Volume 95 ■ Number 3 ■ Fall 2014

PROTECTOR

Setting clinical risk management standards since 1913.

2 A Little Bird Told Me ... *Protector* is Getting a Modern Makeover

4 Managing Medical Emergencies in the Practice Setting: A Three-Pronged Approach

12 From Verbal Insults to Death: The Reality of Workplace Violence in Healthcare

18 When Disaster Strikes, Strike Back: Effectively Preparing for and Managing Environmental Emergencies

28 Unexpected Record Damage: Protecting Your Records From Water Hazards

Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

Protector Continuing Education Program

Medical Protective is pleased to offer a free resource for Continuing Education (CE) hours for our insureds. *Protector* is published three times each year. In order to obtain 1 hour of free CE, you must read the most recent *Protector* and then complete the applicable online test. The online test focuses specifically on the material presented in the *Protector*. You can access the online test by logging on with your username and password at www.medpro.com or visiting http://www.medpro.com/protector-ce.

Allow sufficient time to complete the test in one sitting, as information that is not submitted cannot be saved. Upon submission of a test, you will immediately receive a pass/fail notification. If you pass with a minimum score of 80 percent, you will also receive a certificate that you should retain in your CE file. If you fail, you cannot retake that particular test. Each test will be available for approximately 4 months.

Osteopathic physicians, nonphysician doctors, and advanced practice healthcare professionals can submit certificates to their professional associations for review.

Medical Protective is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Medical Protective designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit.™ Physicians should claim only the credit commensurate with the extent of their participation in the activity. This activity was planned and produced in accordance with the Essentials and Standards of the ACCME.

The Medical Protective Company is designated as an Approved PACE Program Provider by the Academy of General Dentistry. The formal Continuing Dental Education programs of this program provider are accepted by AGD for Fellowship/Mastership and membership maintenance credit. Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement. The current term of approval extends from October 1, 2011 to September 30, 2015. The Medical Protective Company designates this Continuing Education activity as meeting the criteria for up to 1 hour of Continuing Education credit. Doctors should claim only those hours actually spent in the activity.

If you pass two tests within 1 year, you also may be eligible to earn a 1-year risk management premium credit, which will be applied automatically at your next policy renewal.*

This journal-based Continuing Education activity was developed by Medical Protective without commercial support. Continuing Education planners, content developers, editors, committee members, and Medical Protective Clinical Risk Management staff report that they have no relevant financial relationships with any commercial interests.

* LIMITATIONS: Every effort has been made to ensure that *Protector* content is applicable to the risk management learning needs of all healthcare professionals. Approval by ACCME or AGD does not imply acceptance by any other accrediting body. It is the healthcare professional's responsibility to ensure that courses are accepted by their respective licensing boards or accrediting bodies. Premium credit eligibility and amount are subject to business and regulatory approvals and may vary by policy type. Due to state filing restrictions, the premium credit associated with the *Protector* Online Continuing Education test is not available for physicians in Alaska; however, insureds in this state are still eligible for the free CE hours. Doctors who are less than 18 months into receiving a risk management premium credit are welcome to complete the *Protector* test for CE hours, but a further premium credit will not be earned. Doctors who are 18 months or more into receiving a risk management premium credit can take the *Protector* test to earn premium credit toward a future renewal. Completion of a risk management course does not imply or guarantee renewal.

The Medical Protective website is best viewed in Internet Explorer 8 and higher or Firefox 3.5 and higher. If you have questions, please contact the Clinical Risk Management Education team at (800) 463-3776.

Dear Healthcare Provider:

This year's editions of *Protector* have covered a broad range of emerging and persistent risk issues, such as telemedicine, robotic surgery, social media, diagnostic errors, clinical judgment, communication, and more. For the final *Protector* of 2014 — and the final journal-format *Protector* (see page 2 for more details) — we are turning our focus toward emergency preparedness.

Planning and preparation for emergencies, although critical, are sometimes overlooked or deferred in busy office practices because of more immediate concerns. Yet, history has proven that healthcare practices, like other organizations and businesses, are vulnerable to emergency situations, such as natural disasters, acts of violence, man-made catastrophes, and more.

Circumstances can change in an instant during a crisis, and the response that follows may have a significant impact on short- and long-term outcomes. Thus, doctors and their staffs should be knowledgeable of emergency protocols and ready to quickly implement response plans in an effort to ensure safety and prevent potential losses.

The articles in this issue of *Protector* are intended to provide physicians and dentists with useful information about how to plan, prepare, and respond to various emergency situations, such as medical emergencies, violence, environmental emergencies, and medical/dental records damage. By reading the articles in this edition, you should be able to:

- Identify important elements of a three-pronged approach to managing medical emergencies;
- Cite several strategies for preventing violence or managing violent behavior during and after an incident;
- List important considerations for assessing your practice's risk of environmental emergencies; and
- Describe the appropriate approach for managing water-damaged medical/dental records.

As a reminder, Medical Protective is accredited to provide continuing education (CME or CDE) hours for physicians and dentists. One of the ways to earn CME or CDE credits is by taking a test after reading this issue of *Protector*. Online access will make it easy for you to complete the test that accompanies this issue.

MedPro insureds who pass two tests in the same policy year might be eligible to earn premium credits. For more information, please review the inside cover of this issue. Or, visit our website at www.medpro.com.

Medical Protective wishes you happy holidays, and we thank you for your participation in *Protector* over the years. As we move forward with a more modern, dynamic, and diverse version of *Protector* in 2015, we hope you will join us on our journey. Follow us on Twitter beginning in January!

Sincerely,

Laura M. Cascella

Laura M. Cascella, MA
Clinical Risk Management Writer/Editor

A Little Bird Told Me...
Protector Is Getting a Modern Makeover!

For more than 100 years, Medical Protective has provided insureds with *Protector* — the nation's oldest and most comprehensive risk management resource. Although the need and demand for risk management information has not diminished, MedPro recognizes that changes have occurred in the ways in which healthcare providers communicate and prefer to receive information.

To meet our insureds' evolving needs, and to continue to provide exemplary products and services, MedPro's Clinical Risk Management Department is overhauling *Protector* to create a more flexible, engaging, and convenient way to communicate risk management content and news.

Beginning in 2015, *Protector* will shift from a continuing education-based journal that is published three times a year to a more frequent and dynamic information feed, delivered through Twitter and enhancements to our website (www.medpro.com). This new approach will encompass a large breadth of risk resources — such as articles, tools, announcements, links, and more — disseminated in an accessible, at-a-glance format that is designed with you, our valued customer, in mind.

Although the format and dissemination of *Protector* will change, rest assured that Medical Protective continues to place great value on risk education and information, as we have for more than a century. We hope you will enjoy the final journal-based issue of *Protector,* and we look forward to you joining us on Twitter in 2015! ■

Protector Q&A

Below are several Q&As related to *Protector's* transformation, which may help answer questions you have about this important change.

Why is the *Protector* publication changing?

Medical Protective is responding to our customers by offering new technology options that fit their needs. Feedback received from insureds indicates that *Protector* is of great use, but insureds have overwhelmingly requested online-accessible content that is delivered in more frequent, at-a-glance formats.

Are you going to stop offering risk management news and information?

Absolutely not! In fact, this new approach will allow us to provide a broader and more dynamic range of risk management content. The main difference is that *Protector* as a long-form, printed journal is going to be offered in the formats that our customers have been asking for — individual articles, topic-specific resources, and interactive risk management tools available on our website.

Will I still be able to get free continuing education credits and premium discounts?

Yes, but the format will be different in 2015. Medical Protective will release more details about how to take advantage of these new opportunities in the coming months. In the meantime, we encourage you to create a free account at our website, where you can view past *Protector* issues, take interactive risk assessments for your practice, access educational options, and more.

Visit http://www.medpro.com/web/guest/registration to create your account.

Managing Medical Emergencies in the Practice Setting: A Three-Pronged Approach

Laura M. Cascella, MA

Medical emergencies can occur anywhere, including medical and dental offices. In fact, these types of emergencies might not be as uncommon as many people think. For example, one study found that 62 percent of family medicine and childcare offices saw at least one child each week that required urgent care or hospital admittance.[1]

Further, the combined results from two dental studies showed that more than 30,000 emergencies occurred in dental offices over a 10-year period (in a survey of 4,309 dentists).[2]

Medical emergencies in healthcare are a reality, but unfortunately many medical and dental practices are unprepared to handle them. Theresa Essick, Medical Protective's Vice President of Clinical Risk Management, explains that "lack of time, financial constraints, and low prioritization can all play a role in thwarting preparedness efforts."

Lack of time, financial constraints, and low prioritization can all play a role in thwarting preparedness efforts.

This article will further explore the types of medical emergencies that can occur in healthcare offices and will discuss how medical and dental providers and their staff members can take provident measures to prevent, prepare for, or respond to emergency situations.

Overview

Medical emergencies are unexpected events that lead to bodily injuries or medical conditions/crises. The types of medical emergencies that can occur in public places, including healthcare practices, are vast. Some examples include:

- Loss of, or altered, consciousness;
- Respiratory distress;
- Myocardial infarction (MI);
- Sudden cardiac arrest;
- Hypoglycemia;
- Asthma attacks; and
- Allergic reactions.

In the healthcare setting, medical emergencies might be directly related to treatment or therapy, or they may occur by chance.[3] For example, a patient might experience a mild or severe allergic reaction as a result of a medication given during treatment. Or, a patient who is presenting for routine care may suffer a sudden cardiac arrest in the office waiting room.

Certain situations or factors may increase the risk of medical emergencies, such as patients who underestimate the urgency of their conditions and present to a medical office instead of an emergency department (ED). This scenario may partially account for the earlier statistic related to family medicine and childcare offices, as "parents of critically ill children are often unaware of the severity of their child's illness."[4]

Further, several dental resources note that emergency situations may develop as a result of procedures associated with a high-degree of patient anxiety, inadequate pain management, or failure to treat dental phobia.[5]

A three-pronged approach that addresses prevention, preparation, and action can help doctors and their staffs proactively manage office emergencies.

To manage these types of incidents, and other emergencies that may occur, physicians and dentists should be aware of how to potentially prevent these circumstances and how to appropriately respond if an emergency situation does occur. A three-pronged approach that addresses prevention, preparation, and action can help doctors and their staffs proactively manage office emergencies.

Prevention

Although some medical emergencies are inevitable, others can potentially be avoided through careful patient evaluation and assessment.[6] In a 2010 article, titled "Knowing Your Patient," Dr. Stanley Malamed explains that the prevention of medical emergencies is based heavily on gathering information and assessing the patient's level of care-related anxiety.[7] Several steps in the patient care process are critical in the prevention effort, including the medical questionnaire, the doctor–patient encounter, and the physical exam.

First, the medical questionnaire — completed by the patient or a parent/caregiver prior to seeing the doctor — provides an initial glimpse of the patient's current health status and medical history. The importance of this information "cannot be overemphasized,"[8] and it should be updated regularly and reviewed before each visit.

Second, during the doctor–patient encounter, the provider can review the questionnaire and ask for clarification or additional information about any conditions the patient has reported. For example, if the patient is diabetic, the doctor may inquire about management of blood sugar levels. If the patient has previously had an MI, the doctor may ask about any ongoing symptoms, such as shortness of breath. The additional information gleaned during the doctor–patient encounter may reveal potential red flags for a medical emergency.

Third, the physical exam gives the doctor an opportunity to evaluate the patient's physical condition and determine whether the patient has any visible signs of illness or distress. For example, a phobic patient might appear agitated or nervous, even if he or she has not verbalized any anxiety. Additionally, the physical exam allows the doctor to obtain baseline vital signs, a valuable tool for monitoring the patient before, during, and after treatment and recognizing signs of distress.[9]

The information gathered from these three elements of the patient care process — the medical questionnaire, the doctor–patient encounter, and the physical exam — can help the doctor proactively assess the patient's risk of a medical emergency. If the level of risk is concerning, the doctor may want to consider whether (a) a consultation with a colleague, specialist, or other provider would be beneficial; (b) the treatment plan should be modified, or (c) the patient should be treated in a hospital.

Managing Phobic Patients

Patient anxiety or fear related to medical or dental treatment can be problematic and concerning in various ways. These fears may manifest as noncompliance with treatment protocols or appointments schedules, behavioral issues, or medical emergencies.

Case Example

A patient who had an extreme phobia of dental care was diagnosed with generalized periodontitis and agreed to a treatment plan of root planing, chemotherapy, and aggressive maintenance.

The night before the patient's appointment, she took 10 mg of diazepam, which the periodontist prescribed. The morning of the patient's appointment, she ate breakfast and, on her way to the appointment, inhaled a moderate amount of cannabis to try to relax.

Because of the patient's anxiety, she was offered the option of having the procedure done using nitrous oxide analgesia. Unfortunately, the practice had no nitrous oxide protocol in place. Thus, few questions were asked about the patient's recent ingestion of food or other substances.

Prior to starting the procedure, the patient's nitrous oxide level was increased twice due to her anxiety. Shortly into the procedure, the patient vomited, aspirated some of her vomitus, and lost consciousness. Emergency medical services (EMS) was called; while awaiting their arrival, the doctor tried to establish an airway but was unsuccessful. Despite attempted resuscitation at the scene and the hospital, the patient died.

Risk Tips

When developing policies for managing anxious or phobic patients, doctors may want to consider establishing:

- Protocols for premedication;
- Policies related to appointment scheduling and treatment duration;
- Strategies for minimizing patients' waiting time;
- Requirements for monitoring patients' vital signs before, during, and after treatment; and/or
- Protocols for sedation and pain management.[10]

Preparation

Although prevention efforts are an important part of emergency preparedness, medical emergencies can and will occur, making preparation paramount.

A vital step in preparing for a medical emergency is developing a written emergency response plan. When creating or evaluating your office's plan for responding to unexpected medical events, consider the following:

- **The availability of skilled and experienced EMS.** Will EMS be able to respond quickly in the event of a medical emergency? Are they skilled with treating your practice's patient population? Is it likely that you or another healthcare provider will need to provide emergency workers with additional guidance on patient care once they are onsite?
- **Transportation time.** The amount of time it will take to transfer a patient to the ED is an important factor to consider when developing a plan and strategy for medical emergencies. A healthcare office that is close to a hospital ED may have a completely different plan than a rural office that is a considerable distance from the nearest hospital.[11]

The emergency response plan also should include comprehensive information related to staff roles and responsibilities during a medical emergency, communication protocols, policies for staff training, and use and maintenance of emergency supplies and equipment.

Staff Roles and Responsibilities

One of the first steps in designing an emergency response plan is to assign staff roles and responsibilities. "Offices should use all of their staff effectively and have a proactive team approach."[12] The approach should reinforce the important role that each staff member plays in emergency preparedness, and it should stress that appropriate preparation can potentially improve a patient's outcome.[13]

The size of the practice and the staff members' skills and training will help shape specific roles and responsibilities. However, regardless of whether the office has 3 employees or 20 employees, each individual should be well-versed in the office's emergency response plan, understand his or her duties, and know the appropriate steps to follow during a medical emergency. For example, who will:

- Notify the physician or dentist of the medical emergency and direct him or her to where the patient is located (if the doctor is not with the patient when the emergency occurs)?
- Take the lead in providing emergency care to the patient?
- Assist the team leader in bringing the emergency supplies and helping administer care?
- Call 911 (or another emergency service)?
- Meet the emergency responders when they arrive and direct them to the patient?
- Document the course of events?
- Direct the flow of patients while other staff members are responding to the emergency?

Specific responsibilities during a medical emergency should be delegated based on job positions, rather than individuals. This approach will help prevent gaps in responsibility if a staff member is out of the office. However, the individual who is covering the position needs to be notified of the duties that they will be expected to perform. If they do not have the appropriate training or skills, the responsibilities should be reassigned to an appropriate staff member.

Additionally, emergency response accountabilities should be included in written job descriptions for relevant positions. Each position's assignments should be reviewed at least annually to ensure that the office's emergency response plan is thorough and complete. Competencies for each staff position should also include skills that will likely be required for responding to emergency situations.

Communication

During a medical emergency, "anxiety, panic, and negative effects on other patients can be minimized if staff members know their roles and are able to execute them as planned."[14] Critical to the smooth execution of the practice's emergency response plan is the ability of providers and staff member to communicate effectively.

Although the nature of the event may precipitate a chaotic or panic-induced response, the team leader should remind staff to remain calm, speak clearly, and use eye contact when delivering messages. This will help prevent miscommunication or oversight of important information.

A 2010 *JADA* article about preparing office staff for medical emergencies encourages practices to use a "closed-loop" technique when communicating emergency information — meaning that, "when the leader sends a message, the team member acknowledges receiving the instruction, thereby confirming that he or she heard and understood the message."[15] In a closed-loop approach, instructions should be delivered sequentially, and the team leader should wait for confirmation that each action has occurred before giving additional directives.

Further, the practice should support a culture of safety in which staff members are encouraged to clarify information they do not understand or vocalize any concerns during the emergency response process. This strategy may help reduce stress and pressure on staff members and allow them to identify missed steps or gaps in the emergency response plan. As Dr. Malamed, author of the previously cited article, explains, the "team must concentrate on what is right for the patient, not who is right, during a medical emergency."[16]

Critical to the smooth execution of the practice's emergency response plan is the ability of providers and staff member to communicate effectively.

Staff Training

Training doctors and staff members to appropriately manage medical emergencies is paramount to developing an effective emergency response plan. Training ensures that team members have the critical skills that are necessary for handling an emergency situation.

Medical and dental organizations alike advise that all office staff should obtain certification in basic life support (BLS). Further, the American Dental Association (ADA) Council on Scientific Affairs and the American Academy of Family Physicians both encourage routine retraining of BLS skills "because these skills are maintained only through repetition."[17]

Depending on the nature of the practice and the patient population, medical and dental providers also may want to consider training in advanced cardiac life support (ACLS) and/or pediatric advanced life support (PALS). Any training or certification related to BLS, ACLS, or PALS should be documented in staff members' personnel files.

Another key component of staff training involves conducting routine emergency drills. These drills should verify knowledge of emergency techniques, protocols, and usage of emergency response equipment and supplies. Drills should also be used to evaluate the team's ability to effectively provide emergency care at a moment's notice.

Continuing education (CE) also offers opportunities to learn more about emergency medicine and response. CE courses may be available through medical and dental schools, local hospitals, medical and dental societies, and other organizations (such as the American Heart Association [AHA] and the American Red Cross).[18]

Emergency Supplies and Equipment

Medical and dental professional organizations and emergency preparedness literature generally recommend that office practices maintain at least basic emergency supplies and equipment.[19] Beyond that, the breadth and contents of each office's emergency kit will largely depend on:

- The type of practice;
- The patient population;
- The procedures/therapies performed;
- Anticipated emergencies or level of risk;
- Geographic location;
- Provider and staff training and skills; and
- State requirements.[20]

Additionally, specialty guidelines might provide information about the necessary supplies, medications, and equipment needed to manage specific types of medical emergencies or patient populations.

Automated External Defibrillators

Some professional organizations, such as the ADA and the AHA, recommend having AEDs available in healthcare offices — and some states laws mandate having them.[21] Check with your state medical/dental board or association to determine the requirements in the state(s) in which you practice.

Even in states that do not have AED laws, healthcare practices could potentially be sued for wrongful death under common law if a patient dies of sudden cardiac arrest in the office.[22] When thinking about whether to include an AED as part of your practice's emergency equipment, consider the likelihood of a sudden cardiac arrest occurring in your office, the location of your practice (e.g., distance to an ED), and availability of skilled EMS.

Perhaps the most important consideration when purchasing or assembling an emergency kit is ensuring that office providers and staff members have the knowledge and training to administer the emergency medications and use the emergency equipment. "For medical and legal reasons, no office should stock equipment that cannot be used safely by office staff."[23]

Emergency supplies and equipment should be stored in a designated location that is cool, dry, and accessible at all times. Further, emergency kits should be labeled and easy to transport. This will allow staff to quickly transfer equipment and supplies to the person requiring assistance.

An assigned staff member should routinely inventory all emergency medications, check expiration dates, and restock medications as appropriate. Utilizing a checklist or tracking log can facilitate thorough documentation of the results of these inspections.

Likewise, emergency equipment should be routinely inventoried and tested to verify that it is functioning properly. Medical Protective's *Equipment Management* guideline recommends testing critical equipment, such as lifesaving and emergency equipment, at least twice a year.

The practice also should maintain equipment logs to document all inspections, testing, preventive maintenance, and repairs for emergency equipment (as well as other types of equipment).

Action

Although preparing for medical emergencies requires time and resources, the results can prove significant. When an emergency occurs, healthcare providers and staff members must be ready to quickly implement their emergency response protocols.

Even if providers and staff are not experienced with, or highly knowledgeable of, the type of emergency taking place, the common goal is to "manage the patient's care until he or she recovers fully or until help arrives."[24] A 2002 article focusing on a stepwise approach for managing office emergencies recommends a dual strategy that involves a medical response and a communication response that occur simultaneously.[25]

In terms of medical response, a critical aspect of managing the patient's care is ensuring that he or she is receiving a sufficient supply of oxygenated blood to vital organs — a goal that is supported through the delivery of BLS. Various emergency preparedness resources also recommend following the PABCD approach, which involves:

1. P → Positioning the patient appropriately, depending on the situation
2. Assessing and managing (if necessary) the patient's:
   - A → Airway
   - B → Breathing
   - C → Circulation
3. D → Considering definitive treatment, differential diagnosis, drugs, or defibrillation — but only after the previous steps have taken place[26]

More specific algorithms and protocols related to managing certain types of emergencies — such as sudden cardiac arrest, anaphylaxis, bronchospasm, swallowed instruments or devices, chest pain, shock, seizures, etc. — can be obtained through specialty organizations, professional associations, and state and local healthcare resources.

While the medical response is occurring, various communication activities also should take place, including calling for emergency help, directing staff, obtaining information from family members or caregivers and providing them with updates (if applicable), calling the hospital ED to alert them of the situation, and documenting the sequence of events as it takes place.[27]

Although the number of activities involved in an emergency response and the rapid succession with which they must occur might seem indicative of chaos, proactive planning, training, and drilling will help prepare healthcare providers and staff to react quickly and efficiently on the patient's behalf.

Conclusion

Although medical emergencies are often unpredictable, healthcare practices can take proactive steps to ensure that patients receive efficient, appropriate, and coordinated care in an emergency situation.

(Continued on page 32)

Calling for Help

A prompt call for emergency medical services is one of the first steps in managing a medical crisis in the office. In addition to 911, other phone numbers — such as the local hospital's number — should be posted in a visible location to help facilitate the response process. If the caller has to dial a prefix to activate an outside line, that information also should be noted, and the list of emergency numbers should be checked periodically for accuracy.

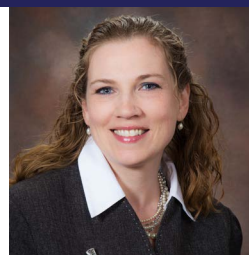
Further, when calling for emergency help, the caller should be ready to provide certain essential information, such as:

- The patient's age and gender;
- A preliminary diagnosis (e.g., a possible stroke);
- Symptoms and vital signs (e.g., whether the patient is conscious and his or her blood pressure reading);
- Details about any emergency treatment the patient is receiving (e.g., BLS, oxygen, and/or medication); and
- The practice's phone number and address, including important identifying information about the office location (such as names of crossroads, proximity to landmarks, specific locations within a building, etc.).[28]

It might also be helpful to assign a staff member to meet emergency responders as they arrive and direct them to the patient's location.

From Verbal Insults to Death:

The Reality of Workplace Violence in Healthcare



Christine M. Hoskin

Christine M. Hoskin, RN, MS, CPHRM

Workplace violence can range from verbal insults to death. The National Institute of Occupational Safety and Health (NIOSH) defines workplace violence as any physical assault, threatening behavior, or verbal abuse occurring in the work setting.[1]

Media headlines over the past several years show evidence that this issue is prevalent in healthcare settings. For example:

- September 2010 — Johns Hopkins Hospital: Gunman Shoots Doctor, Then Kills Self and Mother
- January 2012 — Man Arrested After Assaulting His Mother's Home Health Care Worker
- March 2012 — 2 Dead, 7 Hurt After Man Opens Fire at Pittsburgh Psychiatric Hospital
- December 2012 — Police Kill Gunman Who Wounded Three at Alabama Hospital
- July 2013 — Paramedic Shot in Ambulance While Transporting Patient
- December 2013 — Gunman Kills One, Injures Two in Reno Hospital Shooting
- February 2014 — Nurse in Critical Condition After Beating by Patient
- July 2014 — Psychiatric Patient Fatally Shoots Caseworker

Violence is a reality in healthcare. It can occur in any geographic location and any type of facility, and it can affect patients, doctors, allied health professionals, administrative staff, and families/caregivers. The bottom line is healthcare workers are vulnerable to violence.

Although the previous examples are extreme, and many incidents do not rise to the level of gunfire, they are considered violence nonetheless.

Further, according to the Centers for Disease Control and Prevention (CDC), underreporting of workplace violence is a problem.[2] For example, verbal assaults, threats, and assaults that do not cause permanent injuries (like spitting, slapping, pinching, kicking, etc.) might not be reported for various reasons, such as:

- Many healthcare workers accept violence as one of the risks of the job.
- Often times, patients or their families are under extreme levels of stress, creating an element of acceptance of bad behavior.
- Reporting structures are either not in place or are prohibitive because they are so complex and time consuming.
- Healthcare workers may fear the possibility of negative effects on their licenses, reputations, and/or employment.

The seriousness of this issue has prompted some states to pass laws that make the consequence of physical assault on a healthcare worker a felony. However, laws do not stop these situations from occurring and do not address all types of violence.

Therefore, medical and dental practices — regardless of size — must be prepared for hostile or aggressive situations.

This article discusses important elements of a violence prevention program and offers strategies for preventing or managing violence before, during, and after an incident.

Key Elements of a Violence Prevention Program

In 2004, the Occupational Safety & Health Administration (OSHA) issued its *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. OSHA's five major elements of an effective workplace violence prevention program include:

Medical and dental practices — regardless of size — must be prepared for hostile or aggressive situations.

- **Management commitment and employee involvement.** Teamwork is essential in a crisis situation. A well-trained team needs to be in place before an incident occurs so they are able to execute the plan effectively when needed.
- **Worksite analysis.** Worksite analysis consists of a methodical evaluation of the hazards within your environment. This can include hazards related to human factors as well as your physical building. Every facility has a unique set of hazards that should be addressed. Simply put, ask yourself "Where am I vulnerable?"
- **Hazard prevention and control.** After the worksite analysis is completed, a team should review the information and develop a response plan for the exposures. The plan might include fixing a broken lock, staffing changes, installation of video monitoring, policy development, education, implementation of drills, or even changing workflow. Again, each facility is different — what works for one might not be appropriate for another.
- **Safety and health training.** All staff should be properly trained on the security measures developed for your facility. Staff members need to be familiar with their roles and have an opportunity to practice. Table top drills have some value in educating your staff initially, but physically practicing with drill activity is where the most value lies. Your goal is to save lives, and you need everyone to be prepared. As Gandhi said, "An ounce of practice is worth more than tons of preaching."

- **Recordkeeping and program evaluation.** Recordkeeping is an essential element of any business. Accurate recordkeeping allows you to stay on top of the issues that are most relevant to your practice. Whether it is incident reports, training history, or drill records, you need to have an accurate pulse on your facility to properly plan for the safety of your patients and staff. Program evaluation should be incorporated into the plan to capture the things you can improve on and the things you are doing well.[3]

As the ECRI Institute explains, "It is impossible to eliminate workplace violence in healthcare settings; however, there are ways to reduce the potential for violent occurrences and minimize the impact of any violent situation that may arise."[4]

The next few sections will cover some strategies to consider when developing or evaluating violence prevention policies and plans.

Risk-Reduction Strategies: Before an Incident

The key to being able to handle a violent incident is being prepared. Preparation involves assessing your facility, developing a response plan, educating your staff, and practicing your response.

Assess Your Facility

Having a realistic view of the processes that are already in place in your practice is important when assessing your facility. Reviewing policies, historical data, and community data related to violence can help you understand challenges and limitations as you begin developing a response plan.

However, you should not stop there. A physical assessment of your building and the established workflow also are very important in identifying your risk exposures. More details about the value, focus, and components of a worksite analysis are available in OSHA's *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers* at https://www.osha.gov/Publications/OSHA3148/osha3148.html.

Including staff that work in particular areas is vital. They will be able to provide insight on risk exposures that might not be apparent while doing a walkthrough.

Develop a Response Plan

Research what other organizations similar to yours have done to respond to violent situations. Many good resources are available — but remember, you need to adapt them to meet your practice's needs.

For example, some facilities have "panic buttons" and have incorporated the use of those buttons into their response plans. Although this is a good resource to incorporate into a plan, you may not have the funds or technology for a panic button. In this situation, try to think outside the box on how to make a "panic button" concept work in your facility, and then modify your plans accordingly.

As you develop a response plan, include all levels of staff on your team. This will foster engagement as you implement the plan.

Educate Your Staff

You can have a very well-written plan, but if you do not educate your staff on the process, it is meaningless. In an emergency situation, your staff members need to be able to respond without having to look up policies or read the violence prevention plan. The aggressor will not wait as your staff learns how to respond. Preparing your staff in advance is your best defense.

Practice Your Response

Practicing your response goes hand-in-hand with educating your staff. Once your staff members have been taught the concepts, give them the opportunity to work through the scenarios using a hands-on approach.

As noted earlier, table top exercises are good for learning concepts, but drills are where the real learning begins. Often times, steps are skipped or not well thought out when talking out a plan using the table top technique. Hands-on drills are valuable in (a) determining whether the plan has gaps, (b) identifying logistical issues, and (c) testing equipment along the way.

If your staff has the opportunity to walk through the scenario, there is a greater chance they will identify shortcomings in the response and retain the skills for when they are needed most.

Risk-Reduction Strategies: During an Incident

Understanding that no single response will work in every situation is crucial. A 2012 article from the *Western Journal of Emergency Medicine* notes four main objectives when working with an agitated person. They include:

- Ensuring the safety of the patient, staff, and others in the area;
- Helping the patient manage his or her emotions and distress and maintain or regain control of his or her behavior;
- Avoiding the use of restraint when possible; and
- Avoiding coercive interventions that escalate agitation.[5]

De-escalation might be one appropriate technique that staff can be trained to use. The aforementioned article lists 10 domains of de-escalation, as follows:

1. Respect personal space while maintaining a safe position.
2. Do not be provocative.
3. Establish verbal contact.
4. Be concise; keep the message clear and simple.
5. Identify wants and feelings.
6. Listen closely to what the person is saying.
7. Agree or agree to disagree.
8. Lay down the law and set clear limits.
9. Offer choices and optimism.
10. Debrief the patient and staff.[6]

Details related to these domains can be found in the *Western Journal of Emergency Medicine* resource noted in the box on page 16.

Additionally, the Department of Homeland Security (DHS) is developing a tool for planning and responding to an active shooter in a healthcare setting. Within the tool, the main goal is to prevent, reduce, or limit access to potential victims and to mitigate the loss of life.

The response to this sort of violent situation should be twofold: (1) isolation of the aggressor in as limited an area as possible (such as locking the waiting room door to prevent access to the patient care area), and (2) evacuation as quickly as possible by all means of egress

available. Determining a location to regroup is not necessary in this situation; escape from the dangerous environment is the goal.

If possible, the police should be called before a potential situation turns violent. This should be done sooner rather than later to allow the police time to respond to the scene.

Risk-Reduction Strategies: After an Incident

After an incident, it is essential to bring the involved staff together to talk about what happened. This not only offers a cathartic element by allowing staff to talk freely about the situation, but it also is a valuable method for improving your incident response in the future.

After an incident, it is essential to bring the involved staff together to talk about what happened.

The Agency for Healthcare Research and Quality (AHRQ) has developed a debrief method that can be applied to any incident response situation.[7] The essential questions to ask during a debrief include:

- Was communication clear?
- Were roles and responsibilities understood?
- Was situational awareness maintained?
- Was the workload distribution equitable?
- Was task assistance requested or offered?
- Were errors made or avoided?
- Were resources available?
- What went well?
- What should improve?

Resources on Violence Emergencies

- Agency for Healthcare Research and Quality: http://teamstepps.ahrq.gov/
- Centers for Disease Control and Prevention: Workplace Violence Prevention for Nurses: http://www.cdc.gov/niosh/topics/violence/training_nurses.html
- ECRI Institute: Violence in Healthcare Facilities: https://www.ecri.org/Forms/Documents/Violence_in_Healthcare_Facilities.pdf
- Hospital Association of Southern California: Active Shooter Drill Materials — http://www.hasc.org/active-shooter-drill-resources
- Occupational Safety & Health Administration: Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers — https://www.osha.gov/Publications/OSHA3148/osha3148.html
- U.S. Department of Homeland Security: Active Shooter Preparedness — http://www.dhs.gov/active-shooter-preparedness
- *Western Journal of Emergency Medicine*: Verbal De-Escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup — http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298202/

The effects of violence can be earth shattering and linger for those involved. "Violent incidents can affect staffing as a result of lost work time from injuries, decreased job satisfaction leading to absenteeism and turnover, low employee morale, and fear of an unsafe workplace."[8] Providing for the physical safety and emotional support of staff members involved in a violent incident is an essential part of recovering from the incident and retaining these employees.

Conclusion

Medical and dental providers need to have a well-defined plan to address hostile/aggressive behavior. Preparation for these types of emergencies requires an investment of time to develop and implement a comprehensive program. The program does not need to be complex or expensive to implement, but it should be thorough and practiced regularly. This investment of time far outweighs the loss that can occur if staff members are not alert and prepared to respond appropriately. ■

Christine M. Hoskin is a senior risk management consultant at Medical Protective. She has been involved in risk and quality management throughout her career, providing oversight of clinical education, epidemiology, safety, accreditation, risk management, quality improvement, and nursing. She has experience in a range of care settings — including both inpatient and outpatient facilities, primary care, specialty care, dental care, and rehabilitation — and with various patient populations.

Endnotes

1 National Institute of Occupational Safety and Health. (1996, July). Violence in the workplace. *Current Intelligence Bulletin 57,* DHHS (NIOSH) Publication Number 96-100. Retrieved from http://www.cdc.gov/niosh/docs/96-100/introduction.html

2 National Institute of Occupational Safety and Health. (2013). Workplace violence prevention for nurses. CDC Course No. WB1865, NIOSH Pub. No. 2013-155. Retrieved from http://www.cdc.gov/niosh/topics/violence/training_nurses.html

3 OSHA, *Guidelines for preventing workplace violence.*

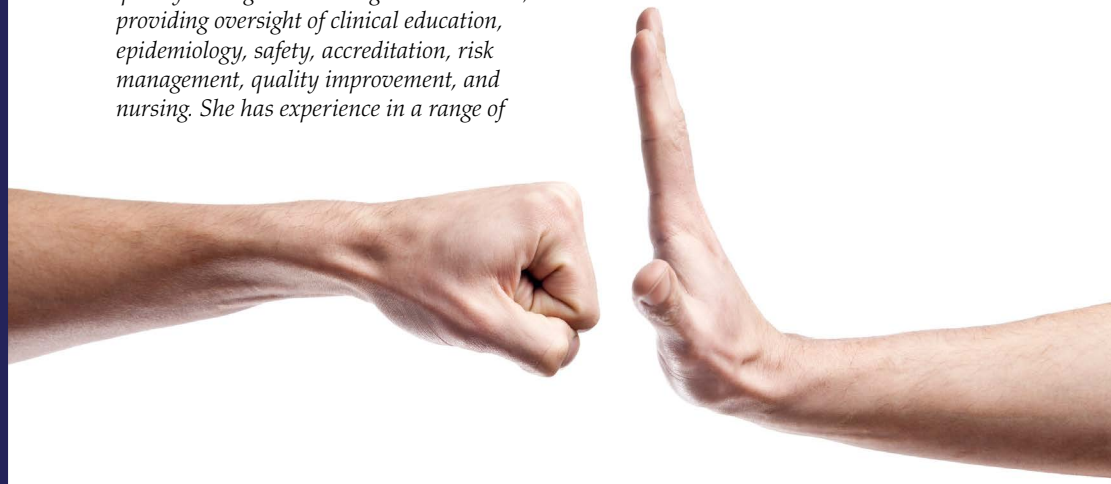
4 ECRI Institute. (2011, March). Violence in healthcare facilities. *Healthcare Risk Control, 2.*

5 Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Zeller, S. L., Wilson, M. P. . . . Ng, A. T. (2012, February). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine, 13*(1), 17–25.

6 Ibid.

7 Agency for Healthcare Research and Quality. (2014, January). *Pocket guide: TeamSTEPPS: Team Strategies & Tools to Enhance Performance and Patient Safety.* Retrieved from http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.html

8 ECRI Institute. (2013, July). Patient violence. *Healthcare Risk Control, 4.*



When Disaster Strikes, Strike Back:

Effectively Preparing for and Managing Environmental Emergencies

Laura M. Cascella, MA

Environmental emergencies can occur at any time and any place, and they can have widespread consequences for individuals, businesses, and communities. Natural disasters, severe weather, industrial accidents, chemical and oil spills, and unintentional radiation exposure are all examples of potential environmental emergencies.

Natural disasters and other environmental crises can occur with or without warning and may necessitate a rapid emergency response.

History has shown society's vulnerability to a myriad of disasters — but it also has shown how preparedness efforts can have a significant impact on disaster outcomes. Despite an element of unpredictability that is inherent in many natural and manmade environmental emergencies, planning and preparation are powerful and effective tools for managing these situations.

For physicians and dentists, planning and preparation for environmental crises are paramount to safeguarding patients, staff, and office infrastructure; minimizing adverse effects; preventing losses; and facilitating recovery efforts.

This article will (a) examine important aspects of the preparedness effort, such as performing a risk assessment, developing an emergency response plan, evaluating resources, and training staff; (b) provide a checklist to facilitate emergency planning and discussion; and (c) offer online resources that can provide further information and guidance.

Risk Assessment

History has shown that natural disasters and other environmental crises can occur with or without warning and may necessitate a rapid emergency response. In the United States alone, 62 major disasters were declared in 2013, and, at the time this article went to print, 38 major disasters had been declared in 2014.[1]

New MedPro Toolkit!

MedPro insureds can now take advantage of the Clinical Risk Management Department's new Emergency Preparedness Toolkit. Containing resources for both office- and hospital-based providers, the toolkit offers emergency preparedness information related to utilities, electronic health records, risk assessment and planning, and more. For more information, log on with your username and password at www.medpro.com or contact your clinical risk consultant at 800-4MEDPRO (1-800-463-3776).

Zip Code Tool

The Insurance Institute for Business and Home Safety offers a zip code tool that can help you identify potential natural hazards in your geographical area.

Visit https://www.disastersafety.org/ to learn more.

A 2011 poll related to Occupational Safety & Health Administration (OSHA) standards asked healthcare workers whether their facilities had ever had to initiate an emergency action plan or evacuation (other than practice drill scenarios). Almost half of participants responded yes.[2]

With the knowledge that environmental emergencies are possible and probable in some cases, a crucial first step in emergency preparedness is identifying and assessing the types of hazards that could affect your practice. A number of considerations should factor into this analysis, such as:

- **Geography.** Is your practice in an area prone to earthquakes, tornadoes, hurricanes, flooding, etc.?
- **Local weather patterns.** Is severe weather more likely during a particular season? Do certain environmental circumstances increase the risk of emergencies? (For example, drought may increase the risk of wildfires.)
- **Local history of environmental emergencies.** Has your area previously been affected by natural or man-made environmental disasters?
- **Proximity to possible hazards.** Is your practice located in a floodplain, near the coast, close to a fault line, near a power plant, close to railroad tracks, near a dam, etc.? Is the practice close to a company that produces, uses, or stores toxic or hazardous materials?
- **Office structure.** Is your practice in a stand-alone facility or part of a larger, multi-use facility? Is the entire practice on one floor or multiple floors? Does the facility have appropriate places to take shelter? Are critical systems and equipment located in safe and secure areas?[3]

These questions represent a sample of factors to consider when identifying and assessing potential risks. For more information, visit http://www.ready.gov/planning.

Once risks have been identified, the next step is prioritizing them based on probability and potential impact. For example, think about:

- **The frequency and duration of the event.** Does the emergency typically occur yearly, every 5 years, etc.? How long does it last?

- **The speed of onset and the potential area affected.** Will the crisis likely occur quickly or develop over time? Will warnings precede it? Will the crisis affect a widespread or localized area?
- **Potential severity and outcomes.** Will the disaster likely result in physical damage, potential losses, service interruptions, etc.?
- **Safety.** How might the emergency affect the safety of patients, caregivers/family members, and staff? Could it cause injuries or deaths?
- **Continuity of care.** How will the crisis potentially affect your ability to provide patient care?

As part of risk identification and assessment efforts, medical and dental practices may want to contact local, state, or federal authorities to obtain emergency preparedness information and resources.

A comprehensive response plan is a critical element of emergency preparation, as it provides the basis for prompt and appropriate action.

Examples of these authorities include local emergency management agencies, local fire officials and emergency responders, the Small Business Association, the National Weather Service, the Federal Emergency Management Agency (FEMA), the Centers for Disease Control and Prevention (CDC), and the Red Cross.

Emergency Response Plan

Following a risk assessment, the next step in emergency preparedness is developing or evaluating your practice's emergency response plan. Having a comprehensive response plan is a critical element of emergency preparation, as it provides the basis for prompt and appropriate action. Further, OSHA requires a written emergency response plan for employers who have 11 or more employees.[4]

Because every practice is unique, "an emergency preparedness plan . . . must be specific and distinctive for each organization."[5] Also, different types of environmental emergencies will likely require different responses, so your practice's plan should individually address the most probable emergency scenarios (as identified by your risk assessment).

Additionally, each practice's plan should cover staff emergency roles, contingency plans, resources, and training. For a sample emergency response plan template, visit http://www.fema.gov/media-library/assets/documents/89518.

Staff Roles and Responsibilities

Similar to the plan for medical emergencies (discussed earlier in this *Protector*), the plan for environmental emergencies should specify staff roles and accountabilities by position and include all members of the team as active participants in emergency response.

As your plan takes shape, consider the various actions and responses that each emergency might trigger, and determine which staff position is best suited to handle the responsibility. For example, who will:

- Serve as the safety coordinator, providing oversight of all emergency functions and making critical decisions about safety protocols and procedures?
- Serve as the emergency response leader, implementing the practice's response plan and coordinating staff activities?
- Oversee technology and equipment, including moving, maintaining, or shutting down systems as necessary?
- Monitor local disaster warning systems and media and communicate essential information to staff members?

- Communicate with external organizations and resources, such as emergency service providers; local, state, and/or federal authorities; local hospitals; and other healthcare organizations?
- Contact vendors, business associates, utility providers, building management, etc.?
- Maintain keys to the office and provide onsite assistance if necessary (e.g., turning off utilities)?

When developing staff accountabilities, make an effort to include all team members in the planning process. Collaboration and staff insight can reinforce the team approach to disaster management, help team members understand their individual responsibilities, and foster an overall awareness of the practice's emergency response plan.

Contingency Plans

An environmental emergency can have short- or long-term consequences, ranging from minor issues or disturbances to severe outcomes or damage. For example, "roads may be blocked or jammed, telephones may be overloaded or nonfunctional, emergency responders and the public health system may be overwhelmed, electricity may be out, and major facilities may be damaged."[6]

A significant element of preparedness is considering how your practice will react and respond if an environmental disaster compromises your staff, infrastructure, or technology. Because different types of emergencies may result in different outcomes, contingency planning often requires thinking about a range of potential scenarios and critical functions. For example:

- How will you notify staff and patients if an environmental emergency affects your office?
- How will you implement safeguards if an environmental emergency occurs while staff and/or patients are in the office?
- Will you be able to provide continuity of care in the event of utility failures, technological interruptions, or loss of vital services?
- What is the maximum amount of time that you can close your practice or experience system downtime without significant consequences?
- How will you identify and procure necessary resources?
- How will you recover from physical damage or losses?[7]

Major areas of consideration in contingency planning include communication, utilities, technology, emergency equipment/supplies, sheltering/evacuation, and relocation. The checklist on pages 26-27 includes basic questions in each of these categories and may serve as a helpful tool in developing, evaluating, or updating your practice's emergency response plan.

Although contingency planning requires a commitment of time and effort, well-developed plans can help minimize the impact of an environmental crisis, establish appropriate safeguards for patients and staff, and facilitate recovery efforts.

For more detailed information about how to develop contingency plans for certain types of environmental disasters, visit http://www.ready.gov/be-informed and http://emergency.cdc.gov/hazards-specific.asp.

Without training, providers and staff members might be unprepared to recognize potential hazards, manage emerging situations, and mitigate potential risks.

Emergency Resources

In addition to assigning staff roles and responsibilities and developing contingency plans, another crucial component of emergency planning is identifying important contacts, vendors, and suppliers who assistance might be required during or in the aftermath of an emergency. Examples include:

- Local emergency contacts, such as the local hospital, emergency management agency, fire department, emergency medical services, public health department, and the police department;
- State and federal authorities, such as the Environmental Protection Agency, the CDC, FEMA, and the Department of Homeland Security;
- Insurance carriers;
- Building and construction contractors or the building landlord;
- Utility companies and utility repair workers, such as electricians and plumbers;
- Health information technology vendors; and
- Medical equipment and supply contractors.[9]

Maintain an up-to-date list of contact information for these resources, and post it in a location in your practice that is accessible and conspicuous (as well as in an offsite location). The list should include the type of service, the main point-of-contact and a secondary contact, the standard business phone number, and an emergency phone number.

Additionally, it's important to note that in the aftermath of an environmental emergency, some resources might be diverted or overwhelmed due to high demand. To address this issue, medical and dental practices should consider vendor/supplier location, emergency response clauses in vendor contracts, and possible alternate or backup resources.[10]

Training

Training for environmental emergencies, as with any type of emergency, can have a significant impact on response delivery and potential outcomes. Without training, providers and staff members might be unprepared to recognize potential hazards, manage emerging situations, and mitigate potential risks.

Training for environmental emergencies should address major components of the practice's disaster response plan, such as staff roles and accountabilities, contingency plans, and recovery efforts. Practices may want to employ a variety of training techniques — such as table top exercises, mock drills or simulations, review of actual disaster response efforts, and equipment training — to help staff develop proficiency with emergency processes. For some types of training, it might be beneficial to involve local emergency responders or authorities.[11]

OSHA notes that training should occur during new hire orientation, and retraining should occur at least annually. Further, employees should receive follow-up training when your plan changes due to "a change in the layout or design of the facility, new equipment, hazardous materials, or processes are introduced that affect evacuation routes, or new types of hazards are introduced that require special actions."[12]

Conclusion

Preparing for environmental emergencies might not seem like a priority until an emergency actually occurs; however, an "out-of-sight, out-of-mind" approach could have serious implications for patient and staff safety, critical systems and infrastructure, recovery, and long-term business viability.

Emergency Preparedness Online Resources

- American Health Lawyers Association: Minimizing EHR-Related Serious Safety Events (see section titled," Emergency Preparedness Checklist for Information Technology Infrastructure and Software Applications") — http://www.healthlawyers.org/hlresources/PI/InfoSeries/Pages/MinimizingEHRSSE.aspx
- Association for Professionals in Infection Control and Epidemiology: Infection Prevention for Ambulatory Care Centers During Disasters — http://apic.org/Resource_/TinyMceFileManager/Emergency_Prep/2013_Ambulatory_Care_during_Disasters_FINAL.pdf
- Centers for Disease Control and Prevention: Emergency Preparedness and Response — http://emergency.cdc.gov/?s_cid=cdc_homepage_topmenu_004
- Federal Emergency Management Agency — http://www.fema.gov/
- Medical Group Management Association: Preparing for a Medical Office Emergency and Other Community Disasters — http://www.mgma.com/about/about-mgma/about-center-for-research/preparing-for-a-medical-office-emergency-or-disaster
- Occupational Safety & Health Administration: Emergency Preparedness and Response — https://www.osha.gov/SLTC/emergencypreparedness/index.html
- Ready.gov — http://www.ready.gov/
- U.S. Department of Health and Human Services: Public Health Emergency — http://www.phe.gov/preparedness/Pages/default.aspx

The Institute of Medicine explains that, for healthcare professionals, the "duty to plan for [naturally occurring and man-made disasters] is an ethical imperative."[13] Additionally, the American Dental Association notes that rapid business recovery from a disaster or emergency could depend on (a) whether a practice's emergency response plan is current and thorough, and (b) how well the plan can be executed.[14]

A prudent approach to environmental emergency preparedness involves identifying risks, developing a framework for emergency response and action, and educating and training staff. Although healthcare providers can't predict with absolute certainty how environmental emergencies might affect them, awareness, knowledge, and vigilance provide the first line of defense. ■

Endnotes

1 Federal Emergency Management Agency. (n.d.). Disaster declarations by year. Retrieved from http://www.fema.gov/disasters/grid/year

2 Medical Environment Update. (2011, July). Vital stats: Weather-related emergency action plans and evacuations. OSHA Healthcare Advisor Blog, HCPro. Retrieved from http://blogs.hcpro.com/osha/2011/07/vital-stats-weather-related-emergency-action-plans-and-evacuations/

3 Federal Emergency Management Agency. (1993). *Emergency management guide for business and industry*. Retrieved from http://www.fema.gov/media-library/assets/documents/3412

4 Occupational Safety & Health Administration, Occupational Safety and Health Standards, 29 C.F.R. § 1910.38.

5 American Health Lawyers Association. (2013). Emergency preparedness checklist for information technology infrastructure and software applications. In *Minimizing EHR-related serious safety events*. Retrieved from http://www.healthlawyers.org/hlresources/PI/InfoSeries/Pages/MinimizingEHRSSE.aspx

6 Glotzer, D. L, Psoter, W. J., & Rekow, D. (2004, November). Emergency preparedness in the dental office. *Journal of the American Dental Association, 135*, 1565–1570.

7 Insurance Institute for Business and Home Safety. (n.d.). Stay open for business toolkit. Retrieved from https://www.disastersafety.org/open-for-business/

8 Federal Emergency Management Agency. (2004). Are you ready? An in-depth guide to citizen preparedness. Retrieved from http://www.fema.gov/media-library/assets/documents/7877

9 Federal Emergency Management Agency, Emergency management guide for business and industry.

10 Insurance Institute for Business and Home Safety, Stay open for business toolkit.

11 Occupational Safety & Health Administration. (n.d.). Develop and implement an emergency action plan: Emergency action plan checklist. Retrieved from https://www.osha.gov/SLTC/etools/evacuation/implementation.html

12 Ibid.

13 Institute of Medicine. (2012). *Crisis standards of care: A systems framework for catastrophic disaster response*. Washington, DC: The National Academies Press.

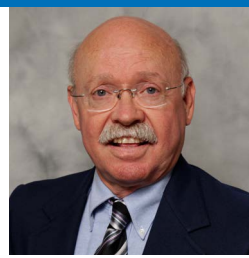
14 American Dental Association. (2003). Emergency planning & disaster recovery in the dental office. Retrieved from http://www.ada.org/~/media/ADA/Member%20Center/FIles/ada_disaster_manual.ashx

Environmental Emergency Contingency Planning Checklist

	YES	NO
COMMUNICATION		
Has your practice identified primary and secondary methods for communicating with staff and patients during an environmental emergency (e.g., phone, email, text, website, social media, etc.)?	☐	☐
Does your communication plan takes into account potential loss of critical services, such as Internet or phone service?	☐	☐
Are staff members aware of who is responsible for internal and external communication and what steps they will take?	☐	☐
Does your practice post and maintain:		
• An up-to-date staff contact list with home, mobile, and emergency contact information for all personnel?	☐	☐
• A current list of local and regional emergency contacts (e.g., local fire department, hospital, and emergency management agency)?	☐	☐
Are contact lists maintained onsite and offsite?	☐	☐
Do you have a dedicated emergency phone number and an emergency email account?	☐	☐
UTILITIES		
Does your practice have contingency plans for managing loss of power and other utilities?	☐	☐
Does your office have emergency lighting that will activate during a power outage?	☐	☐
Does your practice have an emergency generator to supply power during outages?	☐	☐
Is the generator located in the safest area possible (e.g., a cool, dry location that won't be at risk for flooding)?	☐	☐
Will your emergency generator power all of your systems or only critical systems? Have you identified which systems should remain available during a power outage?	☐	☐
Do you have protocols for managing other types of utility failures or hazards, such as natural gas leaks, sewage backups, loss of heating or air-conditioning, and water contamination?	☐	☐
Does your emergency response plan stipulate the need to document all actions taken in relation to utility failures, including notification times and who was contacted?	☐	☐
TECHNOLOGY		
Has your practice developed protocols for managing computer system failures, loss of Internet connectivity, or loss of phone services?	☐	☐
Has your practice assessed all of its IT applications, services, and data to identify the most critical?	☐	☐
Is onsite IT equipment (e.g., servers, laptops, etc.) kept in the safest place possible within your practice?	☐	☐
Are resources in place to maintain and/or safeguard critical systems (e.g., generators and surge protectors)?	☐	☐
Is a contingency plan in place for the continued provision of care, even if IT systems (such as electronic health records) are not available?	☐	☐
Do you have a protocol for shutting down all systems or moving IT equipment offsite prior to an impending disaster?	☐	☐
Does your practice consistently back up its data?	☐	☐

	YES	NO
TECHNOLOGY CONT.		
Is backed up data stored offsite or in multiple locations to prevent loss or destruction if the office is damaged?	☐	☐
Does your practice maintain documentation for critical IT hardware and software (e.g., serial numbers, version/model, lease information, supplier, etc.)?	☐	☐
Do the practice's IT vendors have emergency response plans? Do they offer emergency services as part of their service contracts?	☐	☐
EQUIPMENT AND SUPPLIES		
Have you considered the types of emergency equipment and supplies your practice should maintain based on the most probable emergency scenarios?	☐	☐
Does your practice have basic emergency supplies onsite, such as weather-related supplies (e.g., salt or sandbags), basic tools, flashlights, a first aid kit, fire extinguishers, a portable radio, extra batteries, water, and nonperishable food?	☐	☐
Does your office have working fire alarms and an automatic sprinkler system?	☐	☐
Does your emergency plan specify the need for periodic auditing of emergency supplies and routine testing of emergency equipment?	☐	☐
SHELTERING/EVACUATION		
Does your practice have clear policies for sheltering in place or evacuation based on the type of emergency?	☐	☐
Have you identified a safe location to shelter in place? (Note: The safest place to seek shelter may vary based on the type of emergency.)	☐	☐
Is clear signage in place to indicate the shelter location and all available routes to the location, including preferable routes for people who have limited mobility?	☐	☐
Is the shelter location conducive to communication (e.g., can you get television, radio, and/or Internet reception)?	☐	☐
Is the shelter stocked with adequate emergency supplies, water, and food? (Note: FEMA recommends planning for at least 3 days.)[8]	☐	☐
Have you considered your facility's layout and accessibility when planning evacuation routes?	☐	☐
Has a location been identified where evacuees should congregate for safety and a head count?	☐	☐
Are emergency exit routes posted in visible locations throughout the practice? Do exit signs clearly indicate evacuation routes?	☐	☐
Are staff members familiar with emergency exits and evacuations routes so they can direct patients?	☐	☐
RELOCATION		
Does your practice have a contingency plan for relocating if the office is damaged or inaccessible?	☐	☐
Does the plan specify what equipment, records, and files need to be moved and how they will be transported?	☐	☐
Does the practice have a secondary mailing address and contact information?	☐	☐
Is a protocol in place for communicating information about the relocation to patients?	☐	☐

Unexpected Record Damage:
Protecting Your Records From Water Hazards



James W. Echard, Jr.

James W. Echard, Jr., BS; AAS, Political Science and Law Enforcement; AAS, Fire Science, HEM
Princeton Insurance — A Medical Protective/Berkshire Hathaway Company

Accidents, severe weather, and natural disasters can result in extensive water damage to important documents, such as medical/dental records and X-ray films. For example, hurricanes, heavy rains, broken water pipes, or even an overflowing floor drain can cause unexpected damage to stored records in a basement or storage room. Water damage also can be an unanticipated side effect of fire-fighting efforts.

When a medical or dental practice faces a loss such as water-damaged records and X-ray films, certain steps should be taken. First, report the loss to your insurance carriers (general liability and property). Next, check the records to determine the extent of the damage. Are the records/films completely destroyed, or are some of them only partially destroyed? Could the records potentially be restored? The extent of the damage will determine next steps.

Partially Destroyed Records

Moisture in any form and paper don't mix; when exposed to water, paper begins to deteriorate. The same deterioration occurs with X-ray film jackets, but the process is slower. Moisture infiltrates the paper's cell structure, followed by swelling and discoloration. This creates an environment that will permit the growth of mold and bacteria on the surface of the paper or X-ray film jackets. The growth of mold and bacteria can occur in a domino-like effect, spreading from folder to folder.

Water-damaged medical records and X-ray films can potentially be restored. Although the complete restoration of water-soaked documents often is expensive, it might be wise to attempt to salvage them. However, this process has to begin as quickly as possible because of deterioration.

In warm weather, mold growth might appear within 48 hours. Mold also can be expected to appear in poorly ventilated areas within the same timeframe. Therefore, reducing high humidity and temperature and venting the areas as soon as feasible is imperative. Water-soaked material must be kept as cool as possible with good air circulation. Failure to do so could lead to a higher recovery/restoration cost.

As soon as possible, seek the services of a restoration company to restore your practice's damaged records. Because the restoration company will be working with patient information, you will need to have a HIPAA business associate agreement (BAA) with them. (To learn more about HIPAA BAAs, visit http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html.)

The restoration company will place the materials into commercial freezers. Once frozen, the materials are moved to a freeze-drying chamber. Air within the chamber is removed through a vacuum process, and the temperature is lowered.

The moisture within the materials is converted to a vapor state and then taken out of the chamber. The temperature within the freeze-drying chamber is gradually increased over time, and any residual moisture is removed.

Freezing, followed by vacuum freeze drying, is one of the most effective methods of removing water from paper records and X-ray films. This method has been used in the recovery of books, manuscripts, leather, maps, historical and collectible items, and textiles.

If water damage has resulted from fire-fighting measures, cooperation with the fire marshal and health and safety officials is vital for a realistic appraisal of the feasibility of a safe salvage effort. Fire officers will decide when a building is safe to enter. In these instances, salvage operations are planned so that the environment of water-damaged areas can be stabilized and controlled both before and during the removal of the records and films.

Completely Destroyed Records

When records are completely destroyed, the challenge to the practice will be twofold. First, the destroyed records will need appropriate disposal. Second, new records will have to be constructed from information the practice can assemble.

Damaged records must be completely destroyed to protect patient confidentiality and comply with HIPAA regulations. Dry the records and then shred them if possible. No intact record or X-ray may be discarded. As noted previously, be aware of the likelihood that mold will develop, and try to keep the area where records are stored cool and dry.

When ready to destroy the records, the practice should keep a log of all records that are destroyed, as is done with planned record destruction. This log should include the following information:

- Name;
- Date of birth;
- Social security number;
- Dates of first and last visit;
- General problems, and procedures performed in the office; and
- Documentation of what was destroyed, how it was destroyed, and the date of destruction.

Reconstructing records can be done by pulling together information from other systems and files available to the practice. The practice also should send notification letters to patients whose records were damaged to make them aware of the situation. In the letters, the practice can enclose a medical/dental history form and request that each patient complete the form to the best of his or her ability. A copy of the notification letter should be filed in the patient's reconstructed medical/dental record.

Once each chart is rebuilt, it should include clear documentation explaining that it was reconstructed. This documentation should include at least the following:

- The date the chart was reconstructed;
- The reason for reconstruction;
- Sources of information for reconstruction;
- Efforts made to obtain other information (if applicable); and
- A statement that, due to reconstruction, the information contained in the chart as of the reconstruction date is considered inexact.

Damaged records must be completely destroyed to protect patient confidentiality and comply with HIPAA regulations.

Medicare and other insurance carriers may expect to be notified that patient records have been lost. These organizations expect the practice to provide medical record documentation to support patient claims. If a medical record is destroyed, they may want the practice to sign a form that attests to the unexpected loss of the record.

Prevention

Addressing potential water damage might not seem like an urgent priority. However, without appropriate precautions, important records, X-ray films, and other materials might be compromised or completely destroyed.

In an effort to prevent water damage, consider whether your office is at risk of flooding. For example, ask your local emergency management agency if your office is located in a known floodplain. Determine the elevation of your office in relation to local rivers, creeks, bays, and the ocean.

Further, it is appropriate to evaluate your storage space at least twice a year, though a quarterly examination would be even better. More frequent inspections are appropriate when weather is unusually harsh, no matter the season. Weather extremes expose the vulnerabilities of buildings much more quickly.

Medicare and other insurance carriers may expect to be notified that patient records have been lost.

Routine prevention steps include storing records at the highest level possible inside the office and stacking records and X-rays off the floor. Use shelving units, if possible, and position them as high off the floor as you can. Keep in mind, however, that storing records too high can pose a potential injury concern for staff. A sturdy step stool might be needed to safely access these records.

Plastic tarps can be placed in rolls over the stored records and then unrolled when a storm approaches to protect against rain and roof damage. Additionally, take any paper out of the lower drawers of your desks and file cabinets and place them in plastic bags or plastic containers that can be placed on top of the units. Also, if you know a severe storm is coming, take time to pull lower boxes out of the basement.

Physicians and dentists who maintain paper records also should consider storing copies of their administrative records (financial, insurance, patient scheduling, patient lists) offsite in a secure area.

Finally, develop a system of routine record destruction so that you keep only the records you are supposed to keep. This will limit the clutter in your storage area and reduce the number of records exposed to the risk of water damage.

For more information and guidance about record management, contact your risk management consultant at 800-4MEDPRO (1-800-463-3776).

Conclusion

In summary, each office practice should (a) implement prevention strategies to safeguard medical/dental records and X-ray films, and (b) consider document restoration as part of emergency preparedness and disaster planning. For additional helpful resources, visit: http://www.archives.gov/preservation/disaster-response/salvage-procedures.html. ■

James W. Echard, Jr., is a risk services consultant with Princeton Insurance, a Medical Protective/Berkshire Hathaway company. He has been involved in emergency planning and management throughout his career and previously served as a hospital safety management coordinator, a role in which he was responsible for developing and implementing environment of care plans and occupational health and safety programs. Over the years, James has developed numerous safety-related instructor course guides, security assessment programs, and workplace violence and prevention plans.

Managing Medical Emergencies in the Practice Setting:
A Three-Pronged Approach

(Continued from page 11)

A threefold approach that addresses prevention, preparation, and action can help medical and dental offices develop or evaluate their emergency response plans, implement comprehensive emergency management procedures, support staff training and readiness, and reinforce a culture of safety. ■

Endnotes

1 Toback, S. L. (2007, June). Medical emergency preparedness in office practice. *American Family Physician, 75*(11), 1679–1684. Retrieved from http://www.aafp.org/afp/2007/0601/p1679.html

2 Dentistry IQ. (2004). Medical emergencies in dentistry: Prevention and preparation. Retrieved from http://www.dentistryiq.com/articles/wdj/print/volume-2/issue-10/you-and-your-practice/medical-emergencies-in-dentistry-prevention-and-preparation.html

3 Rosenberg, M. (2010). Preparing for medical emergencies: The essential drugs and equipment for the dental office. *Journal of the American Dental Association, 141*(Suppl 1), 14S–19S.

4 Toback, Medical emergency preparedness.

5 Dentistry IQ, Medical emergencies; Malamed, S. F. (2010). Knowing your patients. *Journal of the American Dental Association, 141*(Suppl 1), 3S–7S.

6 Dentistry IQ, Medical emergencies.

7 Malamed, Knowing your patients.

8 Dentistry IQ, Medical emergencies.

9 Malamed, Knowing your patients.

10 Ibid.

11 Dentistry IQ, Medical emergencies; Toback, Medical emergency preparedness.

12 Sempowski, I. P. (2002, September). Dealing with office emergencies: Stepwise approach for family medicine. *Canadian Family Physician, 48*, 1464–1472.

13 Haas, D. A. (2010). Preparing dental office staff members for emergencies: Developing a basic action plan. *Journal of the American Dental Association, 141*(Suppl 1), 8S–13S.

14 Sempowski, Dealing with office emergencies.

15 Haas, Preparing dental office staff members for emergencies.

16 Malamed, Knowing your patients.

17 Dentistry IQ, Medical emergencies; Toback, Medical emergency preparedness; ADA Council on Scientific Affairs. (2002, March). Office emergencies and emergency kits. *Journal of the American Dental Association, 133*, 364–365.

18 ADA Council on Scientific Affairs, Office emergencies and emergency kits.

19 Rosenberg, Preparing for medical emergencies; ADA Council on Scientific Affairs, Office emergencies and emergency kits; Toback, Medical emergency preparedness; Sepowski, Dealing with office emergencies.

20 Rosenberg, Preparing for medical emergencies; Toback, Medical emergency preparedness.

21 Ford, D. (2013). Does a dental practice have a common law duty to have an AED available? Dentistry IQ. Retrieved from http://www.dentistryiq.com/articles/2013/12/does-a-dental-practice-have-a-common-law-duty-to-have-an-aed-available.html; American Heart Association. (2014, January). AED programs Q&A. Retrieved from http://www.heart.org/HEARTORG/CPRAndECC/CorporateTraining/AEDResources/AED-Programs-Q-A_UCM_323111_Article.jsp

22 Ford, Does a dental practice have a common law duty?

23 Toback, Medical emergency preparedness.

24 Haas, Preparing dental office staff members for emergencies.

25 Sempowski, Dealing with office emergencies.

26 Haas, Preparing dental office staff members for emergencies; Haas, D. A. (2006). Management of medical emergencies in the dental office: Conditions in each country, the extent of treatment by the dentist. *Anesthesia Progress, 53*, 20–24; Sempowski, Dealing with office emergencies; Reed, K. L., (2010). Basic management of medical emergencies: Recognizing a patient's distress. *Journal of the American Dental Association, 141* (Suppl 1), 20S–24S.

27 Sempowski, Dealing with office emergencies.

28 Haas, Preparing dental office staff members for emergencies.

RISK TOOLS AT YOUR FINGERTIPS!

Every practice is different — that's why it is important to identify and understand the primary areas of risk in your practice. But how do you do that?

We can help! Medical Protective's Clinical Risk Department has developed two online assessment tools — the HIPAA Risk Assessment and Office Risk Assessment — to help insureds evaluate clinical and high-risk liability exposures.

These assessments can help you pinpoint your practice's current strengths, so you can build on them; determine potential areas of risk and noncompliance; understand the rationale for implementing various risk strategies; and prioritize risk management actions and activities.

Additionally, at your request, your clinical risk management consultant will review your results with you and provide additional insight and direction.

(Note: Individual results are seen by you only, unless you provide the information for discussion purposes.)

Take Advantage of These Tools!

1. **Visit www.medpro.com and log in with your username and password.** (If you're new to the site, you can register in just a few short clicks.)
2. **Go to the My Risk Management menu.**
3. **Select the HIPAA Risk Assessment or Office Risk Assessment link.**
4. **Proceed with the instructions as indicated.**

Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

Strength. Defense. Solutions. Since 1899.

PRSRT STD
U.S. POSTAGE
PAID
FORT WAYNE, IN
PERMIT NO. 2202

5814 Reed Road
Fort Wayne, IN 46835-3568

Visit us at medpro.com or call 800-4MEDPRO.

Product availability varies based upon business and regulatory approval and differs between companies. All products administered and underwritten by Medical Protective or its affiliates. Visit medpro.com/affiliates for more information.
©2014 The Medical Protective Company.® All Rights Reserved. MEDPRO045