Background screening services available from Strategic Management

PHTS strategic ally Strategic Management and MediRegs, part of Wolters Kluwer Law & Business, are delivering the next generation of self-managed sanction and exclusion checking tools. Sanction Screening Services (SSTM) is a robust and cost-effective web-based tool that allows health care organizations to screen sanctioned, excluded and high-risk individuals and entities against a variety of federal and state databases.

“Healthcare organizations that hire, contract with or accept referrals from excluded individuals or entities risk severe penalties for each item or service furnished by the excluded individual or entity that is listed on a claim submitted for Federal program reimbursement,” said MediRegs General Manager Steve Lefar. “With increased penalties, more stringent and frequent requirements to run checks, and enforcement initiatives underway to ensure compliance with sanction screening, it’s more important than ever to conduct regular screening of employees, contractors and vendors against the federal and state exclusion databases.”

To help organizations manage their sanction screening efforts, SSTM provides:

• Flexible architecture, including user-friendly handling mechanisms and real-time reports
• Downloadable and filterable screening results
• Verification and investigation mechanisms for potential hits
• Secure access and control to protect sensitive information
• Personalized services and client support
• Flat fee pricing with no individual or batch searching transaction charges

Federal and state databases covered under SSTM include:

• OIG List of Excluded Individuals and Entities (LEIE)
• GSA Excluded Parties List System (EPLS)
• Unique Provider Identification Number Database (UPIN)
• National Provider Identifier Database (NPI)
• Office of Foreign Assets Control (OFAC)
• Specially Designated Nationals List (SDN)
• State Databases (e.g. South Carolina, New York, Pennsylvania, Texas, etc.)

“We believe in passing the benefits to our customers of advances in technology that simplify and bring down the costs of sanction screening,” said Richard Kusserow, Continued on page 2
Strategic injuries are as common in operating rooms today as they were more than 10 years ago, when the Needlestick Safety and Prevention Act was signed into law. This could put healthcare facilities at risk for costly lawsuits, notes a feature in Newsletters – Same-Day Surgery.

The publication references an influential report in the Journal of the American College of Surgery which showed that between 1993-2006, sharps injuries rose by 6.7% in the OR while they declined by 31.6% elsewhere in the hospital.

“We do now have a critical mass to make some change,” says Ramon Berguer, MD, FACS, chief of surgery at Contra Costa Regional Medical Center in Martinez, CA, and one of the authors of the journal report. “We have the data. We have second-generation devices that are well-made and well-marketed. We have the endorsement of leading surgical associations.”

One association pushing for sharps safety in the OR is the Association of periOperative Registered Nurses (AORN). The journal report was “very sobering,” says Linda Groah, RN, MSN, CNOR, NEA-BC, FAAN, executive director and CEO of the group. She told Newsletters – Same-Day Surgery that the journal report prompted the association to question, “What can we do to enforce the practices that we know make a difference?”

The publication reports that AORN recently issued “A Call to Arms to Prevent Sharps Injuries in our ORs” through its AORN Journal. The association also plans to release a toolkit for reducing OR sharps injuries, which will be available on the web site (www.aorn.org/PracticeResources/ToolKits).

Two-thirds of sharps injuries in the OR are suffered by nurses and surgical technicians, according to data from the Exposure Prevention Information Network (EPINet). Observers say all the more reason for surgeons and anesthesiologists to make the necessary changes because their decisions affect others members of the OR team.

Details about S3™ can be found at www.sanctionscreening.com or by calling 703-535-1450. For more information on the services available through PHTS/Strategic Management, please contact Adam B. Allen, MBA, CIW, A+, MCP, INS, ARM, AIS, executive vice president & chief operating officer at PHTS, at aallen@phts.com.

Healthcare workers who wear hospital scrubs home or while running errands should be aware they may be picking up or transmitting harmful germs, say infection control authorities who want to limit use of hospital clothes outside the healthcare setting.

Nurses’ uniforms can contain Clostridium difficile, or C. diff, a common bacteria that can cause violent diarrhea, says Dr. Betsy McCaughey, founder of the Committee to Reduce Infection Deaths in New York City. McCaughey, former lieutenant governor of New York, told the Pittsburgh Tribune-Review that healthcare organizations should consider prohibiting scrubs outside the hospital.

“Nurses and nursing students wear their scrubs home, and they’re busy, so they pick up their children and make dinner,” McCaughey said. “They’re carrying bacteria into their home.” C. diff enters the body through the mouth. Caregivers can carry the spores on their uniforms and contaminate a surface.

“They go into a local deli, sit down on a booth and deposit the spores. Someone else touches that booth and picks up a sandwich and swallows C. diff,” McCaughey remarked to the newspaper.

Only a few hospitals expressly forbid employees from wearing scrubs outside the healthcare setting. One such organization is West Penn Allegheny Health System, which has a dress code that dictates employees who work in clinical areas report to work in street clothes and leave in street clothes.
Observers are warning that frequent, almost incessant, alarms at the bedside are endangering patient care. “We have 17 [types of] alarms that can go off at any time. They all have different pitches and different sounds. You hear alarms all the time. It becomes…background,” one nurse told the Boston Globe, which recently highlighted the problem.

Kathryn Pelczarski, director of the applied solutions group at the ECRI Institute, says “I think most hospitals would agree that alarm fatigue is a pervasive problem. To give you an example, in some of the critical care units that I have been in, I have actually seen that their physiologic monitors, their bedside alarms, may be as many as 150-400 physiologic alarms per patient per day.”

“And in these units, the nurse-to-patient ratio is typically one nurse for one or two patients. If you think of a nurse just dealing with two patients, that’s 300-800 alarms. But the problem gets worse when they hear the alarms for all the other patients in that unit – typically alarms for 10 or 12 patients,” she told Patient Safety Monitor Journal.

The ECRI Institute is a nonprofit organization that researches best practices for medical procedures, devices, drugs, and processes. ECRI listed “alarm hazards” as the No. 2 technology hazard for 2011 in its November 2010 issue of Health Devices.

Hospitals should give more thought when purchasing alarm technology and consider whether they need all the alarms money can buy. “Another important factor to consider is how clearly the alarm is displayed and whether a critical alarm’s sound is distinguishable over the noise of the other alarms in the facility,” adds Patient Safety Monitor Journal.

The publication notes that false alarms add to the problem of alarm fatigue. Tailoring alarms to the patient as much as possible is critical, as is ensuring proper skin preparation technique before placing electrodes on the patient. Frontline staff members should also strive to troubleshoot false alarms when they occur, not ignore them or find a way to work around them, it says.

“The only way to prevent alarm fatigue is through better alarm management,” says Pelczarski. “This is really a very complex issue. There are core strategies that can be effective, but they alone are not going to solve the problem.

Continued on page 4
Each hospital and each care area within the hospital really has a unique set of circumstances with unique processes in place, unique vulnerabilities, and variations of many common problems,” she told Patient Safety Monitor Journal.

**Some steps hospitals can take**

ECRI’s Pelczarski suggests the following:

- Make all alarms actionable so the nurses are only alerted to clinically significant alarms and system alarms that need a response. This can be addressed by analyzing whether the default alarm settings are appropriate for the patient population in question.
- Consider incorporating a brief delay in alarm notification (e.g., five to 10 seconds) so an alarm does not go off for a problem that quickly resolves. Of course it’s important to ensure the delay does not jeopardize necessary critical care. Pelczarski gives the example of one hospital that set a 9-second delay for ventilator alarms because alarms would sound every time a patient had a brief coughing spell. The delay ensured alarms wouldn’t sound for brief episodes of coughing.
- Implement appropriate preventive maintenance. Routinely replace electrodes before they dry out. It may be advisable to replace them every 24 hours, depending on what types of electrodes are used.
- Respond to alarms as soon as they go off. Fix the problem so staff does not continue to hear an unheeded alarm.

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**OSHA video shows how to use respirators**

The Occupational Safety and Health Administration has produced a training video ([www.dol.gov/dol/media/webcast/20110112-respirators/](http://www.dol.gov/dol/media/webcast/20110112-respirators/)) that explains the proper use of respirators to protect workers in healthcare settings.

CompNews Network reports the 33-minute video explains the major components of a respiratory protection program including fit-testing, medical evaluations, training, and maintenance. The video also discusses the difference between respirators and surgical masks, and features a segment on common respiratory hazards found in healthcare settings, including airborne infectious agents that cause diseases such as tuberculosis, pandemic influenza, severe acute respiratory syndrome (SARS), chicken pox, and measles.

Demonstrations also show how respirator use helps protect workers from exposure to airborne chemical hazards such as formaldehyde and glutaraldehyde, which are used commonly in hospital laboratories to preserve tissue samples for medical analysis. These toxic substances can cause eye and nasal irritation, headaches, asthma, and other symptoms. Additionally, formaldehyde is a carcinogen and has been linked to nasal and lung cancer, with possible links to brain cancer and leukemia.

“Employers can’t rely on respirators providing the expected protection if they don’t train their workers on how to use them properly,” said Assistant Secretary of Labor for Occupational Safety and Health Dr. David Michaels. “This video is an important training tool that teaches proper respirator use and discusses employers’ responsibilities under OSHA’s respiratory protection standard.”

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### DATEBOOK

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<td>Fourth Annual South Carolina Patient Safety Symposium (Sponsored by SCHA in partnership with PHTS and others)</td>
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<td>March 17</td>
<td>“High Performance in the Revised PPS” (audioconference 1:00-2:30 p.m. EST) (HCPro)**</td>
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<td>March 17</td>
<td>“Hospital Outpatient Wound Care 2011 Update” (audioconference 1:00-2:30 p.m. EST) (HCPro)**</td>
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<td>March 20-22</td>
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** To register or for more information, call 800.650.6787
* To register, please visit [www.phts.com](http://www.phts.com) or contact Camillia Austin, AIM, director of education & chief diversity officer at PHTS at caustin@phts.com
+ Please contact Mary Stargel at mstargel@scha.org with questions regarding registration
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