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Passage of California's needle safety law heightens call for national regs

OSHA asks hospitals to submit data on needlestick prevention

Emboldened by passage of a landmark needle safety law in California, health care worker safety advocates are calling for federal agencies to follow suit and require hospitals — acute and subacute alike — nationwide to implement devices designed to prevent needlesticks.

Sponsored by Assemblywoman **Carole Migden** (D-San Francisco), assembly bill No. 1208 amends the state labor code to require use of sharps safety devices designed to protect workers from needlestick injuries that can result in occupational infections with HIV, hepatitis, and other bloodborne pathogens. **(See highlights of law, p. 136.)**

"Safety needles have been on the market for 10 years now," says Migden. "Failure to use this technology to protect workers has been unconscionable. We've finally changed that."

The first law of its kind in the nation, the California legislation was signed by Gov. Pete Wilson in late September after 11th-hour discussions with legislators, union representatives, and hospital groups. To keep up the pressure, the Service Employees International Union (SEIU), which represents some 600,000 health care workers nationally, organized demonstrations and candlelight vigils by workers.

Seizing the momentum from its California victory, the SEIU made clear it now will lobby federal regulators such as the Occupational Safety and Health Administration (OSHA) and the Food and Drug Administration (FDA) to require or encourage similar measures nationally. For its part, OSHA followed through with its previously announced plans by publishing a request for information on needlestick prevention and safety devices in the *Federal Register*, but the SEIU was critical of that approach in light of the dramatic developments in California.[1]

"While we are proud of our role in protecting 13% of the nation's health care workers through passage of the first statewide safer needle law, California's action begs the question: 'Why haven't OSHA and FDA acted to protect health care workers nationwide?'" says **Andrew Stern**, SEIU international president.

The California legislation directs the state division of Occupational Safety and Health (Cal-OSHA) to enforce the law by amending the state bloodborne pathogen standard — its version of the 1991 federal OSHA bloodborne regulation — by Jan. 15, 1999. Health care facilities in California then will have until Aug. 1, 1999, to comply. Cal-OSHA began the process of drafting a regulation while the legislation was under discussion, and it is expected to meet the January deadline.

Bill gives hospitals time to get up to speed

"The bill requires — ultimately — the use of safer needle devices," explains **Allan LoFaso**, staff aide to Migden. "But the bill accommodates hospitals' need for phase-in time to review technology and gives them a chance to have lead time before compliance."

Moreover, the law allows health care facilities flexibility by not requiring specific types of needle safety devices, which include self-sheathing needles, retractable designs, blunting devices, and needleless connectors for intravenous lines. However, the law calls for Cal-OSHA and the state department of health services to compile and maintain a list of existing sharps safety systems to assist employers in complying with the requirements.

"Neither the bill nor the [Cal-OSHA draft] regulations are specific as to individual devices," LoFaso says. "We have done a lot of work to accommodate hospitals — not requiring specific devices and [allowing] lead time for people to get up to speed. On the basis of those discussions, the California Healthcare Association and other organizations moved from opposition to support."

Still, with regulations to enforce the law still being drafted, it was not immediately clear to what degree California health care facilities will have to phase out conventional needle devices in favor of safety designs. At a minimum, the state law essentially appears to impose a kind of burden of proof on health care employers who have not implemented the devices. The law states that employers now will have to include sharps safety designs "as engineering or work practice controls, except in cases where the employer or other appropriate party can demonstrate circumstances in which the technology does not promote employee or patient safety or interferes with a medical procedure."

Infection control professionals in California should have key roles in evaluating the devices in order to comply with the new law and ensure both health care workers and patients are protected, says **Claire Ginesi**, RN, CIC, infection control coordinator at Sonoma (CA) Valley Hospital. A member of the product evaluation committee at the facility, Ginesi says her hospital already has implemented safety devices to prevent needlesticks when starting intravenous lines and drawing blood.

"We looked at where our risk was housewide — where our needlestick figures were — and started with those areas first," she says, adding that additional protective devices now will be considered in light of the new law.

Although well aware of the risk posed by needles due to her experience as a frontline health care worker, Ginesi echoes other infection control professionals' (ICPs) concerns in warning against "sound-bite solutions" to the complex issue of needlestick prevention. "I've been a nurse on the front lines drawing blood and doing IVs on AIDS patients, so I know how people feel. But [ICPs] don't just jump in and embrace something without understanding how it works and what the implications are for the facility. It is not that we don't wish to protect workers. We do. But just because something is marketed as a needle safety device doesn't mean that it is, or that it works or is cost-effective."

Indeed, federal OSHA took a more cautious approach even as it pushed ahead on the issue by publishing its "Request for Information" on needle safety designs and prevention strategies.

"We have recognized the concerns in this area, and we are going to look at it," says **Susan Fleming**, OSHA spokeswoman. "But nobody has a standard for a 'safer needle.' A safer needle is to some extent in the eye of the beholder and in the eye of the manufacturer. Safer than what? Safer than something that was used in 1900? Safer than the one that your competitor is manufacturing?"

OSHA is aware that epidemiological studies must be conducted to ensure the appropriate device is used to prevent the specific kinds of needlesticks occurring at individual facilities, she says. Given such concerns, the agency decided to request more information. "We will make a decision about where to go from here using that information," Fleming says. "We'll see what kinds of programs have been effective and so on. It could lead to issuing some kinds of guidelines or something — it doesn't have to be a regulatory process. It is an information-gathering process, and it could lead to any number of other avenues."

An SEIU official was critical of the OSHA approach, noting that the agency already cites needlestick prevention data on its Internet Web site, and the Centers for Disease Control and Prevention previously published impressive efficacy data on some of the devices.[2]

"[The California law also] calls into question the fairly tepid, impotent response by federal OSHA to address an identical problem nationwide," says **Bill Borwegen**, health and safety director at the SEIU. "There is a tremendous amount of information out there already."

Likewise, the union is urging the FDA to issue a safety alert to the nation's health care settings, drawing attention to the efficacy and availability of the some 250 needle safety devices it has evaluated and approved. "Basically, they have approved 250 [needle safety] devices and have disapproved a similar number," Borwegen says. "Yet they continually allow the inherently dangerous, obsolete, conventional needles in the market. They never evaluated them."

No validation required

Similarly, OSHA doesn't require employers in other industries to validate whether safety guards on machines are effective — they simply require them, he adds. "I don't know why this situation should be any different except that it is health care, a sector that continues to be largely ignored in areas of occupational safety and health."

The OSHA initiative was welcomed by one ICP, who says regulatory action finally might be in order because bottom-line cost concerns have too long delayed widespread needle safety implementation in the health care industry.

"It certainly is a step in the right direction because right now there are no teeth in the current language [in the OSHA bloodborne pathogen standard]," says **Rita McCormick**, RN, CIC, infection control practitioner at the University of Wisconsin Hospital and Clinics in Madison. "I would like to think that we would have all done this voluntarily, but the fact that we still have 800,000 needlesticks occurring annually [nationwide] tells me that this volunteer effort isn't working."

She is wary of overly prescriptive regulations regarding devices but says some generally worded regulations could improve worker protection without sacrificing clinical flexibility. "I think we need a little boost from the government in terms of a mandate regarding our obligation. Worker safety is clearly an obligation of the employer."

McCormick says needlesticks at her hospital have fallen sharply since implementation of a needleless IV system, and trials are currently under way on phlebotomy equipment with retracting needles or blunting devices. While such devices can cost considerably more than conventional designs, McCormick is hopeful that market forces and competition will push prices down as safety designs are phased into more mainstream use.

Comparing the needle safety issue to auto safety debates that preceded requirements for seat belts and other protective measures, she notes, "at some point you simply have to pay more money to reduce a risk."

References

1. Occupational Safety and Health Administration. Occupational exposure to bloodborne pathogens: Request for information. 63 *Fed Reg* 48,250-48,252 (Sept. 9, 1998).
2. Centers for Disease Control and Prevention. Devices for Preventing Percutaneous Injuries among Health Care Workers during Phlebotomy Procedures — Minneapolis-St. Paul, New York City, and San Francisco, 1993-1995. *MMWR* 1997; 46:21-25. ■

OSHA is asking for input on needlestick prevention

Time to respond is running out

The Occupational Safety and Health Administration (OSHA) is requesting information and comment on engineering and work practice controls used to eliminate or minimize the risk of exposure to bloodborne pathogens due to needlesticks. Published in the Sept. 9, 1998, *Federal Register*, OSHA's action may be a prelude to new regulations or may be used to expand requirements under the 1991 bloodborne pathogens standard.[1]

"Percutaneous injuries [PIs] continue to be a concern in work settings where employees are exposed to bloodborne pathogens," OSHA states in the document. "The agency is considering possible actions that it can undertake to assist in addressing this issue. Consequently, OSHA is interested in strategies for reducing percutaneous injury rates that have been successfully implemented in the work environment, including work

practices and, in particular, the use of devices designed to limit the risk of such injuries."

OSHA has set a Dec. 8, 1998, postmark deadline to receive information and comments based on a series of 16 questions that ask for a full description of the respondent's facility, work force, needlestick rates, and current experiences with the use of needle safety devices. In addition to the questions, OSHA generally encourages respondents to address any aspect of PI prevention strategies they consider pertinent to the issue. For complete details on each question posed, see the full document.

The key issues are as follows:

1. What is the type, size, and employment of your facility? How many of those employees have the potential to sustain a sharps injury, and what are their job classifications?

2. Do you have a surveillance system for tracking PIs? If so, does it track PIs other than those recorded on the OSHA 200 log?

3. What is the total number of potentially contaminated PIs that have occurred in your facility in the past year and previous years?

4. What is the injury rate from potentially contaminated sharps in the past year and previous years?

5. What methods and criteria are used to evaluate the effectiveness of existing exposure controls?

6. Has any type of integrated PI prevention program been established to reduce injuries? If so, describe its structure, content, results, problems and/or successes.

7. To what extent have devices designed to reduce PIs been adopted in your facility?

8. On what basis are decisions made in your workplace concerning selection of safer medical devices? Include design and performance criteria, how PI data are used, input from device users, costs, and other factors.

9. Have safer medical devices been readily accepted and correctly used when provided?

10. What provisions are made to ensure

Highlights of new California sharps law

A recently signed law in California calls for health care facilities to provide sharps safety devices designed to protect workers from needlestick injuries that can result in occupational infections with HIV, hepatitis, and other bloodborne pathogens.

The first law of its kind in the nation, AB 1208 calls for the state's Cal-OSHA program to amend the bloodborne pathogen standard to reflect the following requirements, which are summarized below:

- ❏ The definition of engineering controls must include sharps prevention technology such as needleless systems and needles with engineered sharps injury protection.
- ❏ Sharps prevention technology must be included as engineering or work practice controls, except in cases where the employer or other appropriate party can demonstrate circumstances in which the technology does not promote employee or patient safety or interferes with a medical procedure. Those circumstances shall include, but not be limited to, circumstances where the technology is medically contraindicated or is no more effective than alternative measures used by the employer to prevent exposure incidents.
- ❏ Written exposure control plans must include an effective procedure for identifying and selecting existing sharps prevention technology. Exposure control plans must be updated when necessary to reflect progress in implementing the sharps prevention technology.
- ❏ Information concerning exposure incidents must be recorded in a sharps injury log, including, but not limited to, the type and brand of device involved in the incident.
- ❏ Cal-OSHA and the state department of health services must compile and maintain a list of existing needleless systems and needles with engineered sharps injury protection, which shall be available to assist employers in complying with the requirements of the bloodborne pathogen standard adopted pursuant to this section. The list may be developed from existing sources of information, including the Food and Drug Administration, the Centers for Disease Control and Prevention, and the National Institute of Occupational Safety and Health. ■

adequate training and education in the use of safer devices and / or safer work practices?

11. How effective are safer medical devices and / or safer work practices in reducing PI rates?

12. Has use of safer devices / and or safer work practices in any way affected patient care delivery?

13. Based on observations in your workplace and your knowledge from other sources, describe any obstacles encountered relative to selection, purchase, and effective implementation of safer medical devices in the workplace, along with comments detailing successful and / or unsuccessful methods of overcoming those obstacles.

14. Provide information on costs associated with implementing safer devices and any savings resulting from their use, as well as on methods for calculating costs and savings.

15. Describe any problems associated with sharps disposal containers, as well as successful and / or unsuccessful measures undertaken to correct those problems.

16. Based on experience in your workplace and your knowledge from other sources, what are the most effective means of preventing needlesticks and other PIs? Explain the basis for your opinion and provide any supporting evidence.

[Editor's note: According to OSHA, comments should be submitted in quadruplicate or one original (hard copy) and one diskette (5¼ or 3½ inch) in WordPerfect 5.0, 5.1, 6.0, 6.1, 7.0, 8.0, or ASCII to the Docket Officer, Docket No. H370A, Room N-2625, U.S. Department of Labor, 200 Constitution Ave. NW, Washington, DC 20210. Telephone: (202) 219-7894.

Comments of 10 pages or fewer may be transmitted by fax to (202) 219-5046, provided the original and three copies are sent to the Docket Office thereafter. Comments also may be submitted electronically through information provided on the aforementioned OSHA Internet site.]

Reference

1. Occupational Safety and Health Administration. Occupational exposure to bloodborne pathogens: Request for information. 63 *Fed Reg* 48,250-48,252 (Sept. 9, 1998). ■

Rethink those old notions about pain management

Patients in real pain are undermedicated

Diane Krasner's deep interest in chronic wound pain was not spurred by intellectual curiosity or even by working as a nurse with patients who suffered chronic wound pain. It began when she experienced the pain herself and realized that many patients suffered needlessly because they thought pain was unavoidable, while others appealed for relief but were ignored by a medical establishment mired in a Draconian "no pain, no gain" mentality.

After undergoing surgery several years ago, Krasner developed a serious surgical wound infection that required debridement several times. Each time, says Krasner, the pain was excruciating. In the midst of one of the debridement procedures, Krasner, in tears, piped up about the pain.

"You're hurting me!" she told the doctor. He looked at her with a surprised expression, as if to say, "Oh! There's a patient attached to this wound," then replied, "*You've* been doing this to patients for 10 years."

"You're right," Krasner said, "and I won't do it anymore." With that, her wound care career started unexpectedly on a new track.

Soon thereafter, Krasner chose to focus on venous ulcer pain as the subject of her doctoral dissertation. She received her PhD and now is a postdoctoral fellow at the Johns Hopkins University School of Nursing in Baltimore. She also holds RN, CETN, and CWS credentials.

Who says venous ulcers aren't painful?

Krasner searched the medical literature but found little information about wound pain. In the work she did find, she noticed a common underlying assumption throughout: Venous ulcers are not painful, but arterial ulcers are. This fallacy was even suggested as a distinguishing characteristic when trying to make a diagnosis. Other authors suggested that pain was an unavoidable consequence of chronic wounds.

If professionals believed this, it would follow that patients might hold the same beliefs, Krasner thought. Therefore, patients wouldn't request pain medications even when they were greatly

needed because patients believed pain was an unavoidable consequence of chronic wounds, and clinicians would not regularly assess for pain. The results are the same in both scenarios: Patients in real pain are undermedicated, and they suffer needlessly.

The apparent assumption that pressure ulcers aren't painful because the nerve endings are gone is only partially true; there are still plenty of live sensory receptors around the wound edges and in underlying tissue. Krasner laments that even though the most current research clearly shows that pain and chronic wounds are usually partners, many clinicians still harbor misconceptions about wound pain and pain management.

Krasner noted that interest in and awareness of chronic wound pain seemed to increase in the late 1980s, primarily in the United Kingdom. Researchers there began to look at the effects of pain on quality of life. Krasner began seeing work challenging the notion that venous ulcers aren't painful. Some research showed that 35% to 75% of venous ulcer patients had pain, and that for some patients, pain was the worst symptom. In another study, 59% of patients reported having wound pain of some type, while only 2% were given analgesics for the pain. "This was a real important message that we weren't attending to this problem," Krasner says.

State of pain management is hurting

The overall state of pain management is bad, according to **Margo McCaffery**, RN, MS, a Los Angeles-based nursing consultant. Throughout the American medical establishment, pain is under-recognized and undertreated, she says. "Many people don't consider that a patient's pain is real. Patients give up and figure they just have to endure it," says McCaffery, who is author and editor of a clinical manual on pain management due out in December.[1]

What's frustrating to enlightened wound care professionals is that pain caused by chronic wounds can be reduced with medication. However, there remains a barrier — the persistent myth that patients receiving opioids are liable to become addicted to the painkillers. This is a baseless fear, and there is no evidence that proper prescription of opioids will lead to addiction, says McCaffery. She adds that fewer than 1% of patients receiving opioids become addicted.

Low-level, ongoing wound pain may respond well to anti-inflammatory medications, but as the pain increases, opioids often are indicated. However, many physicians are afraid to prescribe them. Even patients whose pain is well-managed by over-the-counter anti-inflammatories, such as ibuprofen or naproxen sodium, may need stronger medications in preparation for dressing changes and debridement, which often cause acute short-lived pain. Yet McCaffery says she can't understand why many physicians won't consider narcotic painkillers even for these discrete events.

"More people than before realize the problem of wound pain and treatment, but there's still an incredible phobia around the management of pain," says **Frank D. Ferris**, MD, a palliative care physician at the Temmy Latner Centre for Palliative Care at Mount Sinai Hospital in Toronto. "Many people perceive barriers, not the least of which is that they think if you start opioids, the patient will get addicted. That really is a myth. There's no data to support the contention. In fact it's quite contrary. If you use opioids in a situation where you understand the pathology, the patient will do well and get off the opioids, and there will be no problem."

Ferris notes that in some circumstances, unrelieved pain actually can create further physical damage and perpetuate the problem. The goal of pain management should be to treat and minimize pain early in treatment, he emphasizes.

Lia van Rijswijk, RN, ET, a nurse consultant in Newtown, PA, also underscores the points that wounds can cause severe pain and that less-than-adequate pain control is common in patients with chronic wounds. Many patients, she adds, particularly older or immobile people, cannot communicate their level of pain, so nurses must be vigilant for signs of pain, such as grimaces or moans when a patient is turned or during dressing changes. "The patient may not move in bed because that motion may cause pain, and that immobility can cause even more pressure sores," says van Rijswijk.

She explains that all skin trauma and breakdown causes nociceptive pain (pain stimulated by injury). In a chapter to be published in McCaffery's book, she writes, "Even when the dermis and its sensory receptors are absent, as may be the case in full-thickness wounds (such as deep pressure ulcers and third-degree burns), the wound edges as well as the underlying tissues will contain sensory receptors. Also, sensations such as pressure (e.g., from sitting or wound packing materials) and movement (e.g., wound manipulation) will be perceived by the

proprioceptive receptors in the underlying fascia, muscles, tendons and ligaments."[1] She adds that peripheral nerves will regenerate in healing wounds. The immature nerve tissues produced during this process are hypersensitive to wound care procedures and topical agents.

It is also the nurse's responsibility to inform physicians when patients are in pain, McCaffery adds. "Nurses need to know that their job is to let the physician know when the patient needs pain medication," she says. Clinicians also should make regular use of pain assessment tools, such as the pain analog scale or the Wong Baker FACES pain rating scale, says Ferris.

Despite assertions to the contrary, wound pain is real and it often goes undertreated. However, it can be controlled easily if only clinicians would replace their misconceptions about pain control with facts.

Reference

1. McCaffery M, Pasero C. *Pain: Clinical Manual.* 2nd ed. St. Louis: Mosby; in press. ■

New pain models better reflect patient experience

Assessment measures now specific to wounds

The medical community traditionally has classified pain in two categories: acute (pain lasting for less than six months) or chronic (pain lasting for more than six months). A slight modification came in 1986 when the National Institutes of Health Consensus Development Conference on Pain created three categories: acute, chronic malignant, and chronic nonmalignant. Neither system is sufficient for describing or categorizing the varied pain experiences of patients with chronic wounds.

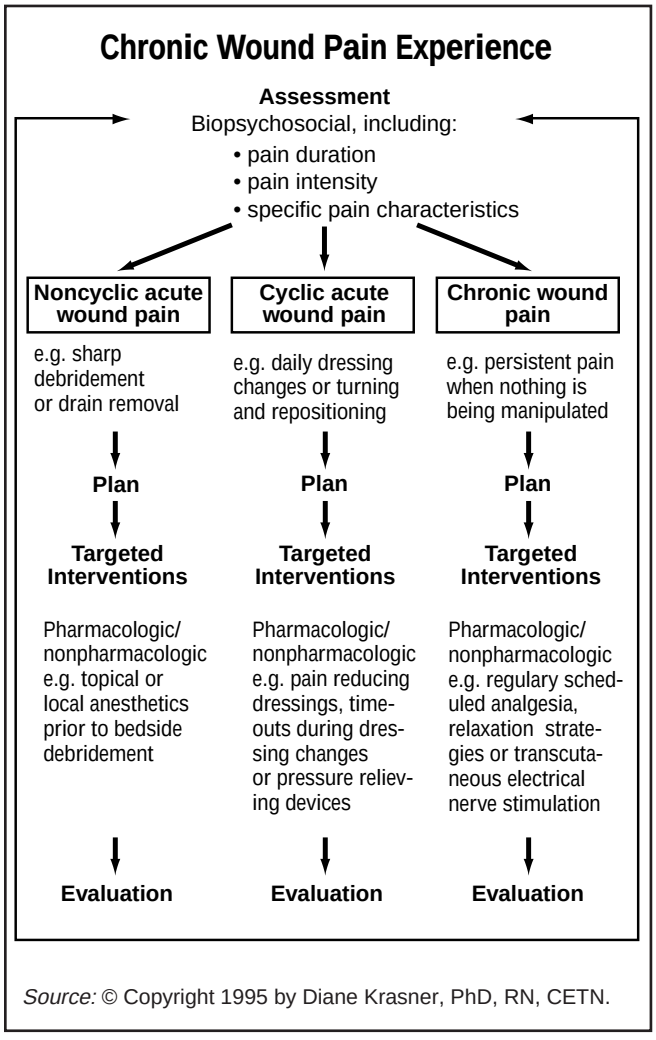
Clinicians and researchers recently have introduced new pain algorithms specific to wound care. One is the Chronic Wound Pain Experience (CWPE) Model, designed in 1995 by **Diane Krasner**, PhD, RN, CETN, CWS, a postdoctoral fellow at the Johns Hopkins University School of Nursing in Baltimore. The CWPE divides pain into three categories: noncyclic acute wound pain, cyclic acute wound pain, and chronic wound pain. **(See chart, at right.)**

Noncyclic acute wound pain occurs during distinct episodes, such as sharp debridement or drain removal. Cyclic acute wound pain is periodic acute pain that recurs as a result of repeated treatments or interventions, such as daily dressing changes, turning, or repositioning. Chronic wound pain is persistent pain that occurs without manipulation, such as the throbbing of an abdominal wound when a patient is just lying in bed, according to Krasner.

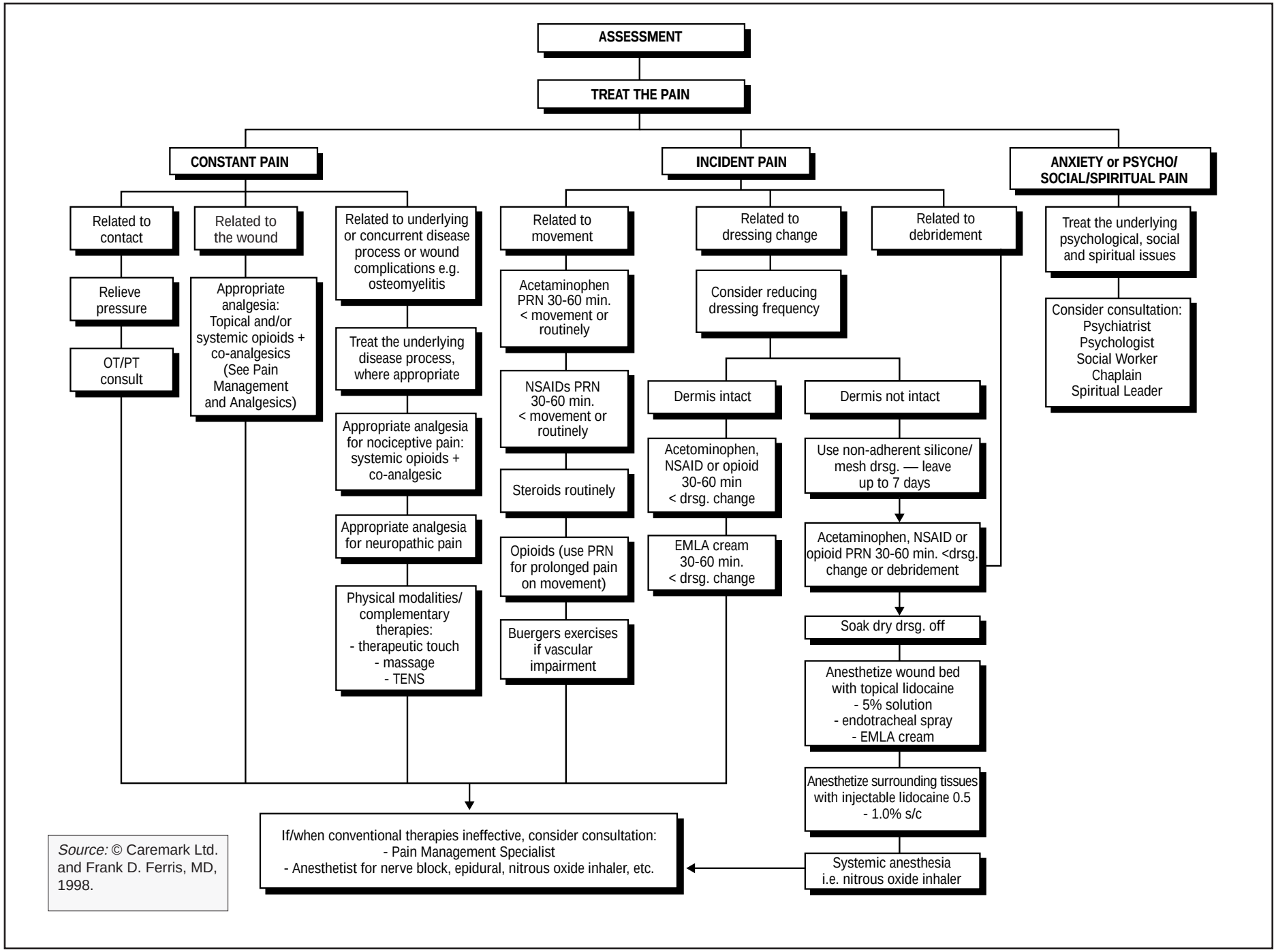
Krasner says chronic wound patients may experience the three types of pain separately or simultaneously. She says the model can help wound care providers assess wound pain more accurately and therefore apply the most effective pain-prevention or pain-reduction interventions, because the type of pain should dictate the measures taken to give the patient relief.

For example, application of a topical anesthetic compress before sharp debridement may be more

(Continued on page 140)



Source: © Copyright 1995 by Diane Krasner, PhD, RN, CETN.



Source: © Caremark Ltd. and Frank D. Ferris, MD, 1998.

effective for reducing the noncyclic acute wound pain that debridement can cause. To reduce the cyclic acute wound pain that may stem from dressing changes, an oral analgesic an hour before the change might be in order. For chronic wound pain, around-the-clock oral medications may be the best route, along with adjunct therapy such as wound cleansing and pain-reducing dressings.

Though these measures seem like common sense, Krasner notes that many clinicians don't take any of these measures, often leaving the patient to suffer unnecessarily.

Another algorithm for pain management was developed recently by **Frank Ferris**, MD, a palliative care physician at the Temmy Latner Centre for Palliative Care at Mount Sinai Hospital in Toronto. **(See chart, p. 140.)** Ferris categorized three major types of wound pain: constant pain, incident pain, and anxiety or psychosocial/spiritual pain.

Constant pain can result simply from the wound's presence, contact between the wound and other surfaces, or from underlying or concurrent disease processes or complications, he says.

> ***"Every wound needs to be assessed with an appropriate pain assessment measure. We have to understand the wound's etiology and have a sense of its pathophysiology."***

Incident pain is related to movement, dressing changes, and debridement. Anxiety or psychosocial/ spiritual pain such as depression can result from the physical pain caused by the wound and related activities. This type of pain also can result in more intense physical sensations, he says. If a patient is convinced an upcoming dressing change will be painful because no pain management measures are taken, for instance, that patient's experience of wound pain may increase needlessly.

Studies also have shown that the presence of a wound can have a notable adverse effect on quality of life. Chronic wound patients often report that they feel socially isolated, depressed, and anxious. These phenomena all would fit into the category of psychosocial/spiritual pain.

As with the CWPE model, a thorough assessment of each patient is crucial to determine the type of pain a patient experiences. This information will allow wound care professionals to select the most effective interventions, according to Ferris. "Every wound needs to be assessed with an appropriate pain assessment measure," he says. "We have to understand the wound's etiology and have a sense of its pathophysiology. Then we need to apply different treatment interventions. We also need an understanding of the pharmacology of medications we're using and the associated psychosocial/spiritual pain that may be present," he says. ■

Get something done when you call a meeting

Even if the participants want to be somewhere else

Would you like to build a reputation for staging the best meetings in the house? To pull it off, you'll need to join the elite 2% who spend as many as five hours planning for them. **(To compare your meeting preparation times with those of your peers, see box, below.)** Actually, those five hours will pass in a flash when you set your meetings up with the same care as the two pros who share their secrets here:

1. Do the homework.

Rosemary Keeley, Improvement Services director at VHA Atlantic in Charlotte, NC, prepares by anticipating data needs and assembling literature reviews. Her goal is to give the participants minimal homework assignments and send them back to work with action goals that change the way they do their jobs.

2. Craft a crystal-clear agenda with time lines.

Keeley shuns vague terms like "old business" and "new business." Rather, she describes each

Prep Time

n=2,855 Respondents

No prep time	7%
1-30 minutes	50%
31-59 minutes	26%
1-4 hours	13%
5-8 hours	1%
more than 8 hours	1%

Source: 3M Meeting Network, 3M Visual Systems Division, Austin, TX.

Weekly Hours in Meetings/Meetings Per Week

1-4 Meetings Per Week n=1,745 Respondents		5-8 Meetings Per Week n=765 Respondents		9+ Meetings Per Week n=338 Respondents	
Length of Meeting		**Length of Meeting**		**Length of Meeting**	
Less than 4 hours	49%	Less than 4 hours	5%	Less than 4 hours	2%
4-8 hours	42%	4-8 hours	35%	4-8 hours	8%
9-12 hours	6%	9-12 hours	36%	9-12 hours	17%
13-16 hours	2%	13-16 hours	15%	13-16 hours	25%
17-20 hours	1%	17-20 hours	6%	17-20 hours	22%
21-24 hours	0%	21-24 hours	1%	21-24 hours	11%
25-28 hours	0%	25-28 hours	1%	25-28 hours	6%
29-32 hours	0%	29-32 hours	0%	29-32 hours	3%
more than 32 hours	0%	more than 32 hours	0%	more than 32 hours	5%

Source: 3M Meeting Network, 3M Visual Systems Division, Austin, TX.

element, such as "results from last week's measures," or "problems with new emergency department admissions protocol."

While your participants might mistake you for a control freak at first, allot a time interval, such as 10 a.m. to 10:15 a.m., for each item. Make it stick by timing it yourself or delegating the task to someone who's assertive enough to handle it. And it goes without saying that any self-respecting leader starts meetings on time.

Take pains to gather the key stakeholders and decision makers around the table because nothing kills enthusiasm like delaying action until you can regroup with the missing player. By the same token, if you find that you don't need the input of everybody you've gathered, give them an opportunity to leave. **Michael Begeman,** manager of the Austin, TX-based 3M Meeting Network says, "It's a beautiful thing to respect people's time enough to let them walk out."

Once you have the core group in place, it's time to get to work using the following steps:

3. Everyone contributes.

Keeley uses gatekeeper techniques to keep the energy up all around the room. To the long-winded, she'll say, "Great idea, John. Now Gwen, what are your thoughts on it?" Sometimes, she conducts round robins where people share ideas by turn around the table. "I make sure people walk out the door having contributed one or two times — even the quietest person," she says.

4. Meeting minutes should be easy to write and a snap to read.

Begeman likes minutes that record three items for each piece of business:

— decisions made;

— action items including who will do it, what he or she will do, and when it will be done;

— open issues stating when discussion will resume. A quick review of action items gets everybody's alignment and solidifies responsibilities for implementation.

Two-minute continuous quality improvement taps the intelligence of your participants.

Begeman closes his meetings by asking for a quick round of input to these two questions:

— What worked at this meeting?

— What would improve meetings like this in the future?

Considering how much time people spend in meetings each week, they'll be able teach you even more than this article about those two questions. **(For details, see above chart.)**

When Keeley leads rapid-cycle change teams, she has to sustain a high level of excitement to effect significant changes in short time intervals. To do it, she sets a three-meeting limit. "I also use the biggest block of time I can get," she explains. "Most people are used to meeting in one-hour time blocks, but we've learned that if we have double-long meetings, we can finish in half the time."

Both Keeley and Begeman write key discussion points on flip charts to help people pay attention and remember what happened. Keeley adds one suggestion: "The person who is leading the meeting should write on the flip chart because that person will get the eye contact." ■

NEWS BRIEFS

Physician, administrator values closely aligned

Although physicians and administrative types seem to be perpetually at odds, the competencies they value are not as polarized as you might think.

At least that's implied by first-phase results from a recent study in progress through the American College of Medical Practice Executives (ACMPE), based in Englewood, CO. The purpose of the study, notes **Andrea Rossiter**, FACMPE, senior vice president of the college, is "to help the physician and administrator members of [medical practice teams] manage and lead together." ACMPE is the professional development and credentialing arm of the Medical Group Management Association (MGMA) also in Englewood, CO.

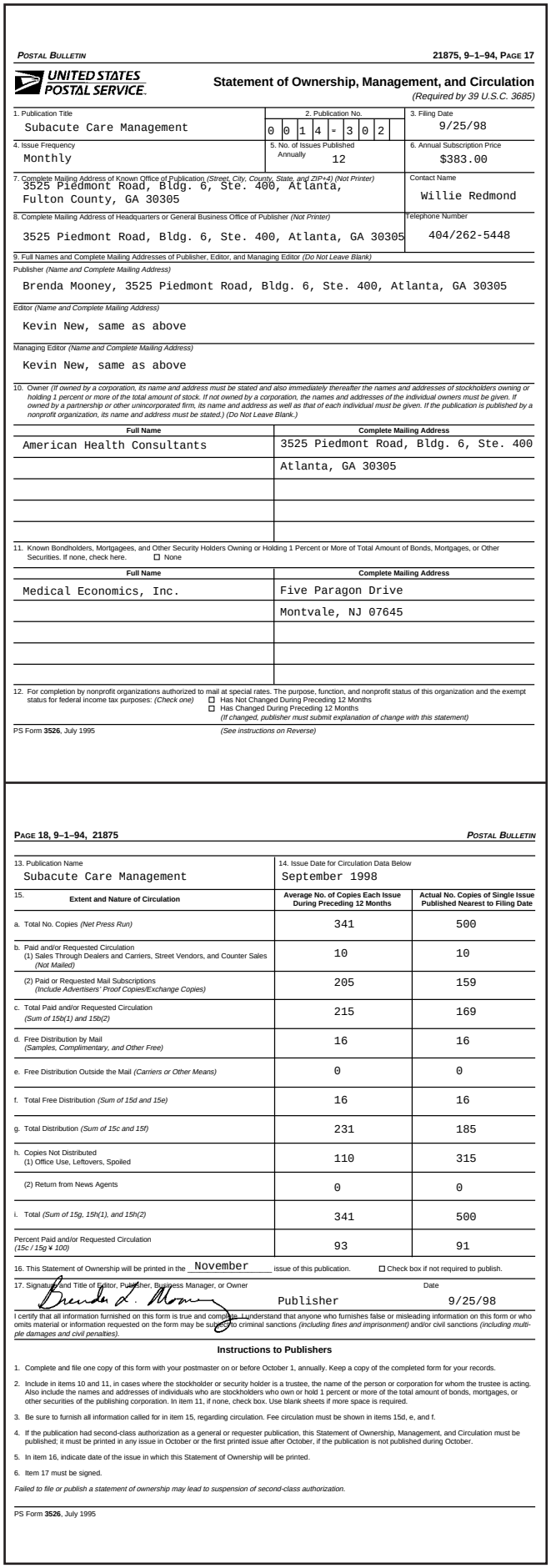
The investigation consisted of two separate surveys: one related to administrator competencies and the other to those of physician executives. In valuing competencies directly connected with quality improvement processes, physicians and administrators showed no appreciable difference. Those competencies include analyzing and managing cost and revenue, running efficient cost-effective practices, and improving clinical processes and outcomes.

Other results show the following differences:

- **Administrators** place highest value on: (1) facilitating and managing change; (2) conducting effective interpersonal, oral, and written communications; and (3) building productive working relationships.
- **Physicians** value: (1) exercising ethical decision making and social responsibility and (2) building teams and conducting effective groups.

Age and number of years in health care or health care administration did not predict individual responses.

[Editor's note: For more details on this study as well as other ACMPE or MGMA services, contact 104 Inverness Terrace E, Englewood, CO 80112-5306. Telephone: (303) 799-1111. Fax: (303) 643-4439. Web: http://www.mgma.com.] ▼



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PS Form **3526**, July 1995

New wound ointment derived from oak tree

Clinical data support positive anecdotal results

A wound ointment derived from oak extract is earning kudos from some health care professionals.

Amerigel, manufactured by AmerX Health Care Corp. in Clearwater, FL, is formulated for application as a wound dressing for management of pressure ulcers, stasis ulcers, diabetic skin ulcers, cuts, and abrasions. Amerigel ointment also is used to alleviate skin irritation associated with peristomal care, according to the manufacturer.

One enterostomal nurse who uses Amerigel has reported that the ointment has sped the healing of many intractable wounds.

"The first time I used it, I saw a wound bed fill up with granulation tissue in four days," explains **Carolyn Hewett**, RN, CETN. Hewett is co-owner of the Specialty Care Center at Helen Ellis Memorial Hospital in Tarpon Springs, FL.

Clinical data show promise

In addition to many positive anecdotal results for Amerigel, there also are some clinical data from a study sponsored by the manufacturer. The study involved 152 patients, 72 of whom had stage I wounds and 80 who had stage II, III, or IV wounds. Twenty-one patients had multiple wounds.

All of the stage I wounds healed with no sequelae. Eighty-eight percent of stage II wounds healed in an average of 46 days; 62% of stage II wounds healed in an average of 54 days; and 16% of stage IV wounds healed in an average of 52 days.

AmerX Health Care Corp. claims that Amerigel ointment acts to increase blood flow to a wound.

Amerigel users have reported that a small percentage of patients can't tolerate the burning sensation that occurs when the ointment is applied.

Amerigel is an over-the-counter product costing about $15 retail. The cost is lower when the product is purchased through medical supply distributors. ■

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