

Healthcare Practice Specialty Concurrent Session Forum with Proposed Panelists

**Aruna Vadgama, RN, MPA, BCSP, COHN-S, BCPE, CPHQ
South Coast Medical Center
Carlsbad, California**

Facilitator: Aruna Vadgama, RN, MPA, COHN-S, BCSP, BCPE, CPHQ-

- Introduction: Cross Walk- Managing SH&E and Infection Control Has No Boundaries- 10 Minutes

Panelist: Mark Shirley-MS, CSP Sutter Health-

- Compliance: Environment of Care Standards- 15 Minutes

Panelist: Ruth Hohnstein- Mayo Clinic-

- Total Safety: Patient, Employees, Visitors, Healthcare Practitioners, Community, Safety Forums/Committees/Clinical & Other Issues- 15 Minutes

Panelist: James M. Sheridan, ARM, ARM-P, AIS, CHSP, CSHM, CHCM- PMA, Insurance-

- Healthcare Risk Control Strategies - 15 Minutes
- Questions & Answers- 5 Minutes

Summary

This healthcare forum panelists will discuss the emerging issues that we SH&E and Infection Control, Risk Management and Loss Control professionals are challenged with in recent years. These issues have no boundaries and will effect the world-wide population. The presenters will present the elements of processes necessary for planning, implementing and sustaining safety beyond four walls.

Cross Walk—Managing SH&E and Infection Control Has No Boundaries

During the past five years the infection control issues have emerged as challenging issues for workplaces beyond the healthcare industry. In 2004 we had to develop infection control plan for SARS. Business travelers were banned from traveling to certain geographic areas in Asia and North America. Many people were guaranteed to contain infection in regions. And then surfaced the man-made infection control nightmare! The news about Anthrax challenged the occupational safety, health, security, environmental, human resources and administration in designing the mail handling procedures and segregating mail room air handling system/HVAC to prevent air circulation to contain potential Anthrax contamination to the mail room only! Last couple of years the Avian Flu and potential for the Flu Pandemic has us thinking! Do we have a plan to handle infectious diseases in our workplaces? I believe that ***The Infection Control is a coalesce issue.*** We will need to develop workplace infection control policies and provide tools to control infections in the workplace.

While the Flu season is approaching with the full speed and with emerging issues regarding the community acquired MRSA it is essential we the health, safety, risk and environment management professionals think outside the box and start embracing infection control as part of our function. The implications of the work/community acquired bacterial infections are in infancy stage! As we don't do the baseline screening for MRSA as pre-placement test and if any employee acquires MRSA by using the workplace gym, playground, equipment, how will we manage the workers' compensation claim? This is something to think about with pandemic flu, MRSA and other emerging issues. One recent study pointed out that 50%-70% men don't wash their hands after using toilet. The statistics cited below will shock you but this was the facts revealed in recent study

Did you know?

- Up to half to three quarters of all men and a 40% to quarter of women fail to wash their hands after they've been to the toilet
- Right handed people tend to wash their left hand more thoroughly than their right hand, and visa versa
- We have between 2 and 10 million bacteria between fingertip and elbow
- Damp hands spread 1,000 times more germs than dry hands
- The number of germs on your fingertips doubles after you use the toilet
- Germs can stay alive on hands for up to three hours
- Millions of germs hide under watches and bracelets and there could be as many germs under your ring as there are people in Europe

With recent breaking news about deaths in academic institutions: "MRSA Causes Death of Student in Virginia", these breaking news stories have set fears in everyone so high that in some instances the reporting of a single child with an MRSA skin infection has been enough to close schools. The fear for contracting this so called "Superbug" was so acute that the public health officials and healthcare providers received voluminous inquiries about the MRSA. The public health officials and the medical society tried to calm the fears through providing the facts about the MRSA. The main message, from the public health and the medical community is that getting

an MRSA infection is no death sentence. While MRSA is strongly resistant to methicillin and some other modern antibiotics, it can be treated effectively with several other, readily available antibiotics. Although there was a panic in the community the healthcare institutions remained calm. Why? Because the healthcare industry has been well aware of MRSA and other multi-drug resistant diseases for quite some time. The Joint Commission and other healthcare quality oversight organizations have developed the National Patient safety Goals. Hand washing and infection control standards require 100% compliance. As such, healthcare organizations have embraced this challenge by instituting HANDWASHING as an integral part of their quality management practice. Hand sanitizing pumps have been installed to increase compliance with hand washing near patient care areas, on entry to the hospital, emergency room, cafeteria, conference rooms, nursing stations, medication carts/rooms and other heavy traffic areas.

Compliance: Environment of Care and Emergency Response

Joint Commission Compliance

In June 2007, the Joint Commission published revisions to its Emergency Management Standards (EC.4.10 and EC.4.20). These changes are effective on January 1, 2008. Standard EC.4.10 has been replaced by eight new standards (EC.4.11 through EC.4.18). Intended to reinforce an all hazards planning approach, the new standards are built around six critical areas: communication, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities. Each of these six areas must be addressed regardless of the size and complexity of the emergency event.

New compliance requirements by the US Department of Health and Human Services and The Joint Commission will soon be in place.

Immediately following the passage of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, a direct response to the 9/11 and the anthrax emergencies, healthcare preparedness activities largely focused on improving readiness for terrorist events. Subsequent emergencies: the 2003 northeast blackouts, 2004 Florida and 2005 Gulf Coast hurricanes, and the 2007 Virginia Tech shootings highlighted the importance of being ready for a variety of disasters.

In response to such events, emergency management has become increasingly more complicated and time consuming for those responsible for hospital emergency preparedness activities. Effective programs are no longer simply dependent on a competent and appropriately resourced coordinator, but must now include a committed organizational multidisciplinary team as well as a coordinated effort with community and regional planners.

NIMS Compliance

On February 23, 2003, the Homeland Security Presidential Directive (HSPD)-5 *Management of Domestic Incidents* directed the Secretary of Homeland Security to develop and implement a National Incident Management System (NIMS). NIMS provides a consistent national approach to preventing, preparing for, responding to and recovering from domestic incidents of all types, sizes and complexity. Federal adoption of NIMS occurred in March of 2004. As a condition of Federal preparedness funding, State, tribal and local adoption was required in 2005. In September of 2006, the NIMS Integration Center (NIC) in collaboration with the Department of Health and

Human Services outlined 17 implementation activities for hospitals and healthcare systems. “Hospitals and healthcare systems” only include facilities receiving emergency medical and trauma patients on a daily basis. Long-term care facilities, nursing homes, clinics and specialty hospitals are encouraged but not required to participate in these activities. For applicable organizations, Federal hospital emergency preparedness funding is also tied to compliance with NIMS activities. The rationale for expanding NIMS to healthcare providers is simple. A coordinated approach between healthcare providers, local public health and other regional agencies is essential for the provision of effective community disaster planning and response activities.

Compliance Element	Requirement
Element 1: <i>Adopt NIMS</i>	Adopting NIMS is straight forward and should be accomplished by ensuring EM program documentation reflects compliance with each of the 17 elements. This can be documented in: training records, plans and procedures, staff guides, annual program goals and objectives, and exercise critiques.
Element 2: <i>Incident Command System</i>	HICS is compatible with ICS; therefore, if your organization utilizes HICS, compliance with Element 2 has been accomplished.
Element 3: <i>Multi-agency Coordination System</i>	Integrating the hospital emergency response activities with the regional emergency operations center, and other local command posts begins with the installation of primary and alternate communication system. These systems might include some of the following: 800Mz radios, satellite communication devices, VHF/UHF radios, Ham radios, and event management software. Cooperative planning and exercising is key to ensuring these communication links are effective.
Element 4: <i>Public Information System</i>	This element requires timely, accurate and consistent public messaging between the hospital, its healthcare partners, and jurisdictional authorities. Processes describing how the institution coordinates with applicable entities should be added to the emergency operations plan and tested during community-wide exercises.
Element 5: <i>Track NIMS Implementation</i>	Tracking of NIMS implementation should begin immediately. Building a simple tracking tool listing each element, its due date, implementation strategies, and compliance status will help emergency planners get a handle on what has been done and what still needs to be accomplished. This tool will also help organizations demonstrate compliance to regulators. Going forward, inclusion of NIMS elements in the annual EM program evaluation will help ensure ongoing compliance.
Element 6: <i>Coordinate NIMS funding</i>	Organizations receiving publicly funded emergency preparedness grants, such as HRSA funds, CDC grants, etc., are required to document receipt and effective deployment of equipment and training. This should be accomplished through a database of equipment and training received, as well as demonstrated use of each in drill and exercise documentation.
Element 8: <i>Participate in Mutual Aid Agreements</i>	Some hospitals already have mutual aid or cooperative agreements in place. Formalized written agreements should be made with diverse groups to help ensure availability of support during an emergency.
Element 12: <i>Incorporate NIMS/ICS into Exercises</i>	Evidence of NIMS and HICS use should be included in exercise procedures and critique documentation. Doing so will assure compliance with Element 12.
Element 13: <i>Participate in All Hazards Community-wide Exercises</i>	At least one annual exercise should be conducted with a variety of community agencies and responders. These exercises should be diverse in nature and test various components of the organization’s emergency plan. Compliance with this element is best demonstrated through exercise documentation.

Element 14: <i>Incorporate Corrective Actions</i>	Hospitals have been required for some time to incorporate process improvement techniques into drills and exercises. Assuming lessons learned from exercises are used to refine plans and procedures, organizations will meet the requirements of this element.
Element 15: <i>Maintain an Inventory of Response Assets</i>	Hospitals must maintain an inventory of response assets. At first glance this would appear to be a simplistic requirement; however, in the spirit of the element, hospitals should conduct a needs assessment to determine the types and quantities of supplies that might be needed for highly probable events as outlined by the organization's hazard vulnerability analysis. Once completed identification of the gap between par levels of supplies on-hand at reorder point and needs will define what must be included in response supply inventories. Response inventories should be regularly re-evaluated and rotated through stock to avoid retention of outdated or obsolete supplies.
Element 16: <i>Equipment, Communication and Data Interoperability</i>	This element is closely tied to Element 3. Not only do hospitals need alternate communication tools, but in order to be effective, they need to be compatible with community partner and response agency tools. This interoperability needs to extend beyond communication tools and include shared equipment and data systems. Compliance with this element can be demonstrated through documentation describing a cooperative procurement process as well as demonstrated effectiveness during drills and exercises.
Element 17: <i>Apply Standardized and Consistent Terminology</i>	This element requires staff to use plain English communication terminology during emergencies. While hospital emergency codes (e.g. Code Blue, Code Red, etc.) are still acceptable, hospital jargon should be avoided to ensure effective communication between the hospital, community partners and responding agencies. Compliance with this element can be demonstrated through documented use of plain English on forms, checklists, procedures and communication protocols.

Total Safety: Patient, Employees, Visitors, Healthcare Practitioners, Community, Safety Forums/Committees/Clinical & Other Issues

“Healthcare is in its infancy in making many major system changes and needs to go through the stage of decreasing variation - as has been done in aviation and other industrial domains - before it can evolve into a more living systems-model. Healthcare is still beset by huge variation in practice and to suggest that this variation be further increased is to court disaster in terms of increased morbidity and mortality for patients.” (A North American with major experience of healthcare sector and previously experience in aviation).

Variation in practice among health professionals is frequently implicated in the accidental injury and death of patients. Variability in physician practice is embedded in the system:

If we didn't simplify complex problems by blaming individuals we would have to acknowledge that the way we manage healthcare is fundamentally flawed and we would have to go through the very painful process of challenging the highly autonomous and fragmented practice of medicine. Every physician affiliated with our hospital has her or his own tacit procedures and timing for the following:

- Coordinating with nurses and other physicians.
- Seeing patients in the hospital.

- Communicating about problems and changes in care strategies
- Treating commonly recurring diagnoses (without assessing collectively for best practice).
- And on and on and on...

This leads to profound fragmentation of care processes, dropped information, misunderstandings among personnel working with the same patients, and continual errors of omission and commission. To truly improve safety we have to reinvent the management of medical practice and healthcare administration. I have no idea what form healthcare systems will ultimately take, but we need to start the journey. Perhaps it's begun, but if so we are in a period of 'fits and starts'. Patankar, Brown, and Treadwell, Ashgate, 2005. (Chapter Six, page 102, Key Themes in Healthcare Safety Dilemma).

We anticipate that the safety and reliability of patient care can and will be advanced by increasing standardization of clinical and administrative processes, procedures, and practices--including the further development and wider adoption of clinical protocols¹.

We also believe there is a need to reduce variation in standards among healthcare organizations, medical device manufacturers, and vendors of information technologies.

However, in addition to standardization of recurrent activities and actions in healthcare, there is an integral need to develop and enhance practitioners' ability to recognize when routine responses (whether consistent with the tacit rules of an individual or group, or standards explicitly adopted by a larger community of practice) are not indicated or even maladaptive. The ability to detect and identify/diagnose problems or anomalies, and recognize a situational need to adapt routine activity and action to avert failure has been discussed by numerous researchers as instrumental to safety in high consequence systems (Klein, 2005; Rasmussen, 1982; Reason, 1997; Roberts and Bea, 2001; Hollnagel, et al., 2006). Moreover, there is increasing consensus that team processes may enhance this adaptive capability, enabling the avoidance or detection and mitigation of erroneous actions or inactions (Lawrence, 2003; Patterson, et al., 2006; Uhlig, et al., 2001; Weick, et al., 1999).

Yet, medical practice remains a highly autonomous undertaking, and hospitals are not organized to support interdisciplinary teamwork; they are organized to support the practice of affiliated physicians with facilities, technologies, and support personnel such as nurses, therapists, and pharmacists (Ludmerer, 1999; Merry and Brown, 2001, Patankar, Brown, and Treadwell, 2005, Sharpe and Faden, 1998). This archaic organizational premise, wherein hospitals exist to support the independent practices of physicians, has created a patient care environment, by default, in which physician autonomy trumps close attention to the management of role interrelationships and interdependencies among care providers. The underlying hierarchy of clinical roles and functions in hospitals is still: a) physicians assess patients and then write patient care orders in the patients' medical record; then b) the disciplines tasked by those orders fulfill them.

Consequently, as new patient care roles have been created over the years, hospitals have established clinical departments such as physical therapy, dietetics, social work, etc., which deploy their members to clinical units to fulfill their tasks as ordered by physicians. Nurses,

¹ While standardization of therapeutic processes begs the discussion of need for improvement in clinical diagnostics, (Croskerry, 2003) we will not address this topic in our response to this reviewer.

therapists, social workers, and other clinical professionals may be observed in virtually any U.S. hospital independently gathering information from patients (much of it redundant), developing a plan of care specific to their professional function, and then entering these plans into the patient's medical record. The medical record is the principal mechanism for coordinating patient care activity among health professionals; a function for which it has become increasingly ill-suited in the face of rising social and technological complexity. Stale or ambiguous data entry, informational gaps, and changes in the patient status necessitate frequent interaction with members of other disciplines to provide or seek alternative perspectives, make sense of changes, or otherwise clarify information. These purposes are pursued through phone calls, paging, and random interactions in hallways, cafeterias, and other locations--there are few, if any, 'designed-in' opportunities in workflow for interdisciplinary sensemaking, planning, and provision of care. The end result of this approach to managing role interrelationship and patient care interdependencies is profound fragmentation of effort that may create or exacerbate problems as much as resolve them.

Healthcare Risk Control Strategies

Invoke a culture change in your facility about risk assessments

A quality safety risk assessment needs to not only identify risk, but show follow-up actions you need to take to reduce or eliminate that risk. The follow-up process must consist of a multi-disciplinary action with feedback from other affected departments such as maintenance and grounds. To effectively involve other departments you need to educate your staff and invoke a culture of change in your facility—a challenging proposition no matter what size facility you work at.

Improper risk assessment can lead to: LOSS of RESOURCES

- Bad press
- Joint Commission consequences
- OSHA issues
- Regulatory issues
- Fines
- Situations that compromise patient and staff safety

With so much at stake, a small investment in an expert's opinion could save you a lot of time, money and stress.

At the conclusion of this program, participants will be able to:

1. Identify The Joint Commission's view of risk assessments
2. Perform a proper risk assessment
3. Recognize how to use the form to document findings
4. Identify what the information gathered means
5. Recognize hot spots and high-risk areas
6. Demonstrate an ability to mitigate risks identified

- I. What is risk assessment?
 - a. Why do it?
 - b. The Joint Commission's expectations
 - c. Impact of risk assessment
- II. Conduct a risk assessment
 - a. Best practices
 - b. Changes
 - c. Understand and use the information gathered
 - d. Results
 - e. Mitigation and abatement plan
- III. Hot spots
- IV. Risk assessment success stories

Worker's compensation costs are a significant expenditure for all organizations. Minimizing worker's compensation costs is important to an organization's bottom line. A well-integrated Return-To-Work (RTW) program can reduce claim costs; allow the injured employee to contribute to the organization's profitability by being productive while still recovering; provide positive reinforcement to the injured worker to recover quickly; and decrease opportunities for repeaters. The success of any RTW program depends on the level of support and direction from senior management. A policy statement written and publicized throughout the organization is an effective means for senior management to provide guidance and demonstrate support for the RTW program. An effective RTW program involves Safety staff, the organization's employees, the medical provider(s), and the worker's compensation (WC) insurance carrier. Each group must know their specific roles and responsibilities and work together to get an injured employee back to work as soon as possible. RTW programs utilizing transitional work (whether modified or alternative duty) have been shown to save money through the reduction of health care costs, lost-time wage payments, and reduced attorney involvement.

Statistics:

- For injuries where one or more work days are lost, 51% of the employees suffering an injury will be away from work more than five days. (Source: National Academy of Social Insurance)
- Attorney involvement increases the cost of a claim by over 50%. (Source: National Council on Compensation Insurance)
- Absence from work accounts for approximately 50% of the cost of the claim. (Source: National Council on Compensation Insurance).
- Within the past 10 years, the average number of lost work days per 100 employees declined from 3.0 to 1.8. Reasons cited were more active management of medical care, more efficient Return-To-Work programs and tightened eligibility rules for worker's compensation. (Source: United States Department of Labor)
- The best opportunity for a company to return an injured or disabled employee back to work is within the first 5 days after an injury. Most employees do return within 30 days of an injury; however, 20% of employees who miss at least one day will be out of work for 30+ days. (Source: Bureau of Labor Statistics)