The Joint Commission

January 2019 Volume 22 Issue 1

EC News

ENVIRONMENT OF CARE® | EMERGENCY MANAGEMENT | LIFE SAFETY

What's New for *EC News*?

INTRODUCING A REDESIGNED FRONT PAGE, ADDITIONAL PRACTICAL TOOLS, MORE OPPORTUNITIES FOR READER FEEDBACK

With this first issue of *Environment of Care News* for 2019, readers will notice a number of changes. First, we've spruced up our "front door" and are using a new image at the top of the front page. (It's always good to update your look for

the new year!) More importantly, we are re-committing to providing health care organizations with the latest resources for complying with The Joint Commission's Environment of Care® (EC), Life Safety (LS), and Emergency Management (EM) standards and elements of performance (EPs) in 2019.

EC News will be providing even more quick, actionable content, including top tips, infographics, and downloadable, customizable checklists and other tools.

We're also adding new features, such as the following departments debuting this month:

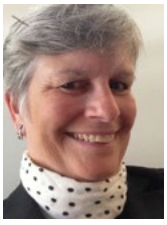
- **"From TJC Department of Engineering"**—Insights into Joint Commission standards and EPs, important news, and other critical EC, LS, and EM information, straight from the experts at The Joint Commission.
- **"What's Your Solution?"**—Periodically, we will ask readers to contribute their own solutions to a frequently asked question. We will publish the best answers and suggestions in a future issue.
- **"Toolbox"**—This enhanced department will provide more checklists and other practical tools to help facility professionals meet Joint Commission requirements, thereby improving the quality of care.

As the new executive editor of *EC News*, I am interested in your feedback as we strive to make the publication a faster read and more responsive to your information needs. In December, we sent a 10-question readership survey to our subscribers. Thank you to everyone who took the time to fill it out.

I also would like to rebuild the *EC News* Customer Advisory Board to make it more representative of various regions of the country and the different types of health care facilities The Joint Commission accredits. (See the following article for more information.)

Most important, I would like to receive comments from readers on an ongoing basis. If you'd like to sound off on something in *EC News* or have suggestions for improving the publication, please email me at cschierhorn@jcrinc.com.

I look forward to hearing from you. Happy New Year!



Carolyn Schierhorn, MA
Executive Editor
Joint Commission Resources

NEXT

PRODUCT IMPROVEMENT

Volunteers Sought for *EC News* Customer Advisory Board

REVAMPED BOARD TO REPRESENT VARIOUS REGIONS OF THE COUNTRY AND TYPES OF HEALTH CARE FACILITIES

To better cover the Environment of Care challenges faced by various types of health care facilities in different regions of the country—and respond with actionable solutions—*EC News* is revamping its Customer Advisory Board.

EC News seeks volunteers from Joint Commission–accredited facilities throughout the United States to provide suggestions for articles and for overall product improvement. This will be a one-year commitment. Volunteers need to be willing to respond to periodic e-mails from the executive editor of *EC News* regarding newsletter content.

Those who are interested in serving on the Customer Advisory Board should send an e-mail to Carolyn Schierhorn at cschierhorn@jcrinc.com, noting the name and location of their health care organization, their role in it, and years of experience. A couple of sentences explaining their desire to serve on the Customer Advisory Board would also be helpful as would a résumé or curriculum vitae.

The deadline for notifying *EC News* of interest in serving on the Customer Advisory Board is January 18.

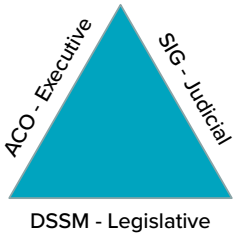
NEXT

New Feature!

From TJC Department of Engineering

New Fluoroscopy, CT Equipment Requirements Rolling Out This Month

by Kenneth A. Monroe, PE, MBA, CHC, PMP



During the past couple of years, *EC News* readers saw an abundance of new or modified standards and elements of performance (EPs) in the "Environment of Care" (EC) and "Life Safety" (LS) chapters, as The Joint Commission began referencing the 2012 version of the National Fire Protection Association (NFPA) *Life Safety Code*®* (NFPA-99-2012) as well as new requirements from the Centers for Medicare & Medicaid Services (CMS). In contrast, 2019 brings far fewer changes:

- Effective January 1, **EC.02.03.01** (managing fire risks), **EP 9** (written fire response plan) clarifies that cooperation with firefighting authorities is a required duty of staff and licensed independent practitioners.
- Also effective January 1, **EC.02.04.03** (inspecting, testing, and maintaining medical equipment) includes new computed tomography (CT) and fluoroscopy equipment requirements: **EP 21** updates the list of imaging metrics assessed during a diagnostic medical physicist's annual performance evaluation of CT imaging equipment, while the new **EP 34** adds the requirement that a diagnostic medical physicist conduct an annual performance evaluation of fluoroscopic imaging equipment.

If you have any questions about these modifications, feel free to contact me at kmonroe@jointcommission.org.

As I have explained to new staff in the Standards Interpretation Group (SIG), you can best understand The Joint Commission by comparing it to the three branches of the U.S. government. At The Joint Commission, the Division of Standards and Survey Methods (DSSM), which writes the standards and EPs, serves as the legislative branch, while the Division of Accreditation and Certification Operations (ACO), which includes the surveyors who conduct tracers at health care facilities, functions as the executive branch. SIG, where I am director of engineering, serves as the judicial branch. We are the group that adjudicates surveyor findings, with my staff specifically addressing findings involving EC, LS, and emergency management (EM) noncompliance.

* The *Life Safety Code*® is a registered trademark of the National Fire Protection Association, Quincy, MA.

With this column, my team and I plan to share news, clarifications, and insights regarding The Joint Commission's EC, LS, and EM standards throughout the year. Please provide your feedback and any concerns. We are looking forward to getting to know the readers of *EC News.*

NEXT ↓

'Must' Mock Tracers

FOCUS ON EMERGENCY GENERATOR ROOMS, EYEWASH STATIONS, AND MEDICAL GAS STORAGE, JOINT COMMISSION SURVEYOR SUGGESTS

Unlike hospitals, ambulatory health care (AHC) facilities often lack an on-site facility manager or engineer with extensive knowledge of the health care physical environment, notes Larry Rubin, CHFM, CHSP, CPE, CEM, a Life Safety surveyor for The Joint Commission. As a result, he typically ends up training AHC staff while performing Environment of Care (EC) tracers.

During his presentation "Mock Tracers in the Environment of Care" at The Joint Commission's 2018 Ambulatory Care Conference in Rosemont, Illinois, in November, Rubin shared what he looks for in AHC surveys, focusing on three problematic areas that have many findings: emergency generator rooms, medical gas storage, and eyewash stations.

Emergency generators need to be kept at a temperature of at least 40° F, per the 2012 version of the *Life Safety Code*®* (NFPA 99-2012), which The Joint Commission uses. "So you need to have a heater in the room," Rubin says, noting that a backup generator located outdoors also would normally be found noncompliant if it doesn't have a heater.

During a Joint Commission tracer, Rubin places his hand on the emergency generator's engine to see if it's warm, ensuring that the crank case oil heater is working. "This is something ambulatory facilities should check during their weekly walk-through," he says. "If the engine is cold, they need to call a service person in to get it fixed."

Rubin then walks by the battery charger to see if it's working correctly. "By the way, we can now use maintenance-free batteries for generators," he notes.

Rubin also looks at the generator's radiator to make sure it isn't covered in leaves, bugs, or even lizards (in Florida). "Is the radiator clean, or is it leaking after many years of service?" are questions he investigates during this tracer.

"If the generator is out of service, what do you do?" Rubin asked his conference session attendees. "You bring in a rental generator."

In addition, Rubin makes sure that the backup generator's power switch is set to "automatic" and that the automatic transfer switch looks to be in good working order. On a lit wall panel that is separate from the generator, the automatic transfer switch should mechanically flip when needed from "Utility" to "Emergency generator" during a power outage.

* The *Life Safety Code*® is a registered trademark of the National Fire Protection Association, Quincy, MA.

What's more, Rubin checks whether a functioning battery-powered emergency light is turned toward the backup generator's control panel. This portable light is normally mounted on the wall. Ideally, it would have two adjustable heads, one turned toward the control panel and the other toward the floor (for safety reasons). "That light is very important to you," Rubin emphasized during his presentation. "It can't be a light from a cell phone."

In medical gas storage rooms, Rubin ascertains, among other things, whether empty gas cylinders are kept separate from full and partially filled cylinders, as required. For safety reasons, the gas cylinders should be individually chained or otherwise individually secured. If chained in groups, several full cylinders could fall on a person and cause serious injury, he explains.

Facility professionals often use playful names such as "bug eyes" or "Mickey Mouse ears" for portable battery-powered emergency lights with two adjustable heads.

For More Information

To learn more about emergency generator and medical gas storage compliance in AHC settings, see the following standards and elements of performance (EPs):

- Standard **EC.02.05.07**, EPs 3–10 (generators). The organization inspects, tests, and maintains emergency power systems.
- Standard **EC.02.05.09**, EPs 1–14 (medical gas). The organization inspects, tests, and maintains medical gas and vacuum systems.

Eyewash stations for caustic chemical handling

Lack of an emergency shower or eyewash station where needed leads to EC findings, according to Rubin. "There needs to be a risk assessment as to why an emergency shower or eyewash station is in a particular location," he says.

Eyewash stations are needed wherever personnel handle caustic or corrosive chemicals, not blood or other bodily fluids, Rubin explains. Consequently, health care facilities should have emergency shower and eyewash stations in some laboratories, power plants where caustic soda is used for the boilers, and janitorial areas, among other locations.

The risk assessment should address the handling of not just injurious or corrosive materials, but also formaldehyde and substances with a pH of less than 2.5 or greater than 10.5, as well as safety data sheet and personal protective equipment requirements.

Staff should be able to access the eyewash station easily within 10 seconds of the hazard. “We find eyewash stations in locations that you can’t use,” Rubin observes. “You need to have enough room to actually get to it. It can’t be behind a door or installed under a counter.” (See Appendix B under ANSI Z358.1-2014 for additional details.)

In addition, each emergency shower or eyewash station requires a mixing valve to ensure that the water is tepid: between 60° and 100° F.

“If you have an emergency shower or eyewash station, you have to maintain it,” Rubin adds. “That means a weekly flush and an annual inspection. You’ve got to take care of it.”

NEXT

New Feature!

What's Your Solution?

Readers Are Invited to Share Their Solutions to Common Compliance Challenges

The Joint Commission sets standards and elements of performance with which organizations must comply, but it's up to Joint Commission–accredited facilities to determine the best way to comply and to identify their own solutions. Beginning this month, *EC News* is encouraging readers to share how their facilities address particular requirements or compliance challenges.

This month, readers are asked to answer the following question by emailing executive editor Carolyn Schierhorn at cschierhorn@jcrinc.com. The best solutions will be published in a future issue of *EC News*.

How does your hospital manage and eliminate corridor clutter?

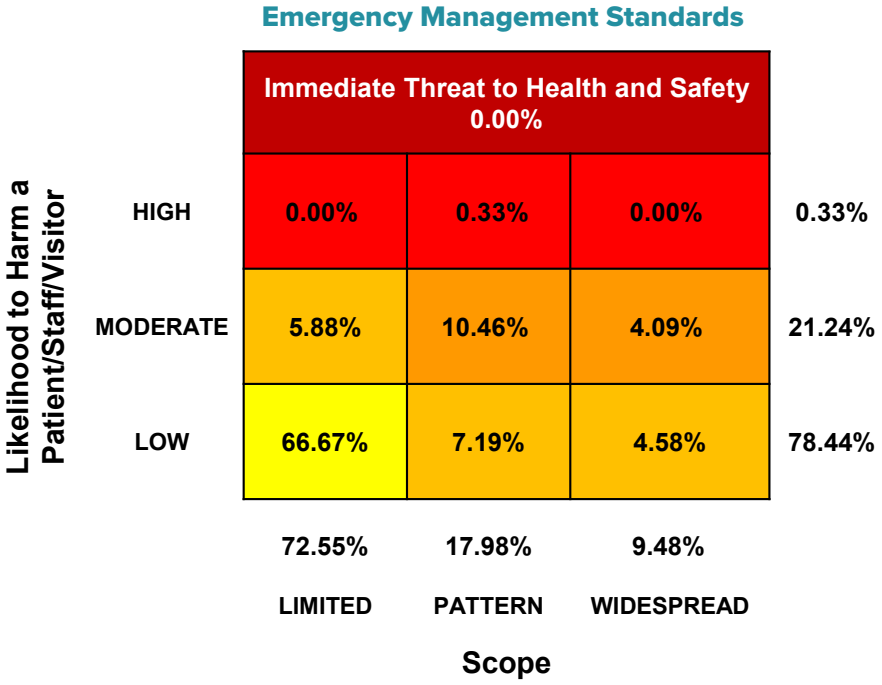
NEXT

Be Prepared

TOP-CITED EM STANDARDS INCLUDE REQUIREMENTS FOR A DETAILED, WRITTEN EMERGENCY OPERATIONS PLAN AND FOR TWICE-ANNUAL EMERGENCY RESPONSE DRILLS

While the vast majority of Joint Commission–accredited hospitals have requirements for improvement (RFIs) in the "Environment of Care" (EC) and "Life Safety" (LS) chapters, only 10% do so in the "Emergency Management" chapter, according to James Kendig, MS, CHSP, CHCM, CHEM, LHRM, who serves as co-chair of the Joint Commission Emergency Management Committee. Likewise great news, among those hospitals that have EM findings, almost none of the citations are in the "Immediate Threat to Life" or "High Likelihood to Harm" category, says Kendig, a Life Safety field director for The Joint Commission.

To illustrate this positive performance, he showed a slide of the following aggregate Survey Analysis for Evaluating Risk™ (SAFER™) Matrix for EM standards during his presentation at The Joint Commission's Hospital Executive Briefing this past October in Rosemont, Illinois.



This aggregate SAFER Matrix reflects EM findings for 1,331 hospital surveys conducted by The Joint Commission between June 1, 2017, and May 31, 2018.

Hospitals also have reason to be proud that for the 1,331 surveys conducted between mid-2017 and mid-2018, 66.67% of the EM RFIs fell in the low-risk, limited scope yellow zone. Nevertheless, with the United States facing more and more natural disasters, from flooding to wildfires, and with active shooter incidents

on the rise, being well-prepared for any emergency should be a top priority for all health care facilities, Kendig emphasizes.

As he explained to his audience of hospital executives, health care organizations can improve their emergency preparedness in 10 key areas that correspond with the top-cited EM standards (shown in the following SAFER Matrix–related bar graph).

This graph is based on EM findings for 1,331 hospital surveys conducted by The Joint Commission between June 1, 2017, and May 31, 2018.

The most-cited standard, EM.02.01.01 covers the development of an Emergency Operations Plan (EOP), which must be updated annually and include a communications plan. Within this standard, the element of performance (EP) most frequently cited that is likely to cause harm is EP 2: "The hospital develops and maintains a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur."

Per this EP, response procedures could include the following:

- Maintaining or expanding services.
- Conserving resources.
- Curtailing services.
- Supplementing resources from outside the local community.
- Closing the hospital to new patients.
- Staged evacuation.
- Total evacuation.

Kendig also talked about EM.03.01.03, EP 1, which calls for emergency response training drills to be conducted at least twice a year. These functional exercises could address facility-specific emergencies such as a burst water pipe or medical gas leakage, as opposed to a natural disaster.

As the following graph illustrates, another commonly cited requirement—EM.02.02.13, EP 2—concerns granting privileges to licensed independent practitioners (LIPs). "I was surprised by this," Kendig told his "Emergency Management Data" presentation attendees. "When I'm on survey with my clinical colleagues, I always ask physicians to make sure that the medical staff bylaws have information related to who can credential the LIPs."

Most Frequently Cited EM Elements of Performance

This graph is based on EM findings for 1,331 hospital surveys conducted by the Joint Commission between June 1, 2017, and May 31, 2018.

According to the data, the No. 1 mostly frequently cited element of performance is EM.02.01.01, EP 3 (notice of external authorization), followed by EM.02.01.01, EP 12 (communication with alternate care sites).

"You need to give notice to external authorities if you're closing a hospital or exceeding your bed capacity," Kendig explained. A hospital also needs to have a plan in place for reaching out to other health care facilities during emergencies.

Crucial during natural disasters, such as hurricanes and earthquakes, "we need to make sure that we're doing our '1135 Waivers,' " Kendig stressed. If the U.S. president declares a disaster or an emergency or the U.S. Department of Health and Human Services declares a public health emergency, affected health care organizations should submit "1135 Waivers" to the Centers for Medicare & Medicaid Services (CMS) state contact. These waivers allow providers to temporarily streamline their procedures so that patients continue to have safe access to care.

Having reviewed numerous Evidence of Standards Compliance (ESC) responses, Kendig observed that none of the ESCs specifically mentioned that the organization's "Emergency Management Professional" would take a needed action. This led him to note that when it comes to compliance, "there seems to be a positive correlation for those organizations that have a designated individual who 'owns' the 'Emergency Management' chapter versus having those responsibilities distributed among many leaders in the organization."

Nevertheless, every member of the hospital staff needs to know his or her role during an emergency. "It is not sufficient for a few key officials and planners to know their roles and responsibilities during a disaster," Kendig said. "The roles of everyone involved must be clearly understood." EC

NEXT ↓

SECURITY

Workplace Violence in Health Care

A THOROUGH RISK ASSESSMENT AND RESPONSE PLAN ARE CRITICAL TO PREVENTING AND MITIGATING VIOLENCE IN HEALTH CARE SETTINGS, INCLUDING ACTIVE SHOOTER INCIDENTS

The recent active shooter incident at Mercy Hospital in Chicago, which left four people dead, brings home the reality that health care facilities are especially vulnerable to workplace violence. The following article is excerpted from the "Security" chapter of Doody's four-star-rated Environment of Care Risk Assessment*, 3rd edition, published by Joint Commission Resources. The book may be ordered here from the Joint Commission Resources webstore.*

Health care workers are among the populations most at risk for workplace violence. The Bureau of Labor Statistics reports that more than 11,000 health care and social assistance workers were injured by workplace violence in 2014—69% of all such injuries in private industry.[1] The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty.[2]

Examples of violence include threats (expressions of intent to cause harm, including verbal threats, threatening body language, and written threats), physical assaults (attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives), and muggings (aggravated assaults, usually conducted by surprise and with intent to rob). The U.S. Occupational Safety and Health Administration (OSHA) defines workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site."[3]

Workplace violence can cover a variety of acts, including the following:

- Verbal threats to inflict bodily harm, including vague or covert threats.
- Verbal harassment, such as abusive or offensive language, gestures, or other discourteous conduct.
- Slander, including making false, malicious, or unfounded statements against other individuals, which tend to damage their reputations or undermine their authority.
- Attempts to cause physical harm by striking, pushing, and other aggressive physical acts, such as sexual assault (which includes rape).
- Domestic or gang violence that follows the victims into the facility or that occurs in a home care residence.
- Disorderly conduct, including shouting, throwing, or pushing objects; punching walls; and slamming doors.
- Terrorism against workers.

These incidents can range in scope from a skirmish in a hallway to an active-shooter situation that puts the entire facility at risk. Also, keep in mind that a small incident can escalate if not dealt with properly.

The topic of workplace violence in health care settings received a great deal of attention in 2016, due in part to a U.S. Government Accountability Office (GAO) report titled "Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence"[4] and an OSHA toolkit released in December 2015 titled "Preventing Workplace Violence in Healthcare."[5]

In response to inquiries from the field, The Joint Commission created a Workplace Violence Prevention Resources portal. The goal of this portal is to broaden the awareness of workplace violence in health care by bringing relevant and timely information and resources applicable across health care settings to a central location. The portal provides links to materials developed by The Joint Commission as well as federal and state government resources and those from professional associations. The portal also includes information from health care organizations that have encountered events and/or effectively reduced workplace violence.

Assessing risk factors

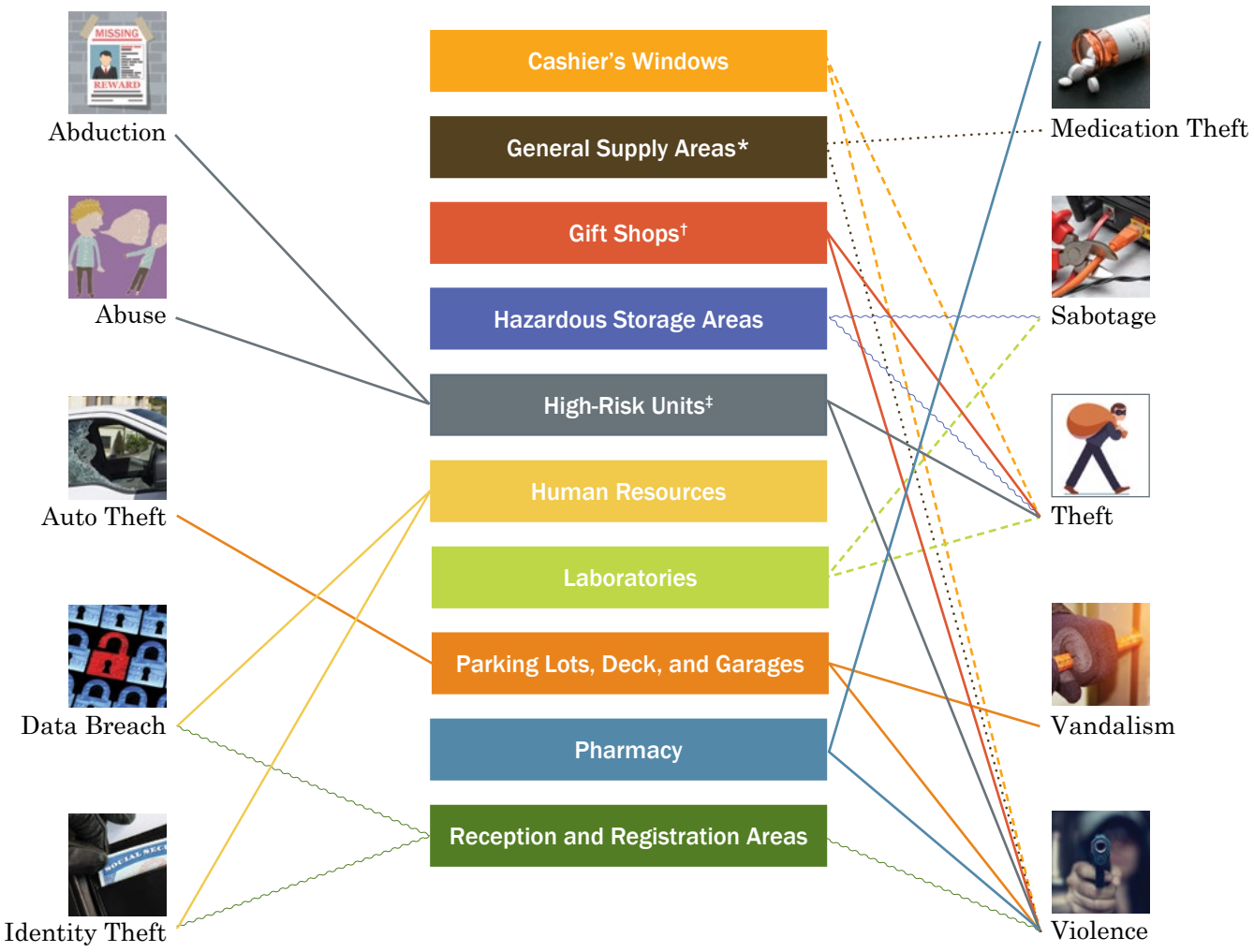
There are a variety of risk factors for the incidence of workplace violence. Organizations should conduct a risk assessment specific to workplace violence that focuses on particular areas, departments, or patient populations. When conducting a workplace violence risk assessment, organizations also should make sure that both the internal environment and surrounding community are included to ensure a comprehensive view of potential risk factors. (*See* "Toolbox" on page 19 for the "Environmental Risk for Workplace Violence Checklist.") For example, a behavioral health care unit may present risks for workplace violence because psychiatric patients can be more prone to violent activity than other types of patients.

Certain areas of health care facilities are at heightened risk for workplace violence (*see* the illustration on page 16). The emergency department, for example, is a common site for incidents of violence in a hospital. Many factors contribute to this, among them the heavy volume of patients, including those with behavioral, psychiatric, and substance use issues; 24-hour access; frequent overcrowding; the potential for external violence (for example, gang or domestic); and patients and visitors who are under the influence of alcohol or illicit drugs.

When assessing an organization's potential for workplace violence, consider the following points:

- Likelihood of patients, families, and visitors to carry a handgun.
- Presence of gangs or gang activity in the community.
- Temptations—such as drugs and money—found in a health care environment.

Commonly Identified High-Risk Areas



In health care organizations, the commonly identified security-sensitive areas listed in the center of this illustration have a higher potential for the issues listed on either side. Organizations need to identify which areas in their facilities are high risk and determine the types of issues that are present. While this illustration provides a sample of high-risk areas and potential issues, it is not a comprehensive list. (This illustration is reprinted from *Environment of Care Risk Assessment*, 3rd edition, published by Joint Commission Resources.)

* These types of areas could house syringes and sharp instruments.

† Gift shops typically are found only in hospital settings.

‡ Certain areas, units, or departments, such as the emergency department, intensive care unit, labor and delivery, pediatrics, and common rooms in behavioral health care organizations, are at high risk for security incidents; however, any area in a health care facility has the potential for these incidents.

- Lower staffing levels during times of increased activity, such as meal and visiting times.
- Changes of shift that occur in the darkness.
- Lighting of parking areas.
- Vegetation around the building that could be a place for someone to hide during evening hours.
- Staff training to recognize and manage hostile and aggressive behavior.
- Accessibility of security hardware, such as panic buttons and call stations.

All of these factors can affect security and workplace violence, either alone or in combination.

Because home care requires staff to enter an individual's residence, there is a greater risk for domestic and/or gang violence from the individual, family, friends, and the community. Home care organizations should train staff on assessing the environment and, if necessary, modify schedules to avoid placing staff in harm's way.

Many organizations have a variety of policies, procedures, and features in place that directly or indirectly relate to workplace violence prevention. These may include a program for nonviolent crisis intervention, call buttons for summoning help in the parking lot, and a code to call for assistance in an emergency situation. All of these can be drawn together under the umbrella of workplace violence prevention. The resulting program must be clearly communicated to staff members, and it must have the support of organization leadership.

Handling an active shooter

One of the most terrifying and widely publicized security incidents is when a person with a gun opens fire or someone with a knife starts attacking. These individuals are known as "active shooters." U.S. government agencies—including the White House, U.S. Department of Justice/Federal Bureau of Investigation, U.S. Department of Education, and U.S. Department of Homeland Security/Federal Emergency Management Agency—define an active shooter as "an individual actively engaged in killing or attempting to kill people in a confined and populated area."[6] These events are often seen as unpredictable and sudden. Although this is in some ways true, it does not mean that there are not ways to mitigate the risk and prepare for such an incident.

Developing a plan to respond to active shooters, as well as training and educating staff about that plan, is critical. This might be handled through the existing security team or by a dedicated threat assessment team. The plan should address the following:

- Training staff to identify individuals who may commit a violent act.
- Procedure for reporting an active-shooter incident.
- When to utilize the "run, hide, and fight" responses.

- Evacuation policy and procedure, including escape route assignments and alternative routes if primary routes are unsafe.
- Lockdown procedures.
- Communications, both internally and with community law enforcement, during an active shooter incident.
- How to interact with first responders and emergency personnel.
- Procedures to follow in the immediate aftermath of an incident.

Staff should be trained on all aspects of the plan, know how to use security features such as alarms and door locks, and they should be empowered to report on any behavior or situation they feel might be unsafe.

For more information on active shooter incidents, see these resources:

"Preventing Workplace Violence in the Health Care Setting," Sentinel Event Alert, Issue 45, The Joint Commission.

"Preparing for Active Shooter Situations," Quick Safety, Issue 4, The Joint Commission.

"Preventing Workplace Violence in Healthcare," U.S. Occupational Safety and Health Administration.

"Active Shooter: How to Respond," U.S. Department of Homeland Security.

References

1. Bureau of Labor Statistics. Table R4. Number of Nonfatal Occupational Injuries and Illnesses Involving Days Away from Work by Industry and Selected Events or Exposures Leading to Injury or Illness, Private Industry, 2014. Accessed Dec 4, 2018.
2. US Centers for Disease Control and Prevention. National Institute for Occupational Safety and Health. Occupational Violence. (Updated Dec 13, 2016.) Accessed Dec 4, 2018.
3. US Occupational Safety and Health Administration. Workplace Violence. Accessed Dec 4, 2018.
4. US Government Accountability Office. Report to Congressional Requesters. Workplace Safety and Health—Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence. March 2016. Accessed Dec 4, 2018.
5. US Occupational Safety and Health Administration. Preventing Workplace Violence in Healthcare. Dec 2017. Accessed Dec 4, 2018.
6. US Federal Bureau of Investigation. A Study of Active Shooter Incidents in the United States Between 2000 and 2013. Sep 16, 2013. Access Dec 4, 2018.

NEXT

TOOLBOX

Environmental Risks for Workplace Violence Checklist

One goal of EC News *is to provide more downloadable Environment of Care® (EC), Life Safety (LS), and Emergency Management (EM) tools that readers can implement in their facilities to improve compliance and, most importantly, patient care and the safety of patients, visitors, and staff. This is the primary purpose of the revitalized "Toolbox" department.*

With shootings and other violent incidents on the rise in health care settings, it's more important than ever before for facility managers and other EC, LS, and EM compliance professionals to assess the environmental risks for workplace violence in their facilities. Assessment is the first step in preventing—or mitigating the harm caused by—such incidents.

The following checklist, which can be downloaded as a functional, customizable Microsoft Word document here, was adapted from the U.S. Occupational Safety and Health Administration's "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers." The adapted checklist appears in the new 2nd edition of the best-selling *The Joint Commission Big Book of Checklists*, just released in December 2018. The book can be ordered online at the Joint Commission Resources webstore.

Would you like to see specific tools in *EC News*? Please email suggestions to cschierhorn@jcrinc.com.

DOWNLOAD

APPLICABLE PROGRAM(S)
☒ AHC ☒ BHC ☒ CAH ☒ HAP
☒ LAB ☒ NCC ☒ OBS ☒ OME

Environmental Risks for Workplace Violence Assessment Checklist

This checklist can be used to assess environmental risks for workplace violence in a health care organization.

Answers to all questions ideally should be **Y** *for* **Yes** *(unless marked* **NA** *for* **Not Applicable***). Use the* **Comments** *section to indicate specific locations of noncompliant areas and any required follow-up action(s) identified by an* **N** *for* **No** *response. Unless otherwise noted, this checklist is applicable to* **all** *program settings.*

ORGANIZATION: _____ DEPARTMENT/UNIT: _____

DATE OF REVIEW: _____ REVIEWER(S): _____

QUESTIONS	Y	N	NA	COMMENTS
GENERAL APPROACH				
Are safety and security issues specifically considered in the early stages of facility design, construction, and renovation?				
Has the organization acted on risks identified in its workplace violence security analysis?				
Does the organization have a process in place to monitor, analyze, and trend workplace violence incidents?				
NEIGHBORHOOD				
Are neighborhood crime patterns evaluated for their potential impact on the safety of the facility?				
Do workers feel safe walking to and from the workplace?				
PUBLIC ACCESS				
Are entrances visible to security personnel?				
Are entrances well-lit and free of hiding places?				
Is there adequate security in parking or public transit waiting areas?				
Is public access to the building controlled?				
Is effectiveness of public access control evaluated as risk factors inside or outside of the facility evolve and/or change?				
Are any exit doors designed to be opened only from the inside to prevent unauthorized entry?				

(continued)

APPLICABLE PROGRAM(S)
☒ AHC ☒ BHC ☒ CAH ☒ HAP
☒ LAB ☒ NCC ☒ OBS ☒ OME

QUESTIONS	Y	N	NA	COMMENTS
Are lockable and secure bathrooms that are separate from patient/client and visitor facilities available for staff members?				
GENERAL SAFETY FEATURES				
Does the organization have good lighting in accordance with IESNA standards?				
Are fire exits and escape routes clearly marked?				
RESPONSE SPACE AND EQUIPMENT				
Is there an internal phone system to activate emergency assistance?				
Have alarm systems or panic buttons been installed in high-risk areas and tested regularly?				
Are designated "safe rooms" available for staff use during emergencies?				
HIGH-RISK AREAS				
Have high-risk areas within the facility been identified?				
Given any history of violence at the facility, is a metal detector appropriate in some entry areas?				
Given any history of violence at the facility, is closed-circuit TV appropriate in high-risk areas?				
PATIENT AND WORK AREAS				
Are reception and work areas designed to prevent unauthorized entry?				
Do reception and work areas provide staff good visibility of patients and visitors?				
If not, are there other provisions such as security cameras or mirrors?				
Are patient or client areas designed to minimize stress, including minimizing noise and crowding?				
PATIENT ROOMS				
When permissible, are door locks in patient rooms appropriate? Can they be opened during an emergency?				

(continued)

APPLICABLE PROGRAM(S)
☒ AHC ☒ BHC ☒ CAH ☒ HAP
☒ LAB ☒ NCC ☒ OBS ☒ OME

QUESTIONS	Y	N	NA	COMMENTS
When applicable, do counseling or patient care rooms have two exits?				
Is furniture arranged in counseling or patient care rooms to prevent employees from becoming trapped?				
SECURE STORAGE				
Are drugs adequately secured?				
Are equipment and supplies adequately secured?				
Is there a secure place for employees to store their personal belongings?				

IESNA, Illuminating Engineering Society of North America.

Environment of Care® News
Executive Editor: Carolyn Schierhorn, MA
Senior Project Manager: Lisa King
Associate Director, Production: Johanna Harris
Executive Director, Global Publishing:
Catherine Chopp Hinckley, MA, PhD

Technical Support and Review:

Department of Engineering
Ken Monroe, PE, MBA, CHC, PMP, Senior Associate Director

Division of Accreditation and Certification Operations
James Kendig, Field Director, Surveyor Management and Development

Joint Commission Resources Consulting
Lisa Hardesty, MA, CFI, CHSP, HEM, Principal Consultant /Environment of Care® and Life Safety

Never miss an issue!

Check when your subscription expires by logging into your account at www.jcrinc.com.

Subscription Information:
Individual online license—$379 for one year
Online site license—$1,029 for one year
Online system license—Contact jcrcustomerservice@pbd.com or 877-223-6866 for pricing.
Discounted pricing available for multiple periodicals and multi-year site licenses.

Environment of Care® News (ISSN 1097-9913) is published monthly by Joint Commission Resources, 1515 West 22nd Street, Suite 1300W, Oak Brook, IL 60523.

Visit us on the Web at https://www.jcrinc.com.

Contact the Standards Interpretation Group with standards questions.

Editorial Policy:
Reference to a name, an organization, a product, or a service in *Environment of Care® News* should not be construed as an endorsement by Joint Commission Resources, nor is failure to include a name, an organization, a product, or a service to be construed as disapproval.