

Environment of Care[®] News

May 2011

Vol. 14 ■ No. 5

The Official Joint Commission Environment of Care, Emergency Management, and Life Safety News Source

Preventing Suicide in Non-Behavioral Health Care Units

Strategies for the Emergency Department and Medical/Surgical Units

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Suicides can happen in general hospitals—not just psychiatric ones.

A patient with an acute heart condition is on suicide watch in a hospital medical/surgical unit. A nurse checks on him every 15 minutes. But during one of these checks, the nurse discovers the worst: The patient has hanged himself with a power cord. The cord was connected to a piece of medical equipment housed in the room.

Incidents like this might be expected to occur only in behavioral health care settings, unfortunately, such incidents occur far too often in general hospital settings. More than 14% of suicides

reported to The Joint Commission Sentinel Event Database occur in non-behavioral health care units. These include medical/surgical units, intensive care units (ICUs), oncology units, and telemetry units. In addition, 8% of reported suicides occur in emergency departments (EDs).¹

Suicide Risks in the ED, Medical/Surgical Units

Although psychiatric settings are designed to be safe for suicidal individuals

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Subscription Information

The 2011 12-issue subscription rates for the United States, Canada, and Mexico are \$319 for both print and online and \$299 for online only; for the rest of the world, the rates are \$410 for both print and online and \$299 for online only. Back issues are \$25 each (postage paid). Add \$25 for air mail delivery. Orders for 20–50 single/back issues receive a 20% discount. Site licenses and multi-year subscriptions are also available. To begin your subscription, call 800/746-6578, fax orders to 218/723-9437, or mail orders to Joint Commission Resources, 16442 Collections Center Drive, Chicago, IL 60693. For more information, call 800/746-6578. *Environment of Care® News* (ISSN 1097-9913) is published monthly by Joint Commission Resources, 1515 West 22nd Street, Suite 1300W, Oak Brook, IL 60523.

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Preventing Suicide Outside Behavioral Health Units

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and are staffed with people specially trained to deal with these individuals, hospital medical/surgical units and EDs are typically not designed to mitigate suicide risk and do not have staff with such training, even though potentially suicidal patients are often present in these settings. Individuals are frequently admitted to general hospitals immediately following suicide attempts. Some seek help in a hospital ED—often at the urging of family or friends—when they are feeling most desperate.² Lack of adequate health insurance for mental health services also leads many individuals to seek initial treatment for mental disorders in the ED, again at a point when they may be desperate and at increased risk of suicide.³

Access to potentially dangerous items is a contributing factor. Compared to a psychiatric hospital or unit, a general hospital presents more access to items that can be used to attempt suicide. These items are either already in the setting—such as equipment and supplies—or may be brought into the facility in the form of contraband. Some specific means of suicide that are readily available in the general hospital setting include bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing, and oxygen tubing.⁴

Compounding the presence of potential means for suicide is the reality of staff distraction during their urgent business of providing care in the ED and on medical/surgical units. There are many instances when a suicidal patient is alone in these settings, which can create opportunities for the patient to attempt or re-attempt suicide.

Mitigating Suicide Risks

To help hospitals improve the safety of their patients, The Joint Commission recently released a *Sentinel Event Alert*

that focuses on preventing suicide in the ED and medical/surgical units. (Go to http://www.jointcommission.org/assets/1/18/SEA_46.pdf for a complete copy of *Sentinel Event Alert* 46.) This *Alert* is a follow-up to one released in 1998. The Joint Commission reexamined this issue because of ongoing concerns regarding patient safety in these vulnerable settings.

One of the primary recommendations of the *Alert* involves consistently screening and assessing patients for suicide risk when they enter the ED and medical/surgical areas. This screening and assessment process will vary, depending on the organization, but should involve watching for behaviors, mental status, and conditions that may indicate risk of imminent suicide. These include the following:

- Acute signs of depression, anxiety, agitation, delirium, and dementia
- Medical or psychological problems that significantly impact judgment, including intoxication with alcohol or drugs
- Chronic pain or other debilitating problems, including chronic illness and terminal cancer

When designing a suicide screening process, some organizations choose to use a form or tool to help with the assessment. In fact, there are many such tools in use in hospitals throughout the country. Screening and assessment tools should be appropriate for a person's age and characteristics. Furthermore, as David M. Sine, A.R.M., C.S.P., C.P.H.R.M., co-author of *Design Guide for the Built Environment of Behavioral Health Facilities*, distributed by the National Association for Psychiatric Health Systems, explains, "While a tool can help identify patients at risk, it should not be considered the only way to identify these patients." He adds, "Sometimes patients who eventually

In Memoriam

Jerry Gervais

1948–2011

Esteemed colleague, standards interpreter extraordinaire, dear friend.

A kind and generous man who always had a smile on his face, a story to tell, and time for everyone who needed a commonsense answer to an EC, EM, or LS question.

We will miss you every day, Jerry.



commit suicide have gone through an organization's screening process and do not screen positive for suicide risk at the time of the screening. A form or tool can be a helpful guide, but staff members must also be aware of the signs and symptoms so they can recognize escalating behavior as it occurs."

Facility and EC Strategies

In addition to thoroughly screening patients for suicide risk, some strategies related to the environment of care (EC) can help mitigate risk. Several of these strategies are discussed here:

- *Assess the room.* Several engineering controls can minimize the risks of patient suicide in the ED and medical/surgical unit. To determine the need for these engineering controls, an organization should perform a comprehensive room assessment to identify potential risks and determine possible mitigation strategies. For example, if the room has a window, the window should have a limited portion that is operational to prevent patient elopement or leaping. Any covers on lights should be replaced with shatter-proof and tamper-resistant material. If the

room houses a shower, it should be equipped with a ligature-resistant shower head, tamper-resistant shower curtains, and so forth. "Some organizations have a roll-down door that covers the medical gas outlets in the treatment room," says Sine. "If the patient does not require medical gas for treatment, the door can lock out the area and prevent access."

When assessing a room for suicide risks, organizations should look at the entire room, as the risks for suicide can be found in some seemingly unlikely places. For example, patients have been known to "hang" themselves from objects as close to the floor as 18 inches, and one study found that 50% of hangings were from heights below the waist of the victim.⁵ (See "Checklist for Assessing Environmental Risks for Suicide," page 10, for a tool to help with the assessment process.)

- *Minimize medical equipment in the room.* Although many risks can be addressed as a result of a room assessment, ED and medical/surgical rooms will still contain a host of equipment and supplies to ensure comprehensive medical care. These can also present hazards. "Not every

patient will require all the equipment and supplies housed in these rooms," says Sine. "When treating patients at risk for suicide, an organization should minimize the equipment in the room and include only that which is absolutely necessary for the patient. To do this effectively, an organization should have a policy in place that addresses what can be removed from the room and what can't. Although an organization certainly can't remove all the equipment and supplies, limiting these to only those that are necessary for a particular patient can reduce risk."

- *Check for contraband.* In addition to equipment and supplies found in the room, patients can bring into a hospital items that can be used in a suicide attempt, such as knives, needles, and weapons. For this reason, it is critical that an organization engage in a reasonable search of person and property when a patient is screened for possible suicide risks. "To prevent confusion about this, organizations should have an explicit policy that covers what a reasonable search entails, when it should occur, and who should perform it," says Sine.

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Preventing Drug Diversion

OhioHealth's Auditing Process Increases Patient Safety, Security

About a decade ago, a nurse was preparing an injection of hydromorphone for a patient. However, as she was opening what she thought was a new vial of the potent narcotic painkiller, she detected a tiny pinprick in the top. So she reported it. This launched an investigation that uncovered another caregiver's long history of removing this substance from vials meant for patients and replacing it with saline. The incident led the organization, OhioHealth, located in Columbus, Ohio, to develop what is now considered one of the benchmark drug security programs in the United States. (See "OhioHealth" on page 5.)

As health care organizations dispense increasing volumes of costly and powerful medications, drug diversion can become a significant security problem. Patient safety, caregiver safety, and the organization's bottom line are all at risk.



Don't make it easy for prescription drugs to be stolen.

However, today's software technologies provide precise, detailed methods for tracking drugs at each step on their path from the manufacturer to the patient. These programs, combined with a strong auditing team and comprehensive investigation process, can prevent your health care organization's drugs from going anywhere but to the patients for whom they were prescribed.

Drug diversion (also known as drug theft) can take one of the following forms, as defined by the International Association for Healthcare Security and Safety (IAHSS), based in Glendale Heights, Illinois:

- *Simple theft*, in which the controlled substance is taken from a cabinet, a dispensing mechanism, or another area where controlled substances are stored
- *Theft by substitution*, in which the controlled substance is removed from its container and replaced with another substance
- *Theft by documentation*, in which medical charts, records, or logs are manipulated to show that the controlled substance was administered and dosage given, when in fact a smaller amount or no medication was actually given
- *Undermedicating the patient*, in which a specific amount of the controlled substance is ordered but only part of it is administered

IAHSS is also in the process of developing material on drug diversion

prevention (see "Steps to Preventing Drug Diversion," page 5).

In the event at OhioHealth, the guilty party had an 80% higher rate of hydromorphone usage than did the other nurses; however, this discrepancy was not detected by the systems in place at the time. The theft continued to occur over a long period of time before it was revealed by the nurse's discovery. As a result of the discovery, OhioHealth leadership decided to restructure its entire drug security program.

Rewriting Policy

Before the hydromorphone event, reports were usually made only after an event had already occurred or until a staff member was found to be impaired on the job. In addition, if drug diversion was suspected, it was the responsibility of the nurse manager to conduct the investigation. There was no centralized system for addressing these reports.

"Nurses are not investigators any more than [we investigators are] nurses," says Chuck Smith, corporate director of Protective Services, OhioHealth. "As investigators, we can be neutral."

After the hydromorphone event, the protective services department teamed up with risk management, legal, nursing, pharmacy, and other departments that deal with medications and/or security to develop a new policy to take a proactive approach to stopping drug diversion.

The New Process

The security team led by Smith now consists of 127 staff members, 2 of whom are responsible for drug diversion audits and investigations. Each month, on behalf of the pharmacy, the investigators use specialized software to review activity on the drug-dispensing machines and look for anomalies, such as higher usage of a particular drug by one caregiver over other caregivers on the unit or unusual usage patterns. When an anomaly is identified, the investigator begins an investigation.

The first step is to compare the dispensing activity to patient charts, including physician orders, medication records, and nursing notes, to see if they correspond. If they do, the investigation is usually closed at this point. If there are still discrepancies, however, the investigator will meet with the clinical manager to look into the issue further and determine whether drug theft is occurring or whether it is a nursing practice issue.

"We want a clinical person from the unit to help review and verify," says Craig Czuckowitz, one of the investigators. "Their training and knowledge of the unit allows them to help identify what may be explainable. If we find that it's a nursing practice issue, nursing can take the information back to the employee and correct the poor nursing practice."

About two-thirds of the people investigated are cleared; however, when the investigator and clinical manager believe a discrepancy to be a case of drug diversion, human resources is notified and a meeting

is held to review the facts and prepare for an intervention. If a drug diversion is identified, appropriate disciplinary action and reporting should occur.

Audits and investigations are sometimes initiated by calls from coworkers or family members who have concerns about an individual. Investigations can also be initiated by caregivers who notice missing medications, pharmacy staff who observe unusual usage patterns or missing drugs, or a clinical manager who simply wishes to ensure that all is well among the staff.

Taking Disciplinary Action

"We use the euphemism *diversion*, but at the end of the day, it's theft," says Smith, who has 33-plus years of experience in health care security, with more than 18 of them at OhioHealth.

Under the previous program, those caught stealing drugs were required to undergo rehabilitation. When they came back to their jobs, they had to sign contracts agreeing to periodic drug testing. However, Smith says, the recidivism rate was over 90%.

OhioHealth

Based in Columbus, Ohio, OhioHealth is a not-for-profit, faith-based group of eight hospitals, nine affiliated hospitals, nine outpatient facilities, two home health and four medical buildings, home health providers, medical equipment, and health service suppliers throughout a 40-county area.

The protective services department handles security for all of the organization's facilities. The department has also established a crime prevention and awareness program to educate staff members, patients, families, and visitors about personal safety and security issues. It conducts community drug safety awareness programs as well.

"Human resources, nursing, and security got together and agreed that bringing these people back was too risky—it was jeopardizing patient care," Smith says. "Now, once someone is determined to be stealing, they should no longer be employed here." This is not to say, however, that OhioHealth will not try to assist the employee with rehabilitation options.

"The bottom line is this: We're not out to get anyone. Good people can make poor choices," Smith says. "This is about the safety of our patients and staff."

An Ounce of Prevention

New clinical staff orientation and the annual training program for all clinical staff now include sections on drug diversion. Any staff member with access to pharmaceuticals, including physicians, pharmacists, and nurses, must undergo this training.

Smith and his staff believe that by educating staff about the audits and making them an ongoing part of organization processes, the audits will deter staff from considering theft in the first place.

"The education lets people know that if they're thinking about stealing, they will get caught eventually," Smith says. "These incidents get reported to regulatory agencies and local law enforcement. If you steal drugs here, you're putting your license on the line." 

Steps to Preventing Drug Diversion

Detailed steps to preventing drug diversion can be found in the material being developed by the International Association for Healthcare Security and Safety (IAHSS). Those steps include clear delineation of drug security responsibilities, monitoring and auditing of controlled substances within the organization, and policies and procedures for addressing a suspected case of drug diversion as well as procedures for reporting such a case to law enforcement and regulatory boards.

Designing Facility Security

Proactively Addressing Risks Associated with New Spaces

The new wing of your hospital has multiple glass entry/exit doors. They provide easy access for patients and staff and allow valuable natural light into the facility. However, at night, your organization wants to limit access to the facility and thus needs to secure most of these doors. Unfortunately, this was not a consideration when the new wing was being designed, and now your organization is scrambling to address the fact that it cannot lock down the wing. The fix will require retrofitting the doors—an expensive proposition that could have been avoided if your organization had proactively considered security issues earlier, during the new wing's design phase.

Including Security in Design

“With the tremendous amount of health care construction under way at this time, we have a real opportunity

to build in security features in new facilities,” says Thomas A. Smith, C.H.P.A., C.P.P., director of hospital police and transportation for University of North Carolina (UNC) Hospitals. “By addressing potential security risks up front in the design phase, organizations can have a big impact on the safety and security of their new spaces. It gets much more complicated, expensive, and resource draining to start thinking about security after the basic designs are in place.” When an organization does not proactively consider security, it may be forced to react to security concerns and incidents as opposed to proactively mitigating them. This may require retrofitting, which, as noted above, can be at best expensive and at worst cost prohibitive. And if the organization cannot address a particular issue, it may leave itself exposed to an adverse event involving security.

Unfortunately, security is often not considered in the design phase. “This happens for a couple reasons,” says Smith. “Architects and users of the space are often focused on other aspects of the area, including functionality and aesthetics. If security is left only to the architects and building occupants, it almost always becomes an afterthought and is easily ‘value-engineered’ out.”

Also, security professionals can be hesitant to involve themselves in the design process because they are not familiar with the concepts and language associated with design and construction and may feel uncomfortable or out of place insisting on including security in design considerations.

Establishing Relationships

To ensure that security is front and center during the design process, security professionals must first and foremost get leadership support. “A design team will do what the organization wants, so having leadership committed to addressing security will help underscore the need to keep these considerations in mind,” says Smith.

Second, security professionals must develop and cultivate relationships with the users of the space. These individuals often have the best, most practical ideas about how to preserve safety, since they use and interact with the environment every day.

In short, everyone needs to be included. “By sitting down with the various people involved in a project and identifying



Think about security while the building is still being designed.

common interests, a security professional can explain the potential security risks in the environment and collaborate with the group about how security can be addressed while still preserving functionality and aesthetics,” says Smith. “Security and aesthetics are not mutually exclusive, and it is up to the security director to communicate that fact to all parties involved. Once people realize that the goal is not to create a jail or prison but to create a functioning, aesthetically pleasing, and reasonably secure space, they are much more willing to consider security.”

To further embed security in design, a security professional may want to seek the advice of outside individuals or organizations familiar with security issues. For example, police departments often have one or more individuals trained in the Crime Prevention Through Environmental Design (CPTED) approach, which focuses on how design of the physical environment can help reduce the likelihood of crime. “Police departments with CPTED-trained individuals are often willing and eager to help with efforts to design security into facilities,” says Smith. “Organizations should consider taking advantage of this valuable resource.” Also, outside consultants familiar with health care design and security can provide helpful input, as they can bring a breadth of experience to the table. Health care security-related associations can also provide valuable information. (See “Guidelines for Designing Security,” right.)

A Critical Step: Conducting a Risk Assessment

Conducting a comprehensive risk assessment of a facility under construction is crucial in order to identify potential security risks and determine mitigation strategies to include in the design phase. Such an assessment should con-

sider the location and functions in the new space and adjacent areas. It should also identify and prioritize all the risks present and consider strategies to address those risks.

To help with the risk assessment, organizations can look at data from the current space—if applicable—and identify what is working well and what needs to be addressed. “In some cases, you can pick up great ideas from the current space,” says Smith. “You can also identify what you don’t want to do. Other areas of the organization can also provide valuable ideas, so it is helpful to review what works and what doesn’t in these areas as well.” Reviewing the security maintenance activities of other organizations is beneficial, too. “A few phone calls, and you can get a pretty good idea if you are keeping up with the local standard of care,” says Smith.

When performed effectively, a risk assessment can help an organization prioritize where to focus its security design efforts. It will also provide points of dis-

cussion and collaboration with the design team and users of the space. Without such an assessment, an organization may not focus its energies on critical issues that will affect the safety and security of the facility’s occupants.

Addressing Vital Aspects of Security

There are some common considerations that all organizations should keep in mind when designing for security. In general, security efforts should involve actually preventing or reducing the likelihood of crime, improving the perception of safety, and mitigating any risks that are present in the space. The following actions can help further enhance security:

- *Look at the perimeter.* An organization should consider how people enter and exit a new facility or space and how to limit entry points. “Entry points can be defined by perimeter landscaping, fences, doors, or other barriers and

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Guidelines for Designing Security

The International Association for Healthcare Security and Safety (IAHSS) and the International Healthcare Security and Safety Foundation (IHSSF) have teamed up to form a task force of experts charged with establishing health care security design guidelines. This fall, the task force will release a set of draft guidelines pertaining to several different areas, including the following:

- General guidelines
- Parking and external campus environment
- Medical office buildings and clinic spaces
- Inpatient facilities
- Security-sensitive areas—including emergency departments, mental health areas, pharmacies, cashier collection areas, and infant and pediatric facilities
- Areas housing patient information, including medical records
- Plant utility areas
- Biological, chemical, and radiological restricted areas

The task force will also present guidelines related to designing for emergency management. All guidelines will undergo a complete field review before being published. More information about these and current guidelines can be found at <http://www.iahss.org>.

Pesticides as a Last Resort

Least-Toxic Pest Management Protects Most-Vulnerable Patients

First, do no harm. Physicians across health care disciplines are expected to practice in accordance with this well-known principle. Professionals ranging from health facilities managers to nurses also adhere to this credo as they go about their daily work and ensure patient and visitor safety. This principle even comes into play when evaluating the effectiveness of a facility's pest control program. If the program that's in place compromises patient safety at your facility, it's time to consider a shift to an integrated pest management (IPM) approach.

The Honeymoon Is Over for Pesticides

The pest control contracts with which customers are most familiar are scheduled maintenance contracts: A vendor comes to spray on a predetermined weekly, monthly, quarterly, or annual basis, regardless of whether pests or pest-related damage have been spotted on the

grounds or within a facility. But these pesticide-dependent practices don't effectively eliminate pests and pest-related problems. Worse still, they endanger health—especially the health of the most vulnerable populations residing in long term care or acute care facilities, including infants, children, the elderly, and people with existing illnesses or those recovering from surgery and other medical treatments.

A recent Maryland Health Care Facilities Pest Management Survey found a general reliance on toxic pesticides at Maryland hospitals and elder care facilities. Of the 25 pesticides identified by survey participants as being used at facilities, 11 are linked to cancer, 12 are associated with neurological effects, 10 are associated with reproductive effects, and 10 cause liver or kidney damage. The survey was conducted by the Integrated Pest Management in Health Care Facilities Project, spearheaded by the Maryland Pesticide Network, based in Baltimore,

and Beyond Pesticides, based in Washington, DC, in collaboration with the grant-funded Maryland Hospitals for a Healthy Environment (MD H2E). For more information, see "Resources for Integrated Pest Management," page 9.

Integrated Pest Management Defined

Although there is no standard accepted definition of IPM, the IPM methodology generally establishes a sustainable approach to managing pests. IPM combines biological, cultural, physical, and—as a last resort—chemical tools in a way that minimizes health and environmental risk. IPM pest management techniques commonly include the following:

- *Exclusion techniques*—Sealing cracks and crevices with caulk or steel wool; repairing door sweeps and leaking pipes
- *Mechanical techniques*—Using traps and vacuuming
- *Sanitation techniques*—Washing all recycle bins, trash cans, carts, kitchens, and floor drain covers

"All nonchemical strategies such as behavior change and trash management must be exhausted before introducing pesticides as the last resort of an IPM program," says Jay Feldman, executive director, Beyond Pesticides.

Prevention Is Part of the Plan

Many clients realize that their conventional pest control service is not working when they examine the number of



Pesticides on the lawn can be tracked in and make patients sick.

“callbacks” in vendor log books. But when IPM is implemented, departments learn how to prevent pest problems. “Here is where IPM has direct overlap with energy conservation,” notes Feldman. “Both efforts are trying to seal up the building envelope. We want to try to exclude pests rather than kill them because this reduces the toxic load in a building. We are talking about both structural and landscape management. Chemicals used in landscaping tend to find a way into a facility, through tracking and other methods.” Natural (IPM-compliant) turf and landscape management promotes soil health and protects public health and the environment through the selection of nontoxic and nonsynthetic inputs.

Jim Chang, C.I.H., director, safety and environmental health, University of Maryland Medical Center (UMMC), Baltimore, says it becomes easier to recognize and resolve pest-friendly conditions when people are in the IPM mindset. “Before IPM, it was easy to walk by the gap under the door,” he says. “But thanks to the efforts of our IPM mentors, the green team, and our sustainability manager, we now look at gaps under doors as a potential waste of heating and air conditioning energy, as well as a route of entry for mice and other creatures to come inside in search of warmth and food.” Chang notes that even remedying the smallest imperfections can benefit the organization from an IPM perspective. “Facilities people also have to work with housekeeping, patients, and visitors to make sure debris, discarded food, and plant waste are kept away from the building,” he says.

The Integrated Pest Management Coordinator

To be the most successful, an IPM program needs an IPM coordinator. An existing safety coordinator, environmental services professional, or person represent-

ing the facility green team is a potential candidate. The IPM coordinator is responsible for implementing the IPM plan and coordinating pest management-related communications between the facility, its landlords, service providers, staff, and patients. Joan Plisko, technical director, MD H2E, points out that 75% to 80% of hospitals in Maryland have green teams, most with leadership buy-in. “Green team members already understand the effects pesticides have on the environment,” she says. Plisko also advises including a nurse leader as part of the IPM team. “This person can really contribute to the IPM education module.”

Pest control vendors and employees should report pest-related problems to the IPM coordinator and generate work orders to fix problems. The IPM coordinator needs to review log books to confirm that the needed work has been completed.

The ability to maintain an IPM program’s continuity over time is critical; turnover in facility management, the IPM team, and the pest control company can undo years of progress if written policies are not in place. The IPM coordinator serves as the guardian of institutionalized policies that dictate how the IPM program works. He or she also needs to make it a priority to obtain a material safety data sheet (MSDS) for each pesticide substance applied at the facility.

Educate and Implement

IPM education for staff should cover information about entryway controls, attraction, and harborage. Entryways such as loading docks and doorways without effective air curtains, door sweeps, or light traps can attract pests. Removing harborage opportunities means eliminating comfortable pest living spaces and involves addressing details about mop storage and dirty-water management. Simple adjustments can eliminate pests without the use

Resources for Integrated Pest Management

Not sure where to start in implementing integrated pest management (IPM)? The Integrated Pest Management in Health Care Facilities Project (coordinated by Maryland Pesticide Network and Beyond Pesticides) has created a Model IPM Policy, Model IPM Plan, Model Landscape Policy, and Sample IPM Contract. To access these model policies, visit <http://www.beyondpesticides.org/hospitals/policies.htm>.

of chemicals (for example, changing trash receptacles or trash receptacle locations). The way people do their jobs—whether they work in environmental services or maintenance—influences the severity of a facility’s pest problem.

“A large portion of pest management is people management,” Plisko says. “The number of food sources for pests in a health care facility is huge. We must teach and reteach staff about how to clean up after themselves.”

Denise Choiniere, R.N., M.S., sustainability manager at UMMC, incorporates sustainability across hospital operations and clinical practice, evaluating patient, employee, and environmental safety. “An effective IPM program has to benefit every department,” Choiniere says. “IPM theory means finding and eliminating the source.” UMMC employees are educated through the facility’s volunteer green team, which is a subcommittee of the environment of care team, and represents 20 departments.

“When employees understand the health effects of pesticides, a light bulb may go off,” Choiniere says. “We want our patients to know we are here to take care of them, not make them sicker.”

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Preventing Suicide Outside Behavioral Health Units

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One-to-One Observation

Even if an organization implements comprehensive policies for assessing the patient room, limiting medical equipment, and checking for contraband, there is still a possibility that a patient could commit suicide in the ED or on medical/surgical units. “You simply cannot remove every possible risk,” says Sine. “So, it is imperative for organizations to have a policy and procedure for one-to-one observation of those patients deemed at risk for suicide.” One-to-one observation means having a trained person sitting with the patient around the clock. “In an observation policy, organizations should think about the qualifications of the sitter and when such a sitter is warranted,” says Sine. “At the very least, organizations want someone who can identify when the patient’s behavior is escalating and know how and when to seek help.” 

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Checklist for Assessing Environmental Risks for Suicide

Following is a brief checklist to help hospitals assess and address suicide risks in their ED and medical/surgical units.

- ☐ Avoid “lay-in” ceilings. These can make it easier for the patient to hide contraband, can provide a convenient place to secure a ligature for self-harm, or may allow the patient access to above-the-ceiling interstitial spaces.
- ☐ If the outside window of the room is operable, limit the opening so a person could not pass through (4–6 inches is considered the architectural standard of care). Alternatively, consider protecting a window with a security screen that is secured by a device that can be removed from the inside only with a special tool (such as a non-common screw head).
- ☐ Make window glazing shatter-proof.
- ☐ Use a tamper-resistant, anti-ligature door knob for the patient’s room.
- ☐ If a hospital bed is in use, secure the electrical power cord on the bed. Consider replacing the bed cord with a “jumper cord” that can be removed by staff, kept in a secure place, and used only when the bed needs to be adjusted. (Check the bed design to ensure that the bed can be mechanically lowered to a “CPR” position.)
- ☐ Use tamper-resistant screws throughout the room.
- ☐ Secure the power cord on the TV. A mounting bracket can be an attachment point for a ligature.
- ☐ Replace cork bulletin boards with dry-mark boards, thus eliminating inadvertent use of thumbtacks.
- ☐ Use shatter-proof and tamper-resistant glass in night lights and other lighting fixtures.
- ☐ Secure light fixtures to restrict patient access to bulbs and sockets.
- ☐ Remove grab bars in the bathroom or fill in the wall “gap.”
- ☐ Eliminate coat hooks, towel bars, cubicle curtain tracks, and closet poles.
- ☐ Ensure that all electrical outlets are GFCI (ground fault circuit interrupter) and tamper resistant.
- ☐ Replace metal outlet covers with shatter-proof non-conductive covers.
- ☐ Protect the piping for the toilet and lavatory.
- ☐ Use tamper-resistant lavatory faucets.
- ☐ Ensure that HVAC (heating, ventilating, and air conditioning) grills are tamper resistant.
- ☐ Use tamper-resistant shower controls and shower heads.
- ☐ Ensure that mirror and picture glazing material are shatter-proof.

Source: Adapted from Sine D.M.: Latent risks in the built environment for the behavioral health patient: Concerns for the healthcare risk manager. In *The American Society for Healthcare Risk Management Handbook*, 6th ed. Chicago: American Hospital Association, 2010.

Designing Facility Security

(continued from page 7)

should be controllable by security personnel or police during emergency situations or times of heightened security,” says Smith. “In cases where entry points are doors or other openings, they should be protected to the degree necessary for the space.” Such protection may involve access control hardware, intrusion detection, video surveillance, and/or personnel for control and screening at designated entrances and times.

- **Differentiate between public, patient, and staff areas.** Certain parts of a facility can be accessible to the public, but others should remain accessible for patients and staff or staff alone. For example, pharmacy storage and distribution locations, food preparation sites, sterile corridors, and research laboratories should be accessible only

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by staff and involve physical and psychological barriers and hardware.

- **Restrict access to high-security areas.** These areas may include mental health units, pediatric units and newborn nurseries, emergency treatment areas, cash-handling areas, and so on. “Such restriction should keep out unauthorized personnel,” says Smith. “This may involve using physical barriers and access controls such as a

locked door with card reader-activated hardware.” Other restrictions may include video surveillance monitors, intrusion detection alarms, and forced-entry-resistant construction.

Security risks can never be completely eliminated in a facility. But focusing on mitigating these risks during the design phase of construction can further patient safety and security while saving the organization time, money, and resources. 

Pesticides as a Last Resort

(continued from page 9)

And employees need to know that they have a direct effect on pest control. “UMMC is writing employee behavioral standards that incorporate IPM. We want employees to know they have a key role in IPM—which is to eliminate the source—and they can be held accountable for their behaviors,” Choiniere says.

The 2011 focus for the University of Maryland grant-based Alliance of Nurses for Healthy Environments (ANHE) is chemical policy and reform. Robyn Gilden, Ph.D., R.N., assistant professor, University of Maryland School of Nursing (UMSON), and a member of the ANHE Research work group, is collaborating with the Children’s Environmental Health Network and its Eco-Healthy Child Care Center Program checklist, of which pesticides and IPM are major components. UMSON offers

an environmental health course that discusses pesticides and IPM in depth.

The Evolving Vendor Culture

An IPM team has to successfully connect pest control vendor efforts back to decision makers and training so everyone knows how to recognize and report pest problems.

“If staff can manage pests without using chemicals, people become engaged,” Feldman says. “But this requires cultural change. Pest control vendors must be required to communicate problems—for example, with cracks or leaky pipes—to the proper person. If elements of an IPM program are adopted and requirements for reporting, disclosure, and communication are in place, vendors can be held to a standard that is in alignment with IPM policy. The contract defines vendor activities. The industry is still evolving to create IPM

contracts that meet the needs of the health care industry.”

Chang advises health facilities professionals who are interested in IPM to seek out their local advocacy groups to learn more. He says, “Groups such as Beyond Pesticides and Maryland Pesticide Network have heard the concerns and skepticism, they know which pest control vendors abide by IPM practices, and they can advise on how to best proceed down this path. Once you make this commitment, it’s amazingly easy to move to sustainment mode. IPM consultants can advise about how to address periodic acute infestations of bedbugs or lice, for example, while still following IPM practices.”

Concludes Feldman, “The health care commitment to ‘first, do no harm’ can play out in the pest management arena as we avoid using toxic chemicals that are really not needed when a good pest prevention program is in place.” 



Environment of Care[®]
News

May 2011
Vol. 14 ■ No. 5

The Official Joint Commission Environment of Care, Emergency Management, and Life Safety News Source

Volume 14, Number 5
May 2011

Send address corrections to:
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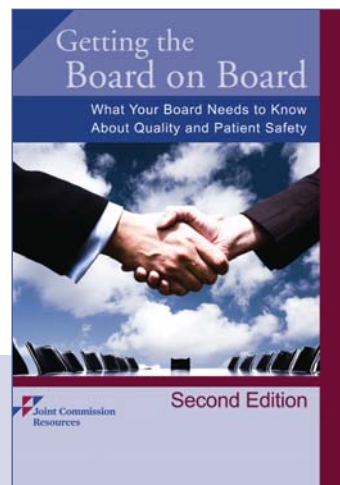
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