



Steven Hirsch and Associates

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Steven Hirsch and Associates

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Ebola Preparedness—Lessons Learned

In early October, Ebola preparedness in acute care hospitals was put on fast-forward when it became known that a Liberian man with Ebola arrived at a Dallas hospital, and that subsequently two nurses involved in his care became infected with the virus. At this point, all facilities faced the daunting task of quickly and efficiently preparing healthcare workers to safely care for a person infected with Ebola.

At our 240-bed community hospital, a multidisciplinary team was formed which included almost every department in the hospital: Nursing, Administration, Respiratory Therapy, Education, Laboratory, Disaster Preparedness, Safety, Medical Staff, Information Services, Public Relations, Volunteer Services, Admitting, Outpatient Services, Materials Management, Security, Imaging, Marketing, Housekeeping, and Infection Prevention. The team communicated daily and updates were e-mailed to all staff three times a week. With teamwork and dedication, a remarkable amount was accomplished in four short weeks. As with any unique challenge, lessons were learned, which are shared in the following paragraphs.

Involve non-management staff in preparations. Not only does this involvement empower staff with a sense of control over the situation, it opens the pathway to unique ways of thinking and creative ideas.

Key players should be visible. In our experience, key players included Administration, the Disaster-Preparedness Director, and Infection Prevention. Work should be delegated among the team with a goal of allotting time for these key staff to make rounds throughout the hospital with updated information and to answer questions. We found that although Ebola preparation updates were e-mailed to all staff on a consistent basis, many staff felt they were not informed. We therefore discovered that a substantial portion of hospital staff do not routinely access their e-mail messages. Additionally, open forums were held, but were not well-attended. Staff found the forums difficult to attend during working hours. This point further emphasizes the importance of rounding with key information.

Circulate visuals. For a number of reasons, including changing CDC rec-

Ebola Preparedness—Lessons Learned Continued...

ommendations, personal protective equipment (PPE) training was delayed. This delay was a huge concern of the staff. In response, we scheduled a photo session of a popular nursing supervisor donned in full gear, including PAPR. The photograph was circulated and posted in all employee break rooms. This action played a large role in allaying staff concerns.

Education should not be a “top-down” monologue. Staff concerns about Ebola transmission should not be viewed as right or wrong; the immediate goal should not be to “bring them around” to the correct way of thinking. It is important to tailor educational efforts to where individuals are in their thinking, and to educate in a way that is relevant to them.

Read the manufacturer’s cleaning instructions. An expensive orthopedic surgical headpiece, which was being trialed for use as potential PPE, was ruined when an attempt was made to clean it with bleach solution.

Inaccurate information circulates. Despite the fact that California has seen no cases of Ebola, some of our staff were under the impression that three patients with Ebola had been seen in our Emergency Room. A simple communication such as, “The hospital has seen no Ebola cases to date,” would have helped squelch any rumors.

Unlike other hospital-associated infections, Ebola is a Category A biologic agent with a high fatality rate. Therefore, it is not surprising that the challenges in its wake include fear and anxiety on the part of healthcare workers. Dealing with these challenges is important in Ebola preparation planning.

References

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Written by Judith “Judy” Hagerty, RN, MS, CIC of Associates

Clinical Alarm Systems

History

In April 2013 The Joint Commission issued Sentinel Event Alert #50 which addressed medical device alarm safety in hospitals. This Alert focused attention of healthcare providers on the number of beeps, buzzers, tones, sirens, and alarms that may be encountered in the course of every work shift in the hospital clinical settings. This auditory assault to the caregivers’ ears needed to be assessed, evaluated and managed. The realization emerged that real danger to patients may occur due to alarm fatigue.

After the publication of Sentinel Event Alert #50, hospitals began the work of self-evaluation of alarms and also initiated work on improved alarm recognition.

In November 2013, the ECRI Institute released its “Top Ten Technology Hazards”, with alarm hazards topping the list. Excessive numbers of alarms may lead to staff fatigue and ultimately the potential for patient harm. Exposure to an excessive number alarms can lead to sensory overload. The alarm may just blend in with other noises that are inherent in a busy patient care area. Delays in response to alarms or an alarm being missed altogether are very real possibilities in such environments.

The Joint Commission issued a new National Patient Safety Goal (NPSG.06.01.01) in 2013. The first phase of this goal went into effect January 1, 2014. During 2014, hospital leaders were to establish clinical alarm system safety as a hospital priority.

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Clinical Alarm Systems Continued...

During that time, work was to be done to identify the most important alarm signals in the hospital. Input from the medical staff and the clinical departments was to be elicited and risk to patients if a particular alarm was not attended to was to be assessed. Hospitals were then to develop a process to determine whether a specific alarm was needed or if it just contributed to alarm noise and thus alarm fatigue. Hospitals then were to review their event notification reports and patient outcomes as well as conduct research of best practices in clinical alarm management as they developed their clinical alarm management plan.

Alarm fatigue became a more familiar concept as hospitals struggled to manage and prioritize their alarms and processes, especially as it was discovered that many alarm signals did not require clinical intervention to the patient.

Current Expectations: January 1, 2016

NPSG.06.01.01 EP 3 and EP 4 are to be addressed by January 1, 2016.

NPSG.06.01.01 EP 3 requires hospitals to have established policies and procedures for managing the clinical alarms that they have identified as having patient care impact or as contributing to alarm noise and fatigue. Policies and procedures are to be established and implemented that address the following: clinically appropriate settings for the alarm signal, when alarm signals may be disabled, when the alarm parameters may be changed and to identify who has the authority to set the alarm parameters, who has the authority to change the alarm parameters, who has the authority to set alarm parameters to “off”. Policies and procedures need to include the requirements for monitoring and response to alarm signals and also how to check individual alarm signals for accurate settings, proper operation and detectability of the alarm.

NPSG.06.01.01 EP 4 requires education to be provided to staff and licensed independent practitioners on the purpose and operation of alarm systems for which they are responsible. Obviously, the approved policies and procedures generated to meet this NPSG need to go through the hospital’s approval process and then be shared with staff.

Currently, hospitals seem to have a good assessment of clinical alarms in their facilities, and have prioritized clinical alarms by risk/importance to patient care. Staff awareness of alarm fatigue is prevalent and the importance of alarm response and management is well recognized.

We at SHA have seen firsthand that many hospitals have not waited until the January 1, 2016 deadline to implement the requirements needed to meet Joint Commission standards and, in fact, have visited many hospitals in which alarm management and related education have become well integrated into orientation and training, and in the provision of care. The hospital must have a mechanism to monitor its activities related to clinical alarm management. Data should be collected, aggregated and reported through the Performance Improvement process, and remedial action implemented if alarm management does not meet expectations as defined in hospital policy.

Resources to assist hospitals in the quest for continuing improvement in clinical alarm safety include the ECRI Institute, AAMI Foundation, The Joint Commission, and numerous publications and online sites, too numerous to mention here. Certainly, SHA is also available if additional assistance is needed.

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