adhering to EC.1.10, as it was the eighth most cited standard during hospital surveys in 2006, according to The Joint Commission. The catch is that the accreditor doesn’t offer a lot of guidance on how to complete risk assessments under EC.1.10. Instead, the onus is on hospitals to develop their own evaluations and then stand by them during surveys.

This dilemma has led some readers to wonder:

• How they should go

Staying ahead of the evolving EC standards was the big theme coming out of HCPro’s inaugural Hospital Safety Symposium.

The symposium, which attracted safety professionals from across the country, took place May 3–4 in Las Vegas.

Below are four important EC areas that our speakers encouraged attendees to check on this year, particularly if their hospitals expect an unannounced survey in 2007 or 2008:

❖ Start prepping now for the new EC.4.10. The Joint Commission announced in May that revisions to EC.4.10 (emergency management plans) and EC.4.20 (emergency management tests) will take effect on January 1, 2008.

As part of the changes, expect the emergency management standards to expand from two to nine, as well as a significant increase in elements of performance. We reported on the draft revisions in the January and February Briefings on Hospital Safety.

EC.1.10: Successful risk assessments assign severity and set time frames

It’s happening a lot: Joint Commission surveyors are rolling safety deficiencies into citations under EC.1.10.

That standard broadly requires hospitals to manage their safety risks. One of EC.1.10’s key points comes under element of performance #4, which mandates that facilities perform risk assessments on any hazard that could negatively affect patients, workers, or the building itself.

Many sites pay the price for not adhering to EC.1.10, as it was the eighth most cited standard during hospital surveys in 2006, according to The Joint Commission.

The catch is that the accreditor doesn’t offer a lot of guidance on how to complete risk assessments under EC.1.10. Instead, the onus is on hospitals to develop their own evaluations and then stand by them during surveys.

This dilemma has led some readers to wonder:
EC changes < p. 1

“The proposed changes are very, very descriptive,” said Dean Samet, CHSP, director of regulatory compliance services for Nashville-based Smith Seckman Reid, Inc. Samet was the keynote speaker during the Hospital Safety Symposium.

Much of the revisions aren’t new requirements, but rather a retooling of existing provisions. Hospitals that want to stay ahead of the curve should review their existing emergency plans under EC.4.10 in light of six expected focus areas in the revisions:

- Communication
- Resources and assets
- Safety and security
- Staff members’ roles and responsibilities
- Utilities
- Clinical activities

As of mid-May, The Joint Commission hadn’t published the final standards. Watch these pages and our free e-mail newsletter Safety Connection for further details as they become available.

Review OSHA’s connections to the EC.

Savvy Joint Commission surveyors may be able to check your EC compliance by referencing standards from OSHA, said Steven Bloom, MS, senior scientist at Environmental Health & Engineering, Inc., in Newton, MA, and director of environmental affairs at Brigham and Women’s Hospital in Boston.

Bloom—another speaker during the symposium—recalled a surveyor who wanted to see an eyewash station installed in a food galley. Staff members brought cooked food from the kitchen to the galley for final preparation.

The surveyor found a bottle of dishwashing liquid under the sink, felt that it was a hazardous material, and as such indicated that it warranted an eyewash station under OSHA’s medical first aid standard (1910.151), Bloom said.

A local OSHA official disagreed with the surveyor’s stance, and eventually the request went away. However, the situation demonstrated how Joint Commission surveyors can invoke OSHA standards, he added.

OSHA can tie into the EC standards through the general duty clause and EC.1.10, which both basically mandate that hospitals assess the risks of any hazards. (For much more about safety risk assessments, see “EC.1.10: Successful risk assessments assign severity and set time frames” on p. 1.)

Slowly but surely, they’ve been shifting back to wanting to see more documentation.”

Dean Samet, CHSP
Occasionally, OSHA requirements can also connect with The Joint Commission’s National Patient Safety Goals. For example, the goal on preventing patient falls can have implications for staff safety during patient handling, Bloom said. Generally, organizing hospital worker safety through the EC standards is a good approach toward complying with OSHA, he added.

Keep your EC paperwork in order. When The Joint Commission debuted its Shared Visions–New Pathways approach to surveys, one of the battle cries was that hospitals would see fewer record reviews and more one-on-one time between surveyors and frontline staff members.

However, that trend appears to be fluctuating with surveyors. “Slowly but surely, they’ve been shifting back to wanting to see more documentation,” said Samet.

EC documents that you should have ready for unannounced surveys include the following, as noted by Samet:
- Your most recent annual evaluations of the seven EC plans.
- Safety committee meeting minutes.
- A current Statement of Conditions (SOC), in particular the basic building information and plans for improvement (PFI). You are already required to file your basic building information electronically, and as of September 1, all PFIs must migrate to the electronic SOC.
- The hospital’s emergency management plan, including the hazard vulnerability analysis and results of your disaster drills.

- All hospitals, including those with fewer than 200 beds, will have at least a one-day visit from a life safety specialist during unannounced surveys (currently, only hospitals with 200 or more beds host the specialists)
- Hospitals with more than 750,000 square feet of area will host life safety specialists for two days

Note that The Joint Commission has already begun two-day life safety specialist visits in 2007 for some hospitals under certain circumstances.

If your facility is on the cusp of the 750,000-square-foot threshold, it should look for avenues to remain below that level, because it will save you the extra $3,500–$4,000 The Joint Commission will charge for the second life safety specialist, Samet said.

The 750,000-square-foot area measurement is for your inpatient facility as listed under your hospital’s accreditation number, he added.

Thank you for attending, and see you in 2008

We wanted to express our thanks to those of you who came to our debut Hospital Safety Symposium in Las Vegas.

Plans are already underway for the second installment of our conference, which will likely occur in spring 2008.

We’ll fill you in on all of the details in the coming months.
Risk assessments

about creating risk assessments and the forms documenting them
- What deficiencies should be identified as risks
- What format The Joint Commission expects these assessments to take

“To tell you the truth, The Joint Commission doesn’t have a format [for risk assessments],” says healthcare consultant and former surveyor Elizabeth Di Giacomo-Geffers, RN, MPH, CNA, BC, of Di Giacomo-Geffers and Associates in Trabuco Canyon, CA.

“You develop the format, you implement it, and [The Joint Commission will] survey the practice, policy, or format,” she says.

In broad strokes, The Joint Commission expects risk assessments to:
1. Identify the issue in question
2. Document the pros and cons of the issue
3. Demonstrate that safety managers and others reached a consensus about the risks
4. Outline appropriate actions to decrease the risks

“This process should be followed for each risk assessment conducted by an organization,” says Elizabeth Zhani, a spokesperson for The Joint Commission.

Safety hazards can add up
Some safety professionals look at EC.1.10 as the cousin of OSHA’s general duty clause in that it allows surveyors to examine concerns that the EC standards may not specifically discuss.

Although that approach sounds abstract, hospitals have received concrete citations for risk assessment weaknesses, says Steven MacArthur, safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. HCPro publishes this newsletter.

During HCPro’s Hospital Safety Symposium in Las Vegas in May, MacArthur outlined the following citations he’s seen or heard about under EC.1.10:
- Wall-mounted, pull-down computer workstations that impede on minimum corridor widths
- Trash compactors without key controls to prevent people from entering the machines
- A single fire extinguisher out of 150 missing an inspection date
- Cigarette butts found adjacent to the kitchen loading dock
- Decorations hung in egress corridors

The Joint Commission cuts a wide swath
The idea of risk assessments is inherent in all EC standards, not just EC.1.10, Zhani says.

She points to Note 3 in the overview section of the EC chapter in the Comprehensive Accreditation Manual for Hospitals, which states that hospitals must develop written plans for:
- EC.1.10
- EC.2.10 (managing security)
- EC.3.10 (overseeing hazardous materials and waste)
- EC.4.10 (establishing emergency management plans)
- EC.5.10 (managing fire safety)
- EC.6.10 (handling medical equipment risks)
- EC.7.10 (managing utility risks)

“Surveyors will look for these written risk assessment plans,” Zhani says.

Trends may point to a need
Large risks, such as a new construction project, are often easy to spot and plan assessments for.

But a rash of incidents in your facility might also uncover a risk, Di Giacomo-Geffers says. Something simple (e.g., multiple purses disappearing from offices or patient rooms) might point to a larger, more complex risk that you need to tackle.

Although formats can vary for risk assessments, the first step is always to recognize a risk, usually from the following areas, as noted by Di Giacomo-Geffers:
- An actual incident that has occurred which highlights a risk
A perceived risk that hasn’t come to fruition yet but is on the horizon
Evidence from The Joint Commission, media, or other sources of information that details risks

**Severity levels help you prioritize**
When you identify a risk, assign it a level of severity. High, medium, and low levels are a basic approach, though you may need to be more specific than that, she says.

The idea behind setting severity levels is to think ahead by seeking out risks and minimizing them before an incident happens.

After prioritizing your list from highest risk to lowest, start correcting the most severe hazards you find. The hospital should come up with a time frame to address risks of different priorities, Di Giacomo-Geffers says.

For example, hospitals might dive into high risks immediately, medium risks within six to nine months, and low risks within a year. However, those are just hypothetical deadlines, she says.

The key on which The Joint Commission will focus is that a hospital sets its own goals and then, when it identifies risks, meets those objectives.

“The last big point is that you need to review your risk assessments periodically,” Di Giacomo-Geffers says, adding that one suggested interval would be annually, and more often if new risks occur.

One example of a new risk occurring is the Virginia Tech shootings: The lessons learned about security and emergency planning from that episode should inspire hospitals to revisit their policies and adjust them accordingly now, instead of waiting for them to come up in the next annual review.

**Create a paper trail for assessments**
Whatever steps you take as part of your risk assessments, be sure to document them, MacArthur says.

Another good tactic is to formally discuss them during safety committee meetings and add them to your meeting minutes.

Surveyors will welcome these efforts, he says.

You can also use hazard surveillance rounds as required under EC.1.20 (testing and inspecting safety elements) to determine whether your risk assessment actions work effectively, he adds.

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### Suggestions for risk assessments

The following concerns offer opportunities to conduct safety risk assessments:
- Needlestick prevention
- Patient lifting and ergonomics
- Radiation safety
- Chemical use
- Lasers
- Assaults on hospital property
- Blood or body fluid exposures
- Patient abductions (particularly infants)
- Staff member and patient falls
- Burn hazards
- Gas vapors and fumes
- Electrical safety
- Asbestos handling
- Patient escapes
- Power tool safety
- Driver safety (e.g., a worker who drives a shuttle bus)
- Overhead work

*Source: Steven MacArthur, safety consultant, The Greeley Company, Marblehead, MA.*

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**Questions? Comments? Ideas?**

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Opening day brings safety opportunities for employees

Before a new building accepts patients, motivate workers about your concerns

Opening a new hospital or a new wing can be tough on safety managers, who might feel that their concerns take a back seat to design, convenience, and bragging rights to having a state-of-the-art medical facility.

However, a hospital can achieve all of those goals and create a safe environment for its workers, too, says Julie Warne, safety manager for Memorial Health System in Colorado Springs, CO.

On April 25, the system opened its 94-bed Memorial Hospital North, boasting 60 acute-care beds, a birth center, and an emergency department among its services. The hospital kept safety on its priority list, and so far it’s paid off. For those of you dealing with new openings now or in the future, Warne offers the following tips she picked up from her experiences:

✓ Put your stamp on plans early. It’s important that safety leaders contribute in the planning stages of a new facility without going overboard, says Warne.

“You have to achieve a balance between making a facility safe and not changing everything in the original design,” she says. “We had a lot of ‘I want this,’ and ‘I want that,’ and you can’t just change things as people suggest.”

Pick the most important matters to negotiate. One example of a small concern that Warne saw and didn’t fight was the placement of eyewash stations in the medication rooms. Although they’re now out of sight and may require a little extra reminding for maintenance, she chose more significant safety-related matters to champion.

✓ Use orientations and fairs to solicit help.

The challenge of telling workers how to overcome safety obstacles cropped up at several stages during staff training for the new building. Managers trying to weave in safety issues prior to opening day had good opportunities during the following times:

- Staff training on new equipment.
- Fire safety drills.
- Practice runs of medical care, which Memorial Health called “A Day in The Life.” During these practice runs, clinicians got to know their new spaces and even worked with fake patients.

Memorial also hosted a learning fair during which staff members could visit booths with information about fire safety, hazardous materials, and other EC matters.

The fair gave safety managers an opportunity to provide new employees the rundown of policies and procedures—and to give veteran workers from other Memorial facilities a refresher course, Warne says.

✓ Build in extra time if you can. One luxury Warne had was extra time: The opening for the new facility got pushed back three weeks at a point when she didn’t have enough time to get everything done for the original date. That break put the safety crew in much better shape.

Rather than relying on such circumstances, though, it’s wiser to add time up front: If you think you need six months to prepare for opening day, build nine into the schedule.

It will still be tough to meet even an extended deadline, because new workers won’t receive training until they’re hired, which often occurs later than anticipated, she says.

✓ Ask staff members about safety priorities.

Warne received help from an outside patient safety and EC consultant who watched over the proceedings with her. Most of all, though, employees came through by offering good ideas. Reminding staff members to think about safety during those crucial first days brought about refinements. For example, thanks to employee input, Warne was able to determine the best places to store equipment so as not to block egress paths.

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Mass vaccinations and media relations are prime areas for hospitals to consider during pandemic flu planning, according to panelists who appeared during a federal Webcast.

The Centers for Disease Control and Prevention (CDC) continues to pursue faster, more accurate tests to identify and perhaps prevent flu infections. In doing so, the agency’s efforts can help keep patient surges into hospitals as low as possible, said Nicole Smith, PhD, MPH, MPP, of the CDC’s National Center for Infectious Diseases Influenza Branch.

The agency presented the Webcast on April 5.

"[Diagnostic tests] play a critical role . . . " Smith said. “They will extend the opportunities for early detection of pandemic influenza . . . and will allow for additional options for directing clinical management during a pandemic.”

**Practice widespread vaccination efforts**

Beyond advanced testing, if a flu pandemic—or even a large community outbreak—occurs, hospitals and public health officials will need to consider options for providing numerous vaccinations.

Hospital safety managers who have such an element in their flu preparedness plan can get pointers from New York City’s experience.

The city’s Department of Health and Mental Hygiene coordinated a one-day flu-shot vaccination program in fall 2006 to see how fast health officials could train volunteers at five vaccination sites.

The plan called for the instant creation of vaccination centers staffed by public health leaders who doled out just-in-time training to each center’s workers on the day of the mass vaccination.

Although New York public health officials didn’t hit their goal of vaccinating 25,000 people in a day, staffers and volunteers inoculated 5,000 throughout the city, said Marisa Raphael, MPH, assistant commissioner of the New York City Department of Health and Mental Hygiene’s bureau of emergency management.

**Spread the word**

Hospitals that will conduct similar drills—or plan to open public vaccination centers in the event of a pandemic—should keep in mind the following advice from Raphael:

- Beef up outreach to get the word out about flu shot sites to the public—appoint a public information officer for the vaccination effort who can publicize where to go and when
- Conduct data tracking to find out who gets vaccinated and where they receive their shots
- Ensure that signs in multiple languages tell folks what to do when they arrive for their shots

“This [drill] will help us further refine and develop our mass prophylaxis plan,” said Raphael, who spoke during the Webcast.

“As with many aspects of planning, this is a continual process and each new exercise presents new issues and challenges that need to be addressed,” she said.

**Work the press into your plan**

The CDC devoted a large portion of the Webcast to dealing with the media. Joint Commission standard EC 4.10 refers to managing media relations during an emergency, so hospitals need to consider this angle.
Pandemic planning  < p. 7

Wise planning in this regard takes place long before an emergency occurs, said Leah Bucco-White, BA, public information officer for the Nebraska Health and Human Services System, who also spoke during the Webcast.

Hospital representatives who deal with the press should distill their comprehensive emergency planning documents into brief, need-to-know summaries for reporters and distribute them beforehand, Bucco-White said. “It’s a simple snapshot [that] media can use in stories and share with the public.”

“Giving reporters tools to pinpoint crucial pandemic flu information quickly not only is appreciated, but it also helps get accurate information out to the public in a timely matter . . . and helps solidify our role as a go-to source for pandemic flu information,” said Bucco-White.

After developing such materials, emergency planning committees should ask hospital spokespeople to reach out to local reporters before an outbreak occurs.

Simulate your media’s actions in drills

When conducting emergency drills, also include mock press conferences during the exercises, Bucco-White said. You could even invite real reporters to participate.

Not only do the mock gatherings help planners recognize new scenarios they might not have thought about, but the events also help get people in a disaster frame of mind.

“It adds an element of realism,” she said.

Hospital planners can e-mail Bucco-White at birdflu@hhss.ne.gov or call her at 402/471-9356, and she’ll send a list of tips that her agency developed for conducting press conferences.

Editor’s note: See a CDC checklist that outlines steps to consider for pandemic plans on p. 9.

OSHA: Frontline workers should review new flu guidance

Just as Briefings on Hospital Safety went to press, OSHA released a new guidance to prepare frontline healthcare workers for an influenza pandemic.

The 104-page document, Pandemic Influenza Guidance for Healthcare Workers and Healthcare Employers, discusses hand hygiene, respiratory protection programs, supply stockpiles, and security, among other issues, said Donald Wright, MD, director of OSHA’s Office of Occupational Medicine.

The guidance “is organized in a fashion that doesn’t necessarily have to be read cover-to-cover to be useful,” Wright said during a press conference on May 21.

It covers infection control and emergency planning, and also features several appendices with sample forms and tips from the field.

Wright encouraged safety officers, clinicians, and support staff members to review the guidance; it should act not merely as a management tool, but also as a frontline resource, he said.

Taking that idea further, the guidance could be good reading for hospital maintenance crews, laboratory technicians, dietary workers, and environmental services personnel, said U.S. Assistant Secretary of Labor Edwin Foulke Jr., who heads OSHA.

Hospital leaders who know that staff members are inconsistent with good hand hygiene or personal protective equipment practices should take this guidance as a kick to increase compliance efforts, Wright added.

To read the guidance online, go to www.osha.gov/Publications/OSHA_pandemic_health.pdf.
**Step-by-step hospital planning for flu pandemics**

Use the following broad checklist to help guide and refine your hospital’s emergency planning efforts for influenza pandemics and associated drills.

1. **Establish a decision-making structure.**
   - [ ] Form a multidepartment planning committee for influenza preparedness
   - [ ] Name a coordinator
   - [ ] Set up liaisons with state, regional, and local preparedness groups

2. **Develop a written influenza response plan that includes the following elements:**
   - [ ] Circumstances under which the hospital will activate the plan
   - [ ] Description of the incident command structure that will be used to execute the plan
   - [ ] Drill simulation exercises to test the plan’s effectiveness

3. **Develop an influenza surveillance plan.**
   - [ ] Watch symptoms of patients
   - [ ] Determine the difference between seasonal and pandemic influenza
   - [ ] Assign responsibility to someone to monitor national data on what symptoms relate to a pandemic
   - [ ] Determine what flu activity will prompt the hospital to activate internal and external monitoring of cases

4. **Create a communications plan.**
   - [ ] Designate someone to report hospital flu statistics to state and federal government
   - [ ] Ensure spokespeople are in place to deal with the local press
   - [ ] Establish redundant lines of communication with key internal hospital personnel and other hospitals

5. **Train the following personnel on their roles during a pandemic:**
   - [ ] Physicians, nurses, and nursing assistants
   - [ ] Laboratory staff members
   - [ ] Emergency department personnel
   - [ ] Outpatient workers
   - [ ] Environmental services crews
   - [ ] Engineering and maintenance personnel
   - [ ] Security officers
   - [ ] Nutrition workers

6. **Develop a triage and admission plan.**
   - [ ] Determine the location to separate possible pandemic flu patients from the general patient population
   - [ ] Develop signs to direct and instruct possible flu patients
   - [ ] Plan how to track admissions and discharges for flu patients

7. **Limit facility access.**
   - [ ] Determine at what point your facility will close to new admissions
   - [ ] Determine visitation policies for flu patients
   - [ ] Give hospital security resources to enforce facility access controls

(Source: Condensed from an online checklist developed by the Centers for Disease Control and Prevention.)
Once again, a twister hits a medical center
A large, wide tornado struck the town of Greenburg, KS, on May 4, causing part of Kiowa County Memorial Hospital to collapse. About 30 people were trapped in the hospital’s rubble at one point, according to The Wichita Eagle.

Meanwhile, five hospitals in surrounding areas treated or admitted about 100 tornado victims with various injuries, The Eagle reported.

Kiowa County Memorial Hospital intends to rebuild, the Kansas Hospital Association wrote in a letter posted online.

This is the second time in recent memory that a tornado struck a medical center, as a Georgia hospital suffered heavy damage from a twister in March (see the June Briefings on Hospital Safety for more details).

Joint Commission study will examine smoke-free efforts at hospital campuses
The Joint Commission will seek hospital comments as it studies how healthcare facilities transition to smoke-free campuses.

The commission will send an electronic survey to more than 4,200 accredited hospitals. The survey will gather information about the experiences of hospitals that have successfully carried out smoke-free campus policies, as well as about the experiences of hospitals that have not yet adopted such policies, The Joint Commission said in a news release on May 8.

The release didn’t elaborate on what the results will mean for accredited hospitals.

The study is funded by a grant from the Robert Wood Johnson Foundation’s Substance Abuse Policy Research Program

NIMS FAQ list addresses compliance concerns
A list of 19 FAQs about the federal National Incident Management System (NIMS) was posted in April on the NIMS Web site.

The FAQs discuss several issues on the minds of hospital safety managers receiving disaster preparedness grants.

Highlights include the following information:
- Hospitals receiving certain federal preparedness and response grants have until September 30, 2008, to fully implement all 17 NIMS activities. It’s “desirable” to implement them by September 30, 2007, but allowing an additional year is more realistic.
- Independent training vendors may create NIMS courses that count toward compliance, as long as they meet NIMS guidance objectives.
- The government lists instructor qualifications for required NIMS courses.

To read the FAQs, go to www.fema.gov/pdf/emergency/nims/hospital_faq_0407.pdf.

Shooting tests hospital’s mass casualty plan
A shootout between an alleged fugitive and state troopers provided a real-life scenario for the Level 1 trauma center at Albany (NY) Medical Center to test its mass casualty response plan.

A suspect shot two state troopers during an incident on April 25, though original reports indicated four troopers had been shot, according to the Albany Times-Union.

Surgeons, nurses, and respiratory therapists prepared the ER; staff members alerted the local blood bank about possible needs; and the hospital diverted ambulances to other facilities as the troopers made their way from the scene to the trauma unit.

One of the troopers died on the way to the hospital.

The CDC releases data, guidance about respirators
In case of pandemic flu, the Centers for Disease Control and Prevention (CDC) has got healthcare workers’ backs—or at least their faces—covered.

On May 3, the CDC reported that it had stockpiled 100 million N-95 respirators and 52 million surgical
masks for frontline healthcare workers. Several million more respirators are on order.

The CDC also released interim guidance for the public about using respirators during an outbreak in their community, which you can read at www.pandemicflu.gov/plan/individual/index.html (scroll to the bottom of the page).

**Preparedness pays off for hospitals after massacre**

Although four small hospitals in the Blacksburg, VA, region had never seen a disaster on the scale of the shootings that took place on the Virginia Tech campus, earlier preparedness plans paid off.

The Near Southwest Preparedness Alliance runs disaster response in the region in conjunction with the Virginia Hospital and Healthcare Association, the state department of public health, and the Western Virginia Emergency Medical Services Council.

The collaborative’s prior emergency management experience helped hospitals and authorities provide more organized and efficient care following the mass shooting on April 16, according to the *American Hospital Association News*.

A student gunman killed 27 students and five faculty members on the university’s campus.

The alliance tests its regional emergency preparedness program weekly, with full-scale drills conducted twice per year.

The alliance’s resources previously helped respond to:
- A norovirus outbreak among Radford University students in January
- The bloody aftermath of a prisoner’s escape from Montgomery Regional Hospital in August 2006
- A mass carbon monoxide poisoning at Roanoke College in July 2006

**Gunman causes Utah hospital evacuation**

A tense situation caused a temporary evacuation of St. Mark’s Hospital in Salt Lake City when a man allegedly pulled a gun on himself in the ER area, according to the May 6 *Deseret Morning News*.

The man handed a receptionist a note indicating that he planned to kill himself, where his car was parked, and that the hospital was to harvest his organs for donation.

Sheriff’s deputies on the scene told the *Deseret Morning News* that the man did not appear to threaten anyone else.

After delivering the note, a nurse took him into a room to calm him while police were en route.

When deputies showed up, the man pulled a pistol from a box disguised to look like a book he had been carrying. At that point, the nurse ran, slamming the door shut with the man inside the room.

The deputies, guns drawn, ordered the first floor evacuated, and soon convinced the man to drop his gun and surrender, the newspaper reported.

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**AHRQ offers free respiratory care DVD**

In May, the U.S. Agency for Healthcare Research and Quality (AHRQ) released a free DVD to train healthcare workers who aren’t employed as respiratory therapists how to provide basic respiratory care during mass casualty incidents.

The DVD, *Cross Training Respiratory Extenders for Medical Emergencies*, covers the following:

- Manual ventilation
- Mechanical ventilation
- Airway maintenance
- Airway suctioning
- Infection control concerns

The DVD’s primary audiences are physicians, physician assistants, and nurses, the AHRQ said.

To learn more or to order a copy, go to www.ahrq.gov/prep/projxtreme.
In the June Briefings on Hospital Safety, we discussed Joint Commission and fire code implications for storing and charging computer workstations on wheels (WOW) in corridors.

An offshoot of that topic is the ergonomic friendliness of WOWs. We asked John Murray, safety director for Baystate Health System in Springfield, MA, and colleague Joe Welch, rehabilitation specialist in the disability management services department, about how they chose the more than 100 WOWs in service at their facility.

Adjustability and adaptability turn out to be the keys to picking out WOWs that fit into the hospital environment, Welch and Murray say. Their biggest challenge was settling on the one product that could work in many settings: emergency departments, medical/surgical nursing units, psychiatric units, cardiac care, ICUs, and doctors’ offices.

Baystate didn’t settle for an off-the-shelf cart: It found a WOW vendor to customize a basic model to its needs. “We worked with the manufacturer and modified a good basic cart into one with quite a lot of user-determined adjustability for the screen and keyboard and mouse,” Welch says. “It could also be used for sitting and standing work.”

Trial and error showed that some workers couldn’t strap everything onto the WOWs that they wanted to—from blood-pressure cuffs to medication drawers—because the overload eventually wore out the WOWs’ parts and limited adjustability. Keep these limits in mind when choosing WOWs for your hospital.

Murray and Welch also see more choices on the market now, a few years after they put in their big WOW order. Instead of having one basic model to adapt to every department, it might be wiser to diversify your WOWs.
Although new technology has played a big role in improving hospital security, it has also created a whole slew of new concerns for security directors.

From camera phones to so-called “nanny-cams,” the improper use of electronic devices not only raises red flags about patient privacy and possible Health Insurance Portability and Accountability Act of 1996 (HIPAA) violations, but can cause headaches for hospital security.

Camera phones make it easy to snap photos of patients without them realizing they’ve been photographed, much less agreeing to it. And these devices are being carried not just by visitors, but by staff members, as well.

Some potential problems may not even be on many hospitals’ radar screens. For instance, at Children’s Hospital in Boston, a nurse recently discovered a Webcam hooked up by parents in their child’s hospital room, according to a report in The Boston Herald. The discovery stunned the patient’s doctor, a pediatric oncologist, and raised questions about privacy issues.

The child’s parents set up the camera so the child’s favorite relative could see what was going on during the hospital stay.

The doctor asked the parents to remove the camera, the newspaper reported, and a hospital spokesperson said families of patients at Children’s Hospital are free...> p. 2

**New technology creates hospital security concerns**

*Policies can address the dangers of camera phones*

**Hospital faces challenge of ID badge access to security-sensitive areas**

*Editor’s note: Each issue of Healthcare Security Alert features an expert’s answers to your security questions. Steven MacArthur, safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, answers this month’s question. If you have a security question for one of our experts, e-mail Senior Managing Editor Joanne Finnegan at jfinnegan@hcpro.com.*

**Q** Our hospital plans to move to microchip electronic scanner ID badges to control access in some of our security-sensitive areas, such as medication rooms. There have been concerns about how we should manage staff members who forget their ID badges, leaving them unable to gain access to these areas. Would you recommend issuing them a temporary badge or possibly making them clock out and go home to retrieve the badge?

**A** There are a couple of important ground rules that you need to establish early in the process, including how staff members will gain access in the event that they forget their ID badge. However,> p. 4
Camera phones

Camera phones are particularly problematic. “The biggest issue is if people walked in with a video camera, we’d stop them,” says Frank Ruelas, a consultant at AZ HIPAA, in Surprise, AZ. “But we don’t even notice cell phones anymore. And getting the picture is only half the problem. The other problem is that you can send pictures directly to e-mail. You can shoot it electronically anywhere, and now the whole world can get to it.”

“This absolutely is a concern for security,” given that security officers are often the front line for enforcement, says Steven MacArthur, safety consultant for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. If there’s someone taking pictures on a patient floor, clinical staff members may try to intervene, but if faced with resistance, they are likely to call security to respond.

Despite widespread recognition of the problem, there is little consensus on how to handle the issue. Some hospitals have considered outright bans on camera phones—which might be difficult to enforce, because camera phones look like any cell phone and are small enough to hide easily. Other facilities have had success simply by enforcing existing photography and cell phone policies.

Take a look at your policy

At Stony Brook (NY) University Medical Center, that approach has led to no complaints so far, says Stephanie Musso, Stony Brook’s privacy officer. The hospital’s cell phone policies require visitors and staff members to leave patient areas and go to a general area or outside when they use their phones. This minimizes the risk of snapping unauthorized photos.

Musso trains her staff to enforce the existing photography policy, which states that no one can snap photos of patients without the patients’ permission. When Musso’s staff members see someone using a camera phone in an unauthorized manner, they inform the offender of the policy and ask him or her to delete the photos if a patient complains.

Part of the problem is that constant surveillance on the part of staff is impossible. And if patients don’t know that someone has photographed them, they won’t know to complain, Musso says. The best line of defense may simply be to inform patients of the protections that your current cell phone and photography policies afford. Also let them know that they can seek staff members’ help if something makes them uncomfortable.

Consider your own staff

However, visitors aren’t the only issue. Your staff members also might carry camera phones. Ruelas has heard reports of physicians snapping pictures of patients to prompt the physicians to include certain items in later dictation.

The problem arises if the physician fails to ask for the patient’s permission or photographs an unconscious patient. Also, staff members might sometimes inadvertently include patients in personal photos of colleagues, perhaps at a party or other event. So it’s important to educate staff members about the need to get consent before taking photos, Ruelas advises.

However, he warns that a specific camera phone policy may be too difficult to enforce in an era when everyone carries a cell phone. As technology keeps evolving, you might also find that there are new gadgets you didn’t think to include in such a policy. Instead, a well-crafted photography policy should cover the problem and remain enforceable, no matter what new gizmo comes along.

It’s important for staff members, including security, to know what will be accepted or tolerated, including what level of intervention they should take if someone is misusing a camera phone, says MacArthur. For example, does the hospital want security staff to confiscate devices? Where do you draw the line? For example, can visitors take pictures of family members? How do you verify who’s family and who is not? These situations raise many questions for hospitals,
MacArthur notes, including the following:
- Do you ask patients to sign releases that they agree to have their picture taken?
- Do you have signs posted or other materials to provide to patients and visitors so they understand your policy?
- Do you prohibit camera phones altogether or prohibit picture-taking in patient rooms, but allow it in the patient lounge or other common areas?

“This is not something that should be decided upon unilaterally,” MacArthur says. “There are a number of stakeholders in the process.”

Include your privacy or compliance officer, security, public relations, administration, and clinical staff members in policy decisions. Discuss the risks and then develop a strategy to manage those risks, he says.

From a survey perspective, be sure your hospital documents its safety and security risk assessment processes, he advises.

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Security plays a role in protecting hospital data

Stolen laptop computers. Records of dozens of newborn babies found in a condominium complex dumpster. Hospital workers charged with stealing patient IDs.

These and other security breaches involving information about hospital patients have been in the news in recent months.

Preventing these kinds of security lapses is best accomplished by a team effort that includes a facility’s security director and staff members. “There should be a good working relationship between the HIM [health information management] professional, the information security people, and the physical security people,” says Tom Walsh, CHS, CISSP, president of Tom Walsh Consulting, LLC, in Overland Park, KS. “They all need to communicate and work together.”

The Health Insurance Portability and Accountability Act of 1996 security rule has led many healthcare providers to upgrade antivirus software, properly set up servers and firewalls, and conduct audits of access to electronic patient health information. Although taking these security measures is important, hospitals should not neglect basic physical security requirements in the process. Physical vulnerabilities can pose just as much—or perhaps more—of a threat to hospitals. Common security problems include the following:
- Failing to promptly shred confidential documents
- Leaving patient information out in the open
- Failing to secure laptops, other portable devices, and paper charts when staff members work remotely
- Failing to scrutinize visitors closely enough

Hospital security departments can help establish visitor policies that protect patient data. Make sure your hospital is taking the proper steps to control visitor access to patient areas, Walsh says. This is important both to protect confidential information and to guard against traditional security risks, such as baby abductions, he says.

Walsh favors a system that uses color-coded badges so that staff members can keep track of visitors on their floor. Some hospitals also use badges that time out—with red lines or the word “void” appearing after 24 hours—so that individuals can’t reuse an old badge to gain admittance to the hospital. “It’s a quick way to look down the hall and see someone with a color on them, and question why they’re there,” Walsh says. “You have to be very cautious about who’s wandering the halls.”

Security staff members, who already patrol the floors, can also be instructed to be on the lookout for data security problems while they’re conducting routine safety checks, he says. Security staff members can report to IT or HIM leaders if they see that computer passwords are left in public view or if they notice that confidential records are piling up in an unsecured bin that anyone can access.
first you really need to look at how you expect the staff to manage the badges in general.

To be honest, this can be a challenging program to establish because there is a fair amount of risk involved if you cannot exercise good controls over badge use. Certainly, there will be periodic instances in which people leave their badges at home, in which case you could consider the issuance of a temporary badge with limited access. I would not recommend issuing a temporary badge with the same level of access as one would normally have, because it can lead to lazy habits if there is no price to pay for forgetting the ID badge.

Of course, this also raises the question of who might be able to access that badge when it is not in the possession of the staff member to whom the hospital assigned it. For that reason, you might consider issuing a new badge and chip and taking the old badge out of the system. In that case, someone cannot use the missing badge to gain unauthorized access in your hospital. This approach can become expensive depending on how often you have a problem, but it does ensure a more secure access control point.

Now, getting back to the ground rules—you need to be clear about expectations for the use of ID badges with access control technology. Staff members need to understand the risks involved with not keeping track of their badges, perhaps even to the point of imposing fines for violations, such as not reporting missing badges in a timely manner. This type of technology represents the classic double-edged sword: It makes it a lot easier for people to gain access to security-sensitive areas for good and for not-so-good.

This is where you can employ the proactive security risk assessment process to great effect, which also reflects well during a Joint Commission survey.

Every level of security should have criteria for participation. In other words, only certain staff members should have access to medication rooms. Or to further limit access, some staff members may only have access to certain medication rooms, but not all. Rather than determining access on a person-by-person basis, it makes more sense to limit access based on specific areas of the hospital.

Make sure you involve as many of the players as you can in making these determinations. For example, in deciding access to medication rooms, involve your pharmacy, as well as department managers and risk management.