avoiding high parking decks to rooftop play areas (a hospital in North Carolina tried it).

“The people that create these spaces create what’s called an attractive nuisance,” he says. “Just by the nature [of] how it’s designed, it has safety issues or people could easily commit suicide.”

Search everyone. Especially in a busy emergency room environment, it can be difficult to assess who will be a violence or a suicide risk, so many hospitals have developed procedures for screening patients as they are admitted. Clothes are removed; sharps, belts, and jewelry are inventoried; and purses and other belongings are placed somewhere safe. In the meantime, a nurse or other staff member asks some basic questions to ascertain each patient’s baseline mental status. Finally, a patient may be given a color-coded set of scrubs to dress in. “Does this mean you strip search everyone? Maybe not, but in some places a purple gown can ID someone as high risk,” Smith says.

Use checklists. Many physicians and hospitals swear by checklists to minimize mistakes in the surgical suite; now, some hospitals are adapting checklists to other areas, such as the behavioral care unit. St. Cloud Hospital uses a checklist that gives staff a list of things to do when preparing a room for a new patient arrival. Tasks on the checklist include things like moving extra garbage cans into the bathroom, removing excess furniture and cords, taking down decorative crucifixes, and folding a room’s computer up into a wall when it’s not being used.

How a rolling OR stool cost a hospital $7 million

After a surgeon’s fall, one hospital in Georgia learned how expensive unsafe furniture can be carry 30% of the blame for the incident, the judgment was apportioned to reflect the hospital’s 70% share in the liability, leaving the facility on the hook for $7 million.

“Unfortunately, this is yet another example of the growing trend of out-of-control jury verdicts,” said William R. Johnson, JD, a partner with the Moore Ingram Johnson & Steele law firm, in a statement. The defense team was correct, he added, to argue that Corbitt should be awarded nothing. (If the jury had saddled Corbitt with at least 50% of the blame, he would not have been entitled to collect damages under Georgia law.)

Rather than appeal the judgment, however, the Hospital Authority of Valdosta and Lowndes County voted in February to authorize a payment of $2.3 million, with an insurance company covering the
remainder of the $7 million tab, as The Valdosta Daily Times reported.

The judgment serves as a stark reminder of just how expensive a simple piece of furniture can become when its presence in a medical setting is implicated in a personal injury case. More broadly, experts say the story points to a need for proactive vigilance in identifying and mitigating ergonomic risks.

Caster safety
At the center of Corbitt’s complaint were four casters attached to the bottom of the four-legged stool. Calling upon expert testimony to bolster his claims, the doctor argued that the stool rolled too easily across the OR floor, presenting a safety hazard.

“The hard, plastic caster wheels may have been perfectly suitable for use on a soft, carpeted flooring surface, but the casters were wholly unsafe and unsuitable for use on the hard, slick flooring surfaces present in Defendant’s operating rooms,” Corbitt stated in court documents. He alleged, furthermore, that South Georgia Medical Center bore sole responsibility for selecting and purchasing the stool, then making it available for use in an inappropriate setting.

Corbitt argued, based on scientific testing conducted by his team of experts, that a stool with hard plastic casters is “over 100 times more likely to roll out from under a user” than a stool with rubber wheels.

Corbitt pointed also to Caster City, a Las Vegas–based supplier of casters and wheels, for general guidance on flooring compatibility. The company’s website notes that hard wheels should be used on carpet, and soft wheels should be used on hard flooring. It includes a chart that juxtaposes seven types of casters with 11 flooring materials, using stoplight colors to code each of the 77 potential combinations: green for “good,” red for “not recommended,” or yellow for “possible,” contingent upon professional consultation.

Safety experts agreed that flooring compatibility should be a key consideration when deciding how to furnish a given medical setting.

“You need to make sure you get the correct type of caster for the job you’re trying to accommodate,” says Cindy Taylor, ARM, CSPHP, director of Workers’ Compensation and Ergonomics for UNC Health Care in Chapel Hill, North Carolina. Even in the absence of a specific regulation pertaining to rolling furniture, she says, OSHA, CMS, and The Joint Commission all expect that medical environments are kept safe for staff, patients, and visitors alike.

“For any environment, it is the responsibility of the safety professional to review data for trends and follow up on any incidents which could have been prevented,” Taylor says. “Identifying potential and existing workplace hazards and taking action to prevent these hazards should be number one for any safety professional.”

If workers report problems with a particular piece of equipment or furniture, efforts should be taken immediately to assess and address the problem, to prevent future mishaps. That’s where South Georgia Medical Center fell short, according to Corbitt’s complaint, which argued that a surgical technician had experienced and reported problems with the same type of stool involved in his fall. Corbitt complained that the technician’s report had not been passed along to the hospital’s safety director and that it did not result in a substantive investigation or corrective action prior to his injury.

Ergonomics and OSHA
Beyond casters alone, the big lesson to be taken from Corbitt’s lawsuit is that healthcare personnel need to be paying attention to ergonomics, says Dan Scungio, MT (ASCP), SLS, a lab safety officer for Sentara Healthcare, a multi-hospital system in Virginia. In older facilities, especially, there are numerous furniture arrangements that offer less-than-ideal working conditions, introducing the prospect of long-term or even immediate harm, he says.

“Some ergonomic injuries are slow, and you don’t realize that that’s happening until it’s too late, until you’re near retirement, until something permanent has happened and it’s not fixable or it has to be fixed by some sort of surgery or a brace or medication or
anything like that,” Scungio says. “Or some of them, like this case in Georgia, are instant.”

For more than 30 years, OSHA has been wrestling with ergonomics issues, offering training and guidance along the way. In late 2000, after several years in the rulemaking process, the administration issued its Ergonomics Program standard, but the regulation was quickly repealed in 2001 when newly inaugurated President George W. Bush signed a congressional joint resolution into law, undoing the rule and barring OSHA from enacting anything substantially similar to it.

Elaine Chao, who served as Secretary of Labor during all eight years of Bush’s tenure in the White House and who now serves as Secretary of Transportation under President Donald Trump, explained later in 2001 that the Republican administration was looking for a way to better approach ergonomics in a manner that would promote worker wellness while also respecting differences across various workplaces and sectors of the economy.

“We want American workers to be safe, but we also want them to have jobs,” Chao said in a speech at George Mason University. “Placing unnecessarily onerous regulations on America’s employers won’t help American workers. It will only help put them out of work.”

Chao said she would instead seek “a reasonable middle ground” that protects workers and their livelihoods.

Even in the absence of a comprehensive rule devoted specifically to ergonomics, OSHA has held that the duty of employers to keep their workplaces generally “free from recognized hazards” includes ergonomic hazards. If an employer fails to make a good faith effort to reduce ergonomic hazards, OSHA could, therefore, issue a citation under the General Duty Clause.

Similarly, the statutes cited in Corbitt’s lawsuit pertain to general provisions of Georgia law, not to laws about specific furniture or flooring materials. This highlights once again that healthcare safety professionals must ensure their dedication to regulatory compliance comes coupled with a commitment to spot and proactively mitigate additional hazards as well.

Despite the successful application of general provisions of law, some contend that a specific ergonomics standard from OSHA could still be a worthwhile addition.

“I’m not always a fan of more rules and regulations,” Scungio says, “but a standard from OSHA would at least force employers to pay more attention to ergonomics when so many don’t.”

Look at ergonomics more broadly

Tamara James, MA, CPE, CSPHP, director of ergonomics for Duke Health and Duke University in Durham, North Carolina, says the Corbitt case should remind institutions to furnish their facilities as meticulously as they design and build them.

“We often see and hear of situations where furniture is specified without regard to the total environment, even without regard to the users, maybe, or how it’s used,” James says. “And that’s a classic situation, it sounds like, where the wrong casters were specified. You don’t put carpet casters on a linoleum floor, you just don’t.”

James, who launched Duke’s ergonomics program 24 years ago, joined forces with Duke Patient Care Ergonomics Coordinator Yeu-Li Yeung, OT/L, CPE, CSPHP, who has worked in the office 14 years, to offer several pointers for safety professionals looking to shore up their ergonomics initiatives:

Review voluntary standards. The American National Standards Institute (ANSI), for instance, publishes a variety of guidelines applying ergonomics principles in specific settings, and the ANSI–accredited Business & Institutional Furniture Manufacturers Association (BIFMA) produces safety and performance standards and guidelines for furniture. The ergonomics team at Cornell University is a great resource for tips and checklists, James adds. (Visit their website at www.ergo.human.cornell.edu.)

Consider all points of interface. When assessing whether to place a given piece of furniture in a given workspace, you should consider who will be using it and for what purposes.

“When we do evaluations, we always look at three
things: how the person, the environment, and the task work together.” Yeung says, noting that it’s often easier to change the environment than it is to change the person or task. “The flow should make sense.” James noted that assessing these “points of interface” should account for any expected movement of the furniture and any number of likely users.

“If that piece of furniture is going into a pediatrics clinic, you need to think about the fact that there’s going to be little kids climbing all over it and jumping on it,” she says. “What’s the impact of that?”

Test a sample. “If you’re going to buy something, then tell the vendor, ‘Bring one to me. Let me try it. Let me use it with my staff to make sure this is going to work,’” James says. “I would never buy a mattress if I didn’t at least lay on it for a few seconds. It’s no different. You have to try this stuff because you can’t just order things online and expect them to work or just order them out of a catalog and expect them to work.” Educate workers. Even if the environment is set up perfectly, there is still potential for individuals to misuse equipment or furniture, Yeung notes. This is where ongoing educational efforts can promote best practices among workers and continue reducing the likelihood of potentially expensive furniture misadventures.

For more on the Duke Ergonomics Division, including links to resources and exercises, visit www.safety.duke.edu/ergonomics.

OSHA: Workplace injuries and illnesses come at a high cost to hospitals

Editor’s note: This sidebar was adapted from the report Facts About Hospital Worker Safety, published in 2013 by OSHA.

When an employee gets hurt on the job, hospitals pay the price in many ways—some obvious, some not. While some of these costs are difficult to quantify, a single serious injury can lead to losses of tens of thousands of dollars or more. Workers’ compensation claims include medical costs to treat or recover from the illness or injury, compensation for wages lost—also known as indemnity—and administrative costs. The costs associated with workers’ compensation claims depend on both the frequency of claims and the severity of these claims.

Claim frequency. In 2011, hospitals experienced injury claims at a rate of 0.099 claims per $100,000 of payroll, according to a 2012 survey conducted by Aon Risk Solutions of 53 healthcare systems across the United States. This represents a decrease over the preceding decade, which Aon attributed to improvements in assistive technology, such as safe patient handling equipment, increased experience of staff due to lower turnover rates, and a focus on improving the safety environment for patients that has also benefited workers.

Claim severity. During the most recent five years studied in Aon’s survey, hospitals have seen a steady loss rate of about $0.78 per $100 of payroll. As the total number of claims has decreased somewhat over time, however, the average loss per claim (the severity) has increased. In 2011, the average loss per claim settled was $15,860. Of this cost, on average, indemnity accounted for $12,420, medical $2,790, and administrative expenses $650 per claim.

A few large claims typically account for a considerable portion of the total cost. Only 1.3% of the claims studied in Aon’s survey exceeded $100,000, but they accounted for more than 47% of the total costs.

Unlike other industries, hospitals can treat their own injured workers on sight. This can result in underestimates of the cost of medical treatment for workers’ compensation claims, as hospital employees are often given an “employee discount” for treatment.

Three-quarters of the hospitals polled by Aon reported being self-insured, as is the case for many hospitals across the industry. So they bear the entire cost of workers’ compensation losses directly.
Joint Commission: Leadership key in push for culture of safety

Solid leadership is central to promoting and sustaining a culture of safety in any healthcare organization, The Joint Commission said in its latest Sentinel Event Alert, published in March to remind leaders that it’s their job to identify and mitigate potential pitfalls on an organizational level.

People will err, and equipment will misfire, but a systemic approach to safety will aim to catch mistakes before they harm patients and, in the event of a negative outcome or a close call, see the situation as a learning opportunity, the alert states.

“Although this latest alert was in regard to patient safety, I do absolutely believe that leadership is central to developing a safety culture for patients, visitors, and staff,” says Cindy Taylor, ARM, CSPHP, director of Workers’ Compensation and Ergonomics for UNC Health Care in Chapel Hill, North Carolina. “If you do not have the support of leadership, you will not be able to create a safety culture.”

The alert, which updates and replaces a previous version issued in 2009, outlines actions leaders should take within their organizations to build trust, accountability, an eye for safety hazards, stronger systems, and means of assessment.

First on the list is ensuring that the adverse-event reporting process is neither opaque nor focused solely on doling out punishments.

This nonpunitive approach can increase error reporting, giving organizations more data points to analyze in the never-ending search for weak spots to be patched.

The alert calls for organizations to root out any intimidating behaviors that might discourage workers from reporting problems, and it encourages them to give special recognition to those who spot and report unsafe conditions. The document urges leaders to quantify the health of their safety culture and track it over time.

Steve MacArthur, a safety consultant for The Greeley Company in Danvers, Massachusetts, who co-authored The Hospital Safety Professional’s Handbook with Taylor, says he doesn’t see anything particularly novel in the latest alert.

“I guess it’s possible that this might light a fire under folks to move the ball forward with a little more quickness, but organizational culture does not turn on a dime,” MacArthur says. “The real focus of this is that it puts organizational leadership on the hook for making this happen.”

The paradox of strong leadership in this case is that you cannot force a cultural change. Leaders can explain and model safety procedures, but they cannot mandate safety culture, says Ken Weinberg, BA, MSc, PhD, consultant in environmental health, safety, and toxicology for SafDoc Systems LLC in Stoughton, Massachusetts.

“What develops a safety culture is getting people to understand how they can create a safe working environment for themselves,” Weinberg says.

Suggested actions

The Joint Commission outlined 11 recommended actions and related resources in SEA 57, noting that the recommendations are designed to be implemented simultaneously, not in a particular order. They are as follows:

1. Reporting systems should avoid secrecy and obsession with punishment. Anyone within your organization should be able to report any mishap, near miss, or unsafe situation without fearing reprisal or penalty for an honest error.

2. Distinguish between mistakes made by individuals and those stemming from flawed systems. Treat individual errors as learning opportunities, while using tools like the Incident Decision Tree published by the UK’s National Patient Safety Agency to promote transparency in your ac-
countability process.

3. **Model good behavior from the top.** Organizational leaders must embody the respectful and engaged demeanor they expect from their staff.

4. **Communicate expectations.** Every team member should be made aware of the safety policies that have been established and enforced.

5. **Praise those who speak up.** To help dismantle the culture of fear that discourages staffers from reporting safety concerns, actively encourage those who spot problems and report them.

6. **Quantify your safety culture.** Measure the health of an organization’s current safety culture using the Agency for Healthcare Research and Quality’s Hospital Survey on Patient Safety Culture.

7. **Study your own data.** Survey results regarding safety culture within your organization could contain clues on where you might improve safety and/or quality. Break the data down by unit, and share what you find.

8. **Create a plan, and test it.** Based on your unit-level data, devise and implement one or more efforts to improve safety culture.

9. **Marry safety culture training with broader projects.** Incorporate safety-related team training as you pursue initiatives to improve overall quality.

10. **Foster an enterprising spirit.** Encourage go-getters to identify strengths and weaknesses of drug-management, electronic health records, and other systems, in order to pursue possible improvements.

11. **Review progress regularly.** Conduct another safety culture review every 18–24 months. Break the data down to the unit level. Share the results.

The Joint Commission’s standards include specific requirements that leaders establish and sustain safety and quality organizationwide. (See LD.03.01.01, EPs 1, 4, and 5.) The full SEA is available online at www.jointcommission.org/sea_issue_57/.

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**Parkland Hospital unveils new HazMat Unit**

Decon SWAT unit formed in new facility on constant alert for chemical and biological emergencies

When an Amtrak train had derailed on the major Washington-New York rail corridor running through Philadelphia on May 12, 2015, officials feared the worst.

Within minutes, at least seven hospitals in the greater Philadelphia area, including Temple, received warning to get ready to receive hundreds of patients, from busloads of walking wounded to critically injured patients coming in via ambulance.

There was one question on everyone’s mind, though, before the first casualty came through the door: Could this be a terrorist attack, and are we looking at a major chemical spill response?

Ironically, Einstein Healthcare Network was one of the Philadelphia hospitals that had been working to create a specialized response team to deal with future cases of Ebola or any other incident requiring a rapid response of individuals trained in decontamination or triage. In the case of the train crash, officials did not know at first if it was a terrorist attack or involved hazardous materials that could affect the safety of the hospital.

“I needed to know about bomb residue, chemicals, or radiation,” says Herbert Cushing, MD, FACP, and chief medical officer of Temple University Hospital. “We were about 40 minutes in and I couldn’t let [staff] them keep treating people if there was an issue. We were able to get information from the scene about whether or not there were [weapons of mass destruction] involved.”

Thankfully, there were not. Officials said the communication system in place allowed officials to make quicker decisions about how to prepare.
“We didn’t have to gear up, but certainly in the back of your mind you’re wondering if this was a terrorist incident, and if maybe one of the patients was involved,” says John Ward, director of safety and materials management for Einstein Health Network in Philadelphia.

But what if the situation had been different? What if hundreds of patients started coming in with hazardous chemicals on them? What if there had been a nuclear accident? What if it happened in a part of the country where hospitals aren’t as numerous or well-trained for such a nightmare scenario?

Most hospitals have at least a rudimentary plan in place for dealing with emergencies dealing with decontamination, but in some areas of the country awareness has been raised about how preparation for such events have not kept up with the threat—after all, some hospitals can’t afford the training and equipment necessary to stay on constant alert for something that may never occur.

In Dallas, Parkland Memorial Hospital just opened up a brand-new 1.7 million-square-foot, 862-bed facility meant to go beyond what the state and Joint Commission requires. Texas Department of State Health Services requires that hospitals maintain a decontamination room but not a team ready to respond, and Parkland officials decided that wasn’t enough.

“Just a few months after I joined the decon team, Ebola hit Dallas and my involvement was critical at that point,” said Jennifer Ochieng, an infection preventionist at Parkland, to Healthcare Facilities Management magazine.

In October 2014, Dallas was put on the map when the first-ever Ebola case in the U.S. hit the city. Thomas Eric Duncan, a Liberian national who was visiting family in Dallas, became the first confirmed U.S. case when he checked into Texas Health Presbyterian Hospital with symptoms. He later died; two nurses that had been caring for Duncan at the hospital also came down with symptoms, but were treated and recovered.

In October, a New York City doctor who had been treating patients in Guinea tested positive for the virus and was later cured at Bellevue Hospital.

Also in late 2014, two large Virginia hospitals had their decon and Ebola response plans tested. The University of Virginia (UVA) Medical Center in Charlottesville and Virginia Commonwealth University (VCU) Medical Center in Richmond both had two separate patients who had been traveling in Africa who fell ill and were brought into their facility, suspected of having the Ebola virus.

“This was far and away the greatest outbreak of this magnitude, and everybody ramped up real quick,” said William Rockwell, BE, CHFM, hospital engineer for UVA Health Care System, which later was picked by the CDC as one of the nation’s 35 designated Ebola treatment centers.

Many large hospitals, including UVA, began thinking seriously about their Ebola plans after August 2014, when the first suspected U.S. case came into Emory University Hospital in Atlanta, and was followed later by Dallas. Following CDC advice, UVA decided to start its planning by focusing on the entry point of the ED.

“The knew they would present there, the staff were going to ask where they have been, and you’re going to go live right there,” Rockwell said.

His philosophy has been the cornerstone of many preparations in hospitals nationwide in the relatively quiet three since the Ebola outbreak, but many facilities know it’s only a matter of time before a major biological, chemical, or nuclear disaster tests the ability of ER staff to effectively treat incoming patients while maintaining the health and safety of their own staff.

So many larger hospitals, including Parkland, have turned to not only meeting the requirements of accreditation agencies that want the hospitals to have the ability to respond to “all hazards,” but also train specialized SWAT teams ready to provide expert care at a moment’s notice should an overwhelming incident occur.

In some hospitals, it’s questionable about who would respond if someone walked into the facility’s ED with symptoms of Ebola, or if several patients presented with exposure to radioactive materials without prior notification. Knowing this, Einstein formed what they call a Special Infectious Disease Response Team.
(SIDRT) that would be first on the scene as soon as the symptoms are identified. The team consists of seven ER physicians, 22 critical care nurses, four respiratory therapy assistants, and a radiological team that would swing into action with their specialized skills. An Ebola response plan has been mapped out that involves blocking certain areas of the hospital off, designating certain rooms as off limits, and pre-stocked carts that can be wheeled into place at a moment’s notice.

“Our plan was to be able to take care of one person for a week,” says Ward. “It’s been nothing but training and they are very motivated.”

At Parkland, officials wanted to go above and beyond the Joint Commission requirement of hospitals to identify hazards and address them. Because Parkland identified the potential to receive contaminated patients as a hazard, it created their new decon team to go along with the new facility.

The team includes a disaster management staff, which is responsible for overseeing decontamination activities, including the training of team members who may be called into service at a moment’s notice. The team has been in development since as far back as 2004, when an explosion hit a manufacturing plant just south of Dallas. Some of the plant’s employees were taken to Parkland Memorial Hospital because of a concern that they potentially were exposed to a cyanide release. The incident caused the health system to develop a mass casualty decontamination team, and the newest venture is an attempt to make sure the hospital is ready for anything.

“Although there are terrorist-type activities that can lead to exposure to or contamination from hazardous materials, it’s more likely to be the result of a natural disaster or accident,” David McCarty, an emergency management officer at Parkland, told Healthcare Facilities Management. “A tornado or a flood could wipe out a chemical plant or an accident at home could result in a dangerous situation.”

Located outside the hospital’s ER, a room has been built that can house up to 10 patients for decontamination before they even enter the hospital. From there, they can have their clothes removed and be thoroughly scrubbed with soap and water before receiving hospital-issued gowns and being taken into the facility.

In the event of a major event involving more than 10 patients exposed to hazardous materials or contaminated, the new unit at Parkland is equipped with an exterior decontamination unit complete with privacy curtains and running water where patients can be washed.

About 100 staff members from throughout the Parkland health system have received classroom and hands-on training, and respond whenever the decon team is activated—the idea in most cases is to have staff members on duty at all times who could respond to such an incident.

Team members are taught how to don and doff personal protective equipment such as gowns, boots, gloves, and masks, including those with self-contained filtration systems. They are also instructed in how to safely and thoroughly rid contaminants from patients.

Of course, new equipment only goes so far. You can have the best equipment money can buy, but if you don’t practice, chances are that employees won’t know how to use it when the real thing hits.

At Temple Hospital, each employee goes through a mass casualty response course, as well as an eight-hour decontamination course, and then is required to take an annual refresher. In addition, drills are an everyday part of working there, and a busy ER and trauma department allows staff to constantly be using their skills.

“Ever since the Boston [marathon bombing] happened, we’ve been training,” says Wesley Light, Temple’s manager of emergency preparedness, who mentioned that the Philadelphia equivalent, the annual Broad Street Run, sends up to 40,000 people right through the hospital’s campus every May and gives them the perfect training scenario.

“It starts a mile north of us and sends big packs of people through here,” he says. “We had just recently drilled on a mass casualty bomb scenario.”
VA hospitals see spike in opioid thefts

Drug diversion from federal hospitals part of nationwide epidemic of healthcare thefts

In what appears to be a continuing trend throughout U.S. hospitals, federal hospitals don’t seem to be able to escape an alarming spike in thefts of opioids and other medications.

According to a report in the March issue of *Outpatient Surgery* magazine, the incidence of opioids and other medications going missing from federal hospitals in more than a dozen states—most of them run by the Department of Veterans Affairs—has spiked more than 2,500 incidents since 2009.

The drug thefts—also known as “drug diversion”—are attributed mostly to thefts by doctors, nurses, or pharmacy staff who are suspected of keeping the drugs for their own use or selling them on the street.

According to the magazine’s report, incidents of drug losses at more than 1,100 facilities (which includes seven correctional hospitals and about 20 hospitals serving Indian tribes) jumped from 272 in 2009 to a high of 2,926 in 2015 before dropping to 2,457 last year, according to the Drug Enforcement Administration (DEA).

In light of such reports, *Outpatient Surgery* reported that the heads of two congressional committees—Rep. Phil Roe, MD (R-Tenn.), who chairs the House Veterans Affairs Committee, and Sen. Ron Johnson (R-Wis.), chairman of the Senate Homeland Security Committee—have ordered the VA to better explain its efforts to stem drug theft and loss in light of rising cases of missing prescriptions and other unauthorized use at VA hospitals.

“The fact that drugs are going missing from facilities further underscores the importance of oversight,” said Roe in an Associated Press (AP) report. “This is a serious issue, and it must be addressed quickly.”

Johnson also described incidents of rising drug loss and theft as concerning. Last year, he raised issues of possible unauthorized use at the Milwaukee VA Medical Center, involving allegations that drugs from the hospital’s pharmacy were going to nonveterans, according to *Outpatient Surgery*.

According to data cited by the AP, doctors, nurses or pharmacy staff at federal hospitals—the vast majority within the VA system—siphoned away controlled substances for their own use or street sales, or drugs intended for patients disappeared.

Aggravating the problem is that some VA hospitals have been lax in tracking drug supplies, according to the reports. Congressional auditors said spot checks found four VA hospitals skipped monthly inspections of drug stocks or missed other requirements. Investigators said that signals problems for VA’s entire network of more than 160 medical centers and 1,000 clinics, coming after auditor warnings about lax oversight dating back to at least 2009.

“Medical practitioners at the VA have a responsibility to provide the best care for the injured and ill veterans in their charge, and these actions are contradictory to the very nature of their professional obligations,” said Garry Augustine, executive director of Disabled American Veterans’ Washington headquarters.

The VA acknowledged it has had problems keeping up with monthly inspections. It said it was requiring hospitals to comply with inspection procedures and develop plans for improvement.

The thefts of drugs from VA hospitals are not limited to just a few facilities. According to a February report in the *Press-Herald* of Portland, Maine, some of the more notable thefts from hospitals include the following:

- At the John L. McClellan Memorial Veterans Hospital in Little Rock, Arkansas, three VA employees were charged with the theft of more than...
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$77,000 worth of drugs, including a pharmacy technician who used access to a medical supplier’s web portal to order and divert 4,000 oxycodone pills, 3,300 hydrocodone pills and other drugs; the total street value was more than $160,000.

- A hospice nurse at the VA Medical Center in Albany, New York, was sentenced last year to more than six years in prison after admitting to stealing pain medication intended for patients. An investigation found that the employee stole the painkiller oxycodone hydrochloride from syringes for his own addictions, and replaced the contents with Haldol, an anti-psychotic medication.

- In Providence, Rhode Island, a former nurse in the intensive care unit of the VA Medical Center pleaded guilty last year to stealing prescription drugs on dozens of occasions over several months in 2015. She apparently had used an override feature of an automated medication dispensing system to obtain hundreds of controlled substance pills, such as oxycodone and morphine. According to the Press-Herald, the nurse had previously been fired from a private hospital for diverting controlled substances, but was hired at the VA after making false claims in her employment application.

- An anesthesiologist at the VA Medical Center in Los Angeles pleaded guilty in 2015 to theft of public property and possession of a controlled substance while treating a veteran. Apparently, while providing anesthesia care to a veteran in surgery, the doctor passed out in the operating room after taking a sedative and injecting himself with several drugs, including fentanyl. The patient, who was fully conscious, reported he was initially frightened that the commotion was due to his own medical condition.

The incidents reported above are unfortunately just a few of what healthcare safety experts say is a growing epidemic in American hospitals.

“The problem is that (drug diversion is under-recognized and under-reported in many instances),” said Kimberly New, JD, a nurse, attorney, and consultant specializing in helping hospitals in the prevention, detection, and response to drug diversion by healthcare personnel, during an April 2016 webinar, “Drug Diversion in Healthcare.” “So many times facilities detect diversion, but they allow individuals to resign their position, move on, and they don’t necessarily do the appropriate external reporting.”

New said that it’s estimated that about one in every 15 healthcare employees may have some sort of addiction, whether it be to alcohol or drugs, and the healthcare environment often offers them the perfect opportunity to get the drugs they need for free. And in many cases, the patients that these employees are supposed to be caring for are put in harm’s way. In some situations, such as the one in Providence and Albany, the diverter will use medicine intended for the patient, and either replace it with another medication for paperwork purposes, or simply inject themselves with an IV of medication previously injected into a patient. This practice, obviously, can leave both patient and practitioner at serious risk of diseases. In 2016, for instance, New said that at least 12,000 patients in the U.S. had to be notified by hospitals that they may have been exposed to bloodborne pathogens as a result of tampering or substitution.

“What we do know is that this is universal among institutions in the U.S.,” she said. “It happens at all facilities. It doesn’t matter how high-tech a facility is. It doesn’t matter how great their patient safety initiatives are. So the best we can do is prevent what we can, detect it quickly, and respond appropriately.”

In addition to the inherent health-related ramifications of the practices related to drug diversion, New said that the thefts open hospitals up to class action lawsuits, lots of negative publicity, and ongoing DEA investigations that can be very expensive for institutions and very disruptive, including increased scrutiny by accreditation organizations.

So what can be done about the problem of the drug diversion? There are many signs of the problem occurring in your facility, and experts say there are many components of a drug diversion control program that should be in place. At the very least, keep in mind the following things.
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Diverters are the best employees. In many cases, drug diversion thefts were conducted by some of the most model employees. New pointed out that diverters don’t fit commonly held perceptions or stereotypes of individuals who are stealing and abusing drugs and so it’s important for staff to understand that these may often be the person that they would least expect to be involved in this type of activity.

“Many times they are top performers, award winners, very hard working,” she said. “They’re always ready to help. They come in early and they stay late. They prefer a fast-paced critical care environment. They’re popular with medical staff. They often have a compelling personal story.”

Ease of obtaining medications. Honestly, how easy is it to get prescription medications on your patient treatment areas in your facility? In many cases, diversions happened in places with little supervision of nurses, or on odd shifts such as overnights where nurses knew no one would be holding them accountable for the medications they were dispensing to patients.

“We tend to use some very, very powerful and dangerous medications, but we see them work well,” said New. “We use them day in and day out and we can become desensitized to the dangers associated with the medications that we’re using. In one instance, a nurse informed me that the medication that she gave as a preop medication was basically treated like water on her unit, because it was just used so commonly.”

Beware of agency nurses or temps. Many hospitals employ nurses contracted by outside agencies, many of whom work in several hospitals at once. This not only gives diverters more access to the drugs of their choice, but it also makes it harder to get caught, and in some cases, agency nurses are not held to the same employee standards as hospital employees would.

“If I work for an agency, I can divert small amounts of opioids or whatever my drug of choice is from various facilities in a geographic area and I can stay under the statistical radar, but also some agencies may not vet their employees as well as many hospitals and other healthcare facilities do,” New said.

Have sufficient auditing, surveillance, and reporting systems in place. Healthcare security experts say that many diversion incidents occur in healthcare facilities that don’t:

- have an accountability program
- properly secure and inventory their drug stock
- hold employees accountable for the drugs they acquire for patients
- have a system in place to report suspicions of drug diversion

“Many times I find in institutions where they’ve had, for instance, a lack of auditing for a period of time, that diverters will test the system and when they find that they can divert undetected, they can become very, very bold,” New said.

In addition, a general lack of a reporting system, and inconsistent practices from one hospital to another make it very difficult to accurately screen employment candidates. So many times a drug diverter who gets caught in one facility can simply go to another hospital and lie on applications in order to get hired.

“That comes primarily from lack of reporting of diversion because as I mentioned, sometimes facilities don’t report diversion,” New said. “Non-meaningful references, and really what that means is that the common practice for healthcare facilities is to report dates of employment. Many times facilities don’t even comment on whether someone is eligible for rehire. So it can be difficult to know what really happened while they were employed at a previous job.”

A healthy culture to institute, she said, is that of an accountable workplace where anonymous reporting is encouraged.

“A little known fact is that employers actually, under the Controlled Substances Act, have a responsibility to report drug diversion within their facility,” she said. “If they have a suspicion of diversion, they need to report it to a responsible individual within the institution, a supervisor, who can address the situation. So the two key terms here are that employees are obligated to report and also that employers shall inform all employees concerning this policy. So it’s important to make sure, as healthcare facilities, that we have notified employees that they have this responsibility to come forward and report.”
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Exploding Samsung phones may be banned from a hospital near you

Regulatory agencies encourage hospitals to rethink security and safety policies about dangerous device

You can add cell phones to the list of things in hospitals that cause fires.

In light of news that the batteries in the Samsung Galaxy Note 7 cell phone can explode and cause major fires, some major hospital advocacy and regulation groups are asking hospitals to take a serious look at whether the devices should be allowed in their facilities.

The American Society for Healthcare Engineering (ASHE), the American Hospital Association (AHA), and the American Society for Healthcare Risk Management (ASHRM), three prominent U.S. healthcare regulatory watchdogs, are urging healthcare facilities to review current policies in light of the Samsung Galaxy Note 7 recall.

In a statement released in December 2016, they say a risk assessment should be conducted to determine possible restrictions or communications to patients, staff, and visitors about the phones, which have been recalled after reports of overheating.

“With patients incapable of self-preservation, hospitals must work diligently to minimize the chance of fire,” according to the statement. “Although Samsung indicates that only 0.01 percent of the more than 2 million devices are impacted by the defect, the Samsung Galaxy Note 7 has the potential to increase the risk of fire. Health care organizations should review current fire safety measures and conduct a risk assessment to determine appropriate next steps regarding the Samsung Galaxy Note 7—including possible restrictions or communications to patients, staff and visitors.”

It’s the latest setback for the cell phone manufacturer, and the healthcare recommendations come after several U.S. consumer safety agencies, including the U.S. Consumer Product Safety Commission, in late September 2016 sent out an advisory urging customers to power down and stop using the Note 7 right away. That advisory was soon followed up by the U.S. Department of Transportation and Federal Aviation Association, which in October issued a ban of the device on all flights until defects could be fixed. News reports indicated that anyone caught trying to fly in a passenger plane with a Samsung Galaxy Note 7 could have their phone confiscated and face fines or criminal prosecution for trying to stash their Note 7 phones in checked luggage to avoid getting caught.

Some hospitals have decided to follow the advice of the regulators and ban the Note 7 from their facilities. According to a report from WTUZ-TV, the administration at Union Hospital in Philadelphia, Ohio decided it was better to be safe than sorry.

Union Hospital Community Relations Director Carey Gardner told the station that after reviewing policies and the consumer alerts, the hospital decided that as a safety precaution for patients and staff, the ban would be initiated, restricting patients, employees, and visitors from bringing the cell phone into the building. A notice was posted at the hospital’s entrances, website, and social media.

The concern about the Samsung Note 7 is the latest of several fire dangers from electronic devices that hospitals have struggled with in recent years. Safety coordinators have long worried about the possibility of Lithium-ion batteries in laptop computers and other commonly used devices in hospitals overheating and exploding. An increasing number of devices are being made portable and wireless, and with that convenience comes a danger of fire. Experts say that certain batteries, such as the lithium-ion batteries found in laptop computers, can explode with great force.

“While there are not a lot of news reports on this issue, when a lithium-ion battery fails, it has the potential of exploding. We had a laptop explode; fortunately, it was not being carried when it happened,” says Bruce Cunha, RN, MS, COHNS, former manager of employee health safety at the Marshfield (Wisconsin) Clinic. “Make employees aware that if a battery device starts smoking, [they should] get away from it immediately.”

Officials believe lithium batteries may be to blame for a fire that started at a hospital in Sayre, Pennsylvania on July 17, 2016, according to a report from WNEP-TV. The fire at Guthrie Robert Packer Hospital started in the manager’s office on the fifth floor, and may have started with a box of lithium batteries used to power various hospital equipment, the report said.
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In March 2014, a patient on oxygen was burned in a fire at a Syracuse, New York, hospital after an electronic cigarette exploded.

In that fire, the unidentified patient suffered second- and third-degree burns. The patient apparently told investigators that she had pressed a button on the device, heard a pop, and then realized she had caught fire.

Electronic cigarettes contain a battery-operated heating element, and a replaceable cartridge filled with liquid nicotine or other chemicals that when heated converts the contents of the cartridge into a vapor. Although considered safer than regular cigarettes, there have been a small number of cases in which the devices have exploded because the batteries were overcharged or put in wrong.

And in what was considered a fluke of an accident, a fire in February 2012 at Doernbecher Children’s Hospital in Portland, Oregon, left a 12-year-old girl with third-degree burns over a fifth of her body. The girl, who was in the hospital for kidney cancer treatment, reportedly used hand sanitizer to clean a table and olive oil to remove glue residue from leads stuck to her head. She rubbed the plastic mattress she was lying on and the vapors from the sanitizer caught fire and were fed by the oil in her hair and on her shirt.