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Robert Folzenlogen MD

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## Hospitalist Update

### *Primum non nocere*

Carla Dyer MD

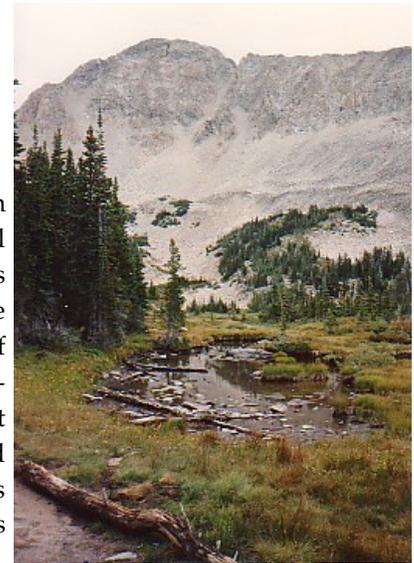
As a follow up to the *To Err is Human Report*, in 2001, the Institute of Medicine described six overall “aims for improvement” in healthcare: care that is patient centered, efficient, timely, equitable, effective and safe. While simple enough, as a practitioner of hospital medicine, one quickly realizes that the realities of universally achieving these goals can be, at the very least, challenging. Patient safety has played an increasingly prominent role in many hospitals over the past 25 years and many important strides have been made in this area.

One example is the *5 Million Lives Campaign*, sponsored by the Institute for Healthcare Improvement in 2006, with the goal of protecting 5 million lives from medical harm by using evidence-based standards of care. Over 4000 hospitals enrolled in that effort, including 60 from Missouri. However, care that does not meet these ideals continues to make headlines. Just this week, an article in the *Archives of Internal Medicine*, by Eber et al., estimates that 48,000 deaths were attributed to health care acquired sepsis and pneumonia in 2006, costing over 8.1 billion dollars (Eber, 2010). The numbers may be controversial and political opinions regarding “fixes” for the current system may vary but the reality remains that, in an era of rising health care costs, our health-care system still has many opportunities to integrate proven methods to make our patients more safe.

Consider these 10 simple ways to improve the care of our patients. These suggestions are adapted from focus areas of the IHI’s *5 Million Lives Campaign* and the 2010 National Patient Safety Goals for Hospitalized Patients (Joint Commission):

### Ten Ways to Provide Safer Care:

1. Practice **good hand hygiene**. Plain and simple. This is the single most effective way to decrease the transmission of infections in hospitalized patients. Alcohol-based hand disinfectants or a 30 second soap and water scrub may be used.
2. Take a **“time-out” prior to invasive procedures**, including common, bedside procedures such as central line placement, thoracentesis, paracentesis, etc. Confirm two identifiers, purpose of procedure, site of procedure, etc. (continued, page 2)



3. **Prevent nosocomial infections.** Catheter-associated urinary tract infections and vascular-catheter associated infections are on the 2009 CMS list of “never events.”

A. **Reduce indwelling urinary catheter use**

B. **Use a central line “checklist” for catheter insertion.** This bundle consists of 1. hand hygiene, 2. maximal barrier precautions, 3. chlorhexidine skin antisepsis, 4. optimal catheter site selection and 5. prompt removal of unnecessary lines. Units instituting this process have seen a dramatic decrease in central venous catheter-related bloodstream infections (Berenholtz, 2004)

C. **Use ventilator “bundle”** to prevent hospital acquired pneumonia: elevate the head of the bed, daily assessment of readiness for extubation, peptic ulcer disease prophylaxis and DVT prophylaxis.

4. **Prevent adverse drug events** through medical reconciliation. Approximately half of all medication errors occur during transitions of care, making medical reconciliation upon admission and at discharge essential.
5. Make **venous thromboembolism prophylaxis** a routine and consistent part of your patient’s care. VTE is the most common preventable cause of death in the hospital setting (Geerts, 2008)
6. Prevent harm from **“high alert” medications**: i.e. insulin, anticoagulants, narcotics and sedatives. Adverse drug events from these medications account for approximately half of preventable events.
7. **Prevent decubitus ulcers.** Decrease morbidity related to pressure ulcers by assessing the skin condition daily, decreasing moisture accumulation, optimizing nutrition and minimizing local pressure.
8. Implement and utilize **Rapid Response Teams**: an unexpected decline in a patient’s status should trigger the immediate response of an interprofessional team to assess, treat and determine the requirements for safe, continuing care.
9. **Demand effective patient handoffs.** Standardized checklists for patient handoffs are increasingly utilized in an effort to improve the thoroughness of information provided during transfer of care. Also, **SBAR techniques** for effective communication are increasingly utilized in healthcare; this system originated in the US Navy as a means of communicating information about submarines. It consists of 4 components: Situation—description of immediate issue; Background—description of clinical findings, related diagnoses, prior treatment etc.; Assessment—what is thought to be going on; Recommendation—for therapy or contingency plans.
10. **Report medical errors and near-misses.** While the culture of reporting these errors is gradually changing, it is important to recognize that transparency is essential to providing opportunities to improve the system and to thereby reduce such events in the future.

(continued, page 3)

National Patient Safety Awareness Week will be March 7-13 this year. Many such “awareness weeks” come and go with barely more than a sign in the elevator to recognize their existence. Take a few moments this next month to look at your own practices and determine which areas could be improved to ensure that safe care is always provided to your patients. Finally, make sure that your entire interprofessional team understands and maximizes their role to provide safe patient care. These efforts will certainly not create a perfect healthcare system but they will move us one step closer to achieving the goals of quality healthcare. *Primum non nocere*—first, do no harm.

**REFERENCES:**

Crossing the Quality Chasm: A New Health Care System for the 21st Century (Institute of Medicine, 2001)

Eber, et al., Clinical and Economic Outcomes attributable to Healthcare-Associated Sepsis and Pneumonia, Arch Int Med 2010; 170(4): 347-353

Berenholtz, et al., Eliminating catheter-related bloodstream infections in the Intensive Care Unit, Crit Care Med 2004; 32:2014-2020

Geerts, William et al., Prevention of Venous Thromboembolism: American College of Chest Physicians Evidence-based Practice Guidelines (8th Edition), Chest 2008; 133(6): 3815-4535

Institute of Healthcare Improvement: [www.ihl.org](http://www.ihl.org)

Joint Commission’s National Patient Safety Goals:

[www.jointcommission.org/patientsafety/nationalpatientsafetygoals](http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals)

Society for Hospital Medicine: [www.hospitalmedicine.org](http://www.hospitalmedicine.org)

National Patient Safety Foundation: [www.npsf.org](http://www.npsf.org)

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## Care of the Hospitalized Patient

Saturday, April 24, 2010

Eric P. Newman Education Center

Washington University Medial Center

Register: <http://cme.wustl.edu>