

Reducing Employee Injuries

Emergency Department
Beth Israel Deaconess Medical Center, Boston

Introduction/Problem

The ED has inherent risks associated with the work we do, however there is always an opportunity to review and improve the work we do.

One of the key goals of the medical center and our department is to ensure a safe and healthy environment to work in. Employee injuries related to needle sticks have average of 12.5 cases since 2012.

When an injury occurs there is stress and anxiety on the part of the staff member associated with the potential for transmission from a blood borne pathogen. The cost both emotionally and from the needed testing and treatment is can be avoided or reduced in some cases.

Any injury to staff is an issue and is an opportunity for improvement.

Aim/Goal

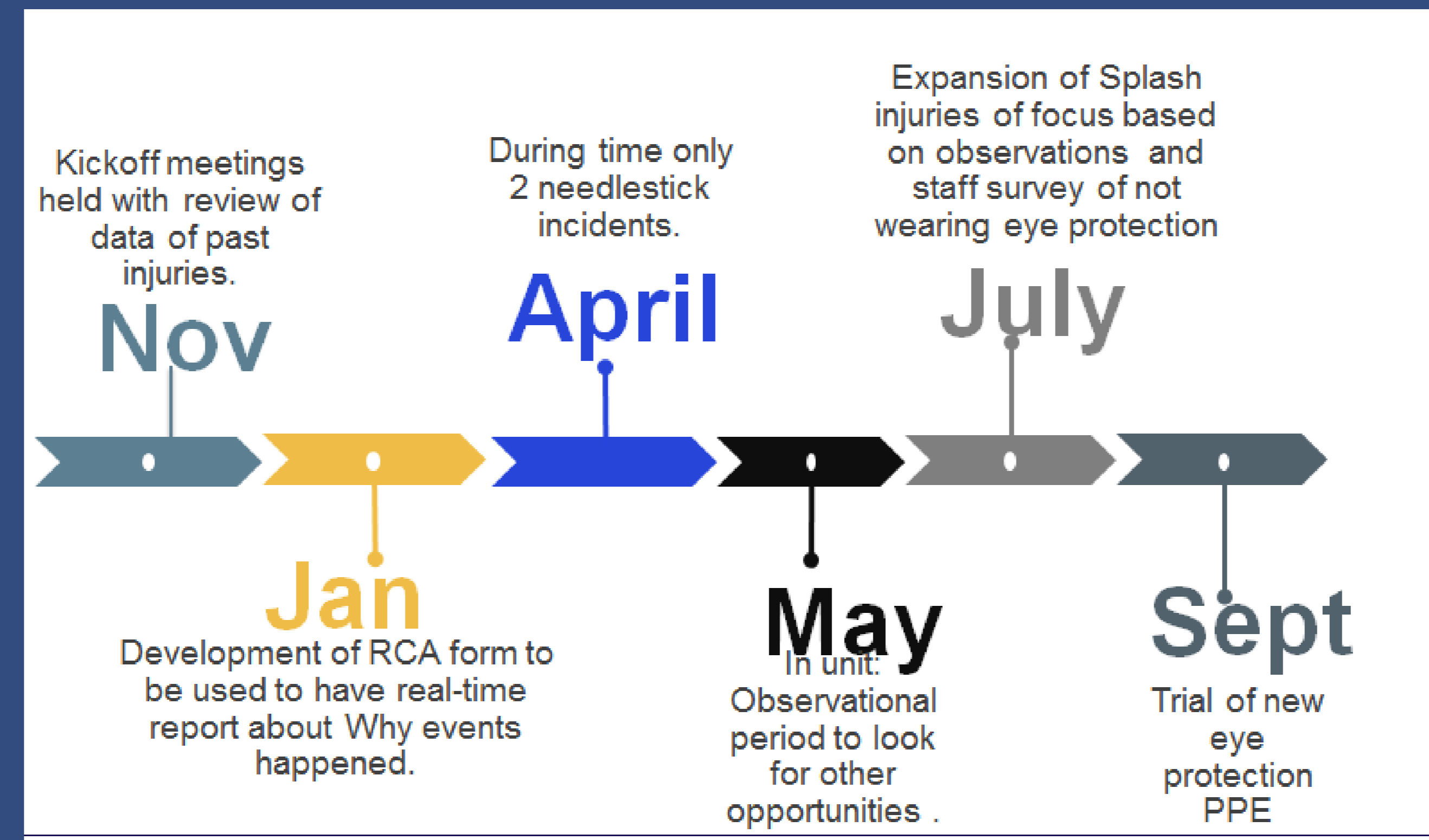
The Patient Education Subcommittee's main task was to create a patient education fact sheet that met regulatory requirements and was in line with the OCC's goal of best practices. The envisioned end product was a fact sheet with the following key features:

- Lower literacy level than other fact sheets we had reviewed
- Includes information on common and serious side effects
- Addresses alternative pain management methods
- Includes action items
- Achieves a tone of information-sharing vs. alarm: makes patients aware of risks without discouraging them from taking needed medicine
- Easily accessible to clinicians in disparate areas

The Team

- Kirsten Boyd
- Shelley Calder
- David Chiu
- Jane Dufresne
- Garry Dunster
- Jeff Lamson
- Dan Nadworny
- Christina Prew
- Carlo Rosen
- Scott Rollins
- Matt Rabesa

The Interventions



Results/Progress to Date

- RCA form created for review of events along with process for team response to review with staff involved.
- Unit observation period identified “blindspot” of splash risk due to lack of PPE
- New eye protection placed into ED
- Sharp injuries decreased from 12 (CY'16) to 8 (CY'17)

Date of Exposure	Time of Exposure	Time Shift Began	Which Room Were You In?
What Device Was Involved? Suture needle <input type="checkbox"/> Curved Suture Needle <input type="checkbox"/> Straight Suture Needle <input type="checkbox"/> Scalpel <input type="checkbox"/> Hypodermic Syringe <input type="checkbox"/> IV Catheter <input type="checkbox"/> Butterfly <input type="checkbox"/> IO Device <input type="checkbox"/> Spinal Needle			
When did injury occur? <input type="checkbox"/> Before <input type="checkbox"/> After <input type="checkbox"/> During...the sharp was used for its intended purpose. If the exposure occurred "during" or "after" the sharp was used, was it: Because the injured was bumped during the procedure <input type="checkbox"/> Because the item was placed in an inappropriate place (e.g. table/bed/trash) <input type="checkbox"/> During procedure reaching for or passing instrument <input type="checkbox"/> While disassembling <input type="checkbox"/> While the sharp was being placed in a container <input type="checkbox"/> While recapping <input type="checkbox"/> Other <input type="checkbox"/> Describe: _____			
Did the Device Have Engineered Sharps Injury Prevention Features? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Was the protective mechanism activated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know			

Why did this needle stick exposure occur at this time? 5-WHYs Model.

Additional Notes:

Lessons Learned

- Trying to make change with low occurrence events can be challenging
- Matching the team providing care with the team problem solving is helpful
- Outside eyes (Employee Health and EH&S) key to identify areas that may be blind to staff who work in the area each day

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