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DEVELOPING A VISITOR MANAGEMENT SYSTEM FOR HEALTHCARE SYSTEMS

With one eye on technology and the other on culture change, here's how Rush University Medical Center revamped its visitor management.

Security Management caught up with Lauris V. Freidenfelds, who was the security director of the Rush University Medical Center in Chicago before recently transitioning to being a senior project manager at Telgian Engineering & Consulting. While at Rush, he undertook a multiyear project to completely revamp how the hospital approached visitor management to decrease the incidence of volatile and potentially violent situations hospital staff had to face.

***Security Management*: How did you get into healthcare security and where did it take you?**

Freidenfelds: It was over 40 years ago now that I started in healthcare as a security officer. It was my first job after getting a criminal justice degree, with the career goal of becoming a federal law enforcement officer. It turns out I really loved being in the healthcare field, and it was a situation I enjoyed, moreso than getting on the road and being in other cities, which is what a federal job would entail. In the late 1980s, the country, and particularly healthcare, ran into some economic problems and I was a victim of that. I began consulting, mostly in higher education and healthcare security areas, and did that until 2008, when I was asked to come in and reorganize a security program at Rush University Medical Center in Chicago. I was only going to do that for five years. Twelve years later, I finally stepped back from that and began consulting again this year.

What was the environment that caused you to look at visitor management?

Traditionally healthcare leadership wanted to maintain an open and inviting kind of atmosphere in the hospital setting. They thought that's what was best suited for the patient and visitor experiences. And I was surprised that they still maintained that posture when I returned in 2008. The need for change, though, was already apparent. The level of violence and aggression and hostility directed at the facility's staff—particularly nurses—was escalating. So we started focusing on that issue, studying the problem.

What did you learn?

We did a risk assessment and analyzed the situation and determined it was patients and their visitors acting aggressively and sometimes violently. It's not like you can keep patients out of the facility; they are who we are there to serve. You deal with patients with different security protocols. But we determined we could do more about the visitors, so we dug into that part of issue.

Visitors in large groups were one problem. The biggest factor is that family dynamics are unpredictable, and when you start getting two or three or six family members together, mix in high tension and emotion associated with having a family member in the hospital for whatever reason, things can get heated quickly. You might have family members who haven't seen each other in years or have strained relationships, and they will start fighting about things that have nothing to do with why they are in the hospital. And it's easy to slip into anger when you feel helpless and a family member is suffering—everyone starts acting in different ways. So we knew the number of visitors would be a key factor in minimizing those volatile situations—those situations that scared the staff. And attempts to limit visitors was not possible without a robust visitor management system—three people might come in one door, four in another, and two more 30 or 40 minutes later, and soon you have 10 people in a tense situation. Those types of situations are tough to deal with when you're just chasing them. You really need a system that prevents the situations from occurring.

Another factor is the no-visitation list the people the patient specifically said they did not want to see. We don't want our nurses having to deal with that and keep track of that, so we needed to push that as far out in the security space as possible, and doing that requires a visitor management process that is not essentially open access for the public.

What kind of guidelines or standards exist for health facility visitor management?

The Joint Commission [a standards and accreditation board for healthcare organizations] has a chapter on security under their environment of care, and one of the issues has always been the Joint Commission wants to see that you are controlling and know who is entering your facility, so there's that requirement. The Joint Commission would come inspect your facility every three years, but traditionally in this area of visitor management, it was loosely interpreted. The institution needed to make some kind of decision about how it would approach visitors, have some kind of policy,

and most of the time they would just accept whatever the institution had in place as satisfying that requirement. They didn't evaluate it to make sure it was an effective program. I think that's started to change. I think it's becoming more recognized that there are serious safety risks regarding visitors in a healthcare environment, and effective measures could help ensure the safety of the healthcare workforce.

The Occupational Safety and Health Administration—OSHA—also has a guideline now that says these are the things you ought to do to prevent violence in the workplace. OSHA won't typically come in and do assessments unless there's a complaint, but if there's a complaint they will come in and go through their guidelines, and one of them is seeing that you control who is coming in to see the patients and who is allowed in the hospital. But OSHA's more of a reactionary agency, whereas the Joint Commission comes through every three years.

How did you go about initiating the project to create a visitor management program?

Those volatile situations I was talking about, they aren't really satisfactory for our staff. We started looking at more of a technology-driven solution. The type that would give us an ability to very reliably identify a visitor and be able to interface with the electronic medical records system. The days of people just coming on up virtually unchecked had to be over.

How did you determine what solution you needed?

It started with that risk assessment, that was the first part of the project. As an experienced security director, you can either do it yourself or you can hire someone to help you. I had the security background to do it, but I still needed a team of people. For one thing, I didn't have enough time to do it all myself, so I hired a good project manager consultant to help me map out and accomplish the process. That was important, I couldn't fulfill my security role and give this major project the attention it needed—and the project was too important to not do well.

So with help, it involved interviewing a lot of people. We interviewed the staff and the leadership, and we did a security review of incidents. It involved observational kinds of things, where you would walk around and see what was working, what wasn't, and where opportunities for improvement exist. You have to ask yourself,

how extensive a visitor management system is warranted? A small rural facility may be able to get by with less. But a large, inner city hospital setting is going to require something more involved.

With that risk assessment, I then turned to the technology to see what was available that would fit with the risks we identified.

And what requirements did you determine you absolutely needed?

There were a few things we knew we wanted in the system. Number one, we needed our medical records system to interface with the system, but that had to be done the right way. The first place I looked was at the big EMR [electronic medical record system] providers, Cerner and Epic, to see if they had visitor management modules, and, well, no, they didn't really have anything, nor did they know much about it. So we had to research a different solution. That solution had to be one-directional. The status of the patient is really driven by the electronic medical record, and we needed to access the record. We needed a system that scraped just the bare minimum of information on the patient: name and location and a no-visitor list if there is one. And the system would not write anything back to the EMR. We have to be very concerned about privacy and HIPAA regulations.

In addition to the integration, we wanted a reliable system that could do what we needed it to do quickly. We didn't want a TSA situation, where there are long lines of people waiting to be approved to visit their family and friends in the hospital, so the experience, and especially the speed, was very important to us. Through our investigations, we determined that we needed to be able to process a visitor in one minute, certainly less than two.

Was the system integration difficult?

You would think it would be, but the technology part—all of it, not just the integration—was really the easiest part of it. HL7 is a protocol that EMR systems use. You see, EMR systems by their nature are always getting and sharing information with other systems—different labs and diagnostic software—so they have been kind of built around being able to integrate with other systems.

So speed and system integration, anything else?

It may not be the first thing you think of, but it was important to us… we wanted a solution that printed badges and looked professional. To these visitors, these badges were representing the institution, so we wanted a high-quality design. We had to look at things like how much effort we wanted to put into capturing an image and what information we wanted visible on the badge. This is as opposed to just having a sticky badge you peel and stick to someone. A professional approach to visitor management can help your staff see that you take it seriously, that you are working for their safety. And same for the visitors—it's important for them to see that you take it seriously and that you are committed to a safety culture in your institution.

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So identify technology and implement technology, is that all there is to it?

Not at all. Once you've done the assessment, the most critical success factor is buy-in. It really does need to be an institutional program. I've said this many times, but if you want a project to fail, just flag it as the security director's project! You know as a security director that your project is designed to protect the people and assets of the institution. In a case like visitor management, which really is a philosophical change when you're going from basically open access to one with fairly tight controls, you need everyone on board.

I put together a visitor management governance committee, and it really started with that assessment. It involved nursing and legal and patient reps. Of course security and HR—leadership—all of these people are needed to develop a plan that is a real culture shift for the organization.

In our case, we wanted to keep an inviting atmosphere. We didn't want a guy in a uniform acting as barrier to a visitor. Instead, we created layers of protection. Visitors are funneled to guest services, and those greeters, not in uniform, would greet and meet people with a smile and take them through the process. To be clear, this was a new and enhanced role for these people, and required training and hiring the right people. From there, we could station security so that they would be positioned between the guest services folks and the portals or pathways visitors would take to get to their intended station. The unit itself, predominantly staffed with nurses and others whose primary mission is to treat and serve patients is now the third and final security perimeter, whereas before they would often be the first and only line.

Did you have to justify the costs through a cost-benefit analysis or something similar?

Actually, we knew there about costs associated with making this culture change. Back when we did the risk assessment, we did a couple of peer reviews, and we found that the institutions that were looking to justify a visitor management system based on financial returns were not the leaders—they took longer and did not do as complete a job. As a result, we looked at it as a necessity to improve the safety and security we provided our staff, and did not seek to justify it by cost savings.

That said, there are certainly things you can look at. If you can drastically reduce the number of incidents that make the staff feel unsafe, that will have an impact on turnover and productivity of staff and fewer lost days of work. I expect in the long run a good visitor management system is going to have a good ROI.

How long did it take you to make these changes?

I think we did a pretty slow, deliberate process, so the change from a basically open system with only minimal controls to the system we ended up with was around three years. But that includes the time spent understanding the issues we were having, and taking small measures, making minor enhancements—going from minimal controls to minimally invasive controls and processes—such as a requirement to check in as visitor and wear a sticky badge. We took those measures as we studied the issue. Once we determined to attempt full culture change, it was nine months from the time we cut the PO to implement a technology system to the time it was in place for in-patient visitations. And even that time frame was driven more by communication and consensus building around policies than around laying in the technology.

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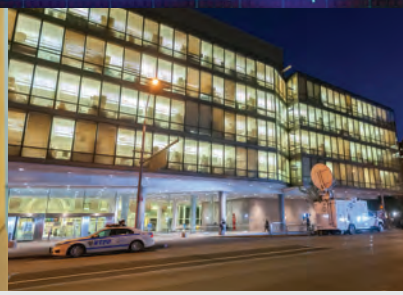

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