Environment of care

TJC re-issues revisions to EC chapter to allow Alternative Equipment Maintenance plans

Read through and get comfortable with new standards revisions that give hospitals more leeway in how they maintain their equipment, but in some cases require new or more detailed documentation.

The latest standards changes from The Joint Commission (TJC), published July 1 and effective July 2, closely follow those released last December in a CMS survey-and-certification letter (S&C 14-07-Hospitals). Both clarify the circumstances when a hospital may depart from manufacturer’s recommendations for the

(see alternative maintenance, p. 5)

Worker safety

Review your safe patient handling equipment needs in face of push for more regulation

Consider buying more safe patient handling equipment to both improve employee morale and drive down costly worker compensation claims, as well as to get ahead of what may be stronger worker protections in the future.

One of the biggest challenges to buying equipment such as lift devices, specialized bed frames and transfer chairs to help nurses and other health care workers move patients is the perception that such an expense would exact too much of a financial toll.

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OSHA

OSHA developing plans to track worker safety with advanced recordkeeping

In November, OSHA submitted a proposal that would require agencies to more frequently submit all employee injury and illness information, which would later be posted to an online database, in order to improve workplace health and safety.

The database will help OSHA to better understand the issues they should explore and identify problem areas, explains Indianapolis health and employment attorney John Gilliland with the Gilliland Law Firm.

Among other things, a database of employee health information would allow OSHA to better grasp the circumstances surrounding violent events as well as workplace hazards and come up with more suitable programs to prevent and address safety in the workplace in a timely fashion, maintains Gilliland.

Agencies worry about data use

In public comments, some health care organizations supported the proposal’s objectives, while others had fundamental concerns about how the employee tracking would be implemented.

The American College of Occupational and Environmental Medicine (ACOEM) pointed out the potential for underreporting and breaches of confidentiality, specifically with employees that work at smaller companies or have unique injuries or illnesses—details that could reveal a worker’s identity. Under HIPAA’s Privacy Rule, employers cannot access a worker’s health records, but any health information found in employment records is not protected.

In its public statement, the National Association for Home Care and Hospice (NAHC) feared the information, taken out of context, could reflect badly on an organization’s safety reputation. NAHC also noted that providing so much detailed information on a quarterly basis was too onerous.

Most employers don’t want to deal with filling out an entire detailed Injury and Illness Prevention Program form, points out Susan Gross Sholinsky, a New York labor and employment attorney with Epstein Becker & Green.

More data can be helpful

However, data collection in general can be positive, says Stacia Hayes, the emergency management program manager at Swedish Medical Center, based in Seattle, Wash., who helped develop the center’s active-shooter response and training program. (ECL 7/7/14.)

“Any type of data is going to help you improve on processes,” explains Hayes. Swedish Medical Center already tracks this kind of information, which Martin Kinsey, the security manager of Swedish Medical Center, notes can lead to changes in policies or education techniques.

OSHA has closed public comments on the proposal. The agency’s spring 2014 agenda lists the ruling as in its final stages and anticipates a final regulation by March 2015. — Dustin Levy (dlevy@decisionhealth.com)
Facilities management

Federal law allows little wiggle room on medical marijuana policy

Take note of state law and any funding your health care facility receives from the government, among other key factors, when creating employment policy toward the medicinal use of marijuana. Since marijuana is illegal under federal law, the wisest plan of action may be zero tolerance, say legal experts.

Medical marijuana, used to mitigate symptoms related to chronic illnesses like AIDS and cancer, is legal in 22 states and Washington, D.C. Legal experts say an employer in these areas can make exceptions for use of the drug, but there are a few crucial differences in the health care industry that make lenient policies undesirable.

James Shore, a partner at Seattle law firm Stoel Rives LLP, cautions health care providers to be aware of their contract with CMS to qualify for reimbursement. Participation in Medicare and Medicaid programs requires providers to sustain a drug-free workplace, in accordance with federal law, or risk CMS terminating their agreement.

“If [employers] make an exception for medical marijuana, they’re in jeopardy of violating their federal contract,” explains Shore.

As long as marijuana remains a Schedule 1 substance under the Controlled Substances Act (CSA), any policy other than zero tolerance toward the drug threatens a health care facility’s government funding, says Vance Knapp, a Denver labor and employment attorney at Sherman & Howard.

Even if an employer makes allowances for patients who use medical marijuana, they must consider the conflict that is created if policy is inconsistent with other policies in place for employees. Numerous unionized health care employers have collective bargaining agreements with their employees, and this becomes a problem if a worker challenges an employer’s medical marijuana policy.

“[Inconsistent policy] can give rise to an issue that can carry weight with an arbitrator,” says Shore.

Employer generally protected

Federal law hasn’t prevented some medical marijuana users from advocating for workplace protections. Lawsuits in California, Oregon and Washington, where medical marijuana has been legalized, were filed by employees who failed drug tests and challenged their termination. However, each court has ruled in favor of the employer because state protections for medical marijuana users do not apply to employment policies since the substance remains federally illegal.

Shore defended one of these cases, Roe v. TeleTech Customer Care Management, which went to the Washington Supreme Court. In an 8-to-1 decision, the ruling upheld TeleTech’s decision to terminate the employment of Jane Roe (a pseudonym used in court papers to maintain anonymity since marijuana is illegal under federal law) for failing a drug test.

The court maintained that Washington’s state Medical Use of Marijuana Act (MUMA) does not support wrongful discharge or adverse hiring. In addition, Washington’s discrimination laws do not hold up either, as accommodating a disability should not require an employer to violate federal law by knowingly allowing a worker to use marijuana.

Essentially, the illegality of cannabis on a federal level preserves employers’ discretion to discipline their workers at will, even if a doctor certifies marijuana for treatment under state law. However, the ruling noted that the legal system views employers’ decisions in context of their past practices and current written policies.

“If an employee was allowed to use [marijuana], and they injure themselves or a coworker, it would be a risk for an employer from a liability perspective,” notes Shore.

Adapting to changes in marijuana legislation

If marijuana law continues to reform in state legislatures across the country, employment policies might begin to change to reflect that. Some states are
starting to legalize the recreational use of marijuana under specific circumstances, which could affect the way employers create policy.

Changing public opinion on marijuana can influence policy, as Shore says he’s had clients who want to adapt their policy to guide public perception of their organization, with some clients wanting more tolerant rules and others wanting more restrictions.

But Susan Gross Sholinsky, a New York labor attorney at Epstein Becker & Green, contends employers won’t be changing their practices concerning medical marijuana in light of the new legislation.

“There’s really not a change to how employers are treating marijuana,” she says.

This was the case for hospitals in Washington when a 2012 ballot measure legalizing the recreational use of marijuana left many hospitals wondering how this would affect existing employment policy.

However, Mary Kay Clunies-Ross, a Washington State Hospital Association (WSHA) spokeswoman, says the initiative does not change anything for employers. “Hospitals and other employers had already built [provisions on employee drug use] into policy.”

Medical marijuana has been legal in Washington since 1998, and the recent measure did not include modifications to employment practices, which the WSHA clarified in a bulletin addressing the concerns of state hospitals.

Clunies-Ross recommends hospitals consult with lawyers and employees when creating policy toward medical marijuana. Internal policy has to make sense for a facility’s needs and the rights of employees, taking into account the provisions on drug use and testing in union contracts. Consulting workers gives employers an opportunity to discuss their expectations regarding medical marijuana policy and “put everyone on the same page,” adds Clunies-Ross.

Advances in marijuana testing could result in new employment rules, as current practices test for the substance in an individual’s system, which sometimes can remain up to 90 days after last use, instead of when an individual is under the influence of cannabis. Shore says improvements in science for marijuana detection would give employers incentive to shift away from zero-tolerance policies.

However, the risk of liability in the health care field makes leniency in medical marijuana policy problematic.

“Quality patient care is the absolute paramount interest, and the employer does not want to take the risk of an employee being on a mind-altering substance,” says Shore. — Dustin Levy (dlevy@decisionhealth.com)

Facilities management

Use this checklist to help in reviewing your policy on medical marijuana

There are several factors to consider when creating employment policy toward medical marijuana in your health care facility. Make sure you are aware of these elements when putting policy into place:

- **Federal law.** Marijuana is categorized as a Schedule 1 drug, according to the federal Controlled Substances Act, which makes it illegal under federal law. This is the most significant element in creating medical marijuana policy, an only an act of Congress can permit legal use of the substance, explains Vance Knapp, a Denver labor and employment attorney at Sherman & Howard.

- **State law.** Pay attention to your state’s marijuana legislation. If medical marijuana is legal in your state, you need a protocol for employees. If any form of recreational marijuana use is legal in your state, your policy should remain unchanged unless employment provisions are specified in the state measure. Knapp suggests for substance abuse policies, even in jurisdictions where recreational or medical marijuana is legalized, to specify that the substance is still illegal on a federal level.

- **Federal contract.** If the government is in any way providing funding to your facility, you are required to maintain a zero-tolerance policy toward illegal substances, in accordance with federal law. “Most health care providers have some government contract with funding or reimbursement that will incorporate a drug-free workplace environment,” says James Shore, a partner at Seattle law firm Stoel Rives LLP. This includes Medicare and Medicaid programs, which require this policy to participate.

- **Unionized work force.** If your employees are part of a union, it is important that your policy remain consistent with all aspects of your facility, including patient use of medical marijuana. Inconsistent policy would support an arbitrator’s argument to allow worker use of the substance. In addition, examine the provisions concerning drug testing in your workers’ union contracts, says Mary Kay Clunies-Ross, a WSHA spokeswoman.
Lawsuits. Legal precedent is a significant factor in establishing the rights of workers when it comes to medical marijuana use. “Every court that has looked at this issue has ruled [in favor of the employer],” explains Shore, which gives employers discretion in employment policy toward the substance.

Current science for detection. Modern testing practices determine whether marijuana has been in an individual’s system for a period up to as long as three months. This disallows leniency toward medical marijuana policy because, as long as science for detecting whether an individual is under the influence is underdeveloped, employers cannot risk a worker handling a patient or equipment while the substance is affecting his or her judgment, according to Shore.

Health care workplace. Facilities like hospitals and physicians’ offices require less detail in policy, as a zero-tolerance plan is typically suitable. It is more difficult to cover all bases in home care because of the issues that arise when it comes to treating patients with medical marijuana, but keep in mind the substance cannot be prescribed legally. Knapp recommends a zero-tolerance policy across the board. — Dustin Levy (dlevy@decisionhealth.com)

alternative maintenance
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maintenance, inspection, and testing of facility and medical equipment.

“There are some new requirements that hospitals might not have been doing in the past,” notes David Stymiest, a senior consultant with Smith Seckman Reid Inc., a Nashville, Tenn.-based engineering, commissioning and technology services firm.

The revisions are in Environment of Care standards EC.02.04.01 on managing medical equipment risks, EC.02.04.03 on inspection, testing and maintenance of medical equipment, EC.02.05.01 on managing utility system risks and EC.02.05.05 on inspection, testing and maintenance of utility systems.

Initially, TJC issued revisions in May, then quickly withdrew them to ensure full alignment with CMS.

Changes allow hospitals flexibility

The July 1 changes allow for the creation of an Alternative Equipment Maintenance (AEM) program, in which hospital staff use their own institutional experiences and expertise to inform testing and maintenance schedules.

However, when that experience varies from manufacturer recommendations, those departures must be adequately explained and assessed.

Among the new documentation and procedural requirements:

- Develop and maintain a written inventory of all medical equipment (EC.02.04.01, EP 2).
- Identify high-risk medical equipment on the inventory that pose a serious risk of injury or death if it should fail (EC.02.04.01, EP 3).
- Lay out all testing, maintenance and testing activities (as well as the frequency of those activities), and whether they are in accordance with manufacturer recommendations or an AEM plan (EC.02.04.01, EP 4).
- Perform safety, operational and functional checks after major repairs and upgrades of medical and utility equipment. The same tests are still required prior to any initial use of this equipment (EC.02.04.03, EP 1, EC.02.05.05, EP 1).

AEM programs must be documented fully

Hospitals that intend to establish an AEM program must document the following:

- How the equipment is used.
- Likely consequences of failure or malfunction.
- Back-up or alternative equipment.
- Incident history of identical or similar equipment.
- Specific maintenance requirements.

AEMs are not permitted when federal or state law or Medicare Conditions of Participation require hospitals to follow manufacturer’s recommendations, or when there is not enough maintenance history to support the use of alternative maintenance strategies (though the language of the revision does not specify how a “sufficient history” might be defined).

Familiarize environment of care staff, compliance teams or other relevant parties with both the CMS letter and TJC’s new revisions, and determine whether documentation processes need to change or if an AEM program makes sense for your institution.

Among the topics to which hospitals should pay particularly close attention, Stymiest suggests:
• Conduct a full inventory of all equipment, especially in cases where you are uncertain whether your current inventory is comprehensive.

• Because state laws vary, check with your state agency having jurisdiction (as well as federal laws and COPs) to find out where AEM program exclusions may exist. For example, emergency power supply systems are not eligible for AEM programs, Stymiest says.

(While Stymiest is chairman of an NFPA technical committee, he spoke with Environment of Care Leader in his role as a consultant, and not as an representative of the NFPA, and his views are not a formal interpretation of NFPA codes or standards.) — Scott Harris (scottharriswriter@gmail.com)

Resources

• Standards Revisions and Clarifications Related to Medical Equipment and Utility System Maintenance: www.jointcommission.org/standards_information/prepublication_standards.aspx

• CMS Survey and Certification: Hospital Equipment and Maintenance Requirements: http://tinyurl.com/CMS-maintenance-req

worker safety

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But not investing in worker safety might end up costing more, say proponents of the equipment and legislation currently before Congress that would create a new OSHA standard to force health care employers to protect workers from patient-handling injuries.

“There’s a perception that [safe patient handling] costs money,” says ergonomics consultant Lynda Enos, who also is a nurse and serves as vice president of the American Association of Safe Patient Handling & Movement (AASPHM). “And it’s very expensive to do.”

“That’s part of the myth we’re trying to bust. Maybe 10 years ago we didn’t have a strong evidence base — we do now.”

Health care leads among lifting injuries

Health care providers lead all occupations in musculoskeletal disorders, accounting for more than 10,000 injuries to registered nurses in 2012 and an additional 25,000 for nursing aides, according to the Bureau of Labor Statistics (BLS). In addition, the increasing rate of obesity in the United States makes safe patient handling a more pressing need in health care facilities.

“There’s no way, as a nurse, I can possibly move [obese] patients,” comments nurse Lena Deter, a long term care safety specialist and board member for Association of Safe Patient Handling Professionals (ASPHP). “The challenge clinically is that a significant portion of our population weighs between 250 and 400 pounds.” Deter notes that other industries regulate lift limits for employees.

Although safe patient handling is an issue commonly associated with nurses, it affects all areas of health care — about a quarter of EMS practitioners suffer career-ending back injuries during the first four years of service, according to the National Association of Emergency Medical Technicians (NAEMT). “Unsafe handling would be any lifting or moving, any kind of thing where we’re moving a patient manually,” says Enos. “You’re dealing with a lot of force, a lot of repetition. It’s the number one risk to health care workers in the U.S.”

Injuries cost money, workers

The average workers’ compensation claim related to patient handling runs $15,600, according to Aon Risk Solutions, a global risk management corporation. Additionally, nurses who leave the field, due to injury or as a precaution, are expensive to replace, totaling up to $100,000 per employee, including the costs of recruiting, hiring, making up for lost productivity and the training of new workers.

Yet that’s not the only cost. “Many times [employers] only look at workers’ compensation,” says Deter. Indirect costs such as replacing employees or compensating for patient injuries must also be taken into account, she says.

Although it can take two to four years to get a return on investment after installing a safe patient handling program, the initiative “continues to pay for itself going forward,” notes Deter.

A cost-benefit analysis study by the Agency for Healthcare Research and Quality (AHRQ) found installing the proper patient handling equipment in one facility saved $200,000 per year.

While touting the cost-effectiveness of safe patient handling equipment, ASPHP, the American Nurses Association (ANA) and others are also working toward more regulation within the health care industry.
The effort includes not only the push for a new OSHA standard but for safe patient handling requirements through CMS and The Joint Commission as well.

**Act would protect health care workers**

Health care safety experts and leaders from the American Nurses Association (ANA) were on Capitol Hill recently to brief congressional staffers on the legislation seeking the new OSHA standard.

Known as the Nurse and Health Care Worker Protection Act of 2013 (HR 2480), the bill was introduced by Rep. John Conyers, D-Mich., and crafted with the help of the ANA, which has been pushing for similar legislation for more than a decade.

Daniel Hervig, a legislative assistant in Conyers’ office, says part of the intent of the bill was to draw attention to the need for safe patient handling equipment and programs to alleviate the physical strain on health care providers. “We focused on emphasizing the development of safe patient handling programs to make sure that health care providers are protected in all circumstances.”

If passed, the act would require OSHA to put out a standard specifically on safe patient handling, instead of relying just on the standing general duty clause, which mandates that employers provide a work environment free of potential hazards.

Hervig says that, ideally, the OSHA standard would come out before any legislation is passed. Implementing an OSHA standard is a long regulatory process, which would be made even more gradual if Congress is involved.

In the absence of legislation, proponents are working on other routes to improving workplace safety for health care workers through safe patient handling.

**Proponents also push for CMS, TJC support**

Noting she “would be surprised if we get federal legislation in the next five years,” Enos says the likeliest course of action to require safe patient handling is through CMS and accrediting organizations like The Joint Commission, especially if the agencies decide quality of care is at risk.

Health care workers dealing with injuries don’t always give the best patient care. Calling in other workers or hiring temporary staff to replace an injured worker affects consistency of care. And the only other option is working short-staffed, which is never ideal.

“Consistency of care has been shown to improve quality of life and care in long term residents,” clarifies Deter. “If you disrupt that, you have a problem”

Manual handling practices put patients at risk for falls, skin tears and pressure ulcers. (Falls and pressure ulcers are also among the hospital-acquired conditions that Medicare has said it will no longer reimburse.) CMS is currently examining the effect of worker safety on patient safety for a research project, and if the agency finds the results significant enough, CMS and The Joint Commission may work together to make safe patient handling a higher priority for more hospitals, says Enos.

— Dustin Levy (dlevy@decisionhealth.com)
Worker safety

Use these tips to review safe patient handling needs in your workplace

Use these tips to review safe patient handling practices in your facility:

- **Use existing committees to review practices.** Start with the Environment of Care committee, says ergonomics consultant Lynda Enos. If patient handling is presenting safety risks in your workplace, it should be among the committee’s concerns.

- **Explore costs and return of investment.** Consistently funded safe patient handling programs have proven to return payments on equipment as well as the cost of staff and patient injuries. (See p 1.) Health care facilities without programs to prevent worker injury will lose money in the long run, experts say.

- **Perform an ergonomic assessment of your facility.** A safety specialist or ergonomics consultant can assess a health care facility, examining the potential hazards unit by unit, and ultimately make a recommendation for a safe patient handling program. An ergonomic assessment will help to determine what areas of your facility are most in need of improvement.

- **Ensure preservation of your safe patient handling program.** Safe patient handling “needs to be funded today, tomorrow and into the future,” stresses Lena Deter, a long term care safety specialist and board member on the Association of Safe Patient Handling Professionals. “It’s a safety program that you live with forever. It’s a change in the culture.” Ensure safe patient handling issues remain a priority by using a skilled expert to run it.

- **Address safe patient handling at your own pace.** “Many times people think you have to do it all at once,” says Deter. “You identify it all at once.” Start with the highest areas of patient and worker injury risk to allow your organization to address the problem directly and avoid breaking the bank.

- **Incorporate safe patient handling into training and education.** Many health care workers leave school without learning how to use equipment or address patient mobility, but this is starting to change. Integrating safe patient handling into education and training will help to establish a more significant culture of transformation.

- **Use resources outside your organization.** Safe patient handling has been a subject of research studies for almost 20 years. Check out safe patient handling information on the websites for OSHA, the National Institute for Occupational Health and Safety (NIOSH), and the American Association for Safe Patient Handling & Movement (AASPHM). There are also YouTube videos about the topic. — Dustin Levy (dlevy@decisionhealth.com)

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