

Safe Passages

Safe Passages is a publication of the Michigan Health and Safety Coalition.

Volume 2, Issue 2



Annual Report now available

The Michigan Health and Safety Coalition's 2007 Annual Report is available. You can view it at mihealthandsafety.org. If you would like to receive a print copy of the report, please call MH&SC at 248-448-0023. A limited number of print copies are available.

MH&SC provides comments about PSO rule

Michigan Health and Safety Coalition members provided comments on the proposed Patient Safety and Quality Improvement Rule contained in the Federal Register dated Feb. 12, 2008.

Consensus comments were developed by MH&SC board and steering committee members Colleen Cieszkowski, Beverley McDonald and Sam Watson; MH&SC consultant A.B. Orlik; and MH&SC's Director of Coalition Activities Diane Valade.

Click [here](#) to read MH&SC's comments. To read other comments on the proposed rules, click [here](#).



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Check out *Wall Street Journal's* health blog

The *Wall Street Journal* has a health blog you can read at blogs.wsj.com/health. It features articles and analysis about health and the “business of health.”

You can search for blog topics in the upper-right corner of the Web site. Recent searches found blogs on the nursing workforce shortage and geriatric care.

Leapfrog Hospital Survey: first results are in

First results for the 2008 Leapfrog Hospital Survey are being compiled and will be publicly reported on Leapfrog's Web site in mid-July. As of June 30, 81 (59 percent) of eligible Michigan hospitals had responded to the survey, a much higher rate than the national average of 37 percent. A listing of participating hospitals is available on the Michigan Health and Safety Coalition's Web site, mihealthandsafety.org. The 2008 Leapfrog Hospital Survey is open until March 31, 2009. The MH&SC urges all hospitals to submit their responses as soon as possible as there is still an opportunity to be considered for Leapfrog's Top Hospital designation.

What do patients think about your hospital?

Web site gives findings for hospitals throughout the country

An average of 68 percent of Michigan hospital patients would recommend the hospital they were in to friends and family. That's just one of the findings available for consumers to view on the Web site hospitalcompare.hhs.gov.

The Department of Health and Human Services asked patients who were admitted to short-term, acute-care, nonspecialty hospitals a variety of questions to find out answers to:

- How often did nurses communicate well with patients?
- How often did doctors communicate well with patients?
- How often did patients receive help quickly from hospital staff?
- How often was patients' pain well-controlled?
- How often did staff explain about medicines before giving them to patients?
- How often were patients' rooms and bathrooms kept clean?
- How often was the area around patients' rooms quiet at night?
- Were patients given information about what to do during their recovery at home?
- How do patients rate the hospital?
- Would patients recommend the hospital to friends and family?

Nationally, an average of 67 percent of patients said they would recommend their hospital to friends and family. In Michigan, 65 percent of patients rated their hospitals a 9 or 10 on a scale of 0 (lowest) to 10 (highest), compared to 64 percent of patients nationally.

You can read more about the survey and see the results by hospital at hospitalcompare.hhs.gov.



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Michigan Health and Safety Coalition members

Blue Cross Blue Shield of Michigan

Chrysler LLC

Ford Motor Company

General Motors Corporation

Michigan Association of Health Plans

Michigan Consumer Health Care Coalition

Michigan Department of Community Health

Michigan Education Special Services Association

Michigan Health & Hospital Association

Michigan Nurses Association

Michigan Osteopathic Association

Michigan Pharmacists Association

Michigan State Medical Society

MPRO

NPSF proposes Universal Patient Compact

In March, the National Patient Safety Foundation proposed developing a Universal Patient Compact to complement the Consumer Bill of Rights and Responsibilities. The Compact will build on principles contained in the Consumer Bill of Rights to establish a mutual covenant between health care providers and their patients.

The Compact focuses on the relationship between the patient and the caregiver by creating an understanding between the parties about how they will work together. It will describe the agreed-upon commitments that all must make to provide a care process that is truly patient- and family-centered, and respects the rights of patients.

The idea for the Compact came out of a roundtable discussion at the 2007 Nursing Leadership Congress.

The next steps in developing the Compact involve gaining consensus within the health care industry on the specific components of the Compact and its use.

Find out more at npsf.org.

RM&PSI newsletter features informative articles

The Spring 2008 issue of *Risk Rx*, a newsletter from the Risk Management and Patient Safety Institute, features two articles you may be interested in reading. The first one, "Physician Partnership in Reducing CMS Hospital-Acquired Preventable Conditions," discusses the eight preventable hospital-acquired conditions, according to the Centers for Medicare & Medicaid Services, and how active participation by physicians is essential to minimize their occurrences. The other article, "Physician Enthusiasm for Root Cause Analysis and How to Remove Existing Barriers," discusses the importance of physicians' participation in root cause analysis, an event analysis tool that can be used to identify opportunities for improving patient care delivery systems while reducing the risk of adverse patient outcomes.

Click [here](#) to read the newsletter.



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To: Agency for Healthcare Research and Quality, Office for Civil Rights, HHS

From: Diane Valade, Director of Coalition Activities
On behalf of the Michigan Health and Safety Coalition

Re: RIN 0919-AA01
Comments on Proposed Rule Implementing the Patient Safety and Quality Improvement Act of 2005

Date: April 14, 2008

Executive Summary

Overall, the Michigan Health and Safety Coalition appreciates the intention and execution of the draft rule. Five areas of concern remain:

1. To enhance participation among providers, we request elimination of some of the proposed rule's exceptions to privilege and confidentiality protections for patient safety work product (PSWP). We believe PSWP should be *more* protected than would be the case under the proposed rule.
2. To enhance participation and streamline operations, we request that the proposed rule specify that privilege and confidentiality protections apply to any PSWP that a provider creates or collects with the intention of reporting to a PSO, whether that data has been transmitted or not. The provider should be required to demonstrate the intent to report in order to gain protections.
3. To enhance the value of patient safety data reporting, we request that the agency develop a centralized mechanism (most likely housed within AHRQ) for patients/consumers to report their experiences of patient safety events. It will not be sufficient to allow PSOs to collect such data, as patients cannot be expected to learn which PSOs have contracts with which providers. It will be critical, therefore, that such a mechanism be centralized, with data being sent to appropriate PSOs per contracts with providers. Only with such a mechanism in place will the critical patient/consumer perspective of a patient safety event be captured to contribute to learning and improvement.
4. To mitigate a potential cost barrier for start-up patient safety organizations (PSOs), we request confirmation that the proposed additional certifications for component PSOs allow such organizations to secure data behind firewalls within existing information systems in lieu of purchasing and maintaining entirely separate systems.
5. To facilitate regional and statewide activities, we request clarification that the proposed rule does not and will not prohibit publication of regional and/or statewide data from the anticipated network of patient safety databases. Further, we would encourage the agency to acknowledge and support these efforts in the final rule.

Context

The Michigan Health and Safety Coalition offers these comments from its perspective as a voluntary coalition of diverse health care stakeholders committed to a common vision: Everyone knows their health care is safe.

Since 2000, Coalition participants have worked together to identify and implement patient safety and quality improvement measures in health care settings across the state. In 2004, the Coalition was designated the State Commission on Patient Safety by Governor Granholm. In this role, the Coalition took public testimony, reviewed the relevant literature, studied activities in other states, and developed a set of recommendations for collaborative statewide action designed to lead to safe care for every patient/consumer/resident every time.

Specific comments on the draft rule follow.

Area 1: Limit Exceptions to Privilege and Confidentiality Protection

The areas of patient safety data collection, analysis, reporting, and protection were the subject of a great deal of public testimony submitted to the Commission, so warranted considerable study and discussion during the Commission's deliberations. This excerpt from the testimony of the VA National Center for Patient Safety reflects the position of many who participated in the process:

The confidentiality of reported information is critical to the success of a reporting system. Without assurance that this information could not be used in a punitive way against the reporter, there would not be a rational incentive to report patient safety information. ... It is important to recognize that making patient safety information confidential does not deprive any of the pre-existing internal or external accountability systems of information that are required.

Overall, the proposed rule does an excellent job of protecting patient safety data and reporting activities without denying patients/families access to information through normal channels when medical errors or unexpected events occur. The proposed rule notes that parallel systems of investigation, data collection, and analysis are *not* subject to these provisions; thus, the availability of the data, reports, notes, and other materials from these parallel systems would continue to be available as they are today.

However, the Coalition is concerned that the following exceptions to privilege and confidentiality protections jeopardize the intended non-punitive nature of the work of PSOs, are likely to discourage development and reporting of PSWP, and thus likely jeopardize the health of this voluntary system of analysis and learning.

Except in very limited cases, we believe Federal, State, local, or Tribal civil, criminal or administrative proceedings should rely on data and information from sources other than PSWP. We therefore request modification to proposed § 3.204(b) as follows:

1. Eliminate proposed § 3.204(b)(1)—Criminal Proceedings, § 3.204(b)(3)—Authorized by Identified Providers, and § 3.204(b)(4)—Nonidentifiable Patient Safety Work Product
2. Modify proposed § 3.204(b)(2)—Equitable Relief for Reporters to permit, with the reporter's consent, release only of the fact that a report was generated/submitted and the timing of the report. Prohibit release of any details from the report, whether nonidentifiable or not. It appears that what would be relevant in cases of equitable relief would be whether a report was filed at a time consistent with the employee's claim of adverse employment action. Details of the patient safety event, if needed to support such a claim, could be obtained through parallel systems.

3. Clarify that the exception contained in proposed § 3.204(c) is intended only to support audits by the agency of the administrative processes related to PSWP generated, collected and analyzed by providers and PSOs under the proposed rule to ensure that this system of patient safety improvement is functioning as intended.

The Coalition recognizes that certain exceptions to confidentiality protections are a necessary accommodation for patient safety activities to thrive. However, to ensure robust reporting, we request the following modifications to proposed § 3.206(b):

1. Eliminate proposed § 3.206(b)(1)—Criminal Proceedings and § 3.206(b)(10)—Disclosure to Law Enforcement. Criminal proceedings and other law enforcement actions should rely on evidence from parallel systems, not from this voluntary, non-punitive learning environment. If proposed § 3.206(b)(1) is not eliminated, the Coalition urges the agency to require a protective order as a condition of this disclosure to guard against further disclosure.
2. Modify proposed § 3.206(b)(2)—Equitable Relief for Reporters to permit, with the reporter's consent, release only of the fact that a report was generated/submitted and the timing of the report. Prohibit release of any details from the report, whether nonidentifiable or not. It appears that what would be relevant in cases of equitable relief would be whether a report was filed at a time consistent with the employee's claim of adverse employment action. Details of the patient safety event, if needed to support such a claim, could be obtained through parallel systems.
3. Eliminate proposed § 3.206(b)(3)—Authorized by Identified Providers. It is particularly troublesome that neither patient nor reporter authorization is required under the proposed § 3.206(b)(3). If this section is not eliminated, we urge the agency to require authorization by reporters and patients and/or their agents before release pursuant to this exception.
4. Retain proposed § 3.206(b)(5)—Disclosure of Nonidentifiable Patient Safety Work Product. We support the more stringent standard of contextual nonidentification with the understanding that data released under this standard may be less useful to external recipients. We believe this stringent standard will enhance participation among reporters, thus improving the usefulness of these systems.
5. Modify proposed § 3.206(b)(6)—For Research and § 3.206(b)(7)—To the Food and Drug Administration to allow disclosure only with provider and reporter identifiers in an anonymized or encrypted but not fully nonidentified form. This provision would parallel to the exception for data sharing by a PSO with other PSOs or other providers that have reported to a PSO as allowed in proposed § 3.206(b)(4).
6. Eliminate proposed § 3.206(c)—Safe Harbor. This provision seems counter to the agency's (and our) concern regarding the potential for adverse employment actions and other consequences for reporters.

Area 2: Application of Privilege and Confidentiality Protection

We recommend that privilege and confidentiality protections apply to any patient safety work product that a provider creates or collects with the intention of reporting to a PSO, whether that data has been transmitted or not. The provider should be required to demonstrate the intent to report in order to gain protections.

Area 3: Centralized Mechanism for Patient/Consumer Reporting

The proposed rule does not address the question of patient/consumer reporting of patient safety events. To enhance the value of patient safety data reporting, we request that the agency develop a centralized mechanism for patients/consumers to report their experiences of patient safety events.

It will not be sufficient to allow PSOs to collect such data, as patients cannot be expected to learn which PSOs have contracts with which providers. It will be critical, therefore, that such a mechanism be centralized, most likely within the Agency for Healthcare Research and Quality or the Office for Civil Rights. This way a single postal address, telephone number, email address, or website address can be made available to all patients/consumers wishing to report the details of a patient safety event. Data collected in this manner should be forwarded to the appropriate PSOs per their contracts with providers.

Only with such a mechanism in place will the critical patient/consumer perspective of a patient safety event be captured to contribute to learning and improvement.

Area 4: Data Security in Component PSOs

Proposed § 3.102(c)(1)(i) could be interpreted to require component PSOs to maintain PSWP on entirely separate information systems from the parent organization. To mitigate a potential cost barrier for start-up PSOs, we request clarification that this section would allow such organizations to secure data behind firewalls within existing information systems in lieu of purchasing and maintaining entirely separate systems. If the section, as proposed, does not permit use of such firewalls in lieu of separate systems, we request that the section be modified to permit use of such firewalls within existing systems.

Area 5: Data Standardization and Use of Regional/Statewide Data

Proposed § 3.102(b)(2)(vi) requires PSOs, to the extent practical and appropriate, to collect PSWP from providers in a standardized manner that permits valid comparisons of similar cases among similar providers in anticipation of a network of patient safety databases envisioned by the Patient Safety Act. We understand that the intention is to encourage aggregation and/or sharing of nonidentifiable data across PSOs. To ensure that regional and statewide activities benefit from the insights of these data, we request clarification that the proposed rule does not and will not prohibit publication of regional and/or statewide nonidentifiable data from the anticipated network of patient safety databases. Further, we would encourage the agency to acknowledge and support these efforts in the final rule.

We greatly appreciate this opportunity to comment on the proposed rule. Should you have any questions regarding our suggestions, please contact

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Thank you.



Physician Partnership in Reducing CMS Hospital-Acquired Preventable Conditions

By Caroline Brill

The Centers for Medicare & Medicaid Services (CMS) has announced that reimbursement will be denied for certain preventable conditions that develop during hospital stays.¹ The cost of treating preventable adverse events is an astounding \$17 billion annually.² In response to the high cost of treating preventable hospital-acquired conditions, as well as other factors, CMS will deny payment to hospitals when patients develop specific conditions during inpatient stays.¹

CMS Preventable Conditions Affect Physicians

Physicians will be directly and indirectly affected by this recent CMS initiative in several ways. Denying payment to hospitals for specific hospital-acquired conditions has paved the way for Medicare to consider reducing physician reimbursement.³ Therefore, physicians are encouraged to evaluate their patient population and identify whether their patients are at risk of developing specific hospital-acquired conditions. If so, active participation in hospital initiatives to prevent the occurrence of the identified conditions specific to their patients is strongly recommended.

CMS targeted eight nonreimbursable conditions that include several National Quality Forum recognized “never events.” The preventable conditions and the known rate of frequency in 2006 are as follows:

- pressure ulcers (322,946)
- hospital-acquired injuries, such as fall, fracture, burn (175,000)
- object left in during surgery (764)
- air embolism (45)
- blood incompatibility (33)
- catheter-associated urinary tract infection (11,780)
- post-CABG mediastinitis (108)
- vascular catheter-associated infection (frequency not specified)²

There are several preventive measures that practitioners may consider to reduce the rate of documented CMS preventable conditions. First, conduct and document thorough patient assessments at the time of admission to capture pre-existing conditions. CMS reimburses based on

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Physician Partnership in Reducing CMS Hospital-Acquired Preventable Conditions

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diagnosis related groups (DRGs) reported at the time of discharge.⁴ In the past, higher payments were made for patients who had complications that arose during a hospital admission.⁴ Beginning on Oct. 1, 2008, CMS will no longer reimburse hospitals when, during a hospital stay, a patient develops any of the eight preventable conditions listed on the previous page.⁴ If documentation supports existence of the condition at the time of admission, then payment on behalf of the patient for that particular DRG can be expected.⁴ Additional suggestions for physician participation in accordance with specific, preventable hospital-acquired conditions are set forth below and on the following pages.

Pressure Ulcers

Assessing patients for the presence of bedsores and documenting findings will be critical at the time of patient admission, both by the physician and the admission nurse:

- a thorough skin assessment, especially over pressure points, is completed by the practitioner, with detailed documentation of any abnormalities
- a referral is made for patients with signs of a decubitus ulcer
- a referral is also made for patients at a high risk for developing pressure sores, such as those with poor mobility, poor skin condition and/or poor nutritional status³

Familiarity with hospital policies and procedures pertinent to skin care is helpful for the medical practitioner. During multidisciplinary patient rounds, patient skin status and the effectiveness of nursing measures implemented to maintain skin integrity are discussed.



Hospital-Acquired Injuries

Falls and Accidents

Patients benefit most from a multidisciplinary approach to fall risk assessment, intervention, and care planning.⁵ Nurses typically assess and document the risk of patient falls at the time of admission and periodically thereafter. When appropriate, the nurse may initiate the hospital fall prevention program and communicate to the physician that the patient may benefit from physical therapy, occupational therapy, dietary, rehab, or pharmacy consults, and a physician order may be requested for certain consults.

Physicians should be aware that a patient's fall risk increases if the patient is elderly and taking four or more medications or taking psychotropic medications.⁵ If the patient's fall risk is increased due to the medication regimen, the physician can consult with the pharmacist to determine whether the medication plan can be modified.⁵

Fall risk identification and education should be provided to patients not only during hospital admission, but also during evaluation in the physician office setting. Physicians should be aware of and monitor their patients for the existence of risk factors and implement preventive measures accordingly. The ECRI Institute offers a list of intrinsic risk factors that includes:

- greater than 65 years of age
- history of falls
- physical impairments
 - incontinence or urinary frequency or urgency
 - lower extremity weakness
 - gait and balance deficits; proprioceptive dysfunction
 - functional impairment (e.g., inability to perform basic activities of daily living)
 - cervical degenerative disorders
 - postural or orthostatic hypotension
 - neuropathy
 - foot disorders

- psychological/behavioral factors
 - changes in mental status, including dementia and depression
 - poor impulse control
 - belief that asking for help is inappropriate
- sensory, vision or hearing impairment
 - reduced visual acuity
 - slowing darkness adaptation
 - perceptual changes (e.g., inability to perceive depth; reduced contrast sensitivity)
 - loss of hearing
- medication use
 - use of tranquilizers, sedative-hypnotic drugs or antihypertensive drugs
 - use of four or more prescription drugs⁶



Physicians may work collaboratively with other members of the health care team to provide education to patients and families regarding measures to take at home to prevent falls. In addition, a home hazard assessment may be offered.⁵

Burns

The risk of surgical fires resulting in patient burns can be lessened when components of the fire triangle (fuels, ignition sources and oxidizers) are reduced or eliminated.⁷ Various members of the surgical team can be a critical factor in the fire triangle. The surgeon has control over ignition sources during the use of cautery devices, lasers, and other light sources; the anesthesia practitioner is involved with oxidizers, including oxygen and nitrous oxide; and nurses typically manage fuels such as operative prep solutions, equipment, drapes and dressings.⁷

Surgeons and anesthesiologists have a highly significant role in creating a safe environment in the perioperative area by:

- identifying specific fire hazards
- obtaining flame resistant solutions, drapes, and other items as available
- engaging in practitioner training for use of cautery devices, lasers, and other light sources and offering proctoring when appropriate
- participating in surgical fire drills with the entire perioperative team

Object Left in During Surgery

In a recent study posted by The New England Journal of Medicine, the risk of foreign body retention after surgery was increased during emergency surgeries, unplanned changes in procedure, and in patients with higher body mass index.⁸ Remarkably, approximately two-thirds of the cases studied reflected verification of final sponge and instrument counts.⁹ Thus, participating in drills to evaluate how the count process may be affected by emergency or unplanned change in procedure may be helpful. In addition, including towel counts in abdominal surgeries in larger patients is recommended.

The American College of Surgeons also provides guidelines for prevention of retained foreign objects, including but not limited to:

- a multidisciplinary team goal to promote best patient outcomes
- effective communication among perioperative team members
- standardization of all involved processes and action steps
- implementation of certain practices to prevent retention of foreign objects, including:
 - standardized counting procedures
 - methodical wound exploration before closure
 - use of X-ray detectable items within the surgical wound
- thorough documentation of surgical counts and actions taken when discrepancies occur or counts are waived
- the presence of policies and procedures that address the prevention of retained foreign bodies¹⁰

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Physician Partnership in Reducing CMS Hospital-Acquired Preventable Conditions

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Air Embolism

Air embolism may occur during central venous catheter insertion. Practitioners must be properly trained and/or proctored in central line catheter insertion to ensure that proper technique is followed. Catheter hubs should be properly capped at all times and the patient should be in Trendelenburg's position during central venous catheter insertion to prevent air embolism.¹¹ Collaborative work with nurses may be highly effective to develop a central line insertion team checklist that includes but is not limited to ensuring hubs are capped and that the patient is properly positioned for central line catheter insertion.



Blood Incompatibility

Acute hemolytic transfusion reactions can be fatal and may result from the administration of incompatible blood.¹² Causes of this type of preventable medical error may include

- collection of blood from the wrong patient
- mislabeled blood specimens
- misidentification of the sample at the blood bank
- incorrect blood supplied by the blood bank
- blood administered to the wrong patient¹²

There are several controllable contributing factors, such as patients with similar or identical names and verbal or stat orders.¹² Therefore, when ordering blood, the physician should refrain from providing verbal/telephone orders for the administration of blood products. In addition, when entering orders for blood products, one must be sure to verify that the orders are being entered into the correct patient's medical record.

Catheter-Associated Urinary Tract Infection

At the time of admission, practitioners must be sure to document patient assessment for signs and symptoms of urinary tract infection. It is helpful to discuss the continued need for urinary catheters, as applicable, during multidisciplinary rounds and then monitor for compliance.

Post-CABG Mediastinitis

The Surgical Care Improvement Project (SCIP), through a collaborative effort with multiple organizations and partnership with hospitals, provided recommendations to reduce surgical complications, including surgical site infections.¹³ SCIP measures call for the administration of intravenous Cefazolin, Cefuroxime or Vancomycin within one hour before coronary artery bypass graft (CABG) surgery to reduce the risk of postoperative infection.¹³ Prophylactic antibiotic therapy should be ceased within 48 hours after the surgery end time.¹³

Physicians, nurses and pharmacists are encouraged to work collaboratively to institute SCIP measures, monitor timely antibiotic prophylaxis, and determine appropriate action plans when goals related to SCIP measures have not been met. SCIP offers several strategies to improve quality outcomes regarding timely and appropriate antibiotic therapy,¹³ such as:

- standing orders for antibiotic therapy
- assign responsibility to infuse preoperative antibiotics to the nurse in the holding area
- ensure the pharmacy stocks the appropriate antibiotics
- utilize forms that facilitate accurate documentation of antibiotic administration
- expand the "time out" procedure to include verification that preoperative antibiotics were administered¹³

Quality outcomes related to SCIP measures are best discussed in the multidisciplinary surgery committee, where actions to meet agreed upon guidelines are determined and approved for implementation. Effectiveness of corrective and preventive action steps are evaluated and necessary changes are made until quality outcome goals are met.

Vascular Catheter-Associated Infection

Best practices for prevention of central line catheter infections have been outlined in the Institute for Healthcare Improvement's (IHI) central line bundle.¹⁴ The bundle includes measures to address

- hand hygiene
- maximal barrier precautions at the time of catheter insertion
- Chlorhexidine skin antiseptis
- optimum catheter site selection
- daily review of line necessity and timely removal of unnecessary lines¹⁴

Physician involvement with initiatives to implement and monitor compliance with central line bundles is indispensable for success. As mentioned above, the implementation of a central line insertion team checklist may be useful to ensure all appropriate aseptic measures are instituted at the time of line insertion.

Conclusion

This article addressed the eight CMS preventable hospital-acquired conditions and discussed how active participation by physicians is essential to minimize the occurrence of the identified conditions. A multidisciplinary approach, including active participation by physicians, nurses, ancillary personnel and hospital leadership, is necessary for the successful elimination of the above preventable conditions, which are soon to be nonreimbursable, as well as any other clinical patient safety hazards in any health care setting.

References

- 1 Caroline Brill, "CMS Won't Pay for Adverse Outcomes in 2008: What is the Optimum Hospital Response?" *RM&PSI Instant E-Mail News*, Sept. 4, 2007.
- 2 Karol Wareck, *New CMS Reimbursement Rule: Eight "Preventable Conditions,"* presentation, November 2007.
- 3 Susan Fitzgerald, "Medicare Takes Aim at Hospital-Acquired Conditions - New reimbursement rules could put hospitalists in the driver's seat," *ACP Hospitalist*, 2007, www.acponline.org/clinical_information/journals_publications/acp_hospitalist/nov07/cover_story.htm, 2/7/08.
- 4 Meredith B. Rosenthal, "Nonpayment for Performance? Medicare's New Reimbursement Rule," *New England Journal of Medicine*, Vol. 357, No. 16, Oct. 18, 2007, pp. 1573-1575.
- 5 Cindy L. Hellerstedt, "Are Patient Falls an Avoidable Medical Error?" *RM&PSI White Paper*, April 17, 2007.
- 6 ECRI Institute "Falls," *Healthcare Risk Control Risk Analysis*, Vol. 2, Safety and Security 2, Sept. 2005.
- 7 The Joint Commission, "Preventing Surgical Fires," *Sentinel Event Alert*, Issue 29, June 24, 2003.
- 8 Atul A. Gawande, David M. Studdert, E. John Orav, Troyen A. Brennan, and Michael J. Zinner, "Risk Factors for Retained Instruments and Sponges after Surgery," *New England Journal of Medicine*, Vol. 348, No. 3, Jan. 16, 2003, pp. 229-235.
- 9 Robert A. Wascher, "Retention of Surgical Foreign Bodies after Surgery," *Jewish World Review*, 18 Shevat, 5763, Jan. 21, 2003, www.jewishworldreview.com/0103/gezunt01203.asp, 2/15/08.
- 10 American College of Surgeons, "Statement on the Prevention of Retained Foreign Bodies after Surgery," *Bulletin of the American College of Surgeons*, Vol. 90, No. 10, October 2005, www.facs.org/fellows_info/statements/st-51.html, 2/15/08.
- 11 David C. McGee and Michael K. Gould, "Preventing Complications of Central Venous Catheterization," *The New England Journal of Medicine*, Vol. 318, No. 12, March 20, 2003, pp. 1123-1133.
- 12 American Blood Centers®, "Hemolytic Transfusion Reactions Part 1: Biological Product Deviations (Errors and Accidents)," *Blood Bulletin*, Vol. 3, No. 3, November 2000, www.sbcinfo.org/publications/bulletin_v3_n3.htm, 2/20/08.
- 13 Surgical Care Improvement Project (SCIP) Module 1: Infection Prevention Update, release date June 5, 2007, www.medscape.com/viewprogram/7214, 2/15/08.
- 14 Caroline Brill, "Central Line Catheter Infections - New Success in Making Them a Thing of the Past," *RM&PSI White Paper*, Dec. 26, 2007.



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Physician Enthusiasm for Root Cause Analysis and How to Remove Existing Barriers

By Cindy L. Hellerstedt

Physicians are passionate about providing high-quality care and achieving positive clinical results. Physicians also have the expertise and knowledge required to conduct a thorough and objective analysis of a significant adverse event and provide insight into how to improve medical management.

Root cause analysis (RCA) is one well-proven tool of event analysis designed to identify opportunities for improving patient care delivery systems while reducing the risk of adverse patient outcomes. At Stanford Medical Center, physician leaders believe that:

Physician participation in this [RCA] process is crucial. We can learn about the perspective of other health care providers, and the brainstorming that occurs can lead to profound changes in how we care for our patients. Accordingly, physician [sic] should embrace this type of analysis as a tool that will help ensure the safety of their patients.¹



In addition to lending clinical expertise to the RCA process, physician participation adds credibility and facilitates medical staff implementation of improvement strategies. “When a physician takes the time to participate in a root cause analysis, it sends a message not just to organization staff, but to the medical staff as well.”²

The Joint Commission has gone so far as to say that, “An RCA will usually not be accepted by JCAHO [The Joint Commission] if the analysis did not include a physician in the process.”² However, it is not always necessary for the same physician involved in the event to be the physician that participates in the RCA. Another physician with knowledge of the process under review or a medical staff department leader could also contribute a physician’s perspective to the analysis.²

Although it appears that physician participation in RCAs is highly recommended, there is often resistance. Reasons for the absence of enthusiasm among physicians to participate in RCAs may include:

- concerns about disciplinary actions or malpractice actions against either themselves or their colleagues as a result of the analysis
- a perception that it will be a waste of time
- a lack of understanding the process^{2, 3}

Here are some suggestions to mitigate these barriers:

RCA results will be used against physicians — Organizations must consistently “walk the talk” to gain physician trust. In other words, the RCA process must truly be focused on systems and processes and not primarily on individuals. If, however, a professional practice concern is indeed identified, it should be addressed separately, through the peer review process.

Explaining state statutory protection of quality review information obtained through the RCA process may alleviate concerns related to potential litigation and discovery. Describing the methods used by the organization to enhance statutory protection, such as highly controlled access to documents and avoiding the use of provider names in documents, is helpful. The Joint Commission has also recognized this concern and offers alternative methods for submitting the RCA that are designed to protect the confidentiality of RCA information.⁴

RCA is a waste of time — Everyone in health care is doing more with less time. The resources needed to conduct a thorough and credible RCA can be considerable. To effectively use physician and staff time, the RCA team leader and team facilitator must be very organized and well prepared ahead of the team meetings. The team leader and facilitator ideally conduct the investigation and prepare draft analysis documents, such as flowcharts, prior to the team meeting and, in a focused manner, solicit team feedback at the meeting to revise the draft until it is complete and accurate.

Scheduling meetings at those times that are most convenient for the physician is important as well. Meetings may need to be scheduled before or after office hours. Also ask whether the physician would prefer to have one or two long meetings as opposed to several shorter meetings. Asking for physician input on scheduling is another way to enhance buy in and participation.

Physicians do not understand the RCA process — Patient safety is not a new concept of health care quality and risk management; however, a groundswell of efforts to safeguard patients from inadvertent harm has emerged since the 1999 IOM report *To Err is Human*. Today, most medical residents receive instruction on how to conduct an RCA.⁵ Physicians who completed their medical training prior to the patient safety movement may not have received training on the RCA process.



RCA education can be provided through various methods, such as:

- internal staff or physician champions providing formal educational programs, informal “just in time” training, or self study materials
- external experts providing formal onsite educational programs, audioconferences or CDs
- online educational programs

Active and enthusiastic physician participation in the RCA process is a contribution of the highest order toward meeting the vision and challenging goals of patient safety in every health care setting.

It is not unusual for the physicians to receive CME credit for completing RCA training. The Massachusetts Medical Society sponsors an online RCA training course, *Patient Safety: Conducting a Root Cause Analysis of Adverse Events*.⁶ NetCE, an online CME site, also offers a course called *Medical Error Prevention and Root Cause Analysis*.⁷ Completion of these courses qualifies the physician to receive AMA PRA Category 1 Credit.

In summary, active and enthusiastic physician participation in the RCA process is a contribution of the highest order toward meeting the vision and challenging goals of patient safety in every health care setting. Ideally, such participation is strongly and materially supported by organizational leaders seeking to make full implementation of new patient safety strategies an undeniable fact of organizational life for future years to come.

References

- 1 Raymond Gaeta, “Getting to the Root Cause,” column by the president of the Medical Staff, Stanford Hospital and Clinics, *Medical Staff Update*, Volume 27, Number 3, March 2003.
- 2 The Joint Commission, “Integrating Physicians into the Root Cause Analysis Process,” *Joint Commission Perspectives*®, Vol. 22, Issue 6, June 2002.
- 3 Robert A. Braun, “Sentinel Events and Root Cause Analysis: Role of the Physician in Risk Management,” CCD Health Systems, page last modified on Aug. 24, 2007, www.sentinel-event.com/physicianrole.php.
- 4 The Joint Commission, *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*, Joint Commission Resources Inc., Oakbrook Terrace, IL, 2007, p. SE-9.
- 5 John Gossbee, “Root Cause Analysis (RCA) - Instructors Guide and Exercise,” VA National Center for Patient Safety, n.d., http://www.va.gov/ncps/curriculum/RCA/InstrPrep/Root_Cause_Analysis_Instru_Guide.doc.
- 6 Online continuing education, sponsored by the Massachusetts Medical Society, “Patient Safety; Conducting a Root Cause Analysis of Adverse Events,” www.massmed.org/AM/Template.cfm?Section=Patient_Safety_Conducting_a_Root_Cause_Analysis_of_Adverse_Events.
- 7 NetCE, continuing education online, “Medical Error Prevention and Root Cause Analysis,” www.netce.com/courseoverview.php?courseid=295.



Meeting the Challenges of Conducting an Effective Root Cause Analysis comes with audio-conference handouts, and physicians purchasing the CD will receive CME credit. For more information about this opportunity, go to www.rmpsi.com, click on education and then audioconferences, or contact us at (888) 466-4272 or at rmpsi@rmpsi.com.

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