Welcome to the Patient Safety Membership Update, a bi-weekly service offering a summary of patient safety news. We welcome your comments; please send them to pso@ecri.org. To access many of these resources, you must log in to the PSO members' website. Need help logging in?

April 28, 2016

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- Research Response: Managing Alcohol Withdrawal Syndrome in the Hospital

Upcoming Presentations from ECRI Institute PSO

Learn more about upcoming webinars and register at the links below:

| May 19, 2016 at 1:30 PM EDT | Jun 16, 2016 at 1:30 PM EDT |
| Collecting and Analyzing Meaningful Data to Reduce Falls | PSO Webinar: ECRI Institute PSO Deep Dive: Patient Identification |
| Jul 21, 2016 at 1:30 PM EDT | Sep 22, 2016 at 1:30 PM EDT |
| PSO Webinar: Sepsis and Septic Shock Adverse Events | PSO Webinar: Health Literacy |
| Oct 20, 2016 at 1:30 PM EDT | Nov 17, 2016 at 1:30 PM EDT |

Health Systems and Addiction: The Use and Misuse of Legal Substances

Join ECRI Institute for this free, public service conference on November 16-17, 2016. www.ecri.org/2016conf

Stayin' Alive: Will CPR Feedback Devices Improve Your Resuscitation Practices?

This webinar on Wednesday, May 11, 2016, from 1:00 to 2:00p.m. (EDT), will review the strengths and weaknesses of CPR feedback devices and how facilities have successfully implemented this technology.

Patient Safety

When Is It Appropriate for a Surgeon to Leave the Operating Room?
The primary attending surgeon is "personally responsible for the patient’s welfare throughout the operation," said the American College of Surgeons (ACS) in a recently-released Statement on Principles. "In general," the statement said, "the patient’s primary attending surgeon should be in the operating suite or be immediately available for the entire surgical procedure. There are instances consistent with good patient care that are valid exceptions. However, when the primary attending surgeon is not present or immediately available, another attending surgeon should be assigned as being immediately available." ACS released the statement after recent news reports raised questions about primary surgeons initiating a second surgery before the first was completed. This led to a larger discussion of reasons a surgeon might leave the operating room during the course of a surgery. ACS said that it is not appropriate for a surgeon to be involved in simultaneous or concurrent surgeries in two different rooms. Overlapping operations, ACS said, are only appropriate in circumstances when the key or critical elements of the first operation have been completed, and the patient must be informed of overlapping procedures. It may be appropriate for surgeons to be present for only part of the surgery when it is a multidisciplinary operation, ACS said, but an attending surgeon must be immediately available for the entire operation. Surgeons may delegate part of the operation to other practitioners but "the primary attending surgeon’s personal responsibility cannot be delegated," ACS said, and the surgeon must remain an active participant through the critical components of the procedure. A surgeon may leave the operating room for a procedure-related task, ACS said, but must be immediately available for recall during such circumstances. In the event of unanticipated circumstances, such as a sudden illness or a family emergency, a backup surgeon must be identified immediately. Surgeons should also explain to patients the different types of personnel and their respective roles in the procedure, and inform patients of any unforeseen changes.

Increase in Dietary Supplements Raises Risk of Drug-Drug Interactions in Older Adults

Almost one in six older adults may be at risk for a major drug-drug interaction, a rate that is at least partly attributable to an increase in use of dietary supplements since 2005, according to a study published online March 21, 2016, by *JAMA Internal Medicine*. The authors conducted interviews and examined the medications of more than 2,000 adults ages 62 to 85 in 2005 and 2006 and again with a similar group in 2010 and 2011. They found that the rate of those using at least one medication, including prescription or over-the-counter drugs and dietary supplements, increased slightly from 84% in 2005 and 2006 to 68% in 2010 to 2011. This increase was largely due to the use of dietary supplements, which rose from 52% to 64% during the study period, including a nearly 50% increase in the use of multiple supplements. The most notable increases in use of dietary supplement and prescription drug rates were for statins (34% to 46%), antiplatelets (33% to 43%), and omega-3 fish oils (5% to 19%). Overall, based on the rates of concurrent use of various medications and supplements, the authors estimate that 15% of older adults in the 2010-2011 group were at risk of a major drug-drug interaction, including renal failure and hemorrhagic complications.

Related resources from your patient safety membership:
- PSO Navigator: Patients’ Use of their Own Medications: How to Address Risk

Standards & Guidelines

Joint Commission Posts Prepublication Standards for CAUTI Patient Safety Goal

Hospitals, critical access hospitals, and skilled nursing facilities will be required to educate providers about the importance of infection prevention and catheter-associated urinary tract infections (CAUTIs) in patients with indwelling urinary catheters, according to new prepublication standards from the Joint Commission. The standards, which support National Patient Safety Goal 07.06.01 ("Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections"), go into effect January 1, 2017. In addition to educating staff and licensed independent practitioners, facilities are also expected to educate patients with indwelling urinary catheters and their families about infection prevention and signs and symptoms of CAUTIs. Additional new expectations under the goal, all of which are scored during survey, include ensuring a consistent method for medical record documentation of indwelling catheter use, insertion, and maintenance; development and maintenance of criteria for indwelling urinary catheter placement; and implementation of procedures for indwelling urinary catheters that address concerns such as limiting use and duration, hand hygiene, aseptic site preparation technique, and replacing the urine collection system when required.

Seeing More Than Age: AGS Outlines Guidance for Multicultural Geriatric Care

With racial and ethnic minorities set to represent nearly 40% of older Americans by 2050, the American Geriatrics Society (AGS) has developed guidance for achieving high-quality, multicultural geriatric care. More than 80 million Americans will be 65 years or older by then, said AGS, and nearly 40% of the elderly will be minority individuals. Health inequities are well documented among older adults, said AGS, but are even more pronounced for older minority Americans. AGS said providing competent care of older minority adults will be about seeing more than their age. Minority individuals over the age of 65 have higher rates of disease and disability compared with whites, and the vast majority of the 36% of Americans reporting limited healthcare literacy are older, less educated, and nonwhite. AGS' new position statement walks providers through several questions to reflect and explore on how cultural identity can impact the care an older patient needs. AGS suggests incorporating a set of culturally sensitive indicators and asking patients questions about their ethnicity, preferred language, and education. The guidance encourages providers to consider an older patient's background while offering treatment and recognize which health conditions may be prevalent in a specific population. AGS also offers tools to increase provider awareness and communication skills and to increase awareness of what biases providers themselves might hold.

In the News

AHQR’s New Database Lets Hospitals Know Where Staffers Think They Can Improve, and Who Is Thinking It

More than half of respondents in the Agency for Healthcare Research and Quality’s (AHRQ) recently released Hospital Survey on
Patient Safety Culture: 2016 Comparative Database Report said their organizations could do a better job with non-punitive responses to error, as well as with handoffs and transitions. AHRQ’s survey of 447,584 staffers at 680 hospitals found that only 45% of respondents gave their hospital a positive response to the “nonpunitive response to error” category, defined as "Staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file." The next most negative response came in response to handoffs and transitions ("Important patient care information is transferred across hospital units and during shift changes"), which received 48% positive responses. The category regarding teamwork within a unit received the most positive responses (82%), followed by "Supervisor/Manager Expectations and Actions Promoting Patient Safety," which received 78% positive responses. AHRQ said that the Supervisor/Manager Expectations composite, which measures the extent to which managers consider staff suggestions for improving patient safety and praise staff for following safety procedure, had the highest increase over time. The responses are further categorized according to hospital location, department the respondent works in, respondent's staff position, and other factors. Respondents who work in rehabilitation had on average the highest percentage of positive responses (71%). The lowest percentage of positive responses came from staff working in emergency departments (59%). On average, small hospitals received more positive responses (69% overall) than large hospitals (61%).

Related resources from ECRI Institute PSO:

- Insight Assessment Services: Patient Safety Culture Survey

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Log in to the PSO members' website to access selected resources and educational materials. Once you are logged in, you can navigate the website without being required to log in again as long as you keep your browser window open. If you do not have a user ID and password for the PSO members' website, or if you have forgotten your user ID or password, please contact the ECRI Institute PSO Helpdesk at psohelpdesk@ecri.org. If you would like information on additional patient safety services, please contact us at patientsafety@ecri.org.