Emergency preparedness will become an even bigger issue for hospital safety committees in upcoming years, thanks in part to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tightening its emergency management requirements.

JCAHO surveyors now conduct designated emergency management sessions during hospital accreditation visits. These sessions start with a review of a hospital's disaster plans, including hazard vulnerability analysis. From there, surveyors observe staff responses to a scenario from the analysis.

With these changes in mind, here are three emergency management themes on which to focus, all of which would make good agenda items for your committee’s next meeting:

Reach out to community emergency coordinators. Remember that hospitals currently need to conduct two emergency drills each year under environment of care (EC) standard EC.4.20.

Bloodborne violations remain steady, but the average OSHA fine rises

Emergency preparedness will become an even bigger issue for hospital safety committees in upcoming years, thanks in part to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tightening its emergency management requirements.

JCAHO surveyors now conduct designated emergency management sessions during hospital accreditation visits. These sessions start with a review of a hospital’s disaster plans, including hazard vulnerability analysis. From there, surveyors observe staff responses to a scenario from the analysis.

With these changes in mind, here are three emergency management themes on which to focus, all of which would make good agenda items for your committee’s next meeting:

Reach out to community emergency coordinators. Remember that hospitals currently need to conduct two emergency drills each year under environment of care (EC) standard EC.4.20.

Bloodborne violations remain steady, but the average OSHA fine rises

Emergency preparedness will become an even bigger issue for hospital safety committees in upcoming years, thanks in part to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tightening its emergency management requirements.

JCAHO surveyors now conduct designated emergency management sessions during hospital accreditation visits. These sessions start with a review of a hospital’s disaster plans, including hazard vulnerability analysis. From there, surveyors observe staff responses to a scenario from the analysis.

With these changes in mind, here are three emergency management themes on which to focus, all of which would make good agenda items for your committee’s next meeting:

Reach out to community emergency coordinators. Remember that hospitals currently need to conduct two emergency drills each year under environment of care (EC) standard EC.4.20.

Bloodborne violations remain steady, but the average OSHA fine rises

Emergency preparedness will become an even bigger issue for hospital safety committees in upcoming years, thanks in part to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tightening its emergency management requirements.

JCAHO surveyors now conduct designated emergency management sessions during hospital accreditation visits. These sessions start with a review of a hospital’s disaster plans, including hazard vulnerability analysis. From there, surveyors observe staff responses to a scenario from the analysis.

With these changes in mind, here are three emergency management themes on which to focus, all of which would make good agenda items for your committee’s next meeting:

Reach out to community emergency coordinators. Remember that hospitals currently need to conduct two emergency drills each year under environment of care (EC) standard EC.4.20.

Bloodborne violations remain steady, but the average OSHA fine rises

Emergency preparedness will become an even bigger issue for hospital safety committees in upcoming years, thanks in part to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tightening its emergency management requirements.

JCAHO surveyors now conduct designated emergency management sessions during hospital accreditation visits. These sessions start with a review of a hospital’s disaster plans, including hazard vulnerability analysis. From there, surveyors observe staff responses to a scenario from the analysis.

With these changes in mind, here are three emergency management themes on which to focus, all of which would make good agenda items for your committee’s next meeting:

Reach out to community emergency coordinators. Remember that hospitals currently need to conduct two emergency drills each year under environment of care (EC) standard EC.4.20.

Bloodborne violations remain steady, but the average OSHA fine rises

Emergency preparedness will become an even bigger issue for hospital safety committees in upcoming years, thanks in part to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tightening its emergency management requirements.

JCAHO surveyors now conduct designated emergency management sessions during hospital accreditation visits. These sessions start with a review of a hospital’s disaster plans, including hazard vulnerability analysis. From there, surveyors observe staff responses to a scenario from the analysis.

With these changes in mind, here are three emergency management themes on which to focus, all of which would make good agenda items for your committee’s next meeting:

Reach out to community emergency coordinators. Remember that hospitals currently need to conduct two emergency drills each year under environment of care (EC) standard EC.4.20.

Bloodborne violations remain steady, but the average OSHA fine rises

Emergency preparedness will become an even bigger issue for hospital safety committees in upcoming years, thanks in part to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tightening its emergency management requirements.

JCAHO surveyors now conduct designated emergency management sessions during hospital accreditation visits. These sessions start with a review of a hospital’s disaster plans, including hazard vulnerability analysis. From there, surveyors observe staff responses to a scenario from the analysis.

With these changes in mind, here are three emergency management themes on which to focus, all of which would make good agenda items for your committee’s next meeting:

Reach out to community emergency coordinators. Remember that hospitals currently need to conduct two emergency drills each year under environment of care (EC) standard EC.4.20.

Bloodborne violations remain steady, but the average OSHA fine rises

Emergency preparedness will become an even bigger issue for hospital safety committees in upcoming years, thanks in part to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tightening its emergency management requirements.

JCAHO surveyors now conduct designated emergency management sessions during hospital accreditation visits. These sessions start with a review of a hospital’s disaster plans, including hazard vulnerability analysis. From there, surveyors observe staff responses to a scenario from the analysis.

With these changes in mind, here are three emergency management themes on which to focus, all of which would make good agenda items for your committee’s next meeting:

Reach out to community emergency coordinators. Remember that hospitals currently need to conduct two emergency drills each year under environment of care (EC) standard EC.4.20.
Emergency prep efforts

If a facility is a disaster-receiving site, one of those drills must include an influx of patients (see “Think about these surge capacity issues” on p. 3 for more about surge preparations).

Additionally, hospitals must involve the community in at least one of the drills or, as an alternative, hold a tabletop exercise with community participants. However, the exercise can’t replace one of the regular drills—in other words, if you conduct a tabletop exercise with community officials, you must still conduct two full-fledged disaster drills.

Community involvement can be challenging. If local authorities don’t regularly stay in touch with hospitals, medical centers must take the initiative to reach out to them.

Ideas of who to invite to community exercises vary, but organizations to consider include local police and fire departments, the Red Cross, the Salvation Army, the local or county bomb unit, emergency medical services, department of health officials, and the community emergency operations center.

Don’t wait until the day of the drill to get to know these people, says James Kendig, MS, CSE, CHSP, vice president of safety, security, parking, and clinical transportation services at Health First in Melbourne, FL.

Your hospital’s hazard vulnerability analysis’ findings should tie into local, regional, and state agencies, so verify that your rated scenarios in that tool take a broad approach.

“What went wrong? That’s my favorite topic here in Florida [after a response].”

—James Kendig

Testing your plans with outside participants will let all sides understand each other’s expectations and help uncover conflicts that could tie up resources during a real incident, MacArthur says.

Kendig adds that by involving the community, hospitals can take advantage of expertise beyond their own when conducting drills.

Push the boundaries of testing.

The JCAHO is pressuring hospitals to toughen their drill scenarios, and the accreditor may issue a more difficult emergency drill standard in 2006.

One of the most important jobs for hospitals during emergency exercises is to “stress their systems,” says MacArthur.

The goal is to see how much a hospital can stretch its staff and resources during a drill. “The main purpose of a drill is to learn what you’re not prepared for,” he says.

Hurricanes Katrina and Rita highlighted the need to plan for unexpected full evacuations of hospitals.

A total evacuation is a huge undertaking, says Kendig, who had to evacuate Cape Canaveral Hospital in Cocoa Beach, FL, twice in recent years because of oncoming hurricanes.

As one of the storms approached, the hospital had to transfer 40 patients, which took six hours, he says.

Hospitals must also consider other items that move along with relocated patients (e.g., blood supplies, refrigerated medications, and bone marrow).

Working with other hospitals to develop supply sharing plans—and then testing those agreements—is critical, Kendig says.
**Dissect drill performance with methodical reviews.**

Perform critiques at the conclusion of any disaster drill or emergency response, says Kendig. Focus on successful efforts, areas that didn’t work well, and ideas for improvement.

“What went wrong? That’s my favorite topic here in Florida [after a response],” Kendig says.

Ask yourself whether the drill response was plausible, realistic, and relevant, says MacArthur. “Don’t provide cookie-cutter reviews. Be creative and try to communicate strengths and weaknesses throughout the organization.”

Writing down your findings is an important step, says Kendig. JCAHO surveyors will look at this documentation as proof of the drill’s performance and how the hospital fixed related problems.

Inviting neighboring hospitals to participate in or observe your drills may allow opportunities to explore further ideas for improvement with your peers, he says.

---

**Think about these surge capacity issues**

Planning for a surge in patients is difficult when many hospital censuses are already at capacity.

Based on a review of federal statistics, 80% of surge patients coming in after a community emergency will arrive on their own, not by ambulance, says James Kendig, MS, CSE, CHSP, vice president of safety, security, parking, and clinical transportation services at Health First in Melbourne, FL.

It’s important to remember that hospitals won’t deal solely with physical injuries during a surge. One Brazilian study of the public’s response to a radiological incident indicated that psychological casualties compared to physical injuries could be represented by a 500-to-one ratio, Kendig says.

People other than patients can add to the surge strain, including relatives, reporters, curious onlookers, and volunteers.

The federal Agency for Health Research and Quality suggests the following surge capacity strategies:

- Discharge patients early if possible and establish a discharge holding area
- Convert outpatient procedure beds to inpatient beds
- Create alternative treatments areas in gyms, cafeterias, and classrooms
- Board patients in hallways

On a related note, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) released a report in December 2005 outlining thoughts about establishing surge hospitals.

The JCAHO considers surge facilities to be temporary spots beyond regular hospitals (e.g., schools, hotels, veterinary hospitals, sports arenas, and convention centers) where staff and volunteers can provide medical services.

Highlighting the report are five case studies about surge hospitals that were built in the Gulf Coast after hurricanes Rita and Katrina.

The update also mentions that JCAHO is considering adding a new set of standards for surge hospitals. To read the full report, go to www.jcaho.org/about+us/public+policy+initiatives/surge_hospital.htm.
OSHA violations

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.

reporting period. On paper, these figures mean that you won’t get cited by OSHA as often as in the past, but when you do, it will hurt more.

Personal protective problems
An interesting statistic is that during the October 2004–September 2005 time frame, personal protective equipment (PPE) violations rose to second place from their previous position of 13th place.

This jump may indicate that hospitals doesn’t conduct enough assessments for safety needs (e.g., eye protection and gloves), says Richard Fairfax, OSHA’s director of enforcement programs. Hospitals must ensure that staff regularly assess whether work conditions require PPE and, if so, that employees use the right items, Fairfax says.

Meanwhile, the electrical systems design standard, which protects workers from electrical equipment hazards, dropped from second place in the number of citations to a sixth place tie in 2005.

Violations of the lockout/tagout standard plunged, from third most cited to a tie for tenth. This decrease could stem from more comprehensive OSHA inspections as a result of complaints by healthcare workers to the agency, Fairfax says.

The respiratory protection standard, which during the previous reporting period had the third most citations, dropped to 12th place on the list.

However, respiratory protection requirements will remain in the news as the hospital industry awaits word on the Centers for Disease Control and Prevention’s upcoming amended tuberculosis guidelines.

Keep up on hazcom training
One standard that consistently generates citations is hazard communication (hazcom), which is third on the OSHA violations list, Fairfax says. Even if hospitals have hazcom programs, it’s difficult to keep up with the related training, he says.

For example, manufacturers and staff may introduce new chemicals into the workplace but not incorporate the substances into the hazcom program.

Other potential problems come when workers who were knowledgeable about hazcom training leave or when new staff arrive without receiving proper training. Education about hazcom requirements must be an ongoing effort, Fairfax says.

OSHA has free resources
A good way for hospital safety officers to examine their sites’ OSHA compliance is to take advantage of the free consultation services provided in each state, Fairfax says.

“It’s a free OSHA visit in which a trained evaluator makes suggestions but no citations are levied,” he says. One such endeavor is known as the Safety and Health Achievement Recognition Program (SHARP), which can help healthcare facilities save money on worker compensation costs, he adds.

This year’s overall drop in citations is probably related to fewer hospital inspections, Fairfax says. “OSHA performs 39,000 inspections a year, and only about 350–400 of them are at hospitals,” Fairfax says.

“We target sites with the highest accident and illness rates,” says Fairfax. Other inspections may come as a result of specific complaints. Hospitals actually have a low rate of injury and illness, so fewer inspections and violations result from these inspections, he says.

Editor’s note: To find out more about the SHARP evaluations, go to www.osha.gov/dcsp/smallbusiness/sharp.html.
## Top OSHA citations in medical and surgical hospitals

Violations in the bloodborne pathogens standard top the list of citations by the Occupational Safety and Health Administration (OSHA) in general medical and surgical hospitals. The statistics do not cover psychiatric and specialty hospitals (e.g., children’s or cancer hospitals). This information covers hospitals only under federal OSHA requirements, not state OSHA plans.

OSHA issued the following citations from October 2004–September 2005. The listed standards are from section 29 of the *Code of Federal Regulations*.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Number of citations/inspections</th>
<th>Penalties*</th>
<th>Description</th>
<th>Previous rank^</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 1910.1030 (bloodborne pathogens)</td>
<td>122/42</td>
<td>$92,659</td>
<td>Controlling exposure to blood or other potentially infectious materials</td>
<td>1</td>
</tr>
<tr>
<td>2. 1910.132 (personal protective equipment)</td>
<td>17/10</td>
<td>$14,230</td>
<td>Choosing and using appropriate personal protective equipment</td>
<td>17</td>
</tr>
<tr>
<td>3. 1910.1200 (hazard communication)</td>
<td>13/9</td>
<td>$5,569</td>
<td>Reporting risks of chemicals to employers and employees (including labeling and training)</td>
<td>7</td>
</tr>
<tr>
<td>4. 1910.213 (woodworking machinery)</td>
<td>12/6</td>
<td>$8,563</td>
<td>Providing safeguards to workers who use woodworking machines, including saws, jointers, and sanders</td>
<td>13 (tie)</td>
</tr>
<tr>
<td>5. 1910.1027 (cadmium)</td>
<td>11/2</td>
<td>$0</td>
<td>Monitoring and reducing worker exposures to cadmium</td>
<td>34</td>
</tr>
<tr>
<td>6. (tie) 1910.151 (medical services and first aid)</td>
<td>10/10</td>
<td>$8,324</td>
<td>Providing first aid personnel, eye-wash stations, and drenching showers</td>
<td>13 (tie)</td>
</tr>
<tr>
<td>6. (tie) 1910.303 (electrical systems design)</td>
<td>10/7</td>
<td>$4,575</td>
<td>Protecting workers from electrical equipment hazards</td>
<td>2</td>
</tr>
<tr>
<td>6. (tie) 1910.1025 (lead)</td>
<td>10/3</td>
<td>$2,350</td>
<td>Monitoring and reducing worker exposures to lead</td>
<td>30</td>
</tr>
<tr>
<td>9. 1910.1048 (formaldehyde)</td>
<td>9/5</td>
<td>$1,500</td>
<td>Controlling exposure to formaldehyde gas, its solutions, and materials that release formaldehyde</td>
<td>20 (tie)</td>
</tr>
<tr>
<td>10. (tie) 1910.147 (lockout/tagout)</td>
<td>8/7</td>
<td>$7,181</td>
<td>Avoiding exposure to hazardous energy, (e.g., electricity, steam, or chemicals)</td>
<td>3</td>
</tr>
<tr>
<td>10. (tie) 1910.1450 (hazardous lab chemicals)</td>
<td>8/3</td>
<td>$4,007</td>
<td>Protecting workers in labs from exposure to hazardous chemicals</td>
<td>20 (tie)</td>
</tr>
</tbody>
</table>

* The penalties column reflects any settlement actions that took place after OSHA originally issued a citation.
^ The last period ranked was October 2003–September 2004.

*Source: OSHA.*
Oil spill plans receive an October 2007 extension

The EPA offers more time for hospitals and others to get their plans in shape

Hospitals have received yet another reprieve when it comes to oil spill prevention plan regulations.

The Environmental Protection Agency (EPA) formerly required most healthcare facilities to make previously published changes to their oil storage and spill prevention plans by February 17, 2007.

However, the EPA has once again pushed back its deadline. The new time frame for all facilities to prepare or amend their oil spill plans is now by October 31, 2007.

And the changes keep rolling

The issues stem from the EPA’s spill prevention, control, and countermeasure (SPCC) rule, which applies to all industries, not just healthcare.

In 2002, the agency issued a series of amendments to the SPCC law, but its ultimate goal remains the same: Facilities that use oil need to use inspections and spill plans to avoid spills into water.

During the past 18 months, the regulations in question ran into a series of roadblocks that included court challenges.

Finally, in December 2005, the EPA proposed two new amendments to the SPCC rule. One change streamlines the regulatory requirements for qualified facilities and equipment regulated by the environmental laws. The other amendment extended the SPCC deadline for all facilities (go to www.epa.gov/oilspill/ for full details).

The most recent deadline extension will allow hospitals the necessary time to apply the provisions. The agency also wants to ensure that affected facilities will have sufficient opportunities to fully understand the information contained in its recently published SPCC Guidance for Regional Inspectors (see the related story below for more details).

Finally, the EPA initiated the delay because it was concerned that facilities affected by the Gulf Coast hurricanes in summer and fall 2005 would not have the ability to meet the compliance dates without an extension.

Mottos to prevent and contain

Hospitals often store oil—anything from heating oil to cooking oil—in large amounts, both above and below the ground.

EPA inspection guidance in a useful tool for hospitals

In December 2005, the Environmental Protection Agency (EPA) published its SPCC Guidance for Regional Inspectors, which helps agency inspectors review how well a facility observes the spill prevention, control, and countermeasure (SPCC) rule.

The guideline aims to establish a consistent understanding among regional EPA inspectors about how to apply particular provisions of the SPCC rule during site visits.

Topics include environmental equivalence, secondary containment, and container integrity testing. The guidance also discusses the inspectors’ role during an oil spill plan review.

Hospitals may find that the information in the guidance acts as a window into the EPA’s mindset, similar to how facilities can learn from inspection directives from the Occupational Safety and Health Administration.

Editor’s note: You can read the guidance online at www.epa.gov/oilspill.
The purpose of the regulations is to prevent spills from occurring. However, if a spill does occur, the rules outline what actions sites can take to minimize an incident’s effects, says Don Grant, an SPCC coordinator with the EPA’s Region I office in Boston.

The SPCC rule applies to facilities that store and use a certain amount of oil that could potentially discharge into navigable U.S. inland waters and streams.

Owners and operators of these facilities must have a SPCC plan that is certified by a professional engineer.

The plan must cover design, operation, and maintenance procedures for preventing discharges, as well as emergency plans to reduce the effects of an accidental discharge.

Originally enacted in 1974, the regulations remained the same until 2002, when the EPA overhauled them, says Grant. The 2002 proposals opened the door for public comment that has caused further delays and modifications.

**Talk to other hospitals about the regs**

Grant suggests that hospitals network to share information and find out which certified engineers have been used to take advantage of existing information.

Hospitals that have oil storage on their properties that may be in violation of current laws must coordinate their spill plans with existing regulations immediately, Grant says.

Precautions—including secondary containment around oil tanks with capacities of 55 gal. or more—are important, says Grant.

Hospitals must determine how they would contain any spills and train staff how to handle oil safely during initial delivery and subsequent use, he says. Security measures are also a requirement, especially for those facilities that are open to the public.

“If a hospital doesn’t have a plan, [it is] in violation” already, Grant says.

Amended regulations will become more flexible with the new changes. For example, previous rules required oil containers to meet EPA provisions, but once the changes takes effect, containers that hold less than 55 gal. will be exempt from SPCC mandates, he says.

**We’re not the Joint Commission, but . . .**

The SPCC plan is not directly a part of the Joint Commission on Accreditation of Healthcare Organizations’ standards, so hospitals tend to overlook the EPA requirements, says Grant.

That can be a mistake because the EPA has taken an increased interest in hospitals, particularly in the New England region, he says. Also, surveyors are more savvy now about environmental regulations.
Editor’s note: This 2005 survey occurred November 14–18, 2005, at Summa Health System in Akron, OH.

Large hospitals can present special problems for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) when it comes to Life Safety Code® compliance.

There’s almost too much territory to cover in a big building, especially during the one day usually allotted to the life safety specialist, says Howard Hunt, the safety officer for Summa Health System.

Summa’s survey was good but didn’t cover as much as Hunt thought it would. The visit was one of the last announced surveys the JCAHO conducted, as January marked the beginning of all unannounced surveys.

The health system includes Akron City Hospital, an 811-bed facility with an average census of 500, and St. Thomas Hospital in Akron, a 400-bed facility with an average census of 220.

The two hospitals merged in 1989, and a third facility joined them a few years ago that is not yet affiliated with the JCAHO but plans to do so by 2007.

The life safety specialist, one of five surveyors, began by reviewing the Statement of Conditions (SOC). SOC compliance falls under environment of care (EC) requirement EC.5.20, one of the hottest standards during surveys these days.

“We had all the [EC] books there, but he was only interested in the SOC,” says Hunt.

Corridor clutter is the enemy again

During the building tour, a major violation was found when the surveyor encountered display tables set up in several high visibility corridors and at a workstation in the x-ray area.

Hunt likes to tell staff that corridors exist for two reasons: as regular walkways and as ways out in case of an emergency.

Even so, items end up in the halls in violation of life safety requirements, primarily because of a lack of space, he says.

“It won’t make me popular, but I’m going to be on a mission to clear the corridors,” he says. “First though, I’ll try to find alternative areas to place things so I don’t come to [staff] and just order them to move something.”

Of course he checked penetrations

The life safety surveyor spent most of his time touring Akron City Hospital, the larger of the two sites.

The surveyor looked for improperly sealed penetrations in barriers and found three such penetrations near cable and computer wiring. The surveyor noted to onlookers that it is almost impossible to not find penetrations somewhere, says Hunt.

The surveyor mentioned something he called the “smile effect,” which is when workers caulk around the sides and bottoms of penetrations and forget about the tops, creating a caulking line that resembles a smile.

An interesting tip the surveyor passed on to Hunt was that computer cabling can act like a candle wick, adding to the potential for fire spread through improperly sealed penetrations.

Other life safety snafus come up

In addition to the three penetrations, the surveyor found prohibited drop-down/kick-down devices on doors, door wedges used to keep doors open, and a violation of the 18-in. sprinkler clearance rule in a gift shop storage area.

Hunt was also unable to produce annual testing results on some vertical and horizontal rolling doors. The hospital has since conducted this testing.
The surveyor rolled all of these life safety deficiencies into one requirement for improvement under EC.5.20 instead of issuing individual ones, which he could have done, says Hunt.

The administrator surveyor, who finished the building tour later in the week, also issued a supplemental finding EC.2.10 (security plans) that dealt with missing risk assessments in the emergency department.

The good old records review returns
The survey wrapped up with what was supposed to have been—according to JCAHO survey guidelines—an interview session with an exchange of EC ideas.

Instead, the meeting turned into an “old-fashioned document review session,” Hunt says. “Luckily, we had everything assembled and were able to get [records] quickly.”

The surveyors wanted copies of the tours of all the off-site locations, which Summa doesn’t keep at the main hospital. Staff had to fax these records from other locations, Hunt says.

The administrator surveyor emphasized that Summa should spend more time coordinating with the off-site locations to ensure consistency.

No EC tracers or staff interviews
The life safety surveyor didn’t conduct any tracers, although other surveys performed patient tracers in clinical areas, says Hunt.

Neither the life safety specialist nor the administrator surveyor talked to staff in any depth, says Hunt.

“We had performed mock survey sessions and coached the staff,” he says. “We were very prepared for an interview session [that] we never got.”

The latest visit wasn’t much different than past surveys, says Hunt, who has been the safety officer at Summa for 12 years. He suspects life safety surveyors are still working their way through their duties. In the future, the JCAHO may want to consider giving the life safety specialists two days at larger hospitals to conduct complete and comprehensive surveys, says Hunt.

Overall, the survey was a good experience, although Hunt admits to disappointments.

“I thought the survey would wrap up with an exchange of ideas, and that didn’t happen,” he says.

“Anyone can review the documents. I thought we might use the session as a learning exchange,” he adds.

“No one ever asked about our management plans, or our biggest success or biggest problem. In my opinion, at least in the environment of care, the survey was a little too focused on paper and not enough on the big picture,” Hunt says.

---

Survey at a glance

**Hot spots:** *Life Safety Code* compliance, document consistency between the hospital and off-site facilities, and environment of care (EC) records review.

**Life safety surveyor on-site:** Yes.

**EC requirements for improvement:** Improperly sealed barrier penetrations, prohibited storage in corridors, door wedges, missing door testing records, and a violation of sprinkler clearances were all rolled into one citation.

**EC supplemental findings:** The hospital couldn’t produce records of required security risk assessments in the emergency department.

**EC tracers:** None.

**Quote of note:** “It won’t make me popular, but I’m going to be on a mission to clear the corridors.”
New accreditor seeks CMS approval
The Centers for Medicare & Medicaid Services (CMS) has begun formal evaluation of a recently completed application by TUV Healthcare Specialists (TUVHS) to become the first new accreditation service for U.S. hospitals in 40 years.

If granted full deeming authority in the coming months, TUVHS will be able to accredit hospitals—in other words, deem them in compliance with Medicare’s Conditions of Participation.

To learn more about TUVHS, go to www.tuvamerica.com/home.cfm.

Stolen equipment contained patient info
Patient personal information may have been compromised after someone stole bone density scanning equipment from Mercy Jeannette Hospital in Pittsburgh in November 2005.

Medical information was not stored on the equipment, but the computer parts of the scanning devices reportedly contained patients’ names, birth dates, and Social Security numbers, the Pittsburgh Tribune-Review reported.

The theft was reported to the police and the hospital is conducting its own investigation, the Tribune-Review reported. The hospital sent a letter to patients informing them of the situation and that the “possibility exists that this data could be used to commit fraud.”

The state Attorney General’s Office has advised patients worried about their personal information to contact credit reporting agencies to request a fraud watch be placed on their accounts.

The hospital established a hotline to answer questions from patients seeking additional information.

Boiler problem leads to an evacuation
Medical staff evacuated or discharged up to 30 patients from Mount Auburn Hospital in Cambridge, MA, after a boiler explosion in December 2005.

Ambulances took the patients, including several infants, to other area hospitals, according to The Boston Globe. No injuries occurred and contractors repaired the boilers the next day.

One of the boilers apparently erupted, which caused a second boiler to fail. The incident disrupted the hospital’s heating, steam, and hot water services, the Globe reported.

The hospital brought in a third boiler to compensate for the lost services. Meanwhile, staff provided blankets to remaining patients as temperatures in the hospital fell to about 55 degrees.

Volunteer smallpox vaccines largely safe
Smallpox vaccine given to potential first responders to a bioterrorism event, including hospital workers, showed a low rate of life-threatening adverse reactions. This result perhaps comes from vigilant vaccine safety screening and education, according to a study published in the December 7, 2005, Journal of the American Medical Association.

The U.S. Department of Health and Human Services began a voluntary civilian smallpox vaccination
program in January 2003. Vaccine was given to federal, state, and local volunteers who might act as first responders during a bioterrorism attack.

A total of 37,901 volunteers received at least one dose of vaccine. Of that total, 822 bad reactions occurred, including 10 life-threatening illnesses and three deaths, according the Journal.

**Texas panel looks into Rita evacuations**

A Texas state task force heard testimony in December 2005 from a county judge who was unable to locate any ambulances to evacuate hospitals before Hurricane Rita, according to the Associated Press (AP).

The judge reportedly ended up pleading with the White House to send military planes to airlift patients from hospitals in eastern Texas.

By the time the C-130 planes were made available, the judge had authorized county workers to replace bus seats with mattresses to transport patients to planes. Crews airlifted patients to 17 states, the AP reported.

Ambulances were unavailable because they were helping in other evacuations in anticipation of Rita.

The task force will recommend methods to improve mobility and communications during evacuations, ensure that fuel is available, and better plan how to relocate those with special needs, according to the AP.

**State hospital draws the ire of a town**

Local officials are questioning security measures after a patient at Tewksbury (MA) State Hospital allegedly caused a three-car accident, reported The Sun newspaper in Lowell.

The state-run hospital, which handles psychiatric patients, is reportedly reviewing its policies.

Due to privacy laws, officials didn’t comment on why the patient was away from the hospital, according to The Sun. The newspaper detailed at least three other alleged security lapses that occurred within a two-week period in November.

**Construction ruled out as infection cause**

Centers for Disease Control and Prevention (CDC) investigators ruled out construction as the cause of two patients becoming infected with the fungus aspergillus during surgery, the Denver Post reported in December 2005.

One patient died and one became ill at the Exempla St. Joseph Hospital in Denver after undergoing heart surgeries. Because construction sites that kick up dirt are the most common sources of aspergillus in hospitals, the CDC initially investigated a renovation project ongoing at the facility.

But after research, the hospital determined the construction on a nearby operating room hadn’t begun when the patients became infected.

The CDC has not made its final ruling on the cause of the infections, although investigators believe that 13 other patients may have been exposed through similar surgeries this spring. It’s possible that a biopaste used to replace heart valves caused the problem, according to the Post.
Tip of the month

**OSHA offers guidance on when HAZWOPER requirements apply**

The Occupational Safety and Health Administration (OSHA) has published a guide about the hazardous waste operations and emergency response (HAZWOPER) standard to help employers and workers understand what the agency considers an emergency response activity.

Anyone possibly exposed to hazardous substances in their work environment, including emergency response operations for substance releases or threats of release, falls under HAZWOPER (1910.120).

Situations that OSHA views as emergency situations requiring response efforts include:

- high concentrations of toxic substances
- environments that are immediately dangerous to life and health
- situations that present an oxygen-deficient atmosphere
- conditions that pose a fire or explosion hazard

- situations that require an evacuation
- conditions that require immediate attention because of the danger posed to employees

**Hurricane aftermath triggers OSHA**

According to OSHA, the new guide was prompted by workers involved in hurricane cleanup and recovery operations inquiring about whether their activities met HAZWOPER requirements.

The guide is divided into two sections: the application of HAZWOPER requirements and employee training. Flowcharts provide references to follow to help people determine if their individual situations might fall under HAZWOPER. The guide is not a new standard, nor does it create any new regulations.

To check out the guide, go to [www.osha.gov/SLTC/hazardoustwaste/application_worksiteresponse.html](http://www.osha.gov/SLTC/hazardoustwaste/application_worksiteresponse.html).
Paid parking facilities can benefit security

Editor’s note: Each issue of Healthcare Security Alert features an expert’s answers to your security questions. Russ Colling, a security consultant for Colling and Kramer in Salida, CO, provides this month’s response. If you have a security question for one of our experts, e-mail Editorial Assistant Kevin Moschella at kmoschella@hcpro.com.

Our hospital is in the initial stages of instituting a paid parking lot. What should my concerns be as a security director?

Security should always be involved in the planning of parking facilities regardless of whether they offer free or paid parking. This involvement will differ depending on whether security provides general safety and security services just as it does for other departments for functions or actually administers and operates the new paid parking program.

A paid parking lot requires specific controls that operate on card access, ticket spitters, and cash...
DVR surveillance

Tapes for seven to 30 days, switching to DVRs opens up a lot of storage room for other needs.

Videotapes also wear out over time, so there can be a significant cost in replacing worn tapes. “We’d have about 100 tapes for each VCR that we’d constantly have to change,” says Dettman. “That’s a lot of extra man hours and cost that you instantly dispose of with DVRs.”

Quality counts

One of the more practical advantages of DVRs is the quality of the recording. DVRs don’t wear down like videotapes, and they also record at a higher resolution.

“What good is catching someone on tape if you can’t make out who they are because of poor quality?” asks Tom Eubank, a service operations manager with Convergint Technologies in Richmond, VA. “Any video on a DVR is much more likely to help you catch a perpetrator and much more likely to hold up in court.”

Because DVRs don’t degrade over time, they will also save money in the long run because they last as long as any VCR, but without the added expense of buying new tapes every year or so.

High-powered search engine

The area in which DVRs may save hospitals the most time, however, is when searching for a specific event. DVRs can link into computer systems, and the software included with most units allows users to search for specific days, times, or actions with the push of a button.

“With a videotape, you’re always looking around and fast-forwarding and rewinding,” says Dettman. “With the DVR, you can narrow your search by the minute or sometimes second. Some software even allows you to search for specific events such as a movement or change in lighting.”

The search feature is especially helpful for departments that don’t have an officer constantly watching closed-circuit television monitors and that need to look for a reported incident later.

DVRs also allow for security officers to make more efficient reports because they can copy any part of the video from the hard drive and onto a disk for future reference. If you want to monitor the hospital, you can set up networks to view the video on any computer, even from home.

Getting hooked up

If the benefits of a DVR to your department are too great to pass up, the first hurdle to clear is cost. A commercial DVR will be more expensive than the VCRs you’re accustomed to buying, especially because you’ll be upgrading an entire system instead of just one unit.

DVRs cost more than $1,000 per unit, but there are ways to defer the cost and make it reasonable (e.g., linking more cameras into one box or storing footage for shorter periods of time). But before you start shopping around for DVR manufacturers, keep the following questions in mind:

- How many cameras does the hospital use?
- How long do you need to keep video archived?
- Will you put the video on a network?

Although most hospitals keep archived footage for at least a week, many keep tapes for up to a month. It’s still possible to do that with DVRs, but the longer you want to keep the footage on the hard drive, the more hard drive space you’ll need and the more you’ll pay.

“We used to keep tapes for 30 days, but now our requirement is seven days,” says Dettman. “Usually if you don’t hear about an episode happening within seven days, you can’t do much about it anyway.”

You can also affect the length of the recording by adjusting the video quality and frames captured per second. Copying the footage onto a compact disc can save space on your hard drive and can be used to
store any important events.

Because one single DVR box can serve as a multiplexer, which handles inputs for up to 16 video cameras, you will also save storage room. But the bigger the multiplexer, the more expensive the box will be. Dettman says a box that can hold 16 cameras and store footage for seven to 15 days will cost about $14,000.

Buying into it
Once you’ve determined your hospital’s DVR needs, start shopping the many DVR manufacturers. Consider the following questions:

• How durable is the box?
• What is the total capacity of the hard drive?
• How long is the warranty?
• Who services the box?

• Will the purchase price include installation, setup, and tutorial?

“A lot of people know DVRs from personal TiVos and similar machines, but you can’t just go to Best Buy or Circuit City and buy a DVR suitable for a hospital,” says Eubank. “Because commercial DVRs serve so many functions and are used so often, hospitals need to make sure they understand what they are buying.”

Be sure that the DVR manufacturer guarantees it will service the boxes if problems arise. Purchasing DVRs for any hospital is a big decision with a high initial cost.

But if you do the right research and shop around for the right deals, it’s an investment that most hospitals are discovering is well worth the money.

Portable surveillance provides temporary help

Even the most secure hospital can’t provide video surveillance in every area of the building. The cost and inconvenience of having that many cameras is just too much to handle. In rooms where hospitals don’t need full-time surveillance but want to get a glimpse of a particular event, portable video surveillance is an option.

The MicroDVR, which was created by Micro Technology Services, Inc., and provides temporary and hidden video images, is one of the leaders in the portable video surveillance market. The MicroDVR combines a video camera, digital video recorder (DVR), monitor, and battery in one small setup that is about the size of a deck of cards.

Security officers can mount it on any wall and allow it to record up to 20 hours of video.

“It’s great for temporary investigative actions,” says Tim Lee, a national sales representative with Micro Technology Services in Richardson, TX. “It’s designed for areas where there is a specific complaint or potential shortage and it will take too much time or money to install permanent video cameras.”

Because many departments use the portable system to gather evidence during a specific ongoing investigation, keeping its use a secret is important. The design of the MicroDVR allows security departments to use it without involving the information technology department.

“People will see it on a wall or on a shelf and have no idea what they’re looking at,” says Lee. “You can even paint it to match a wall.”

The internal battery allows the camera to operate for up to 24 hours, but you can extend that time by changing the settings. You can set the MicroDVR to only turn on in response to motion or sound, extending its battery life up to three days.

Editor’s note: For more information about the MicroDVR, visit www.mitsi.com/security.
collection systems, depending on whether it is paid parking for staff, visitors, or both. In this respect, visitors generally pay cash upon leaving and staff generally pay in advance using a window sticker or a card-access control.

A paid parking program often raises the following questions:

- **What hours will money be collected?** There will be a time during the evening or weekends when it is not economically feasible to maintain a cashier for a limited volume of traffic, thus there will be a “free out” for people who leave after that time. This situation presents a challenge of how to account for tickets issued when there are no fees collected.

- **Will there be a system that allows for certain visitors to receive complimentary parking for a given reason?** The hospital may want to give free parking to patients, but not to all visitors. In this case, departments could stamp patients’ parking tickets to alert the parking cashier.

- **Under what department will cashier personnel be hired?** There needs to be a fully planned operational procedure for staffing a cashier position that takes into account issues such as when the cashier does not report at the last minute, work breaks, accounting procedures, and shift-change protocols. Occasionally, security officers act as cashiers, but that must be a part of their job description and not something in which all officers partake. The more cashiers you have, the more accounting issues there are that can arise.

- **Will parking receipts be income to the security department or hospital’s general fund?** If funds go toward general hospital funds, this can result in an inflated cost to the security department, which adversely affects benchmarking results. If security isn’t receiving the collected money, the extra time spent dealing with the paid parking system will increase the department’s expenses.

- **Which security safeguards should we install at the cashier collection point?** Consider using closed-circuit televisions, communication devices, panic alarms, more lighting, bullet-resistant glazing, more staff training, and cash escorts.

As with any other operational program, there is a constant need for quality control mechanisms, supervision, and dealing with customer questions.
Introduction

Throughout 2005, HCPro polled readers who took part in Joint Commission on Accreditation of Healthcare Organizations (JCAHO) surveys. Our goal was to find out how surveyors evaluated the environment of care (EC) standards and what related citations frequently came up.

On the following pages, you’ll find our final report detailing the results of our anonymous online questionnaire, as well as tips on how you can better prepare for future JCAHO visits as the accredits switches to all unannounced surveys.

For those of you who took the time to tell us about the EC portion of your surveys, we offer our sincere thanks.
Online poll results tie in with key ideas for 2006

In January 2005, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) debuted its new life safety specialists, and it’s clear that these surveyors made an impression, according to poll results gathered by Briefings on Hospital Safety.

Life safety specialists visit hospitals with 200 or more beds, and all surveyors are more aware of fire protection issues than ever before. Our poll results—reported anonymously by hospital safety professionals throughout 2005—show an increased emphasis on all five fire safety standards in the environment of care (EC) compared to 2004.

“There’s been a big increase [in related citations] with the Life Safety Code® [LSC] specialists,” too, says Dean Samet, CHSP, director of regulatory compliance services at the engineering firm Smith Seckman Reid, Inc., in Nashville, TN.

The chart on p. 3 shows the degree to which surveyors emphasized the various EC standards during JCAHO visits in 2005. Among the highlights of the results are the following:

• In 63% of the visits, surveyors intensely discussed EC.4.10 (emergency management plans), making it the most emphasized standard in 2005.
• Only 2% of respondents indicated that they fielded no questions about their compliance with the LSC under EC.5.20, which points to the critical need for hospitals to ensure that their fire protection plans and systems are top notch.
• One out of every three hospitals that responded to our poll received a requirement for improvement, while 55% received less serious supplemental recommendations (see figure one on this page as well as the story on p. 7 for more about EC citations).
• Once again, the least scrutinized EC standard was EC.1.30, which requires hospitals to set nonsmoking policies. Other standards that experienced less survey attention included medical equipment requirements (EC.6.10 and EC.6.20) and medical gas and vacuum testing (EC.7.50).

Three points to remember
Samet believes hospitals should focus on the following three critical areas in 2006:

1. Be ready for all unannounced surveys. “The hottest hot spot is the fact that surveys are going to be unannounced,” he says. “That has raised the anxiety level through the roof.”

By switching to unannounced surveys, the JCAHO hopes to improve upon continual survey readiness at hospitals. On the morning of a site’s survey, the JCAHO will post information and photos of the assigned surveyors onto the facility’s extranet connection with the accreditor.

From 2006 to 2008, unannounced surveys will occur during the year in which any given facility is due for its triennial JCAHO visit. Subsequent unannounced surveys will occur 18–39 months after the facility’s first unannounced survey.

To keep in tune with potential deficiencies that would attract attention during a sudden JCAHO visit, make the best use possible of your hazard surveillance inspections, says Steven MacArthur, a safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. continued on p. 4
A look at what standards surveyors emphasized

Our online poll asked respondents the degree to which surveyors discussed or analyzed the environment of care (EC) standards. The highest percentages we received for any given standard may point to trends in upcoming surveys.

<table>
<thead>
<tr>
<th>Standards</th>
<th>Heavily discussed</th>
<th>Somewhat discussed</th>
<th>Not discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC.1.10 (safety plan)</td>
<td>40%</td>
<td>49%</td>
<td>11%</td>
</tr>
<tr>
<td>EC.1.20 (testing safety elements)</td>
<td>36%</td>
<td>53%</td>
<td>11%</td>
</tr>
<tr>
<td>EC.1.30 (no-smoking policy)</td>
<td>13%</td>
<td>35%</td>
<td>52%</td>
</tr>
<tr>
<td>EC.2.10 (security plan)</td>
<td>36%</td>
<td>60%</td>
<td>4%</td>
</tr>
<tr>
<td>EC.3.10 (hazmat/waste plan)</td>
<td>25%</td>
<td>60%</td>
<td>15%</td>
</tr>
<tr>
<td>EC.4.10 (emergency plan)</td>
<td>63%</td>
<td>33%</td>
<td>4%</td>
</tr>
<tr>
<td>EC.4.20 (disaster drills)</td>
<td>41%</td>
<td>48%</td>
<td>11%</td>
</tr>
<tr>
<td>EC.5.10 (fire safety plan)</td>
<td>52%</td>
<td>43%</td>
<td>4%</td>
</tr>
<tr>
<td>EC.5.20 (Life Safety Code compliance)</td>
<td>53%</td>
<td>45%</td>
<td>2%</td>
</tr>
<tr>
<td>EC.5.30 (fire drills)</td>
<td>47%</td>
<td>47%</td>
<td>7%</td>
</tr>
<tr>
<td>EC.5.40 (testing fire equipment)</td>
<td>43%</td>
<td>37%</td>
<td>20%</td>
</tr>
<tr>
<td>EC.5.50 (life safety deficiencies/interim life safety measures)</td>
<td>40%</td>
<td>42%</td>
<td>19%</td>
</tr>
<tr>
<td>EC.6.10 (medical equipment plan)</td>
<td>24%</td>
<td>49%</td>
<td>27%</td>
</tr>
<tr>
<td>EC.6.20 (testing medical equipment)</td>
<td>21%</td>
<td>50%</td>
<td>29%</td>
</tr>
<tr>
<td>EC.7.10 (utilities plan)</td>
<td>26%</td>
<td>57%</td>
<td>17%</td>
</tr>
<tr>
<td>EC.7.20 (emergency power)</td>
<td>38%</td>
<td>49%</td>
<td>13%</td>
</tr>
<tr>
<td>EC.7.30 (testing utilities)</td>
<td>26%</td>
<td>55%</td>
<td>19%</td>
</tr>
<tr>
<td>EC.7.40 (testing emergency power)</td>
<td>43%</td>
<td>39%</td>
<td>17%</td>
</tr>
<tr>
<td>EC.7.50 (testing medical gas/vacuum)</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>EC.8.10 (appropriate environment)</td>
<td>19%</td>
<td>60%</td>
<td>21%</td>
</tr>
<tr>
<td>EC.8.20 (N/A—reserved for settings other than hospitals)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>EC.8.30 (construction/renovation)</td>
<td>25%</td>
<td>57%</td>
<td>18%</td>
</tr>
<tr>
<td>EC.9.10 (monitoring the EC)</td>
<td>27%</td>
<td>63%</td>
<td>10%</td>
</tr>
<tr>
<td>EC.9.20 (identifying EC issues)</td>
<td>29%</td>
<td>65%</td>
<td>6%</td>
</tr>
<tr>
<td>EC.9.30 (improving the EC)</td>
<td>31%</td>
<td>63%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Poll results  continued from p. 2

HCPro published this special report. During hazard rounds, pay attention to small problems that could result in a citation if looked at cumulatively, MacArthur says. More importantly, share the assessment of these smaller issues throughout the hospital. Facilities should use every set of eyes on the staff to monitor safety concerns as a way to continually stay ready for the JCAHO.

There seems to be a trend in which surveyors roll a series of small deficiencies into a requirement for improvement. Unannounced surveys could easily lead to such situations if hospitals don’t stay on top of EC concerns.

2. Life safety specialists will continue their march. Only one year has passed since the JCAHO introduced its life safety surveyors, which means that two-thirds of hospitals with 200 or more beds haven’t hosted these specialists yet due to triennial survey cycles, Samet says.

Those hospitals expecting the JCAHO in 2006 will find the extended life safety tour to be just as eye-opening as those sites that experienced it in 2005, Samet says (see the related stories on pp. 6–7 for more about life safety concerns).

That being said, most safety professionals seem to appreciate the life safety tours as the equivalent of peer reviews from fellow facility engineers, he says.

3. Emergency management changes will test you. In 2005, the JCAHO conducted a field review of proposed revisions to EC.4.20 (emergency drills). The draft indicated a potentially tougher series of requirements. Ideally, any standard change would force hospitals “to better assess themselves through a more meaningful emergency management drill,” Samet says.

Related to this situation is the JCAHO’s new emergency management session during all hospital visits. Surveyors will spend time reviewing a site’s emergency plan and hazard vulnerability analysis and then testing staff on a scenario from that analysis.

Gone are the days when hospitals might have been able to impress surveyors with an abundance of paperwork in support of their disaster plans, Samet says. Expect a new focus in 2006 on staff knowledge about emergency response procedures. It’s too soon for hospitals to panic about this staff testing without seeing first how visits in early 2006 turn out.

“Give it a chance,” Samet says. Hospitals will succeed if they ensure that every employee knows what to do during an emergency, MacArthur says.

<table>
<thead>
<tr>
<th>What EC documents did the surveyor review?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document</td>
</tr>
<tr>
<td>✔ Statement of Conditions</td>
</tr>
<tr>
<td>✔ Annual evaluation of the seven environment of care (EC) plans</td>
</tr>
<tr>
<td>✔ Safety/EC committee meeting minutes</td>
</tr>
<tr>
<td>✔ One or more actual EC plans</td>
</tr>
<tr>
<td>✔ Hazard vulnerability analysis</td>
</tr>
<tr>
<td>✔ Fire drill records</td>
</tr>
<tr>
<td>✔ Disaster drill records</td>
</tr>
<tr>
<td>✔ Medical equipment preventive maintenance records</td>
</tr>
<tr>
<td>✔ Utilities preventive maintenance records</td>
</tr>
<tr>
<td>✔ Infant security plans</td>
</tr>
<tr>
<td>✔ Safety training records</td>
</tr>
</tbody>
</table>

Note: Respondents could choose multiple categories.
Emergency plan reviews will be more demanding

The new emergency management sessions that hospitals will experience starting this year aim an even brighter spotlight on disaster preparation and response.

The sessions will include a thorough review of hospital emergency management policies and plans, including a site’s hazard vulnerability analysis. Surveyors from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will then develop a scenario based on the analysis and observe staff knowledge and actions related to the scenario.

Don’t expect the JCAHO to ask about the top danger noted in your hazard vulnerability analysis, said David Teeter, PharmD, a nationally certified emergency manager and part-time pharmacist at Wishard Hospital in Indianapolis.

Instead, surveyors may choose to push staff by testing them on the fourth or fifth rated scenario—so make sure that workers receive a broad base of emergency response education, Teeter said.

The JCAHO’s goal is for hospitals to develop emergency programs capable of successful responses regardless of the incident.

Think about emergency complexities

The JCAHO will evaluate compliance with its emergency-management standards by determining how well-prepared hospitals are for catastrophic events, as opposed to a single incident of limited scope (e.g., a utility system disruption).

Although the definition of a catastrophe is going to vary by facility, Hurricane Katrina provides a good example of a sequence of events that, by most standards, represents a catastrophe, said Steven MacArthur, a safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. HCPro published this special report.

As Katrina unfolded, hospitals first had to endure the storm, and then they faced extreme flooding followed by civil disturbances and social collapse outside of their properties. Although there is no requirement for hospitals to conduct drills of Katrina’s magnitude, the hurricane and its aftermath point to the need for sites to introduce complexity into emergency response tests, MacArthur said.

With that in mind, incorporate scenarios that push the boundaries during your required emergency drills. “I think the crystal ball is pretty clear” in regard to the JCAHO expecting more realistic drills in 2006, said MacArthur.

Determine how far your drills have gone in the past and develop scenarios that take them one step beyond. For example,

- if your plan calls for a tanker truck to deliver potable water to your hospital, contact the vendor during a drill and find out the vendor’s response in terms of time and what it could actually provide at that moment
- add the wrinkle of a power outage or telecommunications failure to your next drill
- plan an infant abduction scenario in conjunction with a staff exercise on decontamination procedures

Evacuation knowledge is lacking

An evacuation is another good angle for which you’ll likely find staff unprepared, said Dean Samet, CHSP, director of regulatory compliance services at engineering firm Smith Seckman Reid, Inc., in Nashville, TN.

Samet isn’t convinced that hospitals are truly ready for evacuations, even though hurricanes Katrina and Rita emphasized that need like never before.

“I don’t know that organizations have really looked at partial evacuations or, even worse, full evacuations,” he said. What seems to be lost on some sites is that a natural disaster or terrorism aren’t the only impetuses for evacuating the building, he said.

Editor’s note: MacArthur and Teeter spoke during HCPro’s audioconference “The JCAHO’s emergency management standards: Improving patient safety and survey preparation.” For more information or to order a tape, go to www.hcmarketplace.com/prod-3803.html or call our Customer Service Department at 800/650-6787.
With so much emphasis in 2005 on *Life Safety Code* compliance, we asked hospitals that hosted life safety surveyors which kinds of issues arose during these visits.

Remember, life safety specialists visit hospitals with 200 or more beds for one day of a regular survey, the majority of which they spend touring the physical building.

According to our online poll results, almost all respondents indicated that they were able to handle the issues that the life safety specialists raised (see figure two below).

These surveyors will continue to focus on five environment of care (EC) standards, which we list along with specific areas of interest as noted by our poll respondents.

**Standard: EC.5.20**, which requires *LSC* and *Statement of Conditions* compliance  
**Areas of interest:** Storage of oxygen cylinders, penetrations in barrier walls, who repairs barrier walls, fire doors closing properly, signs on doors to indicate use and storage, staff knowledge about fire drills and evacuation policies, linen chute inlets and outlets, exit signs, door ratings and labels, storage of inappropriate items in corridors, obstructions to corridor width, smoke detector locations, electrical room observations, security officer responses to fire alarms, enforcing decoration policies related to fire safety, the JCAHO’s optional building maintenance program, and tracing exit routes to a public way

**Standard: EC.5.40**, which covers testing, inspection, and maintenance of fire safety equipment  
**Areas of interest:** Fire alarm testing records, portable fire extinguisher conditions, kitchen suppression system operations, sprinkler system testing records, and fire pump testing records

**Standard: EC.5.50**, which covers interim life safety measures (ILSM)  
**Areas of interest:** Construction projects, regular maintenance activities that may affect fire protection features, daily ILSM inspections (including weekends), and contractor knowledge of fire safety during construction and renovation

**Standard: EC.7.40**, which covers testing, inspection, and maintenance of emergency power systems  
**Areas of interest:** Generator-testing records, who tests the generators, generator room observations, and size of generator fuel tanks

**Standard: EC.7.50**, which covers testing, inspection, and maintenance of medical gas and vacuum systems  
**Areas of interest:** Medical gas system testing records and labeling of main supply valves on medical gas systems

Respondents also reported that the length of the building tours varied, likely based on the size of their facilities.

Times ranged from one-and-a-half to eight hours, according to our results. ■

---

**Figure two:**
Do you believe that your facility was prepared to handle the life safety surveyor's queries?  

**Yes:** 96%  
**No:** 4%
Fire safety fuels most EC citations, poll indicates

However, EC.1.10 problems also make a noticeable impression

There's a better than 50–50 chance that if a surveyor issues an environment of care (EC) citation, it will fall under the standards for fire safety.

So say data from hospitals surveyed in 2005 that received requirements for improvement or supplemental recommendations from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The information comes from the results of our online poll conducted throughout 2005.

Regardless of whether you look at the more serious requirements for improvement or supplementals, the number of fire safety citations was more than double that of all other problems in either category.

General safety citations continue to be an area of focus (see figure three below for a breakdown).

New surveyors produce more citations

The JCAHO reported in summer 2005 that 16% of all hospitals surveyed so far that year had received requirements for improvement specifically under EC.5.20 (Life Safety Code [LSC] compliance). The JCAHO’s life safety surveyors, who debuted in January 2005, as well as regular surveyors have found plenty of fire protection problems.

These new, part-time surveyors continue to hold jobs as safety officers and facility directors in hospitals.

“They have the working knowledge and experience of the [LSC], the environment of care standards, and the Joint Commission survey process,” says Dean Samet, CHSP, director of regulatory compliance services at engineering firm Smith Seckman Reid, Inc., in Nashville, TN.

A rundown of the sore spots

According to our poll, the biggest fire safety violations included

- failure to properly inspect, test, and maintain fire protection equipment (EC.5.40)
- fire doors that don’t latch properly (EC.5.20)
- penetrations in barriers that workers haven’t properly sealed (EC.5.20)

The door latching and penetration concerns are among the most pervasive in hospitals. Facilities have the option of including penetrations and several other common problems in a building maintenance program under the Statement of Conditions. The building maintenance program affords scoring advantages based on the performance of regular, documented upkeep of a set list of items.

Door latching will become an even trickier issue on March 13 when both the JCAHO and the Centers for Medicare & Medicaid Services formally prohibit roller latches on all corridor doors. Hospitals must replace these roller latches with positive latches.

A roller latch is a device that releases just by pushing or pulling on a door, as opposed to turning a knob. A positive latch requires someone to turn a knob or push a lever to open a door.

General safety also gets nudged

The JCAHO also noted that one out of every 10 surveyed hospitals received requirements for improvement under EC.1.10 (general safety plans).

continued on p. 8
This statistic ties in with data from our online poll, in which respondents said that 17% of all citations came from general safety concerns under EC.1.10 and EC.1.20. Based on these figures, it appears that EC.1.10 has become a bigger target than in past years.

It wouldn’t be surprising if these citations stemmed from element of performance #4 under EC.1.10, says Samet, former associate director of standards at the JCAHO. That element requires hospitals to conduct forward-thinking risk assessments on all kinds of safety issues. Consider element #4 as a catch-all provision similar to the Occupational Safety and Health Administration’s general duty clause, he says.

Calls inspire raised awareness

What may have also fueled EC.1.10’s citations is that JCAHO officials more frequently hold conference calls with surveyors, which gives the surveyors greater opportunities to explore standards such as EC.1.10, Samet says. During these calls, surveyors are “getting the opportunity to ask questions, get answers, listen, and take it to the bank” during hospital visits, he says.

According to our poll results, general safety violations made a broad impact in numerous situations, some of which included:

- a surveyor noting that blue H street signs weren’t posted on highways to direct people to a hospital
- staff not securing properly an empty oxygen cylinder (the hospital later prepared clarifying documentation showing that staff checked these cylinders during hazard rounds)
- a surveyor wanting a home health representative on the hospital’s safety committee
- a facility not labeling adequately several circuit breaker panels
- areas of a floor worn down due to polishing
- employees’ offices containing too many personal appliances

EC tracers noted by our respondents

Tracers—in which surveyors track a patient or process through a hospital—can always involve the environment of care (EC) even if safety concerns aren’t what prompts the review.

Of the respondents who completed our online poll, 40% reported a tracer that somehow involved EC concerns during surveys in 2005.

Examples of tracers that involved safety issues, as noted in the results of our poll, include surveyors:

- following an IV pump with a patient from the emergency department to the patient’s room
- tracking how staff handle chemotherapy waste, starting in the oncology unit
- reviewing interim life safety measures because of a construction project by which patients traveled by
- asking staff during a clinical tracer about emergency plans, safety programs, and material safety data sheets
- targeting hand hygiene and infection control while tracing a patient