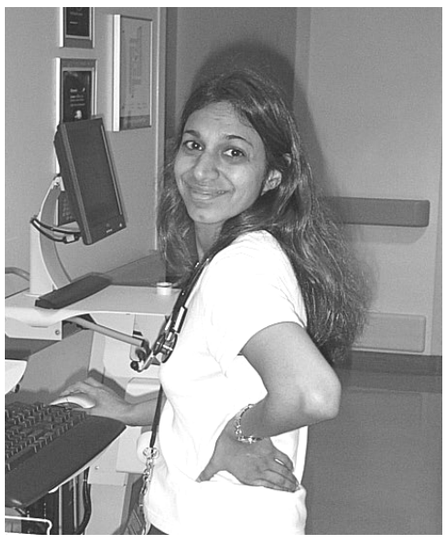

Changing Diet Orders in SCM

As you all know, there are a lot of jokes about hospital food… and for good reason. Despite this, one aspect of caring for our patients that is critical is ensuring that they obtain the diet most appropriate for their conditions.

Keep in mind, unless you physically discontinue a previous diet order, the new diet orders will just stack on top of the prior one. It does not cancel the old order automatically.

Imagine, if you will, that a patient could be NPO, on a clear liquid, full liquid, ADA Renal diet simultaneously! No wonder the food would taste bad! *J Greenwald*

THE INPATIENT TIMES

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If you like the photographs, they were taken by Jeff Greenwald. If you don't, The Inpatient times is unwilling to release the source of the photos. Don't even ask!

The Inpatient Times

All the News that makes you more fit to treat

Vol 3; July 2003

A publication of the Department of Medicine

On Becoming a High Reliability Hospital

The Medicine Service has done an extraordinary job of dealing with the ever-increasing demand for inpatient care. Since fiscal year 1998, you have seen **growth in discharges at 6-7% per year**.

Our challenge is to provide evidence-based care to our patients in a manner that is most effective and satisfying to them while minimizing waste. How can we do this when the workload is always getting bigger and we feel that we don't even have time to breathe? We can gain insight into this challenge from other "high risk" industries like commercial air travel and nuclear power.

Like medical care, these industries find themselves with increasing demands for productivity and very high stakes if errors occur. Unlike medical care, however, these industries have designed systems for safety and effective service delivery and have spent a lot of time and energy educating their people as to their role in these systems. Impartial observers of hospitals quickly conclude that it appears that hospitals are relying on the hard work and good intentions of their very talented workforce alone to bring excellent care to more and more people. They have seen only limited evidence of system design for exceptional performance.

Over the past few years, BMC has begun the journey to high reliability systems. In early 2002, there were over 800 Medicine discharges at any one time that did not have a completed discharge summary. Today, there are only 109 thanks to the hard work of Medicine residents and attending physicians.

In 2001 Boston Medical Center had over 2,000 missing doses of medication to our nursing units per month. After the implementation of computerized order entry and Pyxis drug dispensing cabinetry that number is down to 70.

In early 2002, Boston Medical Center was embarrassed when 2 patients were sent back from nursing homes because no discharge summary was sent with the patient and the nursing home felt inadequately informed to care for the patient. Now, with our design that no patient may leave without the typed discharge summary, we are held as an example to other hospitals.

In 1998 there was no weekend or evening coverage of the IV service in the Newton Pavilion. Today we have service until 11pm in both pavilions 7 days per week and phlebotomy service at night.

These are just a few of the changes that have been made to make us a safer and more reliable hospital. What are our next challenges? Our biggest challenge is to find ways to accommodate more patients. The population is aging and the need for inpatient medical care is growing. We generally have some empty medical/surgical beds at midnight but at 4 pm on almost all weekdays, we have more patients than beds. This causes backups in the E.D. and the O.R.s. This "super" demand is due to the fact that our discharges don't leave until 4 pm on average. By 10pm, the discharges are gone and the admissions that started stacking at 10am are generally tucked in.

The Medicine Service is about to embark on a new experiment on Firm B by using a Nurse Practitioner to assist in the work of discharge when the Team believes that a patient is ready to go. This will allow the interns to continue rounds while the patient "outflow" commences. In addition, an uncovered service, staffed by Physician Assistants is being planned.

These and other designs for exceptional care will help us continue to move toward becoming Boston's best hospital. *J Chessare*

When Should Antiretroviral Therapy Be Started or Stopped in HIV-Infected Inpatients?

Initiating antiretroviral therapy (ARVT) is NOT an emergency in the hospital setting. Indeed, a number of factors need to be considered before antiretroviral therapy can be initiated (e.g. readiness of the person, level of immunodeficiency and rate of disease progression, understanding of short and long-term adverse drug effects). The acute health problem responsible for the patient's hospitalization often require more immediate attention, in particular in patients who are not engaged in an ongoing relationship with a primary provider since very limited health information is likely to be available rapidly. Several case scenarios are possible and summarized below:

- If the patient admitted is NOT engaged in an ongoing relationship with a primary provider, the "General Guidelines on Inpatient treatment of HIV-Infected Patients at BMC"[1] state that ARVT should not be initiated and priority should be given to treatment of opportunistic infections or other presenting conditions.
- If the patient admitted is engaged in an ongoing relationship with a primary provider and is on ARVT, he/she should continue therapy without interruption unless there are significant concerns regarding drug toxicity, tolerance, or drug interactions. The healthcare team needs to insure that the antiretroviral regimen prescribed is appropriate (i.e. appropriate combination, dose, frequency) and consult the ID fellow on call and/or the HIV pharmacist (beeper 2729) to screen for potential clinically significant drug-interactions with antiretrovirals.
- Treatment interruption or discontinuation remains controversial and should only be considered after consultation with the primary provider and an Infectious Diseases specialist, or as part of a clinical trial. Treatment interruption is generally not recommended in HIV-infected patients on therapy, as it is likely to lead to rapid rebound in viral replication and renewed immunologic deterioration.[2] If ARVT is stopped, ALL antiretrovirals should be held at once in order to prevent the development of resistance.

Continued →

References

1. HIV Handbook, Center for HIV/AIDS Care and Research, 2003.
2. Oxenius A, et al. Stimulation of HIV-specific cellular immunity by structured treatment interruption fails to enhance viral control in chronic HIV infection. Proc Natl Acad Sci USA 2002; 99: 13747-52

H Hardy

Urgent Matters

The hospital recently got a Robert Wood Johnson grant to investigate ways in which it could make the operations of the hospital occur more efficiently. It is called the Urgent Matters Grant. Through this grant a multidisciplinary taskforce of physicians, nurses, administrators, information technology experts, and consultants have gathered to brainstorm and implement new systems issues to improve care and throughput efficiency at Boston Medical Center.

The group focuses on three general areas: the prehospital (primarily EMS) area, the Emergency Department, and the inpatient service. For each, various variables are being put under the microscope for the purposes of identifying areas for improvement.

As all have heard repeatedly over the last year or so, the issue of discharge time is one area of concern. Later discharges impede flow out of the Emergency Department and the ICUs.

This grant group has endeavored to redesign flow from the Emergency Department to the floors with nursing's help, but now it is time for the doctors to weigh in with their ideas.

If you have ideas about what slows you down or areas that could use improvement, please let us know. We want changeable or fixable areas identified and addressed. The system is not perfect obviously, nor will it ever be. But we look to all of the physicians, including the house staff, to think creatively about what would make you better able to discharge patients earlier in the day (goal for the project is *only* 1:30pm while now the average is just after 4pm!) safely.

Please contact (email/phone/in person) Jeff Greenwald with your thoughts.

J Greenwald

2003-2004 Hospital Medicine Innoovations and Research Grant

In the second edition of The Inpatient Times, April 2003, the 2003-2004 Hospital Medicine Innovations and Research Grant was announced. Though originally intended to fund a single project, two submissions were felt to be worthy of support. As such, I am very pleased to announce that the following two applications were accepted for funding:

1. Innovation: "www.bmcb4.org" by Stephen A. Martin, M.D., Ed.M., PGY-2 Family Medicine.
2. Research: "Early Discharges – Let's Get Rounds Squared Away" by Ronald Tamler, MD, PGY-2, Internal Medicine

What follows are brief descriptions of the projects Drs. Martin and Tamler have developed.

J Greenwald

BMCB4.org A Website for All Teams

Residency is a time of intense questioning. We're not just talking existential inquiry, we're talking about … What's the differential for chest pain? How do I teach my patient to use an inhaler? Who all at BMC can help out this patient? What does ISDA say about CAP?

There's now a resource to help. It's on the web at www.bmcb4.org or, more specifically, at www.bmcb4.org/Medicine.htm. As the name suggests, this site has initially been put together by the B4 Firm, but is designed for all Firms, though we need your help in doing so.

The axial skeleton of the web site is based on B4's top 20 admitting diagnoses. A web page is dedicated to each diagnosis. Each page generally includes: 1) Overview: what information is most helpful *right now*; this overview will also have a FAQ sheet for each diagnosis. 2) Approach: Our Firm has been developing a common approach and discharge guidelines for each of these diagnoses, as well as a patient handout. 3) Resources: Whether the ACC-AHA guidelines for acute coronary syndrome or NIH guidelines for asthma – or the recent JAMA on renal failure – you'll find them a click away. There are also links to web-based calculators for everything from Framingham risk to BMI. 4) BMC Resources: Something that's often hard for residents, and even attendings, to know is the wealth of help available at BMC or in the Boston area.

Continued →

As you'll see, the site is in a "permanent state of dynamic construction." The site will work for medical teams if it is *built* by medical teams. On the left side of every page is an e-mail address, ideas@bmcb4.org. When you find a great article or a new resource – or if you have any idea about how to make the site better – please just send along an e-mail. Your input – through questions or answers – makes the site work!

S Martin

Early Discharges – Let's Get Rounds Squared Away

One of the areas where we can improve is reducing the time new patients in the ER have to wait for a bed on the wards. There are many factors playing into the process, but one key to success is to enable patients who can be discharged to leave the hospital earlier in the day. This is determined by the medical teams and especially the hard-working housestaff.

Surprisingly, nobody has ever investigated how residents round and what impact they have on discharge time. As a recipient of an inpatient grant, I will be investigating resident rounding behavior and its effect on discharge time. Starting November 11th, two medical teams at the Menino Pavilion will be asked to round on those patients first that are likely to be discharged later that day (assuming that teams always prioritize very sick patients as highest priority). The project will last for four weeks. The other medical ward teams will continue in their usual rounding pattern.

The differences in discharge time, length of patient stay, and team morale will be measured and compared. My hypothesis is that rounding on dischargeable patients first will facilitate earlier discharges, which in turn will help streamline admissions from the ED.

R Tamler

Acute Steroid Use With Infections

There is a commonly held misconception regarding therapy with steroids in patients with infection. Some believe that even short-term steroid use will diminish a patient's ability to fight off infection, like pouring gasoline onto a fire.

Steroids have been used widely for a variety of diseases. Side effects are clearly related to the length of therapy. Clearly, long-term therapy (>3 weeks) significantly hinders host defenses and predisposes patients to a wide variety of infectious complications in addition to many other untoward effects. Doses close to the physiologic replacement level (7.5mg of prednisone) as well as QOD dosing reduces these side effects somewhat.

On the other hand, acute steroid therapy (≤2 weeks) has only three complications: hyperglycemia (not uncommon), hypokalemia (not common), and psychosis (rare). These side effects do not seem to be dose related. Worsening of underlying infection or the development of a super-infection has not been identified in the vast majority of studies looking at short-term steroids.

Continued →

Between 1974-1986, patients with advanced sepsis syndrome were treated with 2.0g of prednis-olone every six hours, intravenously, commonly receiving two to six doses. This therapy was abandoned, not because of complications, but rather because it was ineffective. It is likely that once the sepsis diagnosis was made, the cytokine surge responsible for many of the manifestations had already done the damage (the horse was already out of the barn). Recently, lower doses of hydrocortisone have been advocated for some of these patients, as it is thought that adrenal insufficiency may complicate the picture.

Indeed, steroids have been utilized in a variety of infectious processes with significant benefit including bacterial meningitis, PCP, COPD exacer-bations, debilitating infectious mononucleosis, and even tuberculosis complicated by significant neurological or respiratory embarrassment.

Therefore, one must recognize the difference between the short-term use of steroids and the obvious drawbacks of long-term use. They can be used most beneficially for a variety of acute clinical processes.

J Caslowitz

5West Progressive Telemetry Unit

Have you ever evaluated a patient and felt they were not sick enough for intensive care but too sick for the regular floor? Beginning Fall 2003, there will be another option for those patients: 5West Progressive Telemetry Unit.

Although we have enough critical care capacity now, projected growth is forcing us to look at approaches to reduce intensive care unit needs in the future. This unit will allow for better ICU utilization, assist in quicker flow through of patients through the ICUs, and will help prevent the back up of ICU patients in the emergency department.

Nursing and medicine have worked closely together to come up with admission criteria for this unit. The general principles for admission criteria are below.

- Patient is hemodynamically stable
- Patient is alert and arousable
- Patients able to protect their own airway

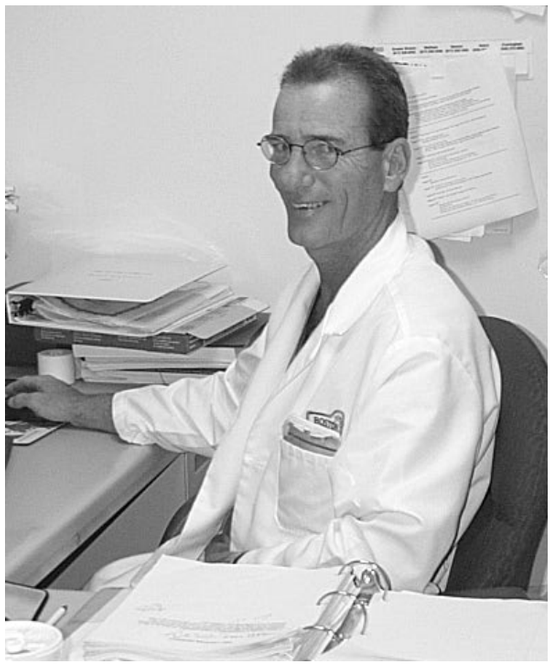
Patients with drug overdoses, DKA with insulin drips, DTs, and Arrhythmias are just some of the patients who ***may*** be candidates for the 5West Progressive Telemetry Unit.

"Six of the 14 beds, on the unit, will be designated as progressive care beds. These virtual progressive care beds can be in any room. This will keep the unit flexible, patient moves will be kept to a minimum and allow us the ability to discharge patients right from the unit," expresses Cheryl Dunnington, Nurse Manager of the unit. The unit anticipates accepting patients primarily from the ICU and from the Emergency Department, though under certain situations, may take floor transfers.

Efforts are ongoing, to educate and train the nursing staff in some of the care of intermediate patients. The nursing ratio in the step down unit will be 3-4 patients/nurse and floor staff will have phlebotomy and iv skills.

The nursing staff is excited about the transition. They are looking forward to the challenge. Look for more information on the opening date and admission criteria this fall!

L Tassinari



A Brief Primer on Section 12's

In Massachusetts a person can be involuntarily hospitalized or brought into a hospital for an evaluation if he or she is felt both to have a mental illness and to be at risk to self or others or grossly unable to care for self because of it. In this state the legal basis for this process stems from Massachusetts General Laws, Chapter 123 (which deals with mental health generally), Section 12. Hospitalizing a patient in this manner is often colloquially referred to as "sectioning" someone. Idiosyncratically, the original paperwork for so doing must legally be printed on "light pink paper", presumably the root of its "pink paper" nickname.

Pink papers have two sides. The "A" side can be completed by any licensed physician, not necessarily a psychiatrist; a licensed psychologist; a licensed and certified psychiatric clinical nurse specialist; or, in emergency situations, by a police officer. The "B" side is used to commit a patient for up to four business days in a state certified psychiatric facility if he/she is unwilling to sign in voluntarily.

At BMC we utilize Section 12 (a)'s for two purposes. The first is to send a psychiatric patient to a locked psychiatric facility after a psychiatric evaluation reveals both mental illness and significant risk to self or others. The second is to bring a person with possible mental illness, in the broadest terms including delirium and/or dementia, for medical evaluation and treatment if failure to come voluntarily for such is potentially severely dangerous to self or others.

If a patient is admitted medically, even involuntarily, and is deemed incapable of making an informed medical decision to leave or is psychiatrically committable, a Section 12(a) is not needed to hold him or her in the hospital. Rather, documentation of lack of capacity and/or risk to self or others or gross inability to care for self suffices.

For further reading, refer to The Essentials of Massachusetts Mental Health Law: a Straightforward Guide for Clinicians of all Disciplines written by Stephen H. Behnke and James T. Hilliard and published in 1998.

A Fitzgerald

"Are You My Doctor?"
Patients Who Know Their Doctor Are Happier Patients

Despite the fact that it may seem sometime that the hospital is only worried about rapid turnover of patients, there is extensive evaluation of patient satisfaction with their BMC experience as well. Surveys are distributed to patients which ask questions about their care from nurses, doctors, and other staff as well as their physical surroundings and other elements of their care.

One theme that seems to boil out from the data in an ongoing fashion is many patients' concern that they do not know who their doctor is. As one can imagine, the myriad of faces that parade in and out of the hospitalized patient's room can be quite confusing and leave patients occasionally unaware of who is "in charge" of their care. While some patients do not seem to be effected by this issue, others are quite disconcerted by it.

To this end, it is worth clearly and expressly stating who you are. Remind your patients periodically that you are their primary inpatient physician (or team) and, perhaps, review with them who else is involved with their care (specialists, therapists, nurses, etc.) so as to decrease the confusion.

To further this clarification, you are encouraged to write down your name, either on a piece of paper at the patient's bedside or utilize the wipe-board that is in the patient's room. (Indeed, these wipe-boards were put in the rooms by HOA/CIR specifically for the health care team's use for purposes of clarifying names, planned tests for that day, or to illustrate any explanations that require drawings.) Physicians with business cards (eg. the attendings) are encouraged to give patients a card. *J Greenwald*

Heading for the Pulitzer?
Start with

The inpatient times!

Contact: Jeff Greenwald to write an article

Diabetes Heart Project

Over 16 million Americans have diabetes mellitus and an additional 40 million persons have the metabolic syndrome, and are at increased risk for developing type 2 diabetes and cardiovascular events. The Metabolic Syndrome is defined as having at least 3 of the following 5 criteria:

- Abdominal obesity: waist circumference >35 inches (women) or >40inches (men)
- Hypertriglyceridemia: ≥ 150 mg/dL
- Low HDL: <50mg/dL(women) or < 40mg/dL (men)
- High blood pressure: ≥ 130/85
- High fasting glucose: ≥ 110mg/dL

The prevalence of the Metabolic Syndrome is roughly 22% in the general US population. A recent survey of patients admitted to the BMC CCU showed the prevalence to be over 60%. Given the increasing prevalence of obesity and the aging of the general population seen in the US, the incidences of diabetes and the metabolic syndrome are expected to rise further.

Cardiovascular disease is the major cause of morbidity and accounts for over 75% of mortality in diabetic patients. In one large population study, diabetes was such a potent risk factor for future vascular events that patients with diabetes and no prior history of MI had roughly the same event rate as patients with prior MI, suggesting that diabetes was a "prior MI equivalent" when considering risk factors.

Several observational studies and randomized clinical trials have shown that cardiac risk factor modification in conjunction with focused pharmacologic therapy (eg. aspirin, angiotensin-converting enzyme inhibitors, beta-blockers, insulin-sensitizing oral hypoglycemic agents, statins, fibrates) can favorably impact on the high cardiovascular risk of diabetics. Despite this impressive data base and wide acceptance of resultant published clinical guidelines, diabetic patients with risk factors are probably being "under-treated".

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In order to evaluate the degree to which cardiovascular risk is being addressed and treated in diabetics, investigators at BMC and Bay State Medical Center created the Diabetes Heart Project (DHP); a web based registry of clinical data on diabetic patients admitted to the hospital. To date, over 700 patients have been entered in to this registry. Preliminary reviews of the data reveal that less than half of this high risk population had lipid levels documented and only 44% had achieved their target LDL level of <100mg/dL. Similarly, a minority of patients achieved systolic BP <130 mmHg, even when on anti-hypertensive medications. We are continuing to enter patient data into this registry at BMC and will soon invite other hospitals to enroll their patients in an effort to increase awareness of this important issue and to encourage clinicians and hospitals to adopt clinical pathways that will improve care for our diabetic patients.

G Philippides

An NP to Join the Inpatient Service

Starting around August 1st, Cheryl Williams, a nurse practitioner, will be joining the Firm B inpatient service at Menino Pavilion. Among other responsibilities, Ms Williams will assist in the running of HoME FuND multidisciplinary rounds as well as identify and facilitate discharges on teams B1, B2, and B3.

Ms Williams is a bright and creative individual who is very much looking forward to working with the house officers. She will be looking for ways to make the inpatient service run better while improving the care we offer our patients. Please join me in making her welcome at Boston Medical Center.

J Greenwald

Follow-up Appointments

Patients who need follow-up appointment made for them (no phone, language barrier, or appointment needed in near future) should have them made by the Unit Secretary by placing the request in SCM one day in advance. If you have any problem with this program, speak to the unit's nurse manager. If that does not resolve this issue, speak to me, John Chessare, or Kathy Davidson. *J Greenwald*

Like Your Mother Always Says… Wash Your Hands!

Some months ago I was sent a copy of a series of articles in the Chicago Tribune about patients who acquire infections while hospitalized using CDC data. Some patients died from these infections. It seems the reporter did something no one had thought about before: take the numbers provided by the CDC and trace them to the specific patient and provider. The results were astounding. When providers pointed out that the number of infections was "within the norm," this did nothing to dispel the perception that staff could be careless with someone's life.

Shortly thereafter the CDC came up with a 12-step program for providers and institutions to prevent infections with resistant organisms. At BMC, we formed a group to look at preventing transmission. We all know that hand washing is the number one way to prevent the spread of infections. But what do we do? In a number of studies where clinicians *knew* they were being observed, they still did not wash their hands between patients.

Our group decided that it was not more education that was needed. What we needed was a way to get people beyond the theory and into the practice. We launched a campaign for hand washing. Our aim was to get a large number of nursing units to take up the issue and see what they could do to increase the number of clean hands. We decided that we would take a novel approach to the campaign and use humor first. We made a costume of a very large dirty hand and borrowed a costume of a hand wash bottle and walked into the Leadership for Change meeting. After the shocked crowd recovered, Carol Sulis, MD presented some before and after slides of washed and unwashed hands, dirty and clean stethoscopes, and artificial nails still contaminated after washing. It really brought the idea of spreading germs home. Dr. Dan Shapiro, from Lab Medicine, has generously offered to help us use large Petri dishes to culture the hands of staff from each of these units to test their hand washing effectiveness. We are hoping to make a real change in the hand washing habits of all staff who touch patients.

Continued →

House officers are central to this process as well. Please, use the waterless system or regular soap based washing system after every patient you see. This decreases infection transmission and may save your patient's life.

R Whalen

HoME FuND Hits Firm B

The pilot program "HoME FuND" began approximately three months ago on Firm B. Each of the three non-HealthNet teams comes daily for a fifteen minute meeting to discuss each patient from a multidisciplinary perspective. The physician leads the discussion with a "snapshot" of the patient's active medical issues, highlighting any pertinent issues or subsequent changes in the areas of medication, or the need for patient education, as well as the patient's current functional status and nutritional issues. Finally, discharge planning is discussed. Hence the HoME FuND comes from: Hospital, Medication, Education, Functional, Nutrtion, and Discharge.

This forum provides the opportunity for the timely exchange of information between, for instance, the pharmacist in attendance and the house officer, so that if recommendations are for a change to a more appropriate medication, dosage, or frequency, that change can happen in a more timely fashion. Additionally, dialogue among a charge nurse, nutritionist, social worker, a rehab staff person, and a case coordinator, all present at the meetings, similarly generates other recommendations for OT/PT/Speech involvement, diabetes nurse educator consultation, or possibly differing nursing needs.

Input from nursing around patients' ADL status, mobility, mental status combines to generate plans for appropriate, realistic discharge plans with the case coordinators. This process begins on hospital day one so fewer "eleventh hour" surprises occur.

From a case management perspective, "HoME FuND" multidisciplinary rounds have developed into a helpful tool for evaluating the patient from all perspectives and lends itself to developing an appropriate, timely, and safe discharge.

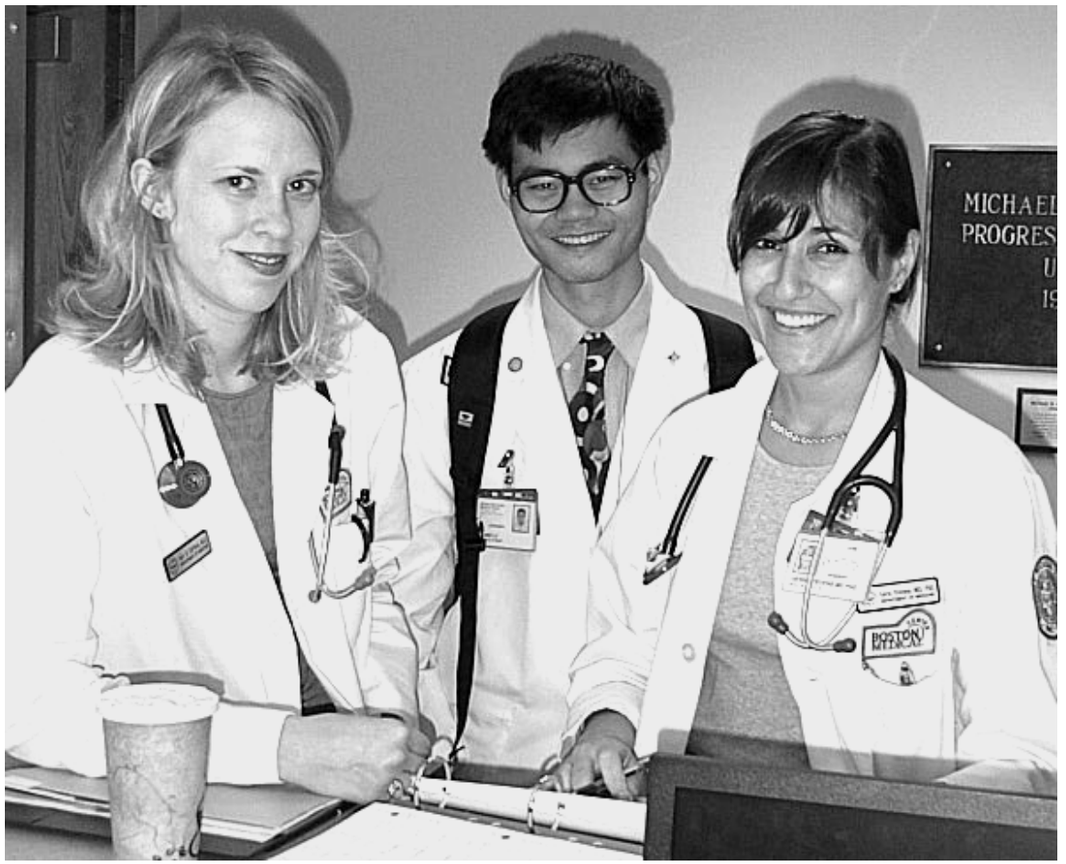
E Keating
A Salter

Your Mother Has Moved!

There has been a recent intensification of problems with "cleanliness" in the conference rooms. For reasons unclear to most civilized individuals, certain people seem to believe it is ok to litter the floors and tables of the conference rooms with whatever refuse they please. I am here to tell you that this is NOT the case. Housekeeping is not hired to clean up YOUR mess, they are here for the patients.

Please, please, please!!! Do not leave the conference rooms a pigsty. Clean up after yourselves. It's a matter of common decency.

J Greenwald



YOU CAN Prevent Medication Errors: Reporting is an Instrument for Change

As brand new physicians, you enthusiastically greet your new patients and are eager to relieve their suffering. You are immersed in a new hospital with new responsibilities, and you are constantly processing new information. You strive to be the best physician you can be. You know your limitations, and you know when to ask for help.

You WILL make mistakes.

Our intense training focuses on clinical medicine, medical decision-making, cost-effectiveness… fundamental skills we continuously build by reading, attending conferences, emulating our role models, and seeing countless patients. We lack any formal training in an area that has become a major focus of public awareness: the quality and safety of medical care in the United States. As you may recall, the Institute of Medicine released a report on medical errors in 1999, in which it claimed that between 44,000 and 98,000 Americans die each year in hospitals as a result of medical errors. Although the accuracy of this report has been widely debated, our health care system has been challenged to improve the reporting of medical errors, and ultimately, to reduce preventable adverse events.

On a busy inpatient service, antibiotic doses are often delayed, medications are ordered in duplicate, drugs are given despite a known patient allergy, the creatinine clearance wasn't calculated… the list goes on. Each of these situations involves many steps at which the error could have been prevented, but the analysis can only begin after the error is reported. The difficulties associated with making a mistake, as well as with discovering someone else's error, are major impediments to reporting. If we accept that most medical errors do not occur out of sheer carelessness or ignorance, and that even the most astute clinicians have made significant mistakes, then reporting becomes a way to start the process of careful analysis with the goal of protecting our patients. We are moving away from a culture of blame to one of prevention.

Each nursing station on the wards has a supply of yellow Adverse Drug Event (ADE) reporting forms, which can be filled out by any health care provider in 2-3 minutes. The forms are collected regularly by pharmacy staff, and a root cause analysis is undertaken for each event. These are reviewed monthly by the Medication Safety Team of the Pharmacy & Therapeutics Committee. Over the last 2 years, the ADE rate at BMC has decreased significantly. This would not have been possible without the implementation of an effective means for reporting.

Continued→

The forms are now available on-line. On the BMC Home Page, click onto "Departments," then find "Pharmacy." On the left side of the Pharmacy Home Page, there is a link to "Adverse Drug Event reporting." Within that section, you may choose from "Medication Safety" or "Adverse Drug Reaction." For further information on the forms or the website, please contact Nancy Dibelka at 414-1724.

As we roll out the electronic Medication Administration Record across both campuses, we are hopeful that many categories of medication errors will be vastly reduced. However, as with most major changes, new problems will arise. YOU are in the frontline. If you identify an error, you can take the next step to prevent it from hurting a patient.

N Torres-Finnerty

Excellent Care for Every Patient: The Challenge of Homelessness

Most of us have chosen to work at Boston Medical Center in order to provide outstanding medical care to those in greatest need. We strive to apply evidence-based medicine to every patient we see, regardless of background or ability to pay. We would never question whether someone with severe obstructive sleep apnea needs a CPAP machine; but what if he doesn't have a home? We jump at the opportunity to start a patient with AIDS on triple drug therapy if there is clear commitment and motivation; but what if she lives in a shelter?

In our medical training we are taught to be objective, nonjudgmental, unbiased, and to avoid stereotyping. In practice, it is quite a challenge to see a homeless person and not make any assumptions. We often assume the patient cannot adhere to a medical plan and quickly use the label "noncompliant." We may also assume that a man who sleeps on park benches because he is afraid of shelters has not had any primary care prior to hospitalization. In these cases our assumptions could become major barriers to providing medical care of the highest quality.

Many homeless patients actually have more consistent primary care than some of our housed patients. Through the McInnis Health Group, formerly known as Boston Health Care for the Homeless, patients obtain medical services at many sites throughout Boston, including a Primary Care Clinic located on the first floor of our Ambulatory Care Center. Other clinics are based in various shelters, including Pine Street Inn, St. Francis House, and Long Island Shelter. Patients can also seek care at a clinic located at Suffolk Downs Racetrack, which serves a large population of workers who live at the tracks. Additionally, there is a Street Team of clinicians who bring medical services to individuals staying at various well-known locations throughout the city.

As providing high quality care entails coordinating management plans among multiple providers, contacting the primary care provider for a homeless patient is of paramount importance. Ask your patients if they have a primary care provider, no matter what the blue card from Admitting says. The Firm A pocket card contains a list of providers for the McInnis Health Group along with their central pager number. Please be sure to call when a homeless patient is admitted. They will often have valuable clinical information dating back for years, as they have had an electronic medical record long before Logician was implemented at BMC.

Continued →

In addition, there is an HIV Clinic within the McInnis Group, which is based in the Ambulatory Care Center. This team provides a multidisciplinary approach to health care for homeless persons infected with HIV, including primary care, case management, nutrition, social services, mental health services, and dental care. An inpatient rounder for the HIV patients, Peggi Marini,RN, provides medical information and leaves useful notes in the chart which include contact information. She can be reached via the same central pager listed on the Firm A cards.

No plan of care is complete without addressing proper follow-up after hospital discharge, and this is even more pivotal for our patients without a home. This process can be initiated upon contacting the primary care provider as noted above. If the patient does not have one, they may be scheduled by calling the main McInnis Clinic number, 414-5090, also listed on the Firm A card. Lastly, there are Walk-In hours at the BMC clinic daily from 8-11am for urgent follow-up as needed. Please be sure to send the discharge summary with the patient to guide the Walk-In provider with the most pertinent issues.

Nancy Torres-Finnerty, one of the Firm A hospitalists, staffs the McInnis Walk-In clinic on Monday and Thursday mornings except during ward months. Please feel free to page her anytime with questions.

N Torres-Finnerty

Got an idea for a story for The Inpatient times?

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