FIRST

Do No Harm

In this Issue:

Quality and Patient Safety Division, Board of Registration in Medicine

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Reducing Hospital Mortality at Saints Medical Center: A Team Approach to Discovering Causes, Improving Care

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Introduction

Saints Medical Center (SMC) is a 157-bed community hospital serving greater-Lowell and the Merrimack Valley since 1839. SMC provides primary and acute care health services to 315,000 residents in 25 communities.

In January 2009, SMC embarked on a journey to reduce hospital mortality. A system level measure to eliminate potentially preventable deaths was approved by the Board of Trustees. Utilizing an Institute for Healthcare Improvement (IHI) framework, a "Move the Dot" campaign was launched.[1] At the outset of our project, SMC used the hospital standardized mortality ratio (HSMR), a risk adjusted methodology developed by Sir Brian Jarman, MD.[2] At that time our mortality "dot" (rate) was higher than the national average. The drawback with using the HSMR, however, was that our mortality rate was calculated using 2 year old data. This led us to look at our raw mortality data (exclusive of hospice), and although not risk adjusted, this data held great value in that it was based on current information. The Medical Executive Committee together with the Board of Trustees set an ambitious goal of reducing mortality by 20% for 2009. We were on our way!

Throughout 2009, awareness increased throughout the hospital; but the mortality rate did not improve. The commitment of the hospital remained strong, however, – from the staff level up to the Board of Trustees. During the annual review of hospital goals in 2009, it was clear that concrete plans were needed for 2010. The results were focused on two strategies: mortality review and data-driven process improvement.

Mortality Review

In 2010, a sub-group of the Medical Staff's Peer Review Committee was established to review inpatient deaths. The team includes four physicians, two nurses and an outcomes analyst. A nurse performs 100% case review using the IHI 2 x 2 matrix [3] to identify appropriateness of level of care. She then performs a more comprehensive chart review of potentially unexpected deaths. Using concepts from IHI's Global Trigger Tool in the investigation of potential patient harm, the nurse determines "whether the 'harm' in question is part of the natural progression of the disease process or a complication of the treatment related to the disease process."[4]

Committee physicians then conduct in-depth review of charts identified with possible "harm." Twice per month, the committee meets. Physicians summarize their case reviews, and the team engages in discussion to discern whether the death may be related to issues such as failure to communicate, failure to plan/diagnose or failure to rescue. Finally, the physicians classify each death using the Greeley Classification System.[5] On a spectrum from 0 (Non-preventable) to 5 (Death attributable to acts of omission or commission), those deaths meeting Classification 5 are forwarded to the Medical Staff's Peer Review Committee for final determination and recommendations for follow-up, as needed. Deaths classified 1 - 4 on the spectrum have less serious issues with process/documentation and are tracked and trended by the committee for process improvement efforts; these cases are not forwarded to the Peer Review Committee.

Data-Driven Process Improvement

Hospital-wide mortality is measured in two ways: a raw mortality rate and a mortality rate index. The raw mortality rate is calculated on a monthly basis. Excluding those patients receiving hospice care at the time of their death, the number of expired patients are divided by the number of discharges to determine our mortality rate. From 2009 to 2010 our raw mortality rate decreased by 7.7%. However, when comparing seasonal mortality from July through December 2009 and 2010, our mortality rate showed a 21% decrease!

An even more powerful tool is the hospital's mortality

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Sharing "Lessons Learned" from Mortality Reviews

Finding that there is not currently a viable measure for public reporting of hospital mortality, the Division of Health Care Finance and Policy's Expert Panel on Hospital-Wide Mortality Measurement recommended to the Health Care Quality and Cost Council that the Quality and Patient Safety Division (QPSD) provide confidential oversight of hospitals' mortality review and improvement programs. Through this oversight process, the QPSD is able to share those best practices and "lessons learned" from mortality data analysis. The Saints Medical Center experience is an excellent example of how hospitals use their mortality data to improve quality and patient safety.

Reducing Hospital Mortality: A Team Approach , continued

index. Using the Care Science risk-adjusted methodology,[6] the index takes into account the co-morbidities of our patients and produces an expected rate of mortality. Our actual mortality rate (with hospice deaths excluded) is divided by our expected mortality rate to give a ratio, or "index." The mortality index standardizes patient acuity across all hospitals and allows for comparison of quality among providers. Regarding control and comparison, an index value greater than 1 indicates a rate above what would be expected given our patient population. (See Table 1)

We have utilized this powerful index information to drill into our mortality data and identify drivers of mortality based on diagnostic related groupings (DRGs). Both the data and the Committee's case review process revealed sepsis care as a primary opportunity to improve our mortality rate.

In September 2010, the Mortality Committee began a focused review of all deaths with Severe Sepsis and Septic Shock. Findings from this review directly led to improvements in sepsis care in the Emergency Department. Coupled with researching best practices, our Mortality Committee re-commissioned a Sepsis Team. Improvement efforts led to the development and implementation of a nurse-driven protocol to begin resuscitation in the Emergency Department. Using an evidence-based algorithm of care and the IHI Sepsis Resuscitation Bundle framework, patients meeting defined sepsis criteria receive intravenous fluid resuscitation and lab phlebotomy in addition to antibiotic therapy initiation during the triage phase of the Emergency Department encounter.

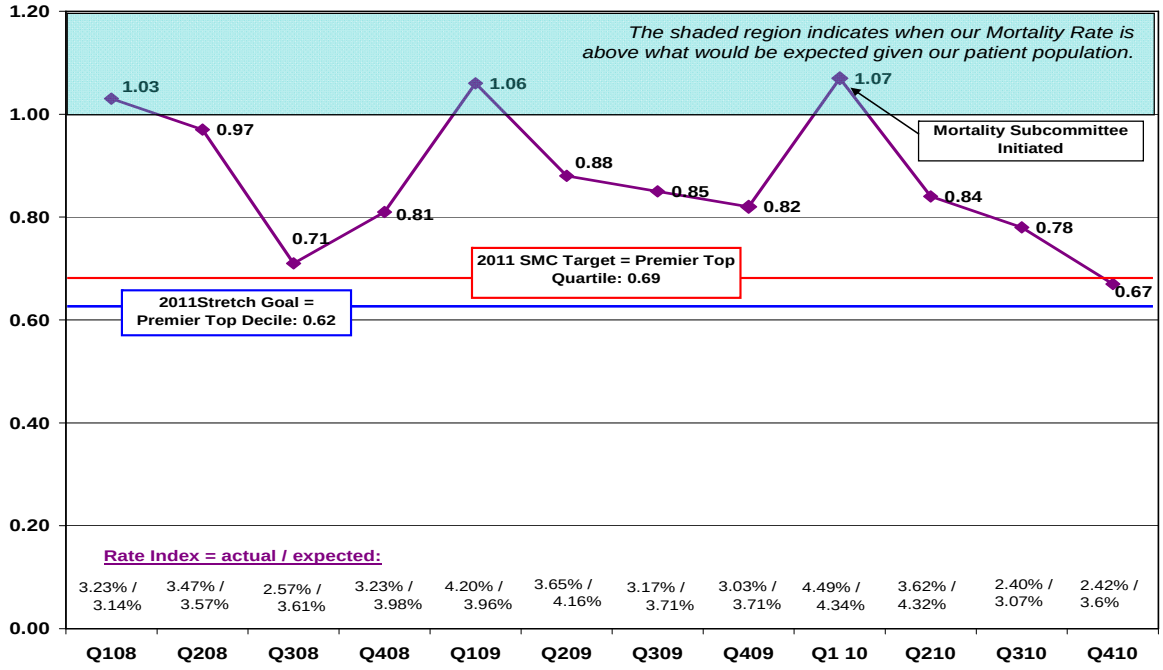
Along with the focused review of severe sepsis/septic shock-related deaths by the Mortality Committee, the Emergency Department engages in on-going quality monitoring to ensure comprehensive and timely delivery of care for patients with sepsis. Pneumonia and Stroke DRGs will be the next focus of our mortality reviews.

References

1. Move Your Dot: Measuring, Evaluating, and Reducing Hospital Mortality Rates. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003.
2. Ibid.
3. Reducing Hospital Mortality Rates (Part 2). IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2005.
4. Global Trigger Tool for Measuring Adverse Events. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2009, 2nd Edition.
5. Marder,R.J., Smith,M.A., Sheff,R.A. Effective Peer Review: A Practical Guide to Contemporary Design, 2nd Ed. HCPro, Inc. 2007.
6. Premier Inc. Quality Advisor Methodologies Guide. March 2011; 41-60. www.premierinc.com

Table 1

Saints Medical Center Mortality Index over Time



MetroWest Medical Center/Vanguard Health Systems is the recipient of *The 2010 Betsy Lehman Patient Safety Recognition Award* for demonstrated commitment to improving care transitions for patients living with the challenges of congestive heart failure. The Quality and Patient Safety Division is pleased to have the opportunity to publish the following article describing this important work.

Transitions in Care – the MetroWest Medical Center Experience

Linda M. Campbell, RN-BC, CPHQ – Director, Quality & Patient Safety, MetroWest Medical Center
Jane Pike Benton, MS, RN, Executive Vice President, MetroWest HomeCare & Hospice

Review of the literature demonstrates care transitions from hospital to home can be confusing and anxiety-provoking for patients and families. This confusion often results in misunderstanding of education and information regarding ongoing care, treatment and follow-up care needed to prevent adverse events from occurring as patients move from the hospital to the community setting. In September of 2009, to make care transitions safer and more effective, MetroWest Medical Center (MWMC), a subsidiary of Vanguard Health Systems, undertook a robust programmatic approach to implement new tools and practices in the transition of our patients across the health care continuum. The program is strong on cross-continuum collaboration with our home health agency, MetroWest HomeCare & Hospice, as well as with many community physicians and other health care providers. The focus patient population selected was individuals with congestive heart failure. This patient population had a 35% monthly rate of 30 day hospital readmission. Rapid cycle, small tests of change were conducted with the end result of a monthly readmission rate of 12.1% by September of 2010 (*See Chart 1: MWMC Heart Failure % readmits within 30 days, age > 64*).

Program Description

MWMC is participating in the multi-state, multi-stakeholder STate Action on Avoidable Rehospitalizations (STAAR) initiative, which aims to reduce rehospitalizations by working across organizational boundaries and engaging payers, state and national stakeholders, patients and families, and caregivers at multiple care sites and clinical interfaces. In October 2009, recommendations regarding the discharge process and transition of care were gleaned from our Patient Family Advisory Council and brought forward to the newly formed STAAR Cross-Continuum and Front Line Teams. Two pilot units were identified, one at each MWMC campus. The Teams developed strategies and processes for enhanced teaching and learning, admission and post discharge needs. All tools and strategies were tested on the pilot units using Rapid Cycles of Change methodology. The interventions embarked upon included: improvement in the continuum of educational materials, use of patient/caregiver teach back methodologies, front loaded home health visits within the first week of discharge, and after care appointments with the physician within the first week of discharge. The goals of these interventions were to enhance the patient and caregiver self management capabilities in the home setting, to assist in symptom based, self management practice immediately on the return home and arrange time with the physician to ensure adequate diagnostic interventions and medication management. We learned within the first eight months of the collaborative that these interventions were not enough to assist people in managing their chronic health condition within the community setting, preventing hospital readmissions within 30 days. We learned that we needed to embrace enhanced community focused strategies. This included reaching out to patients in their homes with follow up phone calls, into nursing homes, and beginning to develop a continuum based care plan to assist providers in all settings in understanding the patients' concurrent needs.

Each month, new tests of change related to patient/family education and involvement in care transitions were initiated. As an organization we learned that our discharge process was not well orchestrated, that the staff to patient/caregiver educational process was not effective, that our handover from hospital to home health and the nursing home providers was inadequate, and follow up by physicians of patients in the community was lacking. The initiatives we undertook included:

- Four key heart failure self management educational points were identified and incorporated into a newly developed Teach Back tool to gauge patient and care partner understanding of the disease process and home management of heart failure. The Teach-Back process requires that the staff nurse initially caring for the patient identify the targeted learners on admission, usually the patient and care partner. The four teach back questions are reviewed twice a day with the patient and care partner until there is 100% recall; if the patient and care partner are unable to achieve a score of 75% or greater, the physician is notified and a referral to home care is recommended. Since the Teach Back tool has been util-

Transitions in Care – the MetroWest Medical Center Experience, continued

ized, the understanding has improved from 75% to 100%.

- In early 2010 a formal process was designed by the STAAR Teams to conduct chart reviews on rehospitalized STAAR patients. Both retrospective and concurrent reviews revealed that factors affecting rehospitalization were related to end of life issues, patient non compliance and the presence of multiple co-morbidities. Plans were designed to engage key community providers and representatives from local skilled nursing facilities in the process redesign.
- MetroWest HomeCare & Hospice enhanced the transition of care for heart failure patients in spring of 2010 by providing "front-loading" of visits, with five visits in the first seven days post discharge, enhanced medication review and education using the Teach Back tool. In addition to visits, patients receive phone calls from their case managers on non-visit days to check on patient status. The protocol includes the use of IV Lasix in the home, as warranted. Standardized heart failure teaching materials were created and approved by members of the Heart Center of MetroWest.
- The role of partnering cannot be overstated in our multi-faceted approach. Our first vendor partner plays a role in our Telephonic Care process by providing standardized, telephonic follow-up to all patients who have a diagnosis of heart failure within 24 hours of discharge home. Five follow up calls are provided over the course of the patients' first 30 days at home. The calls began in September 2010 and are precisely scripted to address key components of Heart Failure follow-up care, specifically asking about ease of making follow-up appointments, obtaining newly prescribed medications, diet recommendations, daily weighing, etc. Any answer that indicates that the patient or care partner is unsure about their home care instructions prompts an escalation to a Care Transition Nurse to facilitate resolution of the issue with the patient and care partner.
- In recognizing the need to involve patients and care partners in decisions about their medical care during hospitalization for greatest success at home, a "Transition Care Coach (TCC)" program was established in November of 2010. The TCC, who is a HomeCare nurse, works with the highest risk patients and their care partners to teach key pillars of home management: medication self management, warning signs and symptoms and the importance of appropriate and timely follow up with primary care or specialist physicians. Patients are identified as "highest risk" if they have a diagnosis of HF, AMI or Pneumonia and have been hospitalized two or more times in the past six (6) months. The TCC builds a coaching relationship at the hospital bedside and then follows the patients at home via phone calls and teaching emails for 30 days.
- Continued chart review indicated that a large percentage of readmissions were from area skilled nursing facilities. BayPath Elder Services and area Skilled Nursing Facilities were engaged and invited to join the STAAR Steering committee. Nursing home education was provided by the MW HomeCare Heart Failure Nurse Specialist on management of the heart

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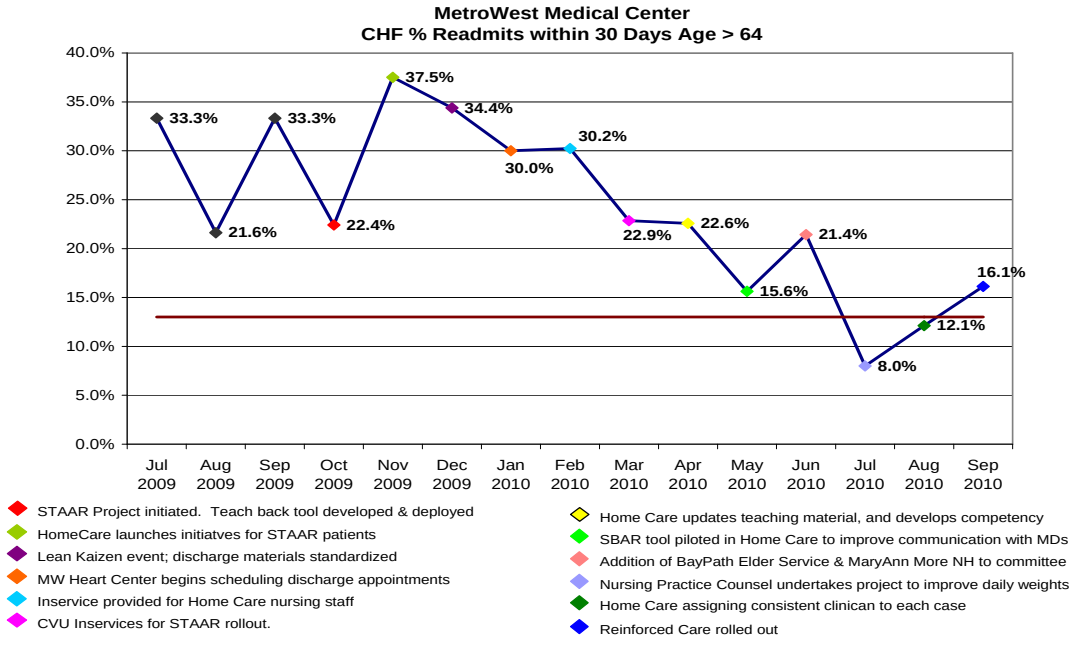
Chart 1



Transitions in Care – the MetroWest Medical Center Experience, continued

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failure patient. A pilot program has been initiated with Mary Anne Morse Nursing & Rehab Center to test our Telephonic Care process with patients in the facility.

- From our chart audits it was clear that many patients who are readmitted to the hospital have chronic illnesses and some of these patients are dealing with end of life issues. Research shows that palliative care has a positive impact on quality of life for patients as well as in a reduction of stress for families and care providers. There is also a positive benefit to the health care system by means of a reduction in expenses on unnecessary testing. A cross continuum Steering Committee was created in collaboration with our team from MetroWest Hospice, and from there a Palliative Care Team was formed. Formal palliative care consults were begun in early February 2011.

Data Collection and Performance Improvement

Data collection and analysis were performed through multiple phases of the project. The annotated statistical process chart (*Chart 1*) outlines the performance improvement journey, beginning in July 2009. We measured all-cause acute care readmissions for patients greater than 64 years of age who had been discharged within 30 days with a primary discharge diagnosis of heart failure. At that time our goal was to reduce our rate, which had been in the mid-30% range to our corporate set goal of 18.62%. This corporate goal was further reduced in FY2011 to 13%. We reached that target in July 2010 with a rate of 8%. Some statistical variation has been shown throughout the process however a steady downward trend is evident.

Commitment to continuing improvement in care transition procedures and practices

A Vanguard Health Systems organization-wide focus on preventing diagnosis-specific rehospitalizations commenced in the Summer/Fall of 2010. An Executive Steering Committee was established to bring a global perspective to the project which is being facilitated by a team of individuals including Senior Leadership, Home Care, Hospital Nursing, Case Management, Patient Safety, Information Technology and two outside vendors.

Continued improvements in identification of patients at risk for rehospitalization, refinement of the role of Transition Care Coach, development of vendor products and expansion to additional patient populations with spread of the program throughout our state, region and the Vanguard Organization is under development. MWMC will continue to keep these projects interconnected and communicate on progress made both internally and externally through our involvement in STAAR and Vanguard initiatives. We will continue to collect and analyze data to form data-driven decisions. The goal is to create a patient-centered, sustainable care transition program reducing the need for frequent hospital care through enhanced patient/caregiver self management in the community.

Ambulatory Surgical Center (ASC) PCA Program Initiative

Clinics licensed by the Department of Public Health under MGL c. 111 s. 51 are required to participate in Patient Care Assessment (PCA) Programs established by the Board of Registration in Medicine (MGL c. 111 § 203 ; 243 CMR 3.00, et seq.). Free standing Ambulatory Surgical Centers (ASCs), formerly exempt from licensure, are now required to be licensed as health care facilities due to changes in Massachusetts law under Chapter 305, the Massachusetts Health Care Reform Act. Similar to licensed hospitals, these ASCs are required to submit PCA Plans, Annual and Semi-Annual Reports, and Safety and Quality Review reports to the Quality and Patient Safety Division (QPSD).

There are presently 61 free-standing ASCs, licensed by the Department of Public Health (DPH). The ASCs care for approximately 250,000 patients annually. Every year the number and complexity of procedures performed in ASCs grows. The QPSD is developing a plan to support ASCs in their implementation of the PCA Program requirements. We will convene a workgroup, to review documents and materials in use, plan a reporting schedule, and develop a plan for training workshops.

In the fall, using the tools and materials developed in consultation with the work group, the QPSD plans to begin oversight and support of licensed ASCs, by requesting submission of their PCA Plans. The QPSD looks forward to working collaboratively with ASCs, as we share the mutual goal of ensuring high quality care for patients in Massachusetts.

First Year Anniversary of the QPSD

It has been a year since the Quality and Patient Safety Division (QPSD) changed its name. With this name change have come many transformations. We are looking forward to another year of exciting work.

We have several new members on our Quality and Patient Safety Committee (QPSC). A list of the current QPSC members is below. The committee members have given many hours of their time: visiting hospitals, participating in our workshops, and providing guidance and expertise to our ongoing work. We appreciate their commitment.

The QPSD's database has been updated to operate as a single system. We are now able to easily access it for research purposes. We plan to utilize this opportunity more frequently to share lessons learned with newsletter articles and alerts. We are also working on the development of an on-line reporting system for our Safety and Quality Review Reports. We expect to go online early this fall.

The QPSD is holding a conference on June 3rd in Worcester on "Engaging Physicians in Quality Reviews." The conference will focus on how to work within the peer review system to enhance physician involvement in adverse event review and other quality improvement activities. We will offer contact hours and CMEs. If you would like to attend or would like more information; please contact Jennifer Sadowski at Jennifer.Sadowski@state.ma.us.

One of our big projects this year is the fulfillment of our regulatory authority to oversee Ambulatory Surgical Centers (ASCs). The "PCA" regulations set forth a scope and purpose to "assist the physicians and health care institutions of the Commonwealth in their efforts to identify problems in practice before they occur and to put in place preventive measures designed to minimize or eliminate substandard practice. This enhancement of patient care assessment will be accomplished through the strengthening and formalizing of programs of credentialing, quality assurance, utilization review, risk management and peer review in institutions and by assuring that these functions are thoroughly integrated and overseen by the institutions' corporate and physician leadership." 243 CMR 3.00.

The regulations also contemplate "active self-scrutiny and reporting of adverse incidents in in-patient and out-patient settings to permit individual physicians, institutions and the Board to recognize patterns requiring corrective action." 243 CMR 3.01. Please see the article entitled, "Ambulatory Surgical Center PCA Program Initiative" on page 5 of this newsletter for more information on our future plans to work with ASCs.

We continue to strive to be a meaningful, high value organization that is working to support Massachusetts hospitals in providing quality patient-centered health care. In the last year, we have seen many innovative examples of this care and we look forward to hearing more about your lessons learned in the year to come. As always, we look forward to your feedback.

Quality and Patient Safety Committee

Peter Paige, MD (Chair) *ED physician, Chair, BORM*
Nicolas Argy , MD, JD, *Radiologist*
Janet Nally Barnes, RN, JD, *PCA Coordinator*
James Bono, MD, *Orthopedist*
Deborah DeMarco, MD, *GME Program Director*
Kimberly Eisenstock, MD, *Internist*
Susan Haas, MD, *Obstetrician/Gynecologist*
Diane Hanley, RN, MS, BC, *MA Board of Nursing*
Julian Harris, MD, *Resident*
John Herman, MD, *Psychiatrist*
Former Chair BORM & PCA Committee
Mark Hershey, MD, *Anesthesiologist*
Sophia Pasedis, Pharm D, RPh, *MA Board of Pharmacy*
Dinish Patel, MD, *Orthopedist,*
Former Chair BORM & PCA Committee
Marc Rubin, MD, *Surgeon*
Arthur Russo, MD, FACP, *Chief Medical Officer*
Robert Schreiber, MD, *Long Term Care Specialist*
Nicola Truppin, JD , *Patient Representative*

Dr. Marc Rubin Named President of American College of Surgeons, Massachusetts Chapter

QPS Committee member, Marc Rubin, MD, FACS, was recently elected President of the Massachusetts Chapter of the American College of Surgeons (ACS) for a two-year term. Dr. Rubin is Chair of North Shore Medical Center Department of Surgery. The Massachusetts Chapter of the ACS was chartered 55 years ago and has roots in both the prestigious Boston Surgical Society and the New England Surgical Society. Dr. Rubin was also elected to the ACS Board of Governors this past October.

Identifying Risk Factors for Fulminant Clostridium Difficile Colitis

The Quality and Patient Safety Division has received a number of Safety and Quality Reviews (SQRs) involving a delay to diagnosis and treatment of Clostridium difficile colitis. An article in the American Journal of Surgery (July 2010) entitled *Surgical aspects of fulminant Clostridium difficile colitis* reviewed the literature on Clostridium difficile colitis and early surgical intervention. The findings may be of interest in your efforts to improve quality and safety.

Noting the increasing prevalence of C difficile infection in hospitalized patients and the rise in a more virulent form of C difficile (BI/NAP1/027), the authors reported that certain patients were more likely to have progression of the disease to fulminant C difficile colitis, which carries mortality rates as high as 85%. These patients developed systemic symptoms of hypotension, oliguria and tachycardia due to release of bacterial toxins. Diarrhea was not necessarily a common finding; up to 20% of patients may not have had any diarrhea.

- The overall mortality rate was lower when medical treatment before surgery was less than 6 days; patients with early colectomy had a 78% reduction in mortality. Most of the studies reviewed demonstrated the benefits of subtotal colectomy with end ileostomy over segmental colonic resection for fulminant colitis.
- Four factors were significantly associated with progression to fulminant C difficile colitis: Leukocytosis greater than 16,000 cells/uL at the start of therapy; surgery within the past 30 days; history of IBD (inflammatory bowel disease), and history of past IVIG (intravenous immunoglobulin) treatment.
- Up to 95% of patients with a WBC greater than 50/L x 10^9/L or with lactate greater than 5 mmol/L died within 30 days of admission without a colectomy.
- Survival was improved in patients with a peak lactate between 2.2 and 4.9, who had colectomies.
- Early use of CT was found to be an effective diagnostic tool. Typical CT findings included colonic wall thickening, dilation, "accordion sign", ascites and pericolonic stranding. Stool toxin titer and endoscopy were also useful.

Conclusions: "The early diagnosis and treatment through subtotal colectomy can reduce the mortality associated with fulminant colitis. For patients who have a history of IBD, recent surgery, or prior treatment with IVIG, there should be a high index of suspicion for the development of refractory colitis and surgical consult should be sought very early in the patient's admission. For other patients, colitis associated with signs of organ dysfunction such as vasopressor requirements and increased lactate, with the addition of leukocytosis greater than 16,000/uL should be parameters that indicate the need for operative intervention. Additionally, early use of CT scan over other diagnostic modalities can provide a diagnosis and guide surgical therapy."

Butala P, Divino CM. Surgical aspects of fulminant Clostridium difficile Colitis. *American Journal of Surgery.* 2010; 200 (1):131-135.

Here are some examples of cases reported as "**Type 4**" events to the Quality and Patient Safety Division.

- Laryngeal nerve injury during thyroidectomy.
- Pulmonary Embolus in anticoagulated patient .
- Laceration of vena cava during laparoscopic assisted nephrectomy.
- Anesthesia emergence delirium, with injury to operative site related to patient agitation.
- Popliteal occlusion following total knee arthroplasty.
- Meconium aspiration, requiring newborn resuscitation and transfer to tertiary care.
- Shoulder dystocia during delivery.
- Stroke during aortofemoral bypass surgery.
- Delayed diagnosis of myocardial infarction.
- Unmonitored patient on general surgical unit found unresponsive on first post-op day.
- Delayed treatment of asthma-related symptoms.
- Sepsis post colonoscopy perforation.
- Wrong radiation dose administered.
- Hemorrhagic pericardial effusion during pacemaker insertion.
- Delayed diagnosis and treatment of lung mass.
- Evidence of sepsis, requiring patient transfer back to acute care (<24 hours after rehab admission).
- Pathology report error resulting in unnecessary surgery.
- Complication associated with IV infiltrate.

"Lessons Learned" and Quality Improvements Noted in Safety and Quality Reviews

- Obstructive sleep apnea (OSA) screening was recently implemented by Winchester Hospital for all patients scheduled for total joint replacement surgery. Patients are asked a series of questions by the surgeon to assess their risk of OSA. The primary care physician is notified of any patients identified as being at increased risk, and pre-op sleep studies ordered, if indicated. All patients identified as at risk are continuously monitored post-op for oxygen saturation and apnea, and narcotics are used judiciously. After the logistics are optimized, the program will be extended to all surgical patients having general or neuraxial anesthesia.
- A case involving delayed recognition of pertussis in an adult patient was reported to the QPSD as an SQR. The etiology of the patient's persistent cough (experienced over a period of 3 weeks), was believed to be due to post nasal drip, secondary to sinusitis. The patient was eventually diagnosed by nasal swab. This case illustrates the necessity for ongoing consideration of pertussis in the adult population.
- A rehabilitation/LTAC hospital conducted a "drill-down" analysis of its falls and uncovered a pattern of falls around meal times. This led to a change in process for delivery of food trays and staff education about the importance of placing tray items within the reach of patients. The hospital reported a decrease in falls following this initiative.
- Responding to complications experienced by a patient following a surgical procedure that was performed for the first time, a hospital implemented a stringent multidisciplinary planning process. It includes comprehensive training and education of all staff that will care for the patient (admission through discharge); development of care plans and order sets; and performance of a Failure Mode and Effects Analysis (FMEA) to identify potential areas of concern that need to be addressed before the surgeon is authorized to perform the procedure.
- Identifying "respiratory decompensation" as a frequent occurrence, requiring transfer of patients back to the ICU, one hospital instituted the following changes to procedure: (1) patients who are recently extubated are automatically held in ICU for a longer period of observation prior to transfer; (2) the Respiratory Therapist is included in the "transfer" discussion regarding the patient's post ICU respiratory needs; and (3) the post ICU plan of care is documented, communicated and understood by the transferring and receiving staff members.

Quality and Patient Safety Division (QPSD) Notes

The QPSD would like to facilitate the dissemination of information about how other facilities have responded to adverse events. We encourage you to share your experiences with us, through submission of articles or by permitting us to write about the "lessons learned" and quality improvements you tell us about in your SQRs and Semi-Annual Reports.

In a recently published comparative study of three methods to detect adverse events in hospitalized patients, the Institute for Healthcare Improvement's Global Trigger Tool found at least ten times more serious events than the other methods. *Classen DC, et al. Global Trigger Tool shows that adverse events in hospitals may be ten times greater than previously measured. Health Affairs 2011; 30 (4): 581-589.* Please let us know if you are using a "Trigger Tool" methodology at your facility. We are very interested in hearing about your experience.

Reminder: By email, dated February 23, 2011, the QPSD had requested that you submit a form describing your processes for mortality review with your Semi-Annual Report. Please contact QPSD if you have any questions about this request.

CONTACT THE QPSD

To be added to the QPSD Newsletter and advisory mailing list, update hospital contact information, submit an article, request an SQR form, or obtain additional information, contact QPSD: Jennifer.Sadowski@state.ma.us or (781) 876-8296.
Send mail to Massachusetts Board of Registration in Medicine, QPS Division, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880.

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