Mac's Safety Space

Mac’s Safety Space: Workplace violence–plotting your own course

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By Steve MacArthur, Hospital Safety Consultant

I know we touched on this a month or so ago, but in the light of a little bit of data from our friends from Chicago, I wanted to run through this (at least) one more time. Based on the April issue of *Perspectives*, it would seem that a few folks were cited in 2022 for not having completed their initial annual workplace violence worksite analysis (not a ton of folks were cited—about two and a half dozen out of the approximately 1500 hospitals surveyed in 2022).

In general, I think we can categorically state that anything new in the standards mix, particularly when it comes to the physical environment, is going to be a “hard stop” during the survey process. To that end, I have a couple of thoughts and a potential resource.

As a global thought, I think the best “place” to present this information is as part of the security management annual evaluation (you could make the case that it would work within the confines of the safety management annual evaluation)—to me, it doesn’t make a great deal of sense for it to exist as a standalone process—integration is the name of the game, particularly when one is accounting for the good works accomplished during the year.

Being sure to include the workplace violence worksite assessment (let’s call it the WVWA) in the annual evaluation process will help keep the topic in mind, but also be a means of informing organizational leadership as to what’s going on and what support might be needed to ensure the appropriate management of the workplace violence risks. The “glory” (if you will) of all of this is that, as outlined in the performance element language, there is no prescribed methodology for conducting the WVWA, so you can adopt and adapt any resource to that end. Of course, you want it to make sense within the context of the assessment, but I think I have something that will be helpful to that end.

The good folks at the American Society for Health Care Risk Management (ASHRM) have developed a very useful workplace violence toolkit (https://www.ashrm.org/resources/workplace_violence) that serves very nicely as the basis for the ongoing evaluation of your organization. I would encourage you to download the materials (after sharing a little bit of information—nothing comes for free any more) and take advantage of the comprehensive evaluation. You can either represent it as the analysis on its own or distill the important elements into a summary—whatever works best for communicating with your intended audience(s).

And speaking of annual evaluations, if I may be permitted a brief rant, it seems that lately I’ve been running into annual evaluations that only include data from the time period being evaluated. Yes, I know that there are no specific requirements to do so, but I always feel “cheated” when the evaluation doesn’t include some historical data. If you consider this as how one demonstrates performance improvement, how can you show sustained improvement without some history? It’s probably just me, but I’ve always wanted the process to tell a story—compliance (unlike diamonds) really isn’t forever. There is typically an ebb and flow to all this stuff and I, as a reviewer, want to see that journey. End of rant…

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Mac’s Safety Space: Active safety culture

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In this past week’s edition of Healthcare Facilities Today, I noticed a news item relating to the release of the annual Press Ganey Safety Culture Trends Report (which you can find here: https://info.pressganey.com/e-books-research/safety-culture-trends-2023 and which you will be able to read after you have provided your work e-mail address—simple, no?).

While I know that this space tends to focus on safety as a function of the physical environment, it is clear that, in the absence of an embracing of a culture of safety throughout all levels of any organization, the folks who manage the physical environment would seem to be at something of a disadvantage.

I know that there is a fair prevalence of “safety huddles” throughout healthcare, but, anecdotally, I get the sense that the huddles aren’t quite as energizing/positive/focused as perhaps they might have been when they started. Certainly, the COVID-19 hangover has a lot to do with that, particularly as a reflection of energy levels, as well as the constant ebb and flow of the diaspora of healthcare professionals of all levels.

At any rate, while I encourage you to check out the data (the big picture is not particularly optimistic, but we tend to be a resilient lot—and somebody has to take care of all these people), there is some “light” at the department level (which may be somewhat of a function of “we’re all on this together”), but meaningful change always seems to take route in the front lines.

There is a sense of a decline in the perception of safety culture at the senior leadership level, including physicians— with Pride & Reputation being sore spots for those groups. But I like Press Ganey’s “3 Actions for Senior Leaders” to create and manage safety culture:

- Committing to safety as a core value and leverage daily leader behaviors to reinforce safety
- Leveraging ongoing pulse measurement of safety culture, and dive deeper into groups with lower safety perceptions to drive understanding
- Ensuring robust analysis of safety events and near misses with transparent communication about safety issues and actions implemented to prevent harm

These are no small actions by any means. But (as they say of the longest journeys) single steps can accumulate over time—and take you to all sorts of places!

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Mac’s Safety Space: Advocacy wins a round—microgrids and sustainable energy

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By Steve MacArthur, Hospital Safety Consultant

In what is hopefully another in an ever-more-frequently covered topic (that being, the removal of barriers to compliance by those charged with determining compliance), CMS released information (https://www.cms.gov/files/document/qso-23-11-lsc.pdf) regarding a categorical waiver that paves the way for the use of microgrids for supplying emergency power to Essential Electrical Systems (ESS).

At present, the 2012 edition of NFPA 99 Health Care Facilities Code, requires emergency power to be supplied by a generator or a battery system. The Categorical Waiver is based on allowances contained within the 2021 edition of NFPA 99 and the 2023 edition of NFPA 70 National Electric Code. Certainly, as I’ve traveled around to various facilities, folks are definitely trying to make the most efficient use of solar and other alternative energy sources, so this sets the stage for an expansion of the use of these alternative energy sources, which should help with whatever might come down the pipeline in terms of requirements relating to environmental sustainability.

As has been the case in the past, adoption of the categorical waiver will require the alternative (or is it alternate? Are they synonymous?) energy source supplying emergency power to be in accordance with the 2021 edition of NFPA 99 and the 2023 edition of NFPA 70, so there will be some homework in the form of analysis. Perhaps the good folks at the American Society of Health Care Engineering (ASHE) will endeavor to shed some light on the subject; clearly sustainability has been a considered focus for ASHE, as well as the American Hospital Association – lots of excellent materials to be found: https://www.ashe.org/sustainability and https://www.aha.org/sustainability.

Speaking of which, The Joint Commission is still working through their version of the requirements relating to sustainability: (https://www.jointcommission.org/standards/standards-field-reviews/proposed-requirements-related-to-environmental-sustainability-field-review), so you might want to bop on over and see what’s what with that. I would think that the categorical waiver is going to be helpful from a practical standpoint.

As we discussed the importance of advocacy a couple of weeks ago (https://www.accreditationqualitycenter.com/articles/macs-safety-space-importance-advocacy-modern-healthcare-facilities-management), I think (hope?!?) that is another example of a collegial way forward for the enforcement of compliance. We cannot do this alone and working together towards a sustainable approach to compliance (energy isn’t the only thing that can be sustainable) can only help increase the focus on what is meaningful and valuable to the patients for whom we care.

And while we’re on the topic of patients, I am currently reading an excellent book called “The People’s Hospital – Hope & Peril in American Medicine” (https://www.simonandschuster.com/books/The-Peoples-Hospital/Ricardo-Nuila/9781501198069) that covers the challenges of providing healthcare, particularly to those individuals with less certain access to health insurance, etc.

Having been in healthcare as long as I have, I can recall some of the historical shifts in how hospitals were operated, but was never really familiar with how it all came to be. Dr. Nuila is a great storyteller and I think you’ll find this a worthy addition to the summer reading list. I’m about half-way through the book (my wife read it first and gave it a thumb’s up) and I am fascinated by all the stories (front, back, sides).

It doesn’t always seem like healthcare can work, but I guess it’s just a question of looking in the right places for inspiration.

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Mac’s Safety Space: The most frequently cited standards…

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…become the most challenging requirements (we don’t have deficiencies, we have challenges and opportunities— they just call them deficiencies on survey reports, kind of like compliance clickbait).

So, we can finally close the book, so to speak, on survey year 2022 and, in so doing, ponder the forces that come into play to increase the degree(s) of difficulty when it comes to compliance. And, in case you hadn’t guessed, the forces that come into play in the (drum roll) physical environment.

In looking at the recently revealed Top 5 (https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/joint-commission-online/april-19-2023/#.ZEKpLXbMJdg), with the exception of issues relating to the safe and appropriate administration of medications (which, as it should happen, usually occurs in the environment – coincidence?), we’re pretty much looking at stuff that fits squarely into the physical environment portion of the process.

Admittedly, I’m stretching things a bit for the most frequently cited standard, which deals with intermediate and high-level disinfection of equipment, devices, and supplies, but in the absence of specific examples of what they’re citing, I can only rely on how I’ve seen things going sideways in this regard and there is much that crosses over into the monitoring of conditions and practices in the environment (expired product, expired or outdated test strips, issues with the pre-treatment of instruments as the await collection in soiled utility rooms, etc.)

The other things that are being cited: management of ligature risks—particularly as a function of how specifically the individual risks are identified in the official risk assessments (I’ll have something more to say about risk assessments in the not-too-distant future – I just don’t want to be too reiterative for those who have followed this space for a while); the general management of interior spaces (much as integrity of egress always use to figure in the most frequently cited standards, I think that as long as the focus of the entire survey team remains in the environment, there will always be “imperfections” to be seen and cited); and, the management of ventilation in critical areas.

Again, in the absence of specific examples, as a process with many, many, many moving parts (some mechanical, some human), ventilation is likely to continue to be a frequently identified opportunity (FIOs, if you will).

So, what does one do to be better prepared? Well, a couple of things spring to mind.

Ligature risk assessments: In general, annual reviews can suffice, but it might be useful to bring fresh eyes into the mix when you revisit assessments—folks who are new to your organization, folks external to your organization, even folks who are unfamiliar with the environment in which you are assessing risk. One of the truisms of this whole endeavor is that every surveyor (much like every person) has a different perspective based on what they’ve seen, learned, etc. And everyone assimilates those elements differently—you want to “mock” as many different outlooks as you can when it comes down to the assessment of risk. It’s almost a case of identifying everything as a risk and then addressing each in turn—a pain to be sure, but it is a methodology that will place you on the most solid footing.

Disinfection and sterilization: Presumably, your organization has been collecting data through rounding, tracer activities, etc., so you should be able to identify where your problem locales are likely to be. There very clearly has been an increase in all sorts of findings as the survey process moves more definitively into the ambulatory care environment—more opportunities than ever to stub one’s metaphorical toe. Our surveyor friends have a very clear understanding of that dynamic and are focusing their energies on where the findings are (go figure!)

Ventilation: As to the ventilation stuff, again, you should have a sense of where the trouble spots are likely to be— make a list of those spots and make sure that as soon as word goes out that Elvis is in the building for the survey, have someone check those potential problem areas. Even if something has been behaving itself recently, bad habits sometimes return at the worst possible moment, so at least you’ll have a shot at making the corrective action before it gets cited. It’s not a guarantee, but it certainly increases the likelihood for success!

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