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THIRD EDITION, 2014

A HEALTHCARE PROFESSIONAL LIABILITY RISK MANAGEMENT NEWSLETTER

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Managing physician risk in an already busy day

BY ANN D. GAFFEY, RN, MSN, CPHRM, DFASHRM

The rate at which hospitals and health systems are acquiring physician practices and hiring physicians from private practice continues to increase steadily. In the 2012 annual report published by Merritt Hawkins, it is reported that solo practices are disappearing, with projections that by the end of 2014, three in four doctors will work for hospitals.[1] Describing the demographics further, Medscape reports more than twice as many physicians under 40 are employed versus self-employed, and more female physicians are employed than male physicians. However, in the age group over 40, more physicians are self-employed.[2] This data may not be surprising, but it does lead risk managers to ask how they will manage this additional risk exposure. Along with an already long list of things to accomplish in a day, unfamiliarity with the risk issues related to physician practices can lead to uncertainty and frustration for even the most seasoned professional. Because office practices have variable settings with limited resources, establishing a framework to approach physician risk prior to acquisition or employment helps set the stage for well-structured risk mitigation.

As hospitals consider acquiring practices, there should be many questions running through the minds of organizational leaders. The following is a short list:

- ✓ *Does bringing physicians on as employees into the hospital or system help meet the organization's strategic goals?*
- ✓ *Are other systems in the area snatching practices up such that your hospital may not be able to meet the community need for population management?*
- ✓ *Is the philosophy to employ physicians before somebody else does?*

Regardless of strategy, risk management should have a seat at the table early on and preferably before the physician is walking through the door for orientation.

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Once the decision is made to pursue a particular physician or group, the following list for "pre-diligence" information gathering should be contemplated as a baseline. A high-level scan can include vetting the physician's interest in and loyalty to your hospital and, for those already holding medical staff privileges, learning about their reputation among other physicians, staff, patients and community members, learning about the group dynamics and office staff turnover, seeking out satisfaction data in the public domain, conducting public internet searches for tax matters and bankruptcy filings, examining Board of Medicine data, and more. As the organization's interest piques and conversations begin with physicians about acquisition and employment, risk management should be poised and ready to get into assessment mode.

While there are many elements that should be covered during the due diligence process for practice acquisitions, spending time in providers' offices can offer insight into practices and culture unlike any other due diligence method – an opportunity to maximize early. Having this window to meet and talk to physicians, practice managers, clinical support staff, and others in their own space allows risk managers to assess the level of sophistication of office leadership and physician engagement in practice management. It's not just these important conversations that are helpful with information gathering, but also the opportunity to tour the space, see the condition of equipment and exam rooms firsthand, observe handling of confidential information, assess patient flow, and ask more pointed questions.

Once armed with data gleaned from an onsite visit, risk managers can offer risk treatment solutions to address the identified gaps that, when filled, will improve patient safety and reduce risk. One example in the office setting is establishing a clear process to track and report the results of lab and other diagnostic tests. Sedgwick healthcare risk management has established a data profiling system that assigns a risk score to physician offices based on their compliance with best practices. From this profile score, risk management goals can be established that can be objectively measured for increased compliance over time. For those with a self-insurance vehicle for liability coverage, these compliance measures can be used to establish premium credits or surcharges during each liability policy year.

In addition to introducing risk management services and event and claim reporting expectations during the visit, risk managers can assist physicians and practice managers in complying with best practices by providing sample policies and procedures and toolkits, periodic telephone support calls, and by organizing self-audits to monitor compliance with new initiatives. Establishing collaborative relationships with physicians and office staff opens opportunities to integrate relevant practices that are already well-embedded on the hospital side of the business into the office setting. These include practices for release of medical record information, patient identification, and specimen management. Education of office staff in basic risk management principles helps extend the risk manager's reach and empowers staff to engage in proactive activities addressing patient safety in each setting.

It's important for risk managers to take a holistic view of what to bring to the table to ensure each physician and their office staff members have what they need to function efficiently, safely, and in a manner that will ensure the best outcomes for patients in the most cost-effective way. Being accessible as an information resource, planning regular visits to the offices, and resourcing risk reduction opportunities identified during the assessment process are practical ways to manage the new risks of employed physicians and acquired practices. A collaborative approach based on sound data metrics and a little mentoring can lead to a win-win partnership.

Ann Gaffey is SVP, Healthcare Risk Management and Patient Safety for Sedgwick.

References

1. 2012 Review of Physician Recruiting Incentives: An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians. Found at: http://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Pdf/mha2012survpreview.pdf
2. Kane, Leslie. (March 11, 2014) Employed versus Self-Employed: Who is better off? Found at: http://www.medscape.com/features/slideshow/public/employed-doctors

Consider the following enterprise approach; when setting up a risk assessment visit, evaluate the following areas:

Operational risk
- Scheduling
- Telephone procedures
- Health information management/documentation
- Electronic health records
- Emergency preparedness for non-medical events
- General safety and environment
- Equipment safety
- Risk management/quality improvement

Clinical risk
- Office procedures
- Medication safety
- Communication and teamwork
- Informed consent
- Infection prevention
- Clinical emergency management
- Patient care

Financial risk
- HIPAA confidentiality
- Legal and regulatory compliance - Americans with Disabilities Act (ADA)
- Legal and regulatory compliance - billing and compliance
- Legal and regulatory compliance - OSHA regulations
- Legal and regulatory compliance - CLIA
- Managed care liability

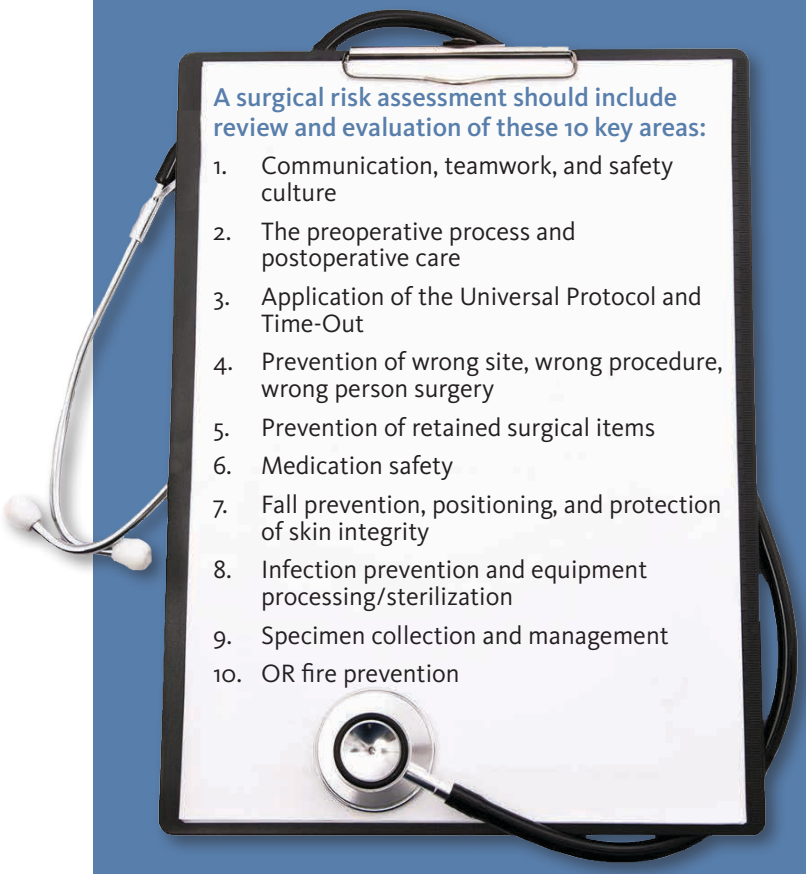
Human capital risk
- Credentialing/competency
- Violence prevention and control
- Hiring practices
- Time pressures
- Environmental considerations
- Distractions
- Workload

Strategic risk
- Long-term planning
- Marketing; expansion and acquisitions
- ACO participation
- Patient-Centered Medical Home participation
- Use of technology

Surgical risk assessment: The foundation for risk reduction in the OR

By Kathleen Shostek, RN, ARM, BBA, FASHRM, CPHRM

The operating room (OR) is among the highest risk areas for patient safety for both inpatients and outpatients. Surgery is where expert teams are most effective when they communicate and perform in cultures and environments conducive to patient-centeredness and teamwork. A surgical risk assessment can serve as the basis for risk reduction in the OR by identifying opportunities for improvement and action-planning.



If a comprehensive assessment of all key areas is not feasible, then staggered, focused assessments of specific areas over time will also yield results, albeit over a longer time period.

An effective method for evaluating these key areas consists of the following:

- Conducting interviews with perioperative staff and providers
- Performing real-time OR observations (preferably using a patient tracer)
- Reviewing documents (policies, procedures, and records)

Collecting information using this three-pronged approach provides for a well-rounded view of the perceptions of the surgical staff and providers, the written policies guiding perioperative care, and the actual practices being carried out. Sedgwick consultants employ this method to assist with optimization of patient safety and risk management in operating rooms during surgical assessment engagements around the country.

Although it has been 10 years since The Joint Commission released the Universal Protocol for the Prevention of Wrong Site, Wrong Procedure, and Wrong Person Surgery,™ we find great variations in its application when conducting surgical risk assessments. Using this key area as an example, the following drives home the value in assessing how the protocol is being carried out as part of an overall patient safety program.

Safe surgery checklists

Many healthcare organizations have implemented variations of a surgical safety checklist to guide and document performance of key components of the Universal Protocol. Sedgwick consultants support and evaluate the implementation and use of safety checklists for the prevention and reduction of surgical events leading to patient harm and subsequent liability claims. These checklists generally include the following:

- ✓ A pre-procedure verification of the patient's identity and planned procedure
- ✓ Notation that the correct surgical site is marked
- ✓ Holding a "Time-Out" or pre-procedure pause just prior to incision
- ✓ Communication of any special concerns regarding care of the patient, i.e., allergies and other medical conditions

While the literature generally supports the benefits of using a surgical safety checklist for improved communication, fewer complications, and reduced mortality, sustainment of optimal checklist use and acceptance of the checklist as standard surgical patient safety work has proved to be a challenge in some organizations. We observe this to be the case when use of the safety checklist has become a perfunctory task of checking off the items on the list. Unfortunately in these instances, there is a lack of involvement in the actions the checklist calls for, including active participation by everyone on the surgery team in stopping what they are doing and paying attention. Often, when we encounter this situation, interviews with staff reveal that the culture is not supportive of teamwork across disciplines and there is a disconnect between the written policies and actual practice. It is this disconnect that negatively affects the risk profile of the surgery service because the risk of wrong site, wrong procedure, and wrong person surgery or other untoward events is likely higher than if the practices mirrored the established policies.

Prioritizing opportunities to improve the culture of safety and close the gap between policy and practice in surgical safety can be addressed in an action plan for improvement. In our experience, convening a committee or task force driven by surgical leaders to establish interventions and measures of effectiveness achieves the best outcomes. Implementing teamwork and communication tools such as TeamSTEPPS® is one strategy for engaging surgical providers and staff in improving patient safety in the OR. Sharing the evidence from improved patient outcomes with the effective implementation of surgical safety checklists can support true buy-in for their use by surgical providers. Conducting culture of safety surveys in the OR and monitoring survey results before and after interventions will help determine whether the interventions aimed at improving safety culture are successful. Sustainment of success is directly related to leadership commitment, engagement, and support.

Kathleen Shostek, RN, ARM, BBA, CPHRM, FASHRM, is Senior Healthcare Risk Management Consultant for Sedgwick.

Enterprise risk management: The challenge of preventing and defending against allegations of decubitus ulcers

By Peter Chidichimo, MS PT

Plaintiff's attorneys have found fertile ground in lawsuits that focus on allegations of failure to prevent and treat decubitus ulcers, also known as pressure ulcers or bedsores. Defending against these lawsuits is often made difficult by incomplete or insufficient documentation, compounded by the challenge of identifying patients at risk and implementing protective measures.

The risk of developing decubitus ulcers is not limited to patients nearing end of life. Any condition causing or leading to prolonged immobility can place a patient at risk. Common examples seen in many malpractice suits include paralysis, coma, cancer, stroke, renal disease, and others. Therefore, it is crucial to identify patients at risk and develop, as well as implement, a proactive plan of care. Research suggests that, for patients requiring wound care, quality of life is especially impacted by pain, change in body image, odors, or mobility.

Much of the success in prosecuting these lawsuits may be based on the public's general unease with nursing homes, which is further fueled by negative headlines of alleged abuse and neglect. While there may be cause for concern with any institutional care, there is a misperception regarding how problematic it can be to prevent skin breakdown in certain patients.

An added burden exists where there is a regulatory presumption (e.g. Department of Health code) indicating that a person who enters a nursing home without decubitus ulcers "should not develop them," unless they were unavoidable following appropriate preventive measures. In essence, the record must show that all reasonable measures were taken to prevent such ulcers and any breach in the record can be problematic to defend against. In addition, on the federal level, the Centers for Medicare and Medicaid Services regulations also place a burden on nursing homes to prevent decubitus ulcers.

First and foremost, skin – an area of roughly 20 square feet – is the largest organ in the body. Skin is ever-changing. It consists of numerous components including water, protein, lipids, and various minerals and chemicals. Our skin has a vital function – to protect us from infections and other invaders.[1] Healthy skin will regenerate approximately every 27 days. Proper care is essential to maintain the vitality of this protective organ.

Like any other major organ, however, skin is susceptible to failure, especially near the end of life. Through aging, illness, or prolonged immobility, we can lose the ability to regenerate skin as well as to maintain appropriate skin care. Plus, physiologic changes that occur as a result of advanced age, disease progression, or impending death can adversely affect the skin. The body may react by shunting blood away from the skin to vital organs, resulting in decreased skin perfusion and a reduction of the normal metabolic process. This results in decreased tolerance to external insults including pressure. These physiologic changes may be unavoidable and occur despite appropriate interventions. Minor insults, such as blisters and skin tears, can lead to major complications including pressure ulcers and infection. These chains of events can be difficult to reverse and are often difficult to predict.

Contrary to popular belief, not all pressure ulcers are avoidable. An expert panel was established in 2007 to formulate a consensus statement on "Skin Changes at Life's End" (SCALE). The panel consisted of 18 internationally recognized stakeholders including clinicians, caregivers, researchers, legal experts, and others. The inaugural forum was held April 2008. The panel discussed the concepts of skin failure and other end of life changes. As a result of the panel's discussion, certain recommendations were proposed.[2]

The responsibility for assessing, preventing, and monitoring decubitus ulcers is typically a responsibility of the nursing staff. The SCALE panel recommends that the plan of care be clearly documented and reflected throughout the entire medical record. Charting should record the patient's clinical condition including comorbidities, risk factors, significant changes, and interventions. Facility policies and guidelines for recordkeeping should be

Reprinted as published in the ASHRM Forum, Second Quarter 2014

followed closely and updated regularly. The impact of interventions should be assessed and revised as appropriate. The record should include the location, staging, and photos of any new ulcers, as well as relevant lab values, especially albumin levels. Documentation is critical in defending against allegations of causing or failing to prevent decubitus ulcers. Much of the success in prosecuting these lawsuits may be based on the public's general unease with nursing homes, which is further fueled by negative headlines of alleged abuse and neglect.

A plan of care should be implemented on a timely basis. Intervention may include turning and re-positioning the patient at regular intervals, avoidance of pressure points, use of a special mattress, use of adaptive devices, proper nutrition, and physical therapy. Caregivers need to be especially cognizant of the warning sign of unintended weight loss, which could be a sign of poor nutrition and can contribute to ulcers or delay healing of existing ulcers. Patients should be monitored regularly and encouraged to eat well, be properly positioned for eating and provided with supplements if necessary.[3] A comprehensive skin assessment should be performed regularly. Special attention should be given to bony prominences, such as the sacrum, coccyx, ischial tuberosities, trochanters, and heels. The skin or wound should be described in detail, especially at admission, discharge, or transfer. The plan of care needs to address pressure, friction, moisture, nutrition, and immobilization. For successful implementation, the plan of care must be matched with the facility's resources (equipment and personnel).

When a patient experiences SCALE, tolerance to external insults, such as pressure, decreases to such an extent that it may become logistically impossible to prevent skin breakdown and the possible invasion of the skin by microorganisms. Incontinence complicates care due to moisture, as does a compromised immune system often seen in patients with advanced stages of cancer or those receiving palliative care. Patients with dementia or mental illness might not understand the purpose of appropriate interventions. Professional liability claims specialists, who review lawsuits against hospitals and nursing homes, note that patient compliance also can be a factor. Patients may be uncooperative with the plan of care and even combative with the nursing staff. Some patients refuse to cooperate with frequent position changes, to participate in physical therapy, or to take prescribed supplements designed to aid with nutrition. Other compliance issues identified include refusal to take medications, consuming foods outside the prescribed diet (i.e. diabetic diet), and wearing inappropriate footwear.

If a patient does develop a decubitus ulcer, it is important to identify the stage of the ulcer as well as record its size and appearance at regular intervals. Appropriate referrals may be necessary for wound care, infectious disease consultation, or surgical intervention. Many facilities use a wound-care team that consists of specially trained nurses, physicians, and wound-care experts who are dedicated to treating decubitus ulcers.

It is important to communicate regularly with the patient and family regarding care goals, interventions, and responses of skin care.[4] Based on discussion, the terminal patient may choose comfort or maintenance as opposed to debridement, a colostomy for incontinence, or other aggressive measures. It may be appropriate in some cases for comfort to be the primary goal, even though it may conflict with best skin care practices. The patient and family should have an understanding that skin compromise may be an unavoidable part of the dying process.[2] This understanding has the potential to defuse the perception of distrust and neglect surrounding long-term facilities. Through educating patients and families that skin conditions are sometimes a normal part of the dying process, there is less potential for assigning blame, and a greater understanding the skin compromise may be unavoidable.[4] Collaboration and communication with the patient and family should be ongoing and even extend to others involved such as healthcare professionals, healthcare administrators, and payors. Preventive care measures should extend across all facility departments and specialties including outside healthcare providers.

In summary, the prevention of decubitus ulcers in the physically compromised patient is an ongoing challenge to the clinical staff assigned to such patients. The challenge is particularly difficult where physiologic changes make the development of such ulcers inevitable. Documentation in the clinical record is imperative, as is ongoing communication with the patient and family about skin changes related to the disease process and what the current goals of care should be – restorative or comfort-focused. Legally defending these cases can be problematic owing to occasional breaches in the continuity of the clinical record, timeliness of preventive measures or intervention, plus the added burden of state and federal regulatory violations.

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References

1. WebMD. Skin Problems and Treatments Health Center. Retrieved April 23, 2014 from http://www.webmd.com/skin-problems-and-treatments/picture-of-the-skin
2. Keefe, Sandy. (September 6, 2011), Skin Changes at End of Life. Advanced Healthcare Network for Nurses. Retrieved April 23, 2014 from http://nursing.advanceweb.com/Regional-Content/Articles/Skin-Changes-at-End-of-Life.aspx
3. Quality Insights Pennsylvania. Pressure Ulcer Reduction Resources. Retrieved April 23, 2014 from http://www.qipa.org/Materials/Patient-Safety/pressure-ulcer.aspx
4. Sibbald, R. Gary, Krasner, Diane L. & Lutz, James. SCALE: Skin Changes At Life's End. Retrieved April 23, 2014, from http://www.medscape.com/viewarticle/715497_1

Infection prevention in ambulatory care settings

By Kathleen Shostek, RN, ARM, BBA, FASHRM, CPHRM and Cynthia Hartsfield, BSN, RN, MA, CPHRM

As the U.S. healthcare delivery system shifts away from inpatient care toward ambulatory care settings, it becomes increasingly important to recognize and plan for patient safety. Vulnerable patient populations rely on frequent and intensive use of ambulatory care to maintain or improve their health. It is critical that all of this care be provided under conditions that minimize or eliminate risks of healthcare-associated infections (HAI).

Ambulatory care settings have traditionally lacked infrastructure and resources to support infection prevention and surveillance activities. Data describing risks for HAI are lacking for most ambulatory settings, although reports of outbreaks and other adverse events were associated with breakdowns in basic infection prevention procedures, such as improper hand washing, multi-use vials, and reuse of syringes.[1] Ambulatory care settings are not designed to implement all of the isolation practices that are recommended for hospitals. However, patients with symptoms of communicable diseases should receive appropriate triage and separation. Early detection and management of potentially infectious patients, such as prompt placement into a single-patient room, should be implemented to protect other patients and staff.

The Centers for Disease Control and Prevention (CDC) published recommendations in the "Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care" that serve as a resource for infection prevention.[2] The recommendations reflect existing evidence-based guidelines, based upon elements of Standard Precautions, and contain minimum infection prevention expectations for safe care in ambulatory care settings. CDC also recommends implementation of administrative measures to ensure that infection prevention is a priority. Leaders and those with administrative oversight must ensure that sufficient human and financial resources are allocated to develop and maintain infection prevention and occupational health programs. This includes assuring availability of sufficient and appropriate equipment and supplies necessary for the consistent observation of Standard Precautions, hand hygiene products, injection equipment, and personal protective equipment, such as gloves, gowns, face, and eye protection. Staff education and training on the principles and rationale for recommended practices are critical elements of Standard Precautions in order to facilitate appropriate decision-making and promote adherence.

Standard Precautions are the minimum infection prevention practices that apply to all patient care settings, including ambulatory care facilities. These practices are designed to protect staff and prevent spread of infections among patients. Standard Precautions include:

1. Hand hygiene
2. Use of personal protective equipment (PPE) such as gloves, gown, and masks
3. Safe injection practices
4. Safe handling/cleaning/disinfecting of environmental surfaces and medical equipment
5. Respiratory hygiene/cough etiquette

Each of these elements is described in detail in a CDC publication that may be downloaded and printed.[3]

Leadership support is essential to drive success in implementing patient safety and infection prevention in ambulatory care settings. Dedicating resources to infection prevention, providing education, modeling behaviors, training and monitoring of all staff regarding Standard Precautions, and monitoring/reporting of HAI as appropriate will support improved patient safety and care outcomes.

Kathleen Shostek is Senior Healthcare Risk Management Consultant for Sedgwick. Cynthia Hartsfield is a contributor and former Sedgwick HCRM consultant.

References:

1. Thompson ND, Perz JF, Moorman AC, Holmberg SD. Nonhospital Health Care-Associated Hepatitis B and C Virus Transmission: United States, 1998-2008. Annals of Internal Medicine. 2009;150:33-39
2. Centers for Disease Control and Prevention (CDC). http://www.cdc.gov/HAI/pdfs/guidelines/Outpatient-Care-Guide-withChecklist.pdf
3. Id., http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Upcoming events

Visit the Sedgwick professional liability and healthcare risk management team at these upcoming conferences:

- **Target Markets Annual Conference**
  October 20-22 | Scottsdale, AZ
  - *Visit Sedgwick in the exhibit hall*
- **American Society for Healthcare Risk Management (ASHRM)**
  October 26-29 | Anaheim, CA
  - *Visit Sedgwick in the exhibit hall, booth 425*
  - *Coworker to Codefendant: Can't we all get along? – Ann Gaffey and Jayme Vaccaro*
  - *Demonstrating Value: Applying Leadership skills for risk reduction and safety improvement – Kathleen Shostek (co-presenter)*
- **Society for Health Care Risk Management of New Jersey**
  November 14 | Princeton, NJ
  - *Telemedicine: Risks and Rewards – Kathleen Shostek*

Managing vendors in healthcare facilities

By Cynthia Hartsfield, BSN, RN, MA, CPHRM

Security and access control for hospitals and other healthcare facilities is a concern, not only for patient safety, but also in recognition of legal and regulatory requirements. Surgical teams welcome vendors into operating rooms (ORs) for assistance during procedures, relying on their knowledge and expertise to manage an ever-growing number of complex medical devices and equipment. Surgeons and OR staff are responsible for their own education and training on new devices and equipment – vendors are present only for the purpose of providing information and guidance. A hospital that allows direct or indirect vendor participation in a surgical procedure risks liability, even if the procedure is a success.

Many healthcare organizations have developed formal policies and procedures and implemented credentialing protocols for vendor access to surgeons in the OR. Vendor management software programs are available to assist in this process. These systems usually are available to healthcare facilities at no cost and may be funded by vendors or their employers in order to have vendor credentials stored in the software systems. Use of such systems relieves hospitals of the need for maintaining records on vendor representatives, such as health records, immunizations, and required safety training.

A recent online survey conducted by Health Facilities Management and Hospitals & Health Networks elicited over 800 responses across 50 states, and results indicated that 86% of respondents have a formal vendor credentialing program.[1] Components of vendor credentialing should include, at a minimum, national criminal background checks; confidentiality and HIPAA training; documentation of immunizations; competency verification in infection prevention, fire, electrical, and radiation safety; and evidence of liability insurance. According to the survey, about half of the vendor access policies and credentialing protocols were created and enforced at the corporate system level and a smaller percentage were created and enforced at the individual hospital level.

More than half of the hospitals surveyed identified patient safety, privacy, and ensuring a safer environment as primary motivations in instituting formal policies on vendor access. Others cited compliance with various legal, regulatory, and accreditation bodies as the main driver, specifically mentioning Joint Commission and Centers for Disease Control and Prevention. Joint Commission expectations regarding non-licensed, non-employee individuals in healthcare organizations, including healthcare industry representatives require:

- ✓ Ensuring that patient rights are respected, including communication, dignity, personal privacy, and privacy of health information
- ✓ Obtaining informed consent in accordance with organization policy
- ✓ Implementation of infection control precautions
- ✓ Implementation of the patient safety program[2]

Enforcement of vendor policies continues to be a hot topic. More than 200 organizations responding to the survey noted above described implementation and enforcement of vendor credentialing policies as a major challenge. Only 10% of respondents reported that vendors *always* comply with policy and 72% of respondents indicated that vendors usually comply with policies. These results point to the need to develop strategies to ensure that vendor policies are enforced.

Healthcare organizations should take the following steps to establish sound vendor monitoring, management, and enforcement activities in their facilities:

- ✓ Review policies and procedures regarding the presence of sales representatives in the OR with staff to ensure understanding
- ✓ Be aware of applicable regulatory, accreditation, and professional organizations' positions on vendors in the OR and incorporate their recommendations in policies and procedures
- ✓ Develop a process for handling noncompliance that delineates clear, specific consequences
- ✓ Require surgeons who ask for vendor assistance to seek prior approval in accordance with policy and procedure
- ✓ Assign responsibility for managing vendor activities and behaviors that violate policy and procedure to surgeons and OR staff
- ✓ Empower OR staff to provide just-in-time coaching and feedback to vendors who do not follow policy or procedure within the OR
- ✓ Ensure that the presence of vendors is documented in the intraoperative record and include patient consent in that process

Vendor access and performance in accordance with hospital policies should be closely monitored. Deviations from policy should be addressed as soon as possible and expectations for compliance reinforced. Vendors who continue to perform without regard to policy should be appropriately sanctioned and have access revoked with report to the vendor's manager in their company. Diligence and a consistent approach to vendor management will improve patient safety and enhance hospital security.

Cynthia Hartsfield, BSN, RN, MA, CPHRM, is a contributor and former healthcare risk management consultant for Sedgwick.

References

1. Managing points of access. Health Facilities Management and Hospitals & Health Networks, (online) October, 1, 2013. Accessed on March 15, 2014 at http://www.hfmmagazine.com/display/HFM-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HFM/Magazine/2013/Oct/1013HFM_FEA_Securitysurvey
2. Joint Commission http://www.jointcommission.org. Non-licensed, non-employee individuals [frequently asked question]. http://www.jointcommission.org/mobile/standardsinformation/jcfaqdetails.aspx?StandardsFAQId=423&StandardsFAQChapterId=19

Sedgwick contributes at 2014 TeamSTEPPS® National Conference

Healthcare Risk Management

Speaking at the TeamSTEPPS® National Conference in Minneapolis, MN on June 11, 2014, Ann Gaffey, SVP for Healthcare Risk Management and Patient Safety, addressed how sound risk management strategies combined with TeamSTEPPS implementation can have a positive impact on medical liability.

Gaffey noted, "Looking not only at your malpractice claims experience, but the causes and contributing factors to the events causing the losses, is important...use this data as you build your case for implementing and funding TeamSTEPPS initiatives." Hospitals are spending unnecessary dollars – money that could be used to support patient safety initiatives – in many ways. For example, penalties asserted by regulatory agencies – perhaps $50,000 for one citation, without including the "soft costs" of leaders' time to investigate, review records, and interview staff – are not always recognized by risk management and patient safety professionals as an opportunity to demonstrate how the use of TeamSTEPPS may have prevented that event from happening, and in turn demonstrating return on investment in TeamSTEPPS implementation.

Gaffey went on to discuss a broad safety initiative undertaken by one Sedgwick client that included risk assessments in perinatal units across the health system, TeamSTEPPS training for over 1,700 obstetrical physicians and nurses, and formal simulation activities. Driven by unfavorable obstetric claims experience, this forward-thinking healthcare system leveraged lessons learned from their claims experience with well-researched risk mitigation strategies to approach their captive insurer for financial support to move forward with the project. The approach for funding included establishing metrics and setting measurable goals specifically outlined in the funding request. Data capture activities will include documenting with each event reported whether TeamSTEPPS tools and strategies were used during the care of the patient. In addition, an analysis of the event will be conducted to determine if TeamSTEPPS tools and strategies may have made a difference in the outcome had they been used. The results of these analyses can be shared back with staff as "lessons learned" and may also guide ongoing re-education needs around specific TeamSTEPPS tools.

The presentation closed with Gaffey encouraging participants to consider all potential sources of information that can be collected and analyzed while preparing to launch a TeamSTEPPS initiative in a particular clinical area. Maximizing the use of available data to not only frame the initiative, but to seek funding sources and to establish metrics for effectiveness, can help demonstrate the return on investment to leadership while advancing patient safety across the organization.

About Sedgwick

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