



FIRST

Do No Harm

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Patient Care Assessment Division, Board of Registration in Medicine

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Leading the Way

It is not often that two individuals can make such a difference in the lives of patients.

Dr. Martin Crane, Chairman of the Board of Registration in Medicine, and Nancy Achin Audesse, Executive Director of the Board of Registration in Medicine, are two such individuals.

Ms. Audesse has been recently appointed as Chairwoman for the National Committee for Quality Assurance (NCQA) Standards Committee. The Standards Committee is a sub-committee that supports the mission of NCQA by

bringing together different health care constituencies to achieve consensus about meaningful and feasible health



quality assessment requirements for NCQA accreditation and certification

programs. It also develops new requirements used to evaluate the structure, processes and outcomes of medical and quality management systems in health care organizations, takes into account input from public comments and NCQA advising committees, conducts ongoing review and revision of existing requirements, as well as changes in quality review focus and emphasis, and evaluates accreditation and certification determination methodologies.

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Patient Safety Action Team™ - One Hospital's Approach to Safety

During infusion of contrast in preparation for a CT, the patient's IV infiltrates. The hand swells, and develops blistering and apparent necrosis. The patient's primary care provider seeks immediate consultation with a plastic surgeon, the complication is treated and the patient has an excellent outcome.

Although this event is not uncommon and does not meet the definition of a "sentinel event," it still deserves multidisciplinary review and action. Given the complexity of most hospital Quality Improvement systems,

how can this review be done efficiently and effectively? Southcoast Hospitals Group ("SHG") has developed an innovative solution through the implementation of the Patient Safety Action Team.™ ("PSAT"). Here is how the PSAT process works.

When an unexpected event occurs that does not require full "sentinel event" review, the responsible SHG vice president is charged with organizing a PSAT to conduct a review. Team members vary, depending on the issues that need to be addressed. The process allows for

a prompt response to the incident, meaning that the work of the team will be completed in two or three meetings.

The PSAT makes recommendations for systems improvements, based on their review of the issue (individual practitioner issues are not addressed in this forum). The team also identifies methods (monitoring indicators) for measuring the outcome of any actions implemented as a result of their recommendations. SHG's Quality

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Various FDA Updates

A few weeks ago, the FDA issued a Public Health Notification regarding the proper cleaning and sterilizing of reusable ultrasound biopsy transducer assemblies. According to the FDA, if these devices are not correctly reprocessed between patients, residual material from a previous patient may contaminate the biopsy needle and needle guide when the system is reused for biopsies. This could lead to patient infections.

Therefore, the FDA advises that the biopsy needle and its containing guide must always be sterilized. This applies even if a sterile barrier sheath is used on the transducer assemblies

during a biopsy procedure, as the sheath is compromised by the penetration of the needle. To read the complete summary, and other advisories, visit www.fda.gov/medwatch/safety/2006.

This summer, the FDA also released a third report from its Counterfeit Drug Task Force. The report announced new steps to strengthen existing protections against the growing problem of counterfeit drugs.

One recommendation was to require drug distributors to provide documentation of the chain of custody of drug products throughout

the distribution system. To review this and prior task force reports, please visit www.fda.gov/counterfeit.

In June, the FDA also announced a permanent injunction for certain infusion pumps (Colleague and Syndeo) made by Baxter Healthcare Corporation. The Corporation must file a corrective action plan to bring the pumps currently in use in the United States into compliance with the Federal Food, Drug, and Cosmetic Act.

For questions about the injunction and for details about the affected pumps, persons may call 888-INFO-FDA.

Health Care Recognition

Notable Improvement

~South Shore Hospital~

South Shore Hospital has made the following improvements to their Hospitalist Service: creation of a brochure for patients that describes the Hospitalist Service; development of Standardized Order Sets for use by Hospitalists; and implementation of face-to-face Hospitalist “sign off” at change of shift. These improvements in communication between caregivers and patients may also be adopted and put into practice at other health care facilities.



Guest Article

Minimizing the incidence of deep sternal wound infection: one surgeon's perspective. By Stancel Riley, MD*

Deep sternal wound infection (DSWI) is an infrequent but devastating complication of cardiac surgery. For the patient, developing a sternal wound infection doubles the mortality rate of the operation and adversely affects the ten year survival after recovery. Preoperative, intraoperative, and postoperative factors affect the propensity to develop DSWI.

Certain comorbid diagnoses, particularly diabetes, preoperative hemodynamic instability, use of bilateral internal thoracic artery grafts, and sepsis have been found by regression analysis in large patient population studies to affect DSWI development. Luckily, only one percent, or less than one percent, of patients having cardiac surgery develop this complication. Even this small percentage, however, is more than most cardiac surgeons would care to deal with in their practices.

What about prevention? Aren't there processes and system improvements that could reduce the incidence of DSWI even more? The answer is "yes", and the most important of these is attitude.

The hospital and the cardiac surgical team should "buy-in" to the following principles. First, everyone is

accountable. Second, a standardized protocol is essential; surgeon preferences have little place. The excuse for not participating in the protocol of "they didn't do it this way where I trained" is not in the patient's best interest. Even though several steps in the protocol may seem mundane, none are beneath execution by anyone on the team. Whatever protocol a health care institution comes up with to reduce its incidence

Cardiac surgery is not a big operation as much as it is a connected series of small procedures done well.

of DSWI, it must be evidenced-based.

For example, a suggested DSWI protocol begins preoperatively with the administration of intranasal mupirocin in all patients. If the patient remains in the hospital, they should receive no more than two days of mupirocin just prior to operation.

Patients should have a shower or bath using a good antibacterial scrub, such as chlorhexidine gluconate, just prior to surgery. If they are outpatients, use of antibacterial soap for two days prior to arrival at the hospital is useful.

Hair removal should be accomplished using clippers with disposable heads. Several companies

have models available, and most are cordless. This should be done as near to the time of surgery as practically possible. The point is never use a razor to shave the skin. Antibiotics should be administered forty-five minutes to one hour prior to skin incision and then every eight hours intraoperatively, and should be discontinued 24 hours postoperatively.

Skin prep in the operating room should be a preparation containing iodine. Several commercial products are available that also contain alcohol and adhere to the skin in a film.

The operation itself should be thoughtfully done. As always, good hemostasis will prevent reoperation for bleeding. For diabetics, tight blood sugar control is essential. There has been some debate over wound closure techniques and whether one or the other methods may predispose the patient to wound infection. Surgeons must decide for themselves which seems best. An occlusive dressing should be applied to the wound.

In the intensive care unit, the occlusive dressing should remain in place until after the patient's extubation to prevent contamination of the wound by secretions. Again, in diabetics, good blood sugar control is necessary, even if it requires use of an insulin drip.

In the step down unit, the incision should be cleaned and an iodine solution applied to it at least once a

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New Executive Order

In late August, the Bush Administration issued an executive order requiring the Health and Human Services Department, the Defense Department, the Veterans Affairs Department and the Federal Employees Health Benefit Program to compile information about the quality and price of care for which they pay, and to share that information with their customers and each other.

The order also directs the agencies to use health information computer

systems that are compatible so that, for example, a veteran in Maine can be viewed by a doctor working in California if the veteran needs emergency care there during a vacation.

Other directives include (1) making available to beneficiaries the prices that agencies pay for common procedures, (2) developing and identifying practices that promote high-quality care, and (3) enacting programs that measure the quality of

care and developing those measures with the private sector and other government agencies.

Agencies must be in significant compliance with the executive order by January 1, 2007. With the federal government paying for 40 percent of health care in the United States, the hope is that this will generate data that insurers and health care providers can use. It may also generate similar orders on the local level in each state's executive office.☞

What's Happening in PCA for Fall 2006

This fall, the PCA Division will be issuing two advisories: the long-anticipated advisory on hydromorphone, issued jointly with the Board of Registration in Pharmacy, and an advisory on vascular closure devices. In addition, the PCA Division will be rolling out a new format for all

Health Care Facility Reviews, which we believe you will find are clearer and more useful. More information will follow.

PCA will also be finalizing its review of data relative to maternal deaths, releasing statistical data on its program, and continuing its popular

training sessions. We hope to continue to bring relevant and useful information to your health quality departments. Quality and safety are our common goals and we appreciate suggestions and feedback. We look forward to working with everyone throughout the remainder of 2006.☞

Excellence in Patient Safety

Per a media release, the Massachusetts Hospital Association announced the presentation of four awards at its Annual Meeting this past June.

The Massachusetts Hospital Association and the Massachusetts Coalition for the Prevention of Medical Errors presented a one-time award for "Excellence in Patient Safety" to four Massachusetts acute care hospitals. The Excellence awards

were based on the hospitals' success in implementing two Coalition initiatives—Reconciling Medications and Communicating Critical Test Results.

Recipients received the awards based on (1) measurable results in improving patient safety, (2) evidence that the hospital has been able to maintain the gains achieved, (3) the scope of improvement, and (4) the engagement of patients and families.

The recipients of the awards were Milford Regional Medical Center and Noble Hospital for Reconciling Medications, and Mount Auburn Hospital and Marlborough Hospital for Communicating Critical Test Results.

Many health care facilities across the state have made tremendous strides in these two areas as well and are commended for their hard work and dedication to patient safety and reducing medical errors.☞



Patient Safety Action Team™ (continued)

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Steering Committee (a senior management committee) oversees the process and must approve the recommendations. The results of PSAT efforts are also presented to SHG's PCA Committee. All the work of the team is subject to the confidentiality protections provided to the hospital's quality improvement activities.

The IV infiltrate case described above resulted in recommendations by the PSAT for several system-wide improvements, including, but not

limited to, the elimination of hand sites for contrast injections and the installation of new Contrast Injectors at all sites where contrast is administered. The new, two-barreled injectors allow technicians to check



the patency of the IV site prior to contrast injection. The team's recommendations were approved by

the SHG's PCA Committee and have now been implemented system-wide.

Upon final review of the case described above, the patient had not actually experienced a necrotic event. However, the insight gained from a review of the event enabled rapid, proactive implementation of systems-based improvements.

Preventing or minimizing future occurrences is the goal when reviewing unexpected events, such as the one involving the IV infiltrate, and SHG's PSAT provides the means to accomplish that goal. ~

Regulations Update

As of the publication of this newsletter, the Regulations Team at the Board of Registration in Medicine is working with other state agencies to finalize the Board's working draft of

the proposed regulations revisions. Once the working draft is completed, the Board of Registration in Medicine will announce and post the date of the next public hearing. The Board expects

the public hearing to take place later in the fall. The schedule and any new regulations drafts will be on the Board's website. Please keep checking for updates. ~

Guest Article (continued)

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day. Visits by anyone on the team, particularly the surgeon, should be preceded by hand washing - preferably in the patient's presence

A good alcohol-based hand disinfectant can be used, although nothing beats soap and water. If anyone on rounds appears to have forgotten, team members should

remind them of their hand washing obligation.

All of this may sound mundane, but to paraphrase Dr. John Kirklin, cardiac surgery is not a big operation as much as it is a connected series of small procedures done well. So too is the prevention of DSWI, and it is obvious that a multi-disciplinary team must fully participate for optimal patient

outcomes.~

**Dr. Riley trained at the University of Alabama at Birmingham and practiced cardiothoracic surgery for 23 years. He received the Thoracic Surgery Foundation for Research and Education Alley-Sheridan scholarship to Harvard's Kennedy School of Government and the School of Public Health. Currently, he is a research associate at the Harvard School of Public Health.*



Leading the Way (continued)

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Committee representation consists of a broad base of key stakeholders and maintains a balance of purchasers, health care organizations evaluated through NCQA programs, consumers and other quality experts.

Dr. Martin Crane has been elected to the Board of Directors and the Executive Committee for the Federation of State Medical Boards. In addition, he is serving on the Navy

Executive Committee for the Medical and Dental Staff. Lastly, he has been appointed to serve on the National Committee for the Evaluation of Foreign Medical Education and Accreditation (NCFMEA). The NCFMEA was established under the Higher Education Amendments of 1992 (Public Law 102-325). The role of the NCFMEA is to review the standards used by foreign countries to accredit medical schools and

determine whether those standards are comparable to the standards used to accredit medical schools in the U.S. The Committee's function is specified in Section 102(a)(2)(B) of the Federal Higher Education Act.

The Board of Registration in Medicine is fortunate to have two such dedicated and respected individuals working to improve patient safety in the Commonwealth and the nation.☺

Preventing Medication Errors

The Centers for Medicare and Medicaid Services recently sponsored a study with the Institute of Medicine with the aim of developing a national agenda for reducing medication errors.

The study focused on the safe, effective and appropriate use of medication in the major components of the medication use system. The committee estimated that on average a hospitalized patient is subject to a least one medication error per day, with more occurring in outpatient and nursing home settings.

At least a quarter of all medication-related injuries are preventable, and many preventative strategies are

available, especially for acute care hospitals.

The report outlines how a provider-patient partnership can be achieved to reduce medication errors. Steps such as educating the consumer of the purpose of the medications, having consumers maintain medication lists, and improving medication information and resources for consumers create such a partnership.

Additionally, the report also encourages health care providers to create high-reliability organizations that constantly improve the safety and quality of medication use. Provider participation is the key to success.

In conducting the study, the committee also identified enormous gaps in the knowledge base with regard to medication error. Current methods for generation and communication of information about medications are inadequate and contribute to the incidence of errors. In addition, incidence rates of medication errors, the costs of such errors, and the efficacy of prevention strategies are not well understood, and the report proposed a research agenda to address these and other gaps.

Access to the executive summary and full report is at: www.nap.edu.☺

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