

**Group 4 Health and Safety Meeting
August 26, 2008, T269**

Present: Jim Angelosante, HS Administration
Ann Aumann, UWMC
Rita Bellanca, WNPRC
Siobhan Brown, School of Medicine
Laura Campbell, Comparative Medicine
Stuart Cordts, EH&S
Retha Hay, ARNP, Employee Health
Robert Hamilton, HMC
Patricia Hedtke, School Pharmacy
Julie Hart, School of Nursing
Liz Kindred, HMC
Barbara Lovseth, School of Medicine
Kathy Maher, HMC
Suzanne Mason, Hall Health
Michael Merrill, EH&S
Cindy Moore, Health Services
Phil Numoto, EH&S
Mamadou Sambou, UWMC
Eshy Shahrazad, Health Sciences Library
Jackelin Tran, EH&S
Chuck Treser, School of Public Health
Julie Worlein, WNRPC
Melinda Young, WNPRC

Absent: **Lisa Anderson, Hall Health**
Thomas Beikler, School of Dentistry
Paul Bentson, WFSE
Gail Harrell Colfax, School of Social Work
Ruth Del Rosario, School of Pharmacy
Bob Ennes, HS Administration
Ed Farnham, HS Administration
Charlene Karr-May, Comparative Medicine
Rich Lee, School of Dentistry
Rene Lucas, School of Public Health
Joyce Tsuji, School Nursing

Meeting called to order at 9:00 am by Chair Barbara Lovseth A quorum was present

1. First order of business was to appoint a recording secretary as Irene Moy is unable to continue in this position. Cindy Moore appointed to the position.
2. Review of the July 22nd Minutes: a) Joseph Kwok presentation on heat exposure; b) Ed Farnham-review of U-wide committee; c) Stephanie Steppe announced her retirement; d) Barbara Lovseth elected chair; e) Committee reports; and f)

Dennis Shapiro review of Harborview incidents. Chuck Treser motioned to accept the minutes as submitted; Patricia 2nd, vote passed

3. Barbara Lovseth removed herself as OARS incident chair person due to overall chairmanship of Group 4. Rita Bellanca agreed to assume this position. Laura Campbell volunteered to serve on the committee (bringing total members to four, who will meet once a month approximately for an hour to review all non-UWMC/HMC OARS report).
4. Incident/Accident Committee Reports:
 - a. Ann Aumann, UWMC I/A Committee: 29 incidents reported July, 2008.
 - 1) UWMC is making progress on PSN (Patient Safety Network) supervisor comments. These are being made and followed up on the reports. Apparently some reports were being forwarded to another dept but lacked follow-up/action reporting. Ann working hard to correct this problem with incident/accident reporting methods. The program itself will be modified effective January to allow tracking of these types of follow-up/action items.
 - 2) Problems noted were ergonomic related to data posting by nurses at nursing stations. Some had to stand up, reach around; no place for write, clicking seemed to be huge problems versus utilizing mouse/pad. The new reporting methods are clicking intensive and believed to have led to a 5% increase in this type of accident/incident reports. Response has been to educate the users, reconfiguration of devices, different positioning of arms/wrists.
 - 3) UWMC is working with managers to respond/report policy as many managers are unaware of the time requirement to respond/report on incidents (10 to report; 45 days to respond, investigate and close the incident). Council will begin enforcing the 10 day response reporting.
 - b. Kathy Maher, HMC, I/A: There were 160 incidents in June and July. A question was asked regarding the length of time it takes to receive the reports by EH&S. The cycle is to gather the reports, send to Joseph Kwok (EH&S) who then bundles and returns the report to the committee for review. Apparently this process takes longer some months than others due to reporting from PSN. Reports of note:
 - 1) There are several typical moving/lifting reports to include motorized bed incident. Apparently the driver of the motorized bed failed to brake in time and pinned cohort between some equipment that required a hospital stay. The brake system was investigated for failure to timely respond but apparently was within manufacture's specifications. The overcrowding of equipment located in the pathway contributed to operator's failure to timely brake. Driving speeds of bed also being examined, based upon different weights/pressure in beds may react differently. There is already a program in place to train drivers of motorized beds.
 - 2) Another manufacture failure was a needle retroactive Catheter device that failed-the committee has brought this to the manufacture's attention for investigation.

- 3) Then floor materials, shoes-especially in the OR are being investigated and evaluated. There were a significant number of slips/trip in past so now floor materials (cork floor that absorbs both moisture/avoids slips, not using a high gloss finish on OR floors, experimenting with different shoes/soles and identification of high accident/incident areas are all currently being investigated.
- c. Barbara Lovseth, Non-HMC/UWMC: 12 incidents in July. Some reports did not list corrective action taken - this information not entered into the system but manually followed up. Incidents of note:
- 1) Continued incidents regarding mouse handlings. Discussed having Comparative Medicine do a presentation at Group 4 on training of both Comparative Medicine employees and external users of the animal facilities. Laura Campbell indicated that a new trainer is being hired. We will try to arrange for this presentation later in the fall.
 - 2) There were 3 incidents from the Primate Center all related to PPE. One incident was related to slipping on wet surface; WaNPRC is looking at boots that may be available to help prevent these slips. The other two incidents were related to animals scratching animal techs through the cages. Primate Center provides ongoing training related to employees wearing PPE and making sure that they are always aware of surroundings.
5. Barbara Lovseth asked the group for meeting topics/committee mission goals that group 4 would like to accomplish the next year as we look ahead.
- a. From the in depth discussion from the group the need to have checklists of mandatory/suggested trainings for supervisors, faculty, administrators, and employees was very high on everyone's list. The group expressed that safety should not be an added task but rather a focus of doing a job-SAFELY! The group discussed how to move forward with this task. As an initial step members agreed to bring checklists from their various departments in order to develop a master checklist. The goal would be to eventually bring a recommendation to the Group Wide Committee.
 - b. The question was raised as to whether or not there would be funds available for a facilitator for Group 4 to help us move forward in a proactive fashion. Barbara Lovseth will follow-up with EH&S.

The meeting was adjourned at 10:20pm

Respectfully submitted,

Cindy Moore