



BRIEFINGS ON HOSPITAL SAFETY

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Options for corpse storage during emergency response

Disasters point to ham radio benefits, too

The January earthquake in Haiti ravaged a city and left hundreds of thousands dead and injured, quickly overwhelming healthcare services.

A few weeks later, a power plant explosion rocked Middletown, CT, putting the local hospital into emergency response mode. (For more details on these incidents, see the box on p. 2.)

Although unrelated, these two disasters nonetheless provide a strong case for planning ahead about how to handle actual or potential mass fatalities.

Joint Commission emergency management standard EM.02.02.11, element of performance (EP) 7, requires hospitals to plan for managing mortuary services during a disaster, particularly should an incident escalate within the community.

Although the United States may never see a death toll approaching that from Haiti's earthquake, even

several hundred deaths in a community would overrun most morgues.

Some hospitals have storage shelf areas that can be cleared and temporarily used to hold bodies. Other sites anticipate using outdoor staging areas; if that approach is used, isolate the area from onlookers to maintain the privacy of the victims. (See a sample fatality management standard operating procedure on p. 4.)

Following the Connecticut power plant explosion, Middlesex Hospital, a 275-bed community facility in Middletown, was quickly put on alert about a potential mass casualty event, says **Jim Hite**, the facility's emergency planner and director of safety and security.



All subscribers can download our exclusive special report about Joint Commission citations in the EC, emergency management, and life safety standards. Log on to www.hospitalsafetycenter.com and click the Special Reports link in the left column. If you don't have a username or password, contact our customer service center at 800/650-6787.

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Healthcare Security Alert

This month's **Healthcare Security Alert**, available exclusively online at the **Hospital Safety Center** (www.hospitalsafetycenter.com), looks at how a Boston hospital reacted after a patient stabbed a physician.

HCP Pro

Hite also had concerns about cadavers from this incident. Although a field morgue was set up at the power plant, he knew the hospital might be asked to store corpses. The facility's morgue capacity is 10 bodies, but the building has a utility hookup that allows refrigerated trucks to connect to hospital systems at the loading dock.

Had it been needed, the hospital could have had a refrigerated trailer at the hospital within a couple of hours to handle an overflow of deceased victims, Hite says. The hospital also had 100 body bags ready, which were available as part of the facility's H1N1 flu preparation.

As it turned out, there were five deaths in the explosion, so morgue services weren't taxed.

> *continued on p. 2*

Emergency response

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Local facilities might share cold storage

Beyond refrigeration trucks, there are several other good choices for temporarily storing mass fatalities.

Beverage and beer distributors, cold storage warehouses, refrigerated rail cars, and mortuary emergency cooling systems (also called MERC units) are all worth investigating in your community, says **John B. Linstrom, MIFireE, CHS-III**, executive director at The Linco Group, LLC, an emergency management consulting firm in Apple Valley, CA.

One option to avoid is the local ice rink. "The surface is slippery for workers, [and] there is no optimized method to store the deceased without freezing them to the surface or stacking the dead on pallets," Linstrom says, adding that the stigma of corpse storage may also cause families and others to avoid the rink in the future.

Other lessons from earthquake and explosion

Hospital safety and emergency management committees should also review the following response aspects from the Haiti and Connecticut disasters:

► **Choose incident commanders wisely.** During off-shifts and weekends, the nursing supervisor on duty at Middlesex Hospital is the designated incident commander. That approach was important because the plant explosion occurred on Sunday morning during Super Bowl weekend, when many top administrators weren't at the hospital.

While the facility's e-mail and phone alert system reached out to off-duty managers and staff, the nursing supervisor huddled with other nurses, security officers,

Snapshot of disasters in Haiti and Connecticut

- **Haiti, January 12:** A large earthquake heavily damaged Port-Au-Prince and collapsed many buildings, including at least one hospital. International emergency aid arrived quickly, but supply bottlenecks at a harbor and the disaster's widespread nature left many in need of desperate help. Triage efforts in the street and in tents were common sights on newscasts as clinicians, many of them volunteers, treated thousands of victims.
- **Middletown, CT, February 7:** An explosion—believed to have been caused by some sort of natural gas leak or purge—occurred at the Kleen Energy Plant, which was under construction at the time and not operating, according to Middletown officials. Contractors were conducting various tests at the site when the blast happened. Five people died and about two dozen were injured.

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and hospitalists to plot out immediate actions in response to the explosion, Hite says. For example:

- Hospitalists began determining which patients could be rapidly discharged in order to free up beds
- OR staff began preparing the post-anesthesia care unit to open up beds
- Security officers were posted at every hospital entrance in anticipation that concerned visitors and reporters would congregate at the facility seeking information about victims

► **Consult with ham radio operators.** It's been proven time and again that communication systems will go down in any emergency, but Haiti's circumstances have strictly reinforced that notion, as there were likely areas of the country with zero modern communication devices operating following the earthquake.

Amateur ham radio is a good resource to look into because it has the ability to overcome other communication outages.

"A cellphone cannot talk to a cellphone without running through a cell tower," which can be compromised during a communications failure, says **Allen Pitts**, media and PR manager at the American Radio Relay League, a national association for amateur radio.

However, ham radio operators are far less reliant on intervening equipment. "Give a ham his radio, a battery, and a piece of wire and [he] will be able to communicate," Pitts says.

A hospital that includes volunteer ham operators as part of an auxiliary team allows the facility to have a backup means of communication to the outside world, he says. Further, ham operators are often involved with other emergency groups, such as the American Red Cross, which may give your hospital a lifeline during a community catastrophe.

If you're unfamiliar with ham operators in your area, go to www.arrl.org/sections for help tracking them down.

► **Look into field triage to alleviate ED stress.** In the immediate hours after the power plant explosion, Middlesex Hospital treated 12 victims from the scene. The call was eventually made to shut down the

emergency operations center at the hospital because it appeared the response was over.

However, the facility then received word that 20–30 more victims were being held at a state hospital in Middletown near the power plant.

Rather than again ramp up the emergency operations center, Middlesex Hospital instead sent an ED physician, a nurse, and a security escort to the state hospital. The clinicians performed field triage of the victims there, and 12 of them came by van to Middlesex Hospital and registered for treatment in the waiting room, Hite says. This approach also kept ambulances free for more urgent calls and took the surge off Middlesex's ED, he adds.

Other hospitals may want to work this type of approach into their emergency planning, and perhaps even recovery, stages.

► **Consider geographic information systems (GIS).** We first wrote about GIS in the January **Briefings on Hospital Safety**. In terms of a large-scale disaster like Haiti, GIS can map supply stockpiles and related travel routes, which will help multiple organizations better manage supply chains, says **Ric Skinner, GISP**, owner of Stoneybrook Group, LLC, a health geographics consulting firm in Sturbridge, MA. Following a disaster, there may be accelerated shortages of critical supplies and an inability to quickly restock them, Skinner says.

► **Determine your family center plans.** Middlesex Hospital opened its family center in the aftermath of the explosion for relatives and friends of victims. The center is staffed with crisis counselors and clergy, and cafeteria workers supply sandwiches and coffee, Hite says.

In fact, part of the cafeteria transforms into the family center through the use of retractable walls. ■



Platinum subscribers to the **Hospital Safety Center** can download a customizable electronic version of the sample fatality management standard operating procedure featured on p. 4. Log on to www.hospitalsafetycenter.com, go the Regulatory Compliance Database, and look in the What's New box.

Fatality management (mass casualty) standard operating procedure

Incident: This procedure outlines steps that the hospital should follow to manage a large number of fatalities resulting from an internal or external event.

Mitigation/preparedness plan

_____ Hospital maintains supplies for the identification and containment of human remains. If additional quantities are not readily available, substitute other materials.

_____ Hospital maintains several areas for storage and viewing of the deceased, including rooms at (locations) _____. Each area is identified, utilized on a regular basis, and has limited storage capacity.

Overflow and temporary storage of human remains shall be initiated by contacting the facilities department management staff to identify appropriate areas where the temperature can be lowered for the temporary storage of human remains.

Overflow and temporary storage of human remains may also be handled through the rental of refrigerated trucks. Materials services shall maintain a list of several vendors of portable refrigeration units as part of the resource inventory.

Response/recovery activities

The incident commander or designee shall determine disposition of fatalities.

A morgue unit leader will be appointed to manage morgue activities.

Identification and personal effects on the body should be collected and placed along with the body in a body bag or other suitable containment.

Bodies should be stored in a refrigerated area (or other suitable area) until disposition of the body is determined by a coroner or other public official (local, state, or federal).

Internal notification procedures

The administrator-on-call/the incident commander will be notified whenever morgue space has reached capacity.

External notification procedures

The Occupational Safety and Health Administration will be notified within eight (8) hours of one (1) employee fatality or three (3) employee hospitalizations resulting from a single incident.

Others will be notified as appropriate upon activation of the Emergency Operations Plan (EOP).

_____ Emergency Management Agency will be notified and be responsible for notifying other appropriate agencies.

Specialized staff training

Staff education shall address fatality management procedures.

Employees participating in the response to a mass fatality event may benefit from stress counseling.

Recovery

The morgue unit leader shall be responsible for ensuring that all non-morgue area(s) utilized for the storage of human remains are cleaned and returned to usable condition upon termination of the EOP.

Source: Clarian Health in Indianapolis, as it appears in HCPro's Emergency Management Compliance Manual.

Preview of the Hospital Safety Center Symposium

EC scoring may herald survey compliance pitfalls

Although it may not rank high on your chore list, take close reads of the scoring behind the EC standards, because they give you compliance hints.

A significant amount of the EC elements of performance (EP) are designated with a C score, meaning surveyors only have to find two instances of noncompliance to issue a requirement for improvement (RFI), said **Steven MacArthur**, safety consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. He spoke during a February HCPro audio conference titled “Physical Environment Compliance 2010: Analyzing The Joint Commission’s Latest Interpretations and Survey Hotspots.”

For example, EC.02.03.05, EP 15, requires hospitals to inspect portable fire extinguishers monthly. If a surveyor finds two extinguishers without proper documentation for the monthly checks, a citation could follow.

Direct impact for some fire safety rules

Although the effects of direct impact EPs aren’t a terrible strain on safety programs, that ranking points to hot spots in the EC standards, said MacArthur, who will also be a featured presenter at the 4th Annual Hospital Safety Center Symposium, which takes place May 6–7 in Las Vegas (go to www.hospitalsafetycenter.com for more details). He’ll discuss the ties between the EC standards and infection control strategies at the symposium.

To quickly review, direct impact requirements—noted by a triangle icon surrounding the number 3 in the standards—are likely to create immediate risks to patient safety. The risks stem from a lack of processes to offset the threats. Under this level, hospitals must submit evidence of standards compliance for cited EPs within 45 days of a survey’s completion to The Joint Commission.

Under EC.02.03.05, there are three direct impact requirements:

- EP 4, which requires testing visual and audible fire alarm components every 12 months. Hospitals trip up

on this provision when they can’t show that all of the individual devices have been tested, MacArthur said. (See “Survey monitor” on p. 8 for more about how this concern came up during a Joint Commission visit.) Often, the problem lies with an over-reliance on outside vendors who perform this testing but don’t provide proper documentation.

- EP 11, which mandates testing fire pumps under flow every 12 months. This EP was made a direct impact requirement for

Steven MacArthur will be a featured presenter at the 4th Annual Hospital Safety Center Symposium.

this year, likely based on the amount of problems with fire pump testing noted in the field.

- EP 19, which requires testing smoke detection shutdown of HVAC equipment. When testing smoke detection devices on air handlers, verify that the intake and exhaust sides of the units close properly.

Generator testing also brings concerns

Emergency generator requirements under EC.02.05.07 also have implications from direct impact requirements.

“There are a lot of direct impact RFIs lurking in the weeds here,” MacArthur said.

EP 6 requires testing automatic transfer switches 12 times per year, at intervals of at least 20 days apart but no more than 40 days apart. Similar to fire alarm components noted earlier, a common problem with automatic transfer switches is a lack of records showing that each switch underwent testing, MacArthur said.

Also, don’t forget to institute interim measures under EP 9 if a required emergency power system test fails. Follow up on any testing failures immediately and get temporary safeguards in place as needed, MacArthur said.

“Your vendor documentation is of all importance,” he added. Ask vendors for written summaries of any emergency power testing problems they discover. ■

The benefits of customizing your HICS position chart

Rewording job titles and responsibilities helps tailor incident command

Many of you have turned to the Hospital Incident Command System (HICS) for organizational support during emergency exercises and actual disasters.

HICS is an incident management system that allows hospitals to distinguish specific job responsibilities during a disaster using a position chart and accompanying job action sheets.

However, some emergency managers find that the standard HICS chart includes too many positions or uses

“[If] a stranger walks in here and is familiar with HICS but not with me, they should be able to read their job action sheet and take care of things.”

—Mary Stoltz, RN, BSN

job titles that don't coincide with their facility. Forward-thinking hospitals like Cookeville (TN) Regional Medical Center have conquered

this problem by making their own adjustments.

In 2008, Cookeville Regional emergency management employees whittled down the original 78-position HICS organizational chart to cater to the specific needs of their facility, says **Mike Hellman**, safety coordinator at the facility.

“One of the reasons we got this ball rolling was because we were doing a regional tabletop drill during the time of the avian flu, and we started an incident command center and started using all the forms and trying to assign all these positions,” Hellman says. “And we were more worried about the positions and what each position's responsibilities were, rather than the actual drill we were responding to.”

Combining positions proves useful

A big part of downsizing the HICS chart was figuring out which positions could be eliminated or combined, based on personnel responsibilities at Cookeville Regional.

That responsibility fell to Paula Jackson, RN, MBA, the permanent ED director, with input from others in the ED, such as **Mary Stoltz, RN, BSN**, currently the acting ED director.

“I talked to her about it while it was going on, and it was obviously apparent that there weren't enough people to assign to all [the positions], so we tried to figure out which positions we could live without or combine together into one or two or three positions,” Stoltz says. “We changed it three different times before we settled on this [version].”

For example, the original HICS document called for one person in charge of mechanical, one person for electrical, and another for heating and cooling.

Upcoming event

HSEEP Webcast on March 25

For more information on emergency preparedness and community planning, join us March 25 at 1 p.m. (EDT) for our 90-minute Webcast **“Simplify Community Planning for Disaster Exercises: Align Joint Commission Requirements with HSEEP.”**

Listeners will learn how to identify the terminology, organizational procedures, and tools for incident command requirements and Homeland Security Exercise and Evaluation Program (HSEEP) guidelines.

Go to www.hcmarketplace.com/prod-8513 for more information and to see the program's full agenda. You can also call customer service for assistance at 800/650-6787.



Platinum subscribers to the **Hospital Safety Center** can view Cookeville Regional Medical Center's amended HICS organizational chart.

Log on to www.hospitalsafetycenter.com, go the Regulatory Compliance Database, and look in the What's New box.



However, there is just one person at Cookeville Regional responsible for facilities management, so all three positions weren't needed under the hospital's HICS approach, Hellman says.

In another instance, the original HICS chart separated transportation and traffic control, but Cookeville Regional put those responsibilities under one person.

Building HICS to fit your facility

The hospital also left enough HICS language in the job action sheets to maintain the original skeleton of the HICS system, which is familiar to most emergency preparedness personnel.

Emergency planners have categorized the job action sheets and explained the responsibilities of the positions addressed, Stoltz says. "So if a stranger walks in here and is familiar with HICS but not with me, they should be able to read their job action sheet and take care of things," she adds.

HICS revisions pass Joint Commission muster

Further, you don't need to fear any regulatory repercussions from The Joint Commission by amending HICS.

Emergency management standard EM.01.01.01, element of performance 7, requires that the hospital use an incident command system that will integrate with the community's command structure.

The Joint Commission doesn't assign a specific type of incident command approach, so HICS is one option that is acceptable under EM.01.01.01.

Hellman says Cookeville Regional was surveyed in 2008, after it had utilized its new HICS chart during a tornado that brought in patients from surrounding counties. Surveyors were satisfied that the hospital had properly demonstrated compliance with emergency management standards.

For facilities that are attempting to reevaluate their HICS chart, Hellman suggests looking at specific positions and processes within the hospital and seeing whether they need to be better reflected under HICS.

Don't be afraid to rename or combine HICS positions so that they make more sense within your organization.

"We know what we call certain things," Hellman says. The revised HICS chart "just feels more customized to our facility, and people are comfortable using it that way."

Shadowing NIMS requirements

HICS aligns to an extent with the federal National Incident Management System (NIMS). Hospitals need to address 17 elements to comply with NIMS, which ties in with some emergency management funds from the government.

HICS assists hospitals in meeting most of these 17 elements, but HICS isn't totally compliant with all NIMS activities for hospitals. ■

Editor's note: To read full details and materials for HICS, go to www.emsa.ca.gov/hics.

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Survey monitor

Past tabletop efforts rewarded during emergency session

Bucking what anecdotally appears to be a trend, Skaggs Regional Medical Center (SRMC) in Branson, MO, actually conducted a tabletop exercise for surveyors during the hospital's Joint Commission visit.

Many facilities **Briefings on Hospital Safety** has talked to in the past year have noted there were no tabletop drills requested during the emergency management session. SRMC was prepared for its tabletop, however, because it frequently uses such methods to educate emergency management committee members about disaster response.

"I have done tabletops with [our employees] several times a year," says **Lou Smith, RN, CHSP, CPHRM**, safety and risk manager at SRMC. Smith is in charge of emergency planning.

She'll bring committee members, hospital directors, and managers into a conference room with little cards in front of each person—for example, one card will ask someone to assume responsibility for logistics, and another will be to take the role of incident commander. From there, Smith explains the scenario, the expected amount of victims, and resulting problems in the community.

"I [also] put surprises ... in there," she says. For example, in a scenario, "I cut off the phones. How are you going to talk now?"

That type of training paid off when surveyors conducted their own tabletop during the July 2009 visit (the hospital's official reaccreditation was posted in October).

During the session, Smith kept quiet and let the emergency management team do the talking. Surveyors often look at committee member participation, rather than

the lead emergency management planner taking the lead, as a way to test how many people are familiar with the emergency operations plan.

The surveyor's scenario for the tabletop was a tornado that hit the hospital. That setup was no problem for SRMC, given that staff had previously drilled on that scenario. Tornadoes and ice storms top the hospital's identified risks from its hazard vulnerability analysis, which is required under EM.01.01.01, element of performance 2.

Smith makes sure that disaster readiness figures into mundane events, too. She recalls activating the emergency operations center when a water main broke outside the hospital.

Seek out fans of emergency training to help you

Lou Smith, RN, CHSP, CPHRM, likes emergency management.

"I'm passionate about it, and I engage people who feel that passion and get them excited about it," says Smith, safety and risk manager at Skaggs Regional Medical Center in Branson, MO.

Her successful endeavors proved fruitful during a recent Joint Commission survey. Smith seeks out employees from the ER to help with emergency management since those folks by nature are ardent about disaster readiness and trauma response. Staff in the OR and surgical units are also good candidates for emergency management work, she says.

The hospital also benefits from supportive administrators, who have allowed Smith to send hospital emergency management committee members to the Center for Domestic Preparedness in Anniston, AL, for hands-on training.

The federal government picks up the tab for attendees' coursework, air travel, lodging, and meals, which means the hospital only has to worry about paying for a workers' time away from the facility, Smith says.

For more information about the Center for Domestic Preparedness, go to <http://cdp.dhs.gov>.



Platinum subscribers to the **Hospital Safety Center** can use our hazard vulnerability analysis tool to help identify disaster risks. Log on to www.hospitalsafetycenter.com and look for the Risk Assessment Workstations heading in the left column.

“That gives people a familiarity of doing it so they get into that mode,” she says.

City has millions of visitors

Branson has more than 50 live performance theaters, bringing tourists from around the country and bolstering the summer population of the city up to 2 or 3 million (the city has about 7,000 actual residents).

SRMC is licensed for 175 beds, but the average daily census is 76 beds, Smith says. Annual ER visits total about 36,000.

“That’s a big ER for a facility of this size,” she says. “So we have to be ready to take care of an emergency should it happen.”

Community cooperation is key in such cases, and Smith’s experience at the hospital helps in this regard. She’s been employed at the facility for 35 years and was formerly the ER director for two decades, so she is able to tap into years’ worth of contacts with fire officials, police, utility providers, ambulance companies, and officials at the nearby College of the Ozarks.

Documenting individual device tests

The EC review was generally painless, Smith says. However, one slipup—which didn’t end up as a citation but could have under EC.02.03.05 (inspection and testing of fire protection equipment)—involved the documentation of various life safety device tests. The hospital presented surveyors with a sheet that stated that the

facility’s fire safety systems and features had all been checked.

“They did not like that,” Smith said. “They wanted documentation that each individual device was tested and was good.”

This is an important point that many safety and facility managers misunderstand. The idea reflects a common saying among Joint Commission officials: “If it’s not documented, it didn’t happen.”

Fortunately, SRMC was able to produce the records of the individual tests, which staved off any findings.

Surveyors like evacuation preparation

Surveyors were impressed with SRMC’s staff training for Med Sleds®, which are portable rescue sleds that allow clinicians to quickly evacuate patients out of units and down stairs by dragging them along the ground.

SRMC has instructed 105 people on Med Sled evacuation techniques by using three-person training teams, in which each participant takes turns manning the head and rear of the sled and acting as a mock patient strapped to the device. The teams practice negotiating stairwells with the sleds, Smith says.

About 10% of the hospital’s 1,049 employees are now familiar with Med Sled use, and each of the facility’s eight units has a regular-size and bariatric sled available.

ER employees wondered why they had to train on the sled use given that they are on the ground floor, but Smith’s reasoning is that those workers may be called to the upper levels to assist in evacuations during a fire or other emergency.

One survey readiness tactic that Smith employs on environmental rounds is to ask nurses to find the location of the nearest portable fire extinguisher.

“I give them a minute to find it and I time them,” she says. “And they’re hustling if they can’t find it.”

If a minute expires and a nurse has been unable to point out the extinguisher’s location, Smith shows him or her, and then requests that the nurse tell everyone else on the unit about the extinguisher’s location, too. That way, many staff members can benefit from the education. ■

Survey at a glance

- **Emergency management highlights:** Surveyors conducted a tabletop exercise using a tornado scenario, which the hospital successfully completed
- **Life safety highlights:** Questions arose about documentation for inspections and testing of individual fire safety devices
- **Standards focused on:** EC.02.03.05 (inspection, testing, and maintenance of fire protection equipment) and EM.01.01.01 (emergency operations planning activities)



Hospital safety notebook

FDA: Hospitals have 18 months to replace SS1

After further consideration, the FDA has extended the deadline to 18 months for hospitals to transition away from using the Steris System 1® (SS1) processor.

Previously, FDA officials said the transition could be made within three to six months. But after hearing from hospitals and others in the industry, the “FDA now understands that a three-to-six-month transition period may present significant difficulties for some healthcare facilities, which could, in turn, adversely affect patient care,” the agency said.

Using the FDA’s original December 2009 announcement of the six-month time frame, this extension would bring the deadline to August 2011.

The SS1 is a popular sterilizing device used by thousands of hospitals and clinics in the United States. The FDA said Steris Corp. of Mentor, OH, modified the SS1 processor and the agency hasn’t approved the modifications yet.

Steris has been critical of the FDA’s stance, saying there has been no documented case of infection caused by the SS1 when the equipment is used properly.

The FDA does not expect to enforce the 18-month timeline for hospitals that don’t stop using the SS1. “But these facilities should be aware that the current SS1 is a misbranded and adulterated medical device because it has not been cleared by FDA as safe and effective for its labeled claims,” the agency said.

For further information, visit www.steris.com/ss1.

EM.02.02.07 now includes wording for pet care

Joint Commission standard EM.02.02.07 requires hospitals to prepare for managing workers during an emergency. Element of performance (EP) 6 states that the emergency operations plans must manage the family support needs of staff.

Examples of this support listed in the EP include child care, elder care, communication, and a new one for this year: pet care.

Is it mandated that the hospital offer pet care services? No. But The Joint Commission adding language about pet care seems to indicate that such support should be at least considered as part of the emergency operations plan. That could involve either designating a space on the property to care for animals or contracting with veterinarians, animal shelters, or pet kennels to help out.

Attend safety symposium virtually this year

For the first time, you can attend the 4th Annual Hospital Safety Center Symposium May 6–7 either in person in Las Vegas or virtually in your facility via a Webcast.

Virtual attendees will view a live simulcast of the presentations on their computers, from the convenience of their own hospitals, with full access to all course materials and the ability to ask questions remotely. This exciting option may help those of you whose hospitals have limited travel budgets for professional development.

Regardless of how you join us, our experts will take you through a jam-packed agenda about environment of care concerns, emergency management approaches, and *Life Safety Code*® compliance.

For more details, go to www.hospitalsafetycenter.com.

No outright mandate for solid bottoms on carts

The need for a solid bottom shelf on supply carts is prime ground for a risk assessment. Infection control standard IC.02.02.01, EP 4, calls for infection prevention steps when storing medical equipment, devices, and supplies.

Because The Joint Commission would consider solid-bottom shelves the equivalent to a best practice, surveyors would likely judge the situation based on whether a risk assessment had been conducted by the hospital.

For further advice, see “Solid bottoms on supply carts? Judge it with a risk assessment” on Mac’s Safety Space blog (go to blogs.hcpro.com/hospitalsafety and search for “supply carts”). ■

OSHA Q&A tackles H1N1 shots, respirators, and more

*Editor's note: As a special feature, we're dipping into the e-mail bag of our sister publication, **Medical Environment Update**, to provide expert answers to readers' OSHA questions. Check out more free OSHA sources online at **OSHA Healthcare Advisor** (www.oshahealthcareadvisor.com).*

Q Can the licensed healthcare professional indicated in the postexposure evaluation be nurses or physician assistants (PA) and from our facility?

A The OSHA definition of a licensed healthcare professional is "a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f), Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up," according to *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens*.

If nurses or PAs meet this qualification in your state, they can function as licensed healthcare professionals and may be used for occupational vaccination and post-exposure evaluations.

It is acceptable to use licensed healthcare professionals from your facility—even though using an outside source makes the confidentiality separation cleaner—but it is not necessary, according to the enforcement document. In such cases, an OSHA inspector should ensure that confidentiality has been followed.

Q Are gloves required for H1N1 flu shots?

A Gloves are not required for this type of procedure, according to OSHA. In most cases, flu shots do not meet the "reasonably anticipated ... parenteral contact with blood ..." portion of the OSHA definition of occupational exposure. However, wearing gloves is not a bad decision; if you don't wear them, you should be prepared to answer your patients' questions.

Check your exposure control plan if gloves are required for injections in your practice. OSHA says you can always

establish higher personal protective equipment criteria than called for in the bloodborne pathogens standard.

Q During the H1N1 swine flu outbreak, we had difficulty obtaining N95 respirators. I heard that PAPRs would be an alternative. Are they reusable?

A Yes. PAPRs, or powered air purifying respirators, are reusable and sometimes a good alternative to N95 respirators.

Not designed as a one-time use disposable item, they are much more expensive and require more maintenance than N95s, but PAPRs can be used by more than one worker.

In some healthcare settings, a few PAPRs can take the place of a storage room full of N95s. Another benefit is that you can forego fit testing when using a PAPR.

Make sure that you provide a medical evaluation for any staff member required to wear a respirator and annual training that follows the manufacturer's written instructions on disinfection, maintenance, and storage as part of your written respiratory protection plan.

For a checklist to assess your protection plan in the event of pandemic influenza, download "Scrambling for a respiratory protection plan," which is available from our sister Web site **OSHA Healthcare Advisor** (www.oshahealthcareadvisor.com).

Q Would OSHA fine a business for worker injuries from a terrorist attack?

A OSHA would not apply enforcement procedures because of the unforeseeable nature of such a workplace emergency, according to "Application of OSHA standards to escape and protection of employees from threats associated with terrorist actions," a May 25, 2004, letter of interpretation. The letter also explains that enforcement is only part of OSHA's mandate and identifies safety preparedness resources for such an unpredictable event. ■



Tip of the month

Consider using a hospital's new MRI safety steps

We've written in the past about the risks of bringing metallic and ferromagnetic objects into MRI suites.

The magnet at the heart of an MRI scanner is powerful enough to drag metallic objects into the cylinder, which could injure or even kill patients.

In light of a heavy fine against a medical center in

A patient was injured when the metal gurney-chair she was on was pulled into an MRI scanner by the machine's magnet.

California, safety committees should double-check their facilities' processes for ensuring that only appropriate

items are being brought into MRI scanner suites.

\$50K penalty issued by authorities

In January, California's Department of Public Health announced a \$50,000 fine against Hoag Memorial Hospital in Newport Beach after an MRI patient was injured when the metal gurney-chair she was on was pulled into the scanner by the machine's magnet, seriously injuring the patient's leg, according to state records.

Radiology managers told investigators that the MRI technologist was on the phone scheduling appointments at the time the victim was brought to the suite.

Staff accompanying the patient failed to notify the technologist, which was a violation of hospital policy that such patients be screened by technologists before entering the scanner room, according to the state.

Hospital reacts with further safeguards

The incident in question took place in January 2009, and since then, the hospital has taken the following corrective actions as noted by the state:

- MRI staff members have received refresher education about what items may not be brought into the suite
- A camera was installed at the MRI entrance door so that the console technologist can better monitor who is entering the area
- An MRI time-out process was established, during which the MRI technologist verifies that ferromagnetic items are not entering the scanner room

You may want to consider these steps in your facility even if you've never had any MRI incidents, given the serious consequences of an accident.

You can also review The Joint Commission's recommendations about MRI safety in its 2008 *Sentinel Event Alert* on the topic. Go to www.jointcommission.org/sentinelevents. ■

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Your trusted source for hospital safety compliance

Options for corpse storage during emergency response
Disasters point to ham radio benefits, too

The January earthquake in Haiti ravaged a city and left hundreds of thousands dead and injured, quickly overwhelming healthcare services.

A few weeks later, a power plant explosion rocked Middletown, CT, putting the local hospital into emergency response mode. (For more details on these incidents, see the box on p. 2.)

Although unrelated, these two disasters nonetheless provide a strong case for planning ahead about how to handle actual or potential mass fatalities.

Joint Commission emergency management standard EM.02.02.11, element of performance (EP) 7, requires hospitals to plan for managing mortuary services during a disaster, particularly should an incident escalate within the community.

Although the United States may never see a death toll approaching that from Haiti's earthquake, even

several hundred deaths in a community would overrun most morgues.

Some hospitals have storage shell areas that can be cleared and temporarily used to hold bodies. Other sites anticipate using outdoor staging areas; if that approach is used, isolate the area from onlookers to maintain the privacy of the victims. (See a sample fatality management standard operating procedure on p. 4.)

Following the Connecticut power plant explosion, Middlesex Hospital, a 275-bed community facility in Middletown, was quickly put on alert about a potential mass casualty event, says **Jim Hite**, the facility's emergency planner and director of safety and security.

All subscribers can download our exclusive special report about Joint Commission citations in the EC, emergency management, and life safety standards. Log on to www.hospitalafetycenter.com and click the **Special Reports** link in the left column. If you don't have a username or password, contact our customer service center at **800/650-6787**.

IN THIS ISSUE

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A hospital shows the benefits of customizing the Hospital Incident Command System's position chart.

P. 5 **Symposium preview**
In an early look at our 4th Annual Hospital Safety Symposium, learn about how EC scoring can benefit Joint Commission survey efforts.

P. 8 **Survey results**
Joint Commission surveyors conducted a tabletop exercise during this visit and scrutinized how the hospital documented the safety equipment tests.

Healthcare Security Alert
This month's **Healthcare Security Alert**, available exclusively online at the **Hospital Safety Center** (www.hospitalafetycenter.com), looks at how a Boston hospital reacted after a patient eluded a physician.

Hite also had concerns about cadavers from this incident. Although a field morgue was set up at the power plant, he knew the hospital might be asked to store corpses. The facility's morgue capacity is 10 bodies, but the building has a utility hookup that allows refrigerated trucks to connect to hospital systems on the loading dock. Had it been needed, the hospital could have had a refrigerated trailer at the hospital within a couple of hours to handle an overflow of deceased victims, Hite says. The hospital also had 100 body bags ready, which were available as part of the facility's H1N1 flu preparation.

As it turned out, there were five deaths in the explosion, so morgue services weren't taxed.

> continued on p. 2