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SAVE THE DATE
NM Department of Health Hospital Incident Reporting – UPDATE
Via WEBINAR November 16, 2016
10:00-11:00 AM
Contact einterlandi@nmhsc.com for details

Hospital Sinks May Contribute to Hospital-Acquired Infections

From STAT NEWS
In a case of unintended consequences, hospital sinks have been linked to outbreaks of serious infections in hospitals from Baltimore to Shanghai in recent years.

At a time when concern is mounting about antibiotic resistance, finding ways to slow the development and spread of drug-resistant bacteria is a major preoccupation of infection control teams. As a result, evidence that hospital sinks could exacerbate the problem presents healthcare specialists with a quandary.

When it comes to hospital sinks, there are two major issues. First, the water coming into them can contain bacteria. Municipal water treatment systems don’t produce sterile water. But a bug that isn’t a risk for a healthy person can be dangerous for immune-compromised patients or someone who is recuperating from surgery. The other problem is that sinks, particularly the pipes that drain them, are ideal places for bacteria to proliferate. The bugs form what are known as biofilms – colonies where they gang together and attach to a surface. These water-dwelling bacteria especially like the U-shaped bend in pipes that drain the contents of a sink. Sinks often have gooseneck faucets that direct water straight down into the drain. The pressure creates a splash, with tiny droplets of bacteria-laced water spraying onto nearby porous surfaces where medical staff prepare tubing and other equipment used in patient care. Important changes for use of these sinks include: 1) have it drain off the side of the bowl, 2) do not allow it to splash, 3) make sure it’s deep enough that it can’t splash on employees and clothing, and 4) make sure that the area around the sink is waterproof. As problems with sinks have become apparent, experts have been working to design better and safer sinks.

To read more, visit:
https://www.statnews.com/2016/10/25/hospital-sinks-infections/

CMS Hospital Improvement Innovation Network (HIIN)
NM Hospital Association to Subcontract with Health Research and Educational Trust (HRET) of American Hospital Association (AHA) to Continue Improvements in Patient Safety

The NM Hospital Association will again partner as a subcontractor through HRET/AHA to continue efforts in reducing preventable hospital-acquired conditions and readmissions. Through 2019, the Hospital Improvement Innovation Network (HIIN) will work to achieve a twenty percent decrease in overall patient harm and a twelve percent reduction in 30-day hospital readmissions from the 2014 baseline. Significant improvements have been made by The Centers for Medicare and Medicaid Services (CMS), an estimated 2.1 million fewer patients harmed, 87,000 lives saved, and $19.8 billion in cost-savings from 2010 to 2014, per Patrick Conway, M.D., CMS acting principal deputy administrator and chief medical officer.

By joining the NMHA HIIN, NM hospitals receive:
- On-site and virtual technical assistance and coaching on quality improvement, culture change, patient and family engagement, and data submission, interpretation, analysis and more.
- Cross-cutting resources targeting the HIIN harm areas.
- Clinical topics-specific resources and peer-to-peer resources including up-to-date checklists, change packages and case studies.
- Peer-to-peer networking and sharing at national virtual trainings and in-person events.
- Best practice hospital stories and case studies which highlight specific topics and provide detailed information on successes and lessons learned.

How can you participate?
Please contact Susan Sanches ssanches@nmhsc.com, 505.343.0010 for more information on joining.

There are currently almost 30 acute care hospitals in NM who have signed our pledge, our goal is all acute care hospitals.

Please visit the HRET HIIN website:
http://www.hret-hiin.org/
The Challenges of Reporting Adverse Events Related to Medical Devices

The U.S. Food and Drug Administration (FDA) posted a blog highlighting the challenges surrounding reporting of adverse events related to medical devices and pledging to work with the hospital field and clinicians to improve the reporting system.

Based on media reports of adverse events related to some devices, the FDA initiated inspections at 17 hospitals to identify possible breakdowns in the reporting system and start a dialogue on how to improve it. As outlined in the blog, the agency found that some of the inspected hospitals did not submit reports to the FDA for deaths or serious injuries associated with medical devices, and that staff were not always aware of and trained to comply with FDA’s reporting requirements.

The FDA requires hospitals to report a suspected medical device-related death to both the FDA and the device manufacturer. A summary of the reporting requirements can be found on FDA’s website.

The blog highlights the need to modernize medical device safety reporting. Hospitals have an array of reporting requirements that they follow when a safety event occurs.

What You Can Do:

Share this Advisory with the Chief Quality Officer, Chief Medical Officer and Compliance Officer to ensure they understand current reporting requirements.

Report any adverse events that have occurred in your facility and resulted in death or serious injury that were related to a medical device and ensure proper reporting procedures were followed. If not, report event to the FDA.


CMS Issues Emergency Preparedness Requirements

On Sept. 16, the Centers for Medicare & Medicaid Services (CMS) published a final rule establishing new emergency preparedness requirements for Medicare and Medicaid-participating health care facilities. The regulations apply to 17 different provider types, including hospitals, critical access hospitals (CAHs), ambulatory surgical centers, long-term care facilities (LTCs), intermediate care facilities for individuals with intellectual disabilities, and rural health clinics. All organizations will need to conduct a thorough evaluation of their existing emergency preparedness programs to determine necessary changes and additions needed to comply with the final rule. 


CDC Links Patient Infections to Potentially Contaminated Heater Cooler Devices

The Centers for Disease Control and Prevention (CDC) has informed hospitals that some Heater-Cooler devices may have been contaminated with Mycobacterium chimaera (M. Chimaera) in the manufacturing process, and that patients for whom these devices were used during cardiac surgery may be at risk of developing infections.