Meeting Agenda
Perioperative Quality Improvement Committee Meeting

Aim: To review systems issues uncovered by the morbidity and mortality process related to surgical patients with the goal to identify and Correct systems issues determined to be detrimental to patient care or staff safety.

Meeting Date:	Tuesday, December 15th 2009	Leader:	Dr. Jeff Dattilo	Facilitator: Scribe:	Susie Leming-Lee Mary Kay Matthys
Time:	6:30 a.m. -7:30 a.m.	Attendance:	Please see Attendance List		
Project:	Perioperative Quality Improvement Committee				
Location:	5245 D Medical Center North, Blalock Conference Room	Guest/New Member/s:			

Objective(s) of the meeting **Note: Record additional attendance on opposite side**

1.	To review issues related to the December 2009 M&M Conference Cases
2.	To review issues related to the September 2009 M&M Conference Cases
3.	To continue review of issues related to the June 12th M&M Conference Cases
4.	To review update Management of Trauma Patients with Orthopedic Injury
5.	To review Risk of Exposure: Disinfection and Sterilization of Instrument Case: How to Notify Patient and Family
6.	To review update on Central Line Placement and Management: SonoSite Training for Residents and Faculty/Boot Camp
7.	To review update Coagulation Protocol Progress Report Update
8.	To review update Packing of Surgical Wounds Not Being Removed once patient leaves OR Update

Pillar	Time P.M.	Who	Topic	Summary or conclusions, decisions, assignments, and next steps
Quality & People			I. INTRODUCTIONS	
	6:30 to 6:31	Dr. Jeff Dattilo	A. Purpose of Today's Perioperative Quality Improvement Committee Meeting	
	6:31 to 6:33	Dr. Jeff Dattilo	B. Introductions of New Committee Members or Guest: Dr. William Nealon, Surgeon in Chief	
	6:33 to 6:35	Dr. Jeff Dattilo	C. Ground Rules and Housekeeping	
			II. NEW BUSINESS- No New Business	
			A. Case 1- Colorectal Surgery, 93 year old male expired, surgical site infection	
			1. Improvements Needed: To continue long term plan for preventing surgical site infections in the colorectal surgery patients; also to spread the lessons learned to other surgical services.	
			B. Case 2-Craniotomy Surgery, 48 year old female, wrong side surgery	
			1. Revise the Time Out Critical Safety Step to ensure the task is fail safe	
			2. Develop a Star Form noting Site/Side	
			3. Revise Inform Consent Form to include Site/Side of procedure	
			4. Enforce the Universal Protocol Policy to ensure:	
			a) That the Care Provider that Marks the Patient's Site is Present in the OR	

Pillar	Time P.M.	Who	Topic	Summary or conclusions, decisions, assignments, and next steps
			b) Entire OR Team Participates in the Time Out-NO EXCEPTIONS	
			III. BUSINESS FROM PREVIOUS MEETING	
	6:35 to 7:00	Dr. Jeff Dattilo	A. Update on M&M Conference September 2009 Cases: Recommendations for Action	
			1. Intracranial Aneurysm –Nerve Palsy Case:	
		Dr. Jeff Dattilo	a) Refer Radiology Forms issue to the Hospital Safety Committee	
		Stephanie Randa	b) Report on Progress of Task Force Deployed to Address Communication Issues: • Need for more specific orders for Radiological Studies • Need for Protocol to determine type of Radiological test/studies required for Patient- If any question go to "Gold Standard" for testing • Need for two pieces of information when orders are specific to Radiology: • ICD-9 Code • Brief, one line descriptor of what the physician is looking for related to the patient's condition • Improve communication between specialties	
			2. Exposure Case:	
		Stephanie Randa	a) Meet with Administrative Leadership of Anesthesiology, Surgery, and the SSIPC to Discuss Resolutions to the Following Issues: 1) Implement both isolation and contact isolation precautions at the beginning of the treatment when Strep is present 2) When aerosolized particles are present consider higher quality level of mask 3) Staff, Surgeons, Anesthesia providers in the OR having close direct with body fluids should wear impervious gowns, double glove, and boot covers	

Pillar	Time P.M.	Who	Topic	Summary or conclusions, decisions, assignments, and next steps
			4) Limit excessive OR Traffic	
			5) Remove shoe covers before leaving OR	
			6) Consider Showering if exposed to harmful pathogens	
			7) Communication Triggers for Contact Investigation	
			8) Make scrubs readily available, not in the machine so that scrubs can be easily changed	
			9) Case cancellation if Surgeon is ill	
			IV. OLD BUSINESS	
	7:00 to 7:25	**Dr. Jeff Dattilo**	**A. M&M Conference June 2009 Cases: Recommendations for Action**	
			1. Need to employ Standard Institutional Communication at *every* level of contact with *every* patient. Re-evaluation before transfer needs to happen with <u>all</u> patients and documented in <u>all</u> cases.	
		Nancye Feistritzer	**a) Meet with Family Council to discuss need to collect more data regarding family needs**	
		Nancye Feistritzer	**b) Add tab to Star Panel to document the correct notification contact family member**	
		Barbara Martin	**c) Develop a Tool that will provide a method for Determining if a Patient is Still Appropriate for Transfer: Ms. Martin will ask for the *Creation of Identification of Primary Caretaker Form* and take this Form to the ICC Medical Directors Forum and then to the ICCC for Discussion**	
		Barbara Martin	**d) Develop/design a tool that will allow determination if patient is still appropriate for transfer.**	
		Barbara Martin	**e) Identify high risk population at patient's initial visit. Consider an in-dwelling catheter for drainage to allow monitoring of bleeding (if it happens).**	
		Barbara Martin	**f) Get Radiology contact to call with reading when film does not post electronically.**	

Pillar	Time P.M.	Who	Topic	Summary or conclusions, decisions, assignments, and next steps
		Barbara Martin	g) Floor team needs to actively look for signs of complications after surgical procedures. Look into purchasing x-ray machines that allow digital reading at bedside. Have bedside ultrasounds available	
	7:15 to 7:30		**B.** Safety and Care Issues Related to Previous M&M Conferences	
			1. Risk of Exposure: Disinfection and Sterilization of Instrument Case: Patient Exposed to Unsterile Instruments:	
		Dr. Jeff Dattilo and Committee Members	a) Disclosure of Error to Patient and Family: What is most efficient and effective method?	
			3. Central Line Placement: Safety Committee Meeting Update:	
		Dr. Peter Bream	a) Presentation of the Central Line Placement Credentialing to Institutional Critical Care Committee	
		Dr. Peter Bream and Barbara Martin	b) Dovetail Infection Control's Curriculum with the Central Line Placement Boot Camp Credentialing and Create a Website and Video	
		Stephanie Randa and Devin Carr	5. Update: Packing of Surgical Wound Not Being Removed: Prevention	
			a) Create Method to Address Nursing Handoff Process Regarding Packing of Patient's Wound	
			b) Create a Learning Module after Surgical Wound Packing Issue is Resolved	
			IV. NEXT STEPS	
		Dr. Jeff Dattilo	**A.** Summary of Today's Meeting Activities, Next Steps & Evaluation.	

Next Meeting

Date:	Tuesday January 19th 2009	Recorder:	Mary Kay Matthys
Start Time:	6:30 a.m.	End Time:	7:30 a.m.
Location:	Blalock Conference Room, 5245 MCN		

Signature Line: ____, Chairperson/Leader of Meeting/Improvement Initiative