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Sedgwick supports Patient Safety Awareness Week March 13-19

We strive to help healthcare providers and health systems keep patients safe and reduce the risks of providing care every day. This includes guiding healthcare leaders in identifying patient safety risks that can have a negative effect on patient care and outcomes, and working alongside them to develop solutions for prevention and mitigation.

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Healthcare-associated infections – Where are we today?

By Ann D. Gaffey, RN, MSN, CPHRM, DFASHRM
Healthcare Risk Management and Patient Safety Consultant

Healthcare-associated infections (HAIs) are a major threat to patient safety. They can be serious and even deadly to the patient, yet they are often preventable. According to the World Health Organization, HAIs are the most frequent adverse event in healthcare delivery worldwide.[1] In addition to the harm they can do to patients, healthcare organizations may be penalized financially for these infections by the Centers for Medicare and Medicaid Services (CMS) and other payers due to non-payment. HAIs account for nearly $45 billion in direct hospital costs.[2] Recent studies, however, suggest that by implementing existing prevention practices up to a 70% reduction in certain HAIs can be achieved. The financial benefit of using these prevention practices is estimated to be $25 billion to $31.5 billion in medical cost savings.[3]

Current state

HAIs generally include central line-associated bloodstream infections (CLABSIs), catheter-associated urinary tract infections (CAUTIs), select surgical site infections (SSIs), hospital-onset *Clostridium difficile* infections (*C. difficile*) and hospital-onset methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia (bloodstream infections). The setting where these infections occur is not limited to hospitals – also included are ambulatory outpatient care centers, long-term care facilities and same-day surgery centers.

The power of data is evident in the statistics available to the public through the National Healthcare Safety Network (NHSN), a national HAI tracking system. Over 14,500 healthcare facilities participate by reporting HAIs to this database, which is the largest in the U.S. Progress has clearly been made in reducing the number of these HAIs. The most recent NHSN National HAI Progress Report includes data supporting this improvement.

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The NHSN's National HAI Progress Report shows:

- A 46% decrease in CLABSIs between 2008 and 2013
- A 19% decrease in SSIs related to the 10 select procedures tracked in the report between 2008 and 2013
- A 6% increase in CAUTIs between 2009 and 2013 (although initial data from 2014 seem to indicate that these infections have started to decrease)
- An 8% decrease in hospital-onset MRSA bacteremia between 2011 and 2013
- A 10% decrease in hospital-onset *C. difficile* infections between 2011 and 2013[4]

Opportunities for additional improvements with CAUTIs exist

As noted above, one of the more elusive HAIs to improve is CAUTI. The literature about CAUTIs is abundant with numerous toolkits available to guide reducing these infections. Key strategies center on indications for catheter placement and reducing inappropriate urinary catheter use, catheter insertion by appropriately trained individuals using aseptic techniques and sterile equipment, maintaining a closed drainage system with unobstructed flow, limiting the length of time the catheter is in place to 24 hours or less and consistently carrying out proper hand hygiene.[5] While the trend for CAUTIs is now more favorable, patient care management interventions warrant robust analysis of "bundles" and isolated strategies, as well as teamwork and communication issues, which may be barriers to further reducing these infections.

A recent systematic review and meta-analysis of CAUTI-minimizing interventions was published by Meddings, et al. One of their key summary points reported that "catheter reminders or stop orders reduced the rate of CAUTI by 53%. An updated literature review identified many recent interventions with reminders or stop orders reducing CAUTI rates and/or urinary catheter use."[6] Realistically, the practicality of implementing alerts and stop orders to further reduce CAUTIs may be inhibited depending on the culture of the unit and leadership's participation in the initiative.

Teamwork and communication

The use of alerts or reminders, stop orders and protocols for nurse-directed removal of unnecessary catheters have shown success in further reducing CAUTIs. To be successful with these strategies, however, it is important to understand the safety culture of the unit where the initiative is being implemented. Consider the following comments from three nurses working in different care settings around the country:

- First perspective – "A section of charting was added so nurses can chart the reason the catheter is still in place. An order set was created for physicians to fill out daily. The order set consists of a list of reasons the catheter needs to be continued. One problem that continued to occur was nurses were not removing catheters if physicians did not renew the order. The nurses were in fear of being wrong about the removal, and this led to catheters being in place longer than 24 hours when it was not necessary. On the physicians' side, they were failing to renew orders and catheters were being removed that should not have been, resulting in reinsertion of catheters. With nurses not removing catheters that did not have orders to renew, physicians not renewing orders and catheters being reinserted, the number of CAUTIs did not seem to be decreasing. Nurses and physicians were re-educated on the process and their responsibilities. A prompt was added to the charting system for nurses to ensure the order was renewed, and physicians received prompts daily when logging into the patient's chart, requiring them to renew the catheter order or discontinue it. With these prompts and daily reminders we have seen an overall decrease in CAUTIs in our unit."[7]
- Second perspective – "The most difficult aspect of the new CAUTI protocol was getting the nurses and physicians on the same page. Our nurses were told to remove the catheters if the order wasn't renewed within 24 hours. Our physicians were neglecting to write the renewal orders. Nurses were either discontinuing the catheters on their own, or having to call the physicians to remind them. Even though the physicians were told it was their responsibility to write the renewals, they weren't doing so and they began defaulting to telephone orders when nurses who were considerate enough to remind them made the call. It wasn't until leaders stepped in and no longer allowed renewal orders to be given over the phone did physicians start to remember that daily renewal orders needed to be renewed daily. When physicians began having to return to the facility after leaving for the day just to write renewal orders, the CAUTI protocol became successful."[8]
- Third perspective (summarizing leadership opportunities to implement change) – "...if we are getting to the point of reward and punishment to implement change, we are missing something bigger. Why isn't everyone on the same page? Is everyone receiving the same training or data presentation? Is there something preventing open lines of communication before a catheter is removed? Is it possible to implement daily multidisciplinary rounds to include nurses, doctors, techs, etc. where everyone can discuss the plan and interventions for the day? It can't possibly be pleasant for patients to have catheters inserted and removed just because of a communication issue among staff."[9]

Impressive progress has been made in reducing HAIs. As demonstrated above, more than clinical strategies are needed. The importance of teamwork and communication cannot be understated, and must always be considered when

new initiatives are presented and compliance is expected. Implementing a teamwork and communication training program such as TeamSTEPPS® is one approach to consider. This evidence-based leadership system "provides higher-quality, safer patient care by producing highly effective medical teams that optimize the use of information, people and resources to achieve the best clinical outcomes for patients; increasing team awareness and clarifying team roles and responsibilities; resolving conflicts and improving information sharing; and eliminating barriers to quality and safety."[10] By teaching individuals how to be good team members, they learn to share their mental model, use standardized language and close-loop communicate. Teams that care for patients have briefs, huddle and debrief to evaluate what went well with a procedure or treatment plan, what they could improve and what they might do differently the next time. These teamwork activities lead to improved care and improved outcomes for patients.

The business case

While the case for improving patient safety should speak for itself, those on the front lines often have to make the business case to advance patient safety initiatives. Significant work was done by Kennedy, et al. in the development of a tool estimating customized hospital costs of CAUTIs. The authors note that their "tool can help infection control professionals demonstrate the values of CAUTI prevention efforts to key administrators, particularly at a time where it has become increasingly necessary to develop a business case to initiate new interventions or justify the continued support for ongoing programs."[11] The CAUTI Cost Calculator[12] estimates a hospital's current cost of CAUTIs, and can also be used to project costs after a hypothetical intervention is implemented.

Future state

With seven years under our belt since CMS implemented non-payment for certain hospital-acquired conditions, it is evident that significant strides have been made in reducing HAIs. Safety collaboratives around the country continue to use the best available evidence to further improve care, identify the most successful strategies to use and support the work being done in hospitals every day. Teamwork and communication training continues to be implemented on a unit level and across healthcare systems, further embedding patient safety strategies at the point of care. We still have work to do, but the future is bright.

Resources available to address CAUTIs and antibiotic resistance

- CAUTI Prevention Toolkit: http://www.cdc.gov/HAI/ca_uti/uti.html
- On the CUSP: Stop CAUTI: http://www.onthecuspstophai.org/on-the-cuspstop-cauti/toolkits-and-resources/
- Institute for Healthcare Improvement: How-to Guide: Prevent Catheter-Associated Urinary Tract Infection: http://www.ihi.org/resources/Pages/Tools/
- CDC Vital Signs – Making Healthcare Safer: Stop Spread Antibiotic Resistance, found at: http://www.cdc.gov/vitalsigns/stop-spread/ (accessed August 28, 2015)

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RADIOLOGY SAFETY: TOP FIVE QUESTIONS FOR ASSESSING THE RISK

By Kathleen Shostek, RN, ARM, FASHRM, CPHRM, CPPS, Vice President, Healthcare Risk Management

In radiology services, there is a high potential for adverse events and errors resulting in patient harm and liability due to the large number of imaging studies performed as part of the diagnostic and treatment process. The technologies and processes used, the providers and staff delivering care, as well as the physical environment in inpatient and outpatient radiology facilities can all present safety risks. Asking the questions on page 4 can help assess the top risks, identify areas for more in-depth evaluation and lead to the development of risk mitigation strategies to improve patient safety.

1. Are the procedures for verifying the correct patient and correct imaging study/procedure effective?

Have events involving the wrong patient, study or radiology procedure occurred (or almost occurred)? Assess the process for receiving orders and completing examinations for radiology studies and procedures. Does the process follow the concepts for the Universal Protocol as recommended for procedural-based care?[1] The Pennsylvania Patient Safety Authority reported that wrong events in radiology were related to order and scheduling inaccuracies, patient misidentification and inaccurate procedure verification practices.[2]

2. Are critical imaging exams identified and results communicated timely and documented in the patient's record?

Radiology departments and services must define what studies constitute critical examinations that require results reporting within an established time period no matter what the interpretation is such as a computed tomography of the head with stroke alert. Critical results include findings that are important for urgent patient care and intervention such as pneumothorax, acute aortic dissection, acute deep vein thrombosis and ectopic pregnancy. Assess compliance with established timeframes along with documentation of the date, time and name of reporting provider and verification that the report was received by the ordering or treating provider. This should be an ongoing patient safety and quality indicator for the radiology service.

3. Is there an effective falls prevention program in place for radiology?

Monitor the frequency and severity of falls reported in radiology. Serious events involving falls comprised 8% of all radiology events reported in a state-mandated reporting program.[3] Issues involved in these events included syncope, slips/trips and loss of balance, falls from tables or stretchers, and medication-related effects. Injuries included fractures, lacerations and head trauma. The lack of fall risk screening, failure to use safety measures, inadequate falls prevention training and inattention to environmental safety all contribute to falls in radiology.[4]

4. How is medication safety addressed in radiology departments and services?

Ensure that medication-related events in radiology get reported so that contributing factors to the events can be identified and reduced or eliminated. Consult with a pharmacist to evaluate the medication-use processes in radiology to reveal risks that could lead to harmful errors, and to implement and monitor safe medication practices. Radiology staff competency in performing medication-related functions must be validated. Several areas require dedicated risk management and patient safety oversight including:

- The complexities of various types of contrast injection systems, contrast precautions and administration (reactions and infiltrations)
- The protocols for use of nephrotoxic contrast agents such as gadolinium
- Performance of medication reconciliation
- Compliance with policies and procedures for medication labeling, administration, storage and documentation

5. Is there a robust imaging technology inspection and preventive maintenance program in place?

Ask the physics engineering department to demonstrate how the radiology technology and information systems are inspected and maintained to assure the safety and performance of sophisticated imaging equipment. Most organizations with imaging services are continually moving equipment or adding new technologies to meet the demand for the latest diagnostic and treatment modalities. This is usually accomplished with computerized maintenance management software. Another area to ask about is how safety-related recalls are received and acted on. Case in point: ECRI Institute lists gamma camera mechanical failures with serious injury or death as number 8 in its "2016 Top 10 Health Technology Hazards" due to multiple reports of mechanical failures involving heavy gamma cameras that rotated into or fell onto a patient or staff member. In some cases, camera safety recalls were not acted on.[5]

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Reducing risks in instrument processing: A Gemba Walk approach

By Sharon A. McNamara MS, RN, CNOR, Perioperative Consultant for Sedgwick Healthcare Risk Management and Patient Safety

Safe processing of instruments is a basic tenet of patient safety. Understanding the importance of clean, sterile instruments that function as intended and are readily available to the surgical or procedural team is primary to the prevention of surgical site infections (SSI) — an area that has gained heightened attention with the recent focus on healthcare-associated infections.

Breakdowns in the instrument ready processes can lead to post-operative infections, surgical errors and delays that adversely affect patient outcomes.[1] Identifying gaps and vulnerabilities in the instrument cleaning and sterilization process is akin to performing a risk assessment to identify and lessen safety risks, and other risks such as reduced productivity and fiscal solvency.

Lean methodology offers a tool, the Gemba Walk, to assist you on your journey to evaluating instrumentation processes and identifying gaps and areas of vulnerability. Gemba is a Japanese concept for the real place where value is created. The idea is to take management to the point of care to find the ground truth; the information collected at the point of care is used to compare reality to perception.[2] Consider involving frontline staff in the Gemba Walk process because they are the experts in sorting reality from perception — determining what the policy is versus what the actual practice is. Observations are made where the work is actually carried out and the observers learn what the problems are and what the contributing factors are. The Gemba Walk also affords interaction with frontline workers to find the best solutions to identified problems. Gaps that are identified may require a detailed drill down into each aspect of the particular process to identify potential latent failures that can include throughput issues, cultural aspects of the team, staffing or environmental conditions.

The author has developed an Instrument Readiness Gemba Walk Chart that can be helpful in evaluating instrument reprocessing (see chart on page 6). Using the tool requires the observer to evaluate the presence or performance of the elements in the indicator. A "Yes" score would mean indicator is completely met. A score of "No" could mean elements of the indicator are missing or incomplete or data is not available to evaluate.

"No" scores require comments to provide information for quality improvement or further investigation through a root cause analysis process for that gap.

The Gemba Walk includes the following sections:

- General indications to be considered in all areas where instruments are processed or used; this relates to immediate use steam sterilization (IUSS) and cleaning of instruments outside the central processing areas
- Intraoperative indications relate to where instrument processing begins in the operating or procedure room at the patient interface and progresses through observation of case set up, care of instruments throughout the procedure, use of IUSS if available, immediate post procedure care and transport
- High-level disinfection if used on instruments in the procedural area
- Decontamination area evaluates the implementation of authoritative guidelines, presence of and access to instructions for use, availability and functioning of decontamination equipment and staff performance
- Inspection, sterilization and storage reviews the methods selected, identification of load number and documentation of contents for potential recall

Involving frontline staff in the Gemba Walk process can facilitate team building and strengthen the culture of safety. For example, the instrument processing technicians (staff members who assemble, label, place indicators and filters and wrap the instrument trays) could take the intraoperative section of the tool and make observations during a surgical procedure. These staff members may also check the documentation and perform the biologic testing on the IUSS machines. Because they receive the instrument sets in the decontamination area too, they can provide input on how to address improper care of the instruments post procedure and transport.

This approach establishes a forum for problem solving with an emphasis on quality improvement and team building. Often working at different levels and places in the organization, clinicians and technicians involved in the Gemba Walk will have an opportunity to meet fellow team members in person. By working together, they can come to appreciate the important role each person plays in ensuring patient safety.

INSTRUMENT READINESS GEMBA WALK CHART

INDICATOR	YES	NO	COMMENT "NO" requires a comment
General indications within or outside of the sterile processing department			
Are personnel performing the sterilization/disinfection properly trained at commencement of employment and annually evaluated for competency?			
Are personnel supervised to ensure consistent adherence to the facility procedures?			
Is appropriate equipment available, functioning and staff trained to use it correctly?			
Is proper monitoring of equipment being conducted and documented correctly with documentation of specific contents of each load?			
Is maintenance on equipment being completed on a time schedule and documentation retained?			
Intraoperative indications			
Case set up: are the RN circulator and scrub person checking container locks, external and internal indicators/integrators, filters and wraps for holes before sterile contents are moved to the sterile field?			
Scrub person wiping instruments, rinsing channels throughout procedure with water not saline?			
Immediately post procedure instruments are placed in fluid-resistant closed containers and enzyme is applied before transport?			
Immediate use steam sterilization (IUSS) being used only for emergency situations and documented completely and correctly?			
Appropriate testing of IUSS sterilizer function being done timely and documented appropriately?			
Disinfection			
Selection of disinfectants done with collaboration from infection prevention practitioner?			
Selection of disinfectant and timeframe comply with manufacturer's instructions for use (IFU)?			
Concentration of disinfectant validated with each use?			
Testing strips within date range?			
Rinsing was performed per manufacturer's IFU?			
Automatic washer/disinfector: cycle parameters were checked for accuracy before removing item for use?			
Decontamination area			
Are authoritative guidelines for decontamination being followed - U.S. agencies: CDC, FDA; professional associations: IAHCSMM, APIC, AORN, SGNA); manufacturer's reprocessing recommendation/IFU?			
Are manufacturer's IFU for cleaning of instruments and equipment available and accessible?			
Is equipment available and properly functioning?			
Proper sorting, disassembly, preparation for and loading of automatic washers in process?			
Staff wearing proper personal protective equipment?			
Instrument inspection, assembly and packaging			
Proper equipment and supplies available to perform inspections (lighting, magnifying glass) for cleanliness and correct packaging for the sterilization method?			
Instruments being inspected for cleanliness, pitting, staining and function?			
Instruments with multiple parts are disassembled and all parts accounted for?			
Lumens checked for debris?			
Rapid cleaning monitoring tests being used?			
Inventory lists checked to insure complete trays and correct instruments?			
Correct packaging for item(s) and sterilization method selected?			
Internal and external indicators/integrators in place, correct identification of contents and person assembling contents labeled?			
Sterilization and storage			
Correct method selected, load number identified, contents documented for potential recall?			
Sterilizer loaded properly per IFU?			
Correct cycle chosen? Time, temperature, pressure parameters checked at cycle end?			
Adequate environment and time for drying of load before storage?			
Storage areas meet regulatory requirements, sterile product is handled minimally?			
Transport from storage area to procedure areas is carried out in contained manner (closed/covered case carts)?			

Resources available on instrument processing

- High Level Disinfectant (HLD) and Sterilization Booster Pak. The Joint Commission. www.jointcommission.org.
- Immediate need for healthcare facilities to review procedures for cleaning, disinfecting, and sterilizing reusable medical devices. January 6, 2016. CDC. http://stacks.cdc.gov/view/cdc/34153.
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"Did you know?" Sedgwick knowledge series

Healthcare Risk Management

We spoke with Darrell Brown, Chief Claims Officer, for an expert view of what is on the horizon for Sedgwick's claims management solutions and the workers' compensation landscape in 2016.

Darrell: As the industry leader in claims management, Sedgwick is always looking for opportunities to improve the process and the experience for our clients' employees and customers. To this end, we will be rolling out a complex claims team that will assist our claims colleagues by providing oversight and technical assistance with catastrophic and complex claims issues. It is our goal that this team will not only help with the cases they are assigned to, but will also work to elevate our claims process across the organization by establishing new best practices for managing and preventing complex claims. Some workers' compensation and liability claims are catastrophic from the start, but there are others that morph into catastrophic claims. Resolving these claims may sometimes require additional resources. Our claims and case management teams will work on coordinated solutions and strategies to help them reach the best outcomes. These cases encompass a small percentage of the claims, but they are responsible for a greater percentage of the dollars. Having a team that is helping our examiners get those claims resolved in a way that is favorable for our clients' employees and customers, as well as our carrier partners, benefits everyone involved.

In addition, as chief claims officer, I'm excited about what the partnership and collaboration between some of our key departments and our Performance 360 quality initiative can yield in terms of results for our customers and their employees. What we've seen is that when we work together to solve issues, we're very successful.

RiskResource: How has technology improved the claims process?

Darrell: We have made incredible strides in terms of getting employees access to their claims information. With our self-service application, viaOne® express, they can access real-time information using their personal computer, smartphone or other mobile device. We are also sharing payment status and other key claim updates through our push technology option. As we continue to expand these options, I think they will continue to be very well received.

RiskResource: Looking at the regulatory environment, recent law changes and the changing political landscape, do you think topics important to the claims management industry will be a part of ongoing debates?

Darrell: From an industry perspective, it is a very interesting time for workers' compensation because so much has changed in terms of demographics and preferences. We have to understand the different cultural groups, increased diversity and how societal changes and topics such as recreational and medical marijuana impact what we do in claims administration. We will continue to think about how workers' compensation is impacted with respect to these changes and other regulatory and law changes. There could be continued national attention on workers' compensation between now and the election this year. The related conversations will impact not just claims and workers' compensation, but the broader range of issues for employers. With the changes in the political landscape, our industry and our business need to change with it. We will continue to look at new laws and changes that could impact our clients and the work we do at Sedgwick, so that we will be prepared to respond.

Darrell Brown is Chief Claims Officer for Sedgwick. Darrell is responsible for Sedgwick's Total Quality Initiative, Performance 360 and innovation. He is based in our Long Beach, California office and has over 20 years of experience in claims management.

Upcoming events

Visit the Sedgwick professional liability team at these upcoming conferences:

- **Long-Term Care Legal Risk Forum**
  March 9-11 | Las Vegas, NV
  visit the Sedgwick booth
- **Society for Healthcare Risk Management of New Jersey webinar**
  March 18 | 12:00 pm
  Managing the Risks of Midlevel Providers – speakers: Kathleen Shostek & Coleen Flynn (CNA). Register: http://shcrmnj.org/meetinginfo.php?id=11&ts=1455642947
- **Crittenden Medical Insurance Conference**
  April 3-5 | Miami, FL
  Session #501 - Healthcare Access at Your Big Box Store: The Arrival of Retail Healthcare – speakers: Kathleen Shostek & Jayme Vaccaro
- **Professional Medical Underwriter Association Medical Professional Liability Symposium**
  April 20-21 | Chicago, IL
  MedPL: Claims Trends to Watch in 2016 – speaker: Jackie Lakins
- **Becker's Hospital Review 7th Annual Meeting**
  April 27-30 | Chicago, IL
  visit the Sedgwick booth
- **Marsh Western Region Healthcare Summit**
  May 23-24 | Anaheim, CA
  Changing Face of Healthcare – speaker: Jayme Vaccaro
- **"Heart of Safety" National Patient Safety Foundation Congress**
  May 23-25 | Scottsdale, AZ
  visit the Sedgwick booth
- **RL Palooza**
  June 7-10 | Toronto, ON
  Social Media's Impact on Healthcare - The Good and The Bad – speaker: Jackie Lakins
- **Claims and Litigation Management Alliance Medical Legal Conference Midwest Chapter**
  June 23 | Omaha, NE
  Healthcare Mega Breach-Information Security – speaker: Jayme Vaccaro

About Sedgwick

Sedgwick is the leading global provider of technology-enabled claims and productivity management solutions. Our healthcare risk management consultants bring years of risk management and patient safety experience to help clients identify risk and patient safety strategies for success. Our team of national experts addresses both traditional and emerging risks affecting healthcare organizations.

Are you concerned about a lack of teamwork in your perioperative area affecting patient care, possibly leading to retained foreign objects or wrong-site surgery? Our demonstrated success in reducing perioperative risk through assessments, team training, coaching, and ongoing education may be the solution for you. Please contact us today for a customized approach to your perioperative risk management and patient safety challenges.

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