IPRO
Improving Healthcare for the Common Good

Hospital Patient Safety News

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A NEWSLETTER FOR HOSPITAL STAFF PARTICIPATING IN IPRO'S PATIENT SAFETY INITIATIVE

Spring 2010

Welcome to the Spring 2010 issue of IPRO's *Hospital Patient Safety News*.

In this issue we present updates on the Centers for Medicare & Medicaid Services (CMS) 9th Scope of Work (SOW) Patient Safety Initiative Projects, upcoming events, articles of interest and educational resources. If you have a best practice, tools or resources that you would like for us to feature in a future issue, please forward the information to Gloria Stone at **gstone@nyqio.sdps.org**.

If you have colleagues that you believe should be receiving this newsletter, they can request their own subscription by sending an e-mail to Gloria Stone at **gstone@nyqio.sdps.org**.

IN THIS ISSUE:

IPRO's Patient Safety Initiative Projects

MRSA Project:
Reducing rates of healthcare-associated Methicillin-resistant *Staphylococcus aureus* (MRSA) infections;

Surgical Care Improvement/Heart Failure (HF) Project (SCIP):
Improving inpatient surgical safety and heart failure treatment; and

Medication Safety:
Reducing the prevalence of prescribing potentially inappropriate drugs with anticholinergic properties to seniors and improving the quality of warfarin management.

MRSA Project

Preventing HAIs: The Solution is in Your Hands

Follow Hand Hygiene Guidelines
A National Patient Safety Goal

- Protect Patients
- Save Lives
- Prevent Infections

Healthcare-associated infections (HAIs) are infections that patients get while being treated for other conditions in a healthcare setting. In the US approximately 5 to 10 percent of hospitalized patients develop an HAI, which causes approximately 99,000 deaths per year. MRSA is a type of HAI and causes about 19,000 deaths a year. Preventing the spread of MRSA and other infections protects patients and saves lives.

The most common mode of transmission of pathogens is via the hands. Proper hand hygiene has been shown to terminate outbreaks and reduce infections. Hand hygiene compliance remains the single most important weapon in the battle against HAIs and is a national patient safety goal.

IPRO will be providing hospitals participating in the MRSA Project with tools to support their hand hygiene compliance, including staff teaching materials, positive reinforcement tools and audio-visual resources. These materials will be available this summer. In the meantime, other free hand hygiene educational resources are available at:

- CDC: **http://www.cdc.gov/handhygiene/**
- WHO: **http://www.who.int/gpsc/en/**
- Joint Commission: **http://www.jointcommission.org/PatientSafety/InfectionControl/**

Hospital Surveys

SAVE THE DATE: Thursday, June 17th

To further support facilities in their efforts to improve patient safety, IPRO is hosting *Using Survey Data to Create a Culture of Patient Safety,* a conference featuring Barbara Balik, Executive Vice President for Safety and Quality Systems, Allina Hospitals and Clinics; Institute for Healthcare Improvement; Press Ganey; and regional hospital leaders.

Please feel free to forward the following information to your Patient Safety Officer or other individuals in charge of collecting patient safety surveys for your facility.

This conference will be held at the LaGuardia Marriott Hotel, 8:30AM–3:30PM, and will present best practices for using data from the AHRQ Patient Safety Culture Survey, HCAPS, and HLQAT Hospital Leadership Survey.

Please follow this link to register for this conference: **https://www.regonline.com/survey_patient_safety**
For more information please contact Karline Roberts at **kroberts@nygio.sdps.org**

Improving Patient Safety

Preventing Hospital-Acquired VTEs

Under the Agency for Healthcare Research and Quality's (AHRQ's) Knowledge Transfer/Implementation contract, IPRO has developed a Quality Improvement Organization (QIO) Learning Network, which includes AHRQ, clinical experts, QIOs from seven states including New York, and associated hospital providers. Nine hospitals in New York State are participating in IPRO's Learning Network.

Working collaboratively to disseminate AHRQ-developed evidence-based tools and research findings into the healthcare system, Learning Network participants exchange ideas and experiences about specific topic areas; share experiences to identify best practices; and work together to solve problems or barriers to the dissemination of best practices.
Using resources from *Preventing Hospital-Acquired VTE: A Guide for Effective Quality Improvement,* developed by Dr. Gregory Maynard, this Learning Network focuses on preventing hospital-acquired venous thromboembolisms (VTEs).

For more information about this project, please contact Vicky Agramonte at vagramonte@nyqio.sdps.org.

Facts about hospital-acquired VTE:

- Over two million Americans suffer from VTE each year, with more than half developing VTE in the hospital or in the 30 days immediately following their discharge. The incidence of proximal deep-venous thrombosis (DVT) and clinical pulmonary embolism (PE) is largely due to the underutilization of simple, cost-effective prophylactic measures.
- VTE leads to substantial morbidity, mortality, and unnecessary costs.
- Increasingly, VTE prevention is being incorporated into public reporting, regulatory agency actions, and national quality initiative priorities.
- Thoughtful, evidence-based protocols, multidisciplinary system changes, and comprehensive educational efforts are required to achieve optimal VTE prophylaxis in the complex hospital setting.

Improvement in Medication Reconciliation and Management

Also under the AHRQ Knowledge Transfer/Implementation contract, IPRO has developed a second QIO Learning Network, which includes AHRQ, clinical experts, QIOs from nine states including New York, and associated providers.

The goal of this Learning Network is to help participants develop and implement an improvement plan for medication reconciliation and management using evidence-based best practices and improvement tools, and focuses on five areas:

- assessment of current practices,
- integration of tools and resources,
- staff training and development,
- patient/caregiver teaching and training, and
- measurement of interventions.

This Learning Network is using the *MATCH - Medication Reconciliation Toolkit,* which was designed by Dr. Gary Noskin, Northwestern Memorial Hospital, Chicago, to assist all types of organizations with their medication reconciliation process by establishing a single list to document a patient's current medications. This "one source of truth" list is then shared and used by all physicians, nurses, pharmacists and others caring for

the patient - a team approach to medication reconciliation. More information about the *MATCH Medication Reconciliation Toolkit* can be found at **http://www.nmh.org/nm/for+physicians+match**

For more information about this project, please contact Vicky Agramonte at vagramonte@nyqio.sdps.org.

Educational Resource

Can a structured checklist prevent problems with laparoscopic equipment? This article reports on a study aimed to determine the extent to which a checklist reduced the number of incidents with technicallaparoscopic equipment and is posted on JENY at **http://jeny.ipro.org/showthread.php?t=3385**

Reference Materials **May is National Hepatitis Awareness Month**

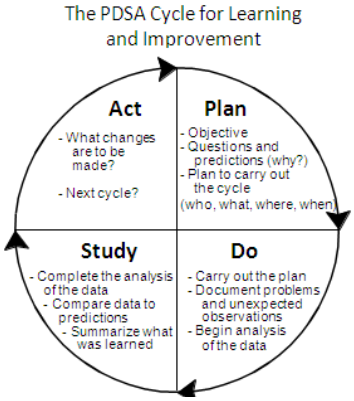
First designated by the Centers for Disease Control and Prevention (CDC) in 2001, National Hepatitis Awareness Month, was created to help raise awareness about viral hepatitis. With as many as five million Americans affected by chronic hepatitis B and C, there is much that still needs to be done to improve prevention, education and access to medical care and treatment. For more information, go to: **http://www.cdc.gov/ncidod/diseases/hepatitis/resource/index.htm**

Back to Basics Corner

The PDSA Cycle for Learning and Improvement

As we all get caught up in trying to fix broken processes and conduct rapid cycle improvements, it is easy to forget the basics by inadvertently skipping part of the improvement cycle.

First, it is important to develop a clear and concise statement that includes a time-specific and measurable improvement goal. A time frame should be defined for the execution and completion of the change.



PDSA

For a strategy change to be considered a PDSA the following steps are essential:

- **Plan** the change.
- **Do** the change. Try testing the change in a pilot before full implementation; collect data.
- **Study** the change. Review the data and determine if a change has occurred. Use quantitative measures to determine if a change actually led to an improvement. Ask: Are there improvements? What did we learn?
- **Act** upon what was learned. If the change was successful and resulted in improvement, implement the change on a broader scale. If the change did not lead to improvement, modify or eliminate the change.

Keys to success include:

- support from leadership;
- a measurement system;
- a strategy for the change;
- having the right people on the team; and

- knowing answers to the 4 Ws:
  - **What is being tested?**
  - **Who is conducting the test?**
  - **When is the testing?**
  - **Where is the testing?**

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