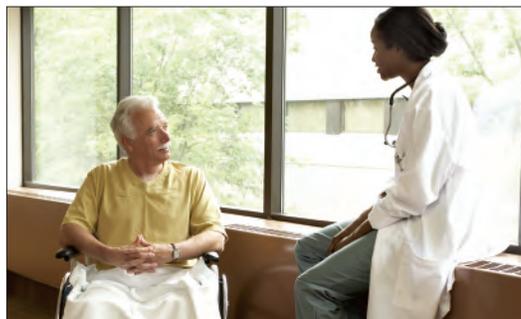


Hospital Patient Safety News

Spring 2013

A Newsletter for Hospital Staff Participating in IPRO's Patient Safety Initiative

www.ipro.org



Welcome to the Spring 2013 issue of IPRO's Hospital Patient Safety News. This newsletter features information on upcoming events, articles of interest, and educational resources related to the Centers for Medicare & Medicaid Services (CMS) Healthcare Associated Infections (HAI) Prevention Initiative. If you have a best practice, tool, or resource that you would like us to feature in a future issue, please

forward the information to Teré Dickson, MD, MPH at tdickson@nyqio.sdps.org. Subscriptions to this newsletter can be requested by e-mail to Susan Ulmer at sulmer@nyqio.sdps.org.

Your comments are valuable for improving our newsletter. Please share your input with us in this brief questionnaire:
www.surveymonkey.com/s/YL2RZZG.

News You Can Use

Antimicrobial Catheters Do Not Reduce Risk of CAUTI

December 2012. *MedWireNews* reports on a study originally reported in *The Lancet*, which found that for adult patients requiring short-term catheterization, silver alloy-coated catheters do not reduce the risk of catheter-associated urinary tract infections (CAUTI) as compared with standard catheters. In addition, reductions in CAUTI observed with nitrofurazone-impregnated catheters compared to standard catheters were found to be clinically insignificant, leading researchers to conclude that their current findings did not support the use of antimicrobial-impregnated catheters. These were the results of a study conducted at Newcastle University, UK, in which investigators compared CAUTI rates among 2,097 patients who were randomly assigned to receive silver alloy catheters, 2,153 patients who received nitrofurazone catheters, and 2,144 who received standard polytetrafluoroethylene (PTFE)-coated latex catheters. After adjusting data for age, gender, comorbidities, indication for catheterization, and antibiotic use prior to catheterization, the study found that silver alloy catheters reduce CAUTI rates by only 4%, while nitrofurazone catheters reduced rates by 19%. For the complete article, visit: www.news-medical.net/news/20121210/Antimicrobial-catheters-do-not-significantly-reduce-UTI-risk.aspx.



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The Hospital Patient Safety Staff at IPRO



Quality Improvement Organizations

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News You Can Use

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Doctors' Income Tied to Quality of Care

January 2013. A recent *New York Times* article reports that complaints from patients and other measures of patient care at New York City's public hospitals will soon be reflected in doctors' paychecks. Due to the changes outlined in the Affordable Care Act, both public and private hospitals are preparing to connect doctors' income to patient outcomes and cost containment; but New York City's Health and Hospitals Corporation (HHC), which runs the city's 11 public hospitals is extending the financial incentive directly to front line physicians who are directly responsible for treatment. The physicians and hospitals are currently negotiating the plan.



Within the next few years, the Federal Government will begin to financially reward or penalize facilities based on their performance on certain benchmarks that are believed to correlate with better patient outcomes. HHC's goal is to align doctors' pay with these same benchmarks in an effort to prepare for the Federal incentive program. The proposed Federal plan would offer bonuses of up to \$59 million over a three-year period. These bonuses would be dispersed to more than 3,300 doctors, and would be paid out to physicians as a group at each hospital, rather than on an individual basis. For the complete article, please visit: www.nytimes.com/2013/01/12/nyregion/new-york-city-hospitals-to-tie-doctors-performance-pay-to-quality-measures.html?smid=li-share&r=1&.

Experts Address Antibiotic Resistance

November 2012. In an effort to address the serious and growing problem of antibiotic resistance, 25 national health organizations, including The Centers for Disease Control and Prevention (CDC), have signed a statement indicating their shared commitment to a set of principles aimed at conserving and replenishing antibiotic resources. These principles include:

- 1) Promotion of antibiotic stewardship programs and interventions to ensure that patients receive the correct antibiotic for the appropriate duration,
- 2) Support of research that validates current trends in antibiotic resistance and use,
- 3) Improving surveillance and reporting activities for drug-resistant infections,
- 4) Encouraging pharmaceutical companies to develop products that combat antibiotic resistance, and
- 5) Recognition that antibiotic resistance is a public health threat that requires immediate and global action in addressing the current scarce supply of effective antibiotics.

The Extending the Cure (ETC) research team, based at The Center for Disease Dynamics, Economics & Policy (CDDEP), one of the 25 organizations that signed the statement, conducts regular research and issues commentaries on topics such as healthcare-associated infections, trends in drug resistance, and the costs—both human and economic—posed by rising resistance rates. ETC is laying groundwork for the comprehensive solutions needed to combat this problem. The team, led by CDDEP Director Ramanan Laxminarayan, advocates for a natural resource economics approach. This strategy focuses on incentive-based policy solutions that call for prescribing antibiotics judiciously, encouraging vaccinations, controlling infection in hospitals, pursuing novel treatment strategies, and giving the government a central role in determining how antibiotics are allocated and used. The philosophy behind their approach is “while we can't beat the bacteria, we can slow them down by recognizing that antibiotics are a natural resource that we must use conservatively if we want them to remain effective.”

To read the complete article about CDDEP's current strategies in combating antibiotic resistance, please visit: www.rwjf.org/en/grants/grant-records/2007/04/continuation-of-short--and-long-term-policy-responses-to-the-cha.html. To view the complete list of principles developed by the national health organizations and the CDC, please visit: www.rwjf.org/en/research-publications/find-rwjf-research/2012/11/joint-statement-on-antibiotic-resistance-from-25-national-health.html?cid=XEM_A6651.

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CUSP Corner

The Comprehensive Unit-based Safety Program (CUSP) offers a variety of tools and techniques to help clinical teams identify and resolve patient safety issues at the unit level. The five-step program features a structured, strategic framework for safety improvement that also empowers staff to take charge and address identified safety hazards. To learn more about CUSP visit: www.onthecuspstophai.org.

Improving Nurse and Physician Communication

January 2013. As reported by *Advance for Nurses*, poor communication between hospital nurses and physicians are more often the norm than not. Kathleen Bartholomew, author of *Speak your Truth: Proven Strategies for Effective Nurse-Physician Communication* acknowledges this communication barrier, "When nurses and physicians don't communicate, it's the patient who loses every time. The bottom line is: negative relationships equal negative patient outcomes." A 2009 survey conducted by the American College of Physician Executives, found that in a one-year period, 98% of 2,100 nurses and physicians had witnessed behavioral problems between the two groups. Thirty percent of the respondents reported that they had observed problems on a weekly basis, and ten percent reported it as a daily occurrence in their facilities.

The Solution

Establishing a leadership model for both nurses and physicians can help bridge the communication gap between the two. To address concerns that nurses and physicians were not working collaboratively, Pennsylvania Hospital—an affiliate of the University of Pennsylvania Health System (Penn Medicine)—piloted a unit-based clinical leadership (UBCL) approach with an eye towards coordinating care for the patient in a timely and correct manner. For each unit, a nurse manager, physician leader, nurse educator, and a quality coordinator partnered to collect and analyze data. Nurses and physicians shared responsibility for leading multidisciplinary rounds and worked to improve compliance and documentation by hospital staff. The pilot allowed physicians and nurses to better understand the complex day-to-day demands of each others' jobs. As a result, communications between the two professional groups, as well as the quality of care delivered to patients on the unit was vastly improved. The UBCL approach is now standardized across all units in Pennsylvania Medicine's three hospitals. To read the complete article, please visit: <http://nursing.advanceweb.com/Features/Articles/Straight-Talk.aspx>.



- 5 Five Steps of CUSP**
1. Educate staff on the Science of Safety
 2. Identify defects in the system
 3. Engage senior leadership
 4. Learn from one defect per specified time period
 5. Implement teamwork tools

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Patient Corner

A Physician's Battle: Working to Improve Patient Care in the Health System

December 2012. *Health Affairs* reports the story of a Boston physician whose mother died after receiving poor care for an infection. Dr. Jonathan Welch is an instructor of medicine at Harvard Medical School and an emergency room physician at Brigham Women's Hospital in Boston, Massachusetts. After his mother's death, he and his family would have liked for the hospital to provide an explanation for what happened, along with an apology and assurances that the mistakes that caused their mother's death would not be repeated. The family carefully crafted a letter to the hospital's administration, outlining the errors that led to their mother's death and suggesting specific ways that the hospital could improve their protocols in treating patients with systemic infections. After several months, the family learned that the hospital acted upon some of their suggestions for change; however they realized that they had a passive role in the process.



Dr. Welch and his mother
(family photo)

For Dr. Welch, this personal tragedy highlighted the need for patients and families to be part of the hospital quality improvement process. He realized that while the hospital where he worked consistently strove to improve the quality of care offered to their patients, they had never sought patient or family feedback in any of the quality improvement activities. He now eagerly works to further a patient-centered agenda in quality improvement, strongly advocates incorporating the patient and family voices into care, and believes that patients and families should be interviewed after hospitalizations—especially when there's a bad outcome.

Dr. Welch points to The University of Pittsburgh Medical Center and the Children's Hospital of Pittsburgh's patient- and family-centered program as a best practice. The program, named "Condition H" (Help), encourages patients or families to call a rapid response hotline for assistance if, while in the hospital, they feel like they are not receiving adequate care. A rapid response team consisting of a physician, patient relations coordinator, nursing coordinator and a floor representative immediately visit the patient's bedside to remedy the problem.

To read the complete article, please go to: <http://content.healthaffairs.org/content/31/12/2817.full>.

Small Steps to Success

Use of Disinfection Cap Is Associated with Fewer Bloodstream Infections



Marc Oliver Wright, MT (ASCP), MS, CIC

January 2013. An article in *Newsweek* highlights study findings recently published in the *American Journal of Infection Control*. Researchers discovered that use of disinfection caps on central intravenous catheters reduced infections by more than half. Due to the results of the study conducted at all four hospitals in the NorthShore University

Health System, disinfection caps are now used as a standard of practice at the health system for all central IV catheters.

According to the study's lead author and corporate director of infection control for NorthShore, Marc Oliver Wright, MT (ASCP), MS, CIC, "Most hospitals have a hard time ensuring proper disinfection of IV needleless connectors. Contaminated connectors are a major source of central line associated blood stream infections (CLABSI)." Use of the disinfection caps was also found to be cost-effective, resulting in net cost savings for hospitals. For more information, please visit: <http://newsweek.com/articles/study-finds-use-of-disinfection-cap-is-associated-with-fewer-blood-stream-infections>.

Hospital Patient Safety News welcomes stories from our readers. If you have a success story you would like to share in our newsletter, please contact Teré Dickson, MD, MPH at tdickson@nyqio.sdps.org.

<http://hai.ipro.org>

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SPECIAL ARTICLE 1

The “One & Only” Way to Prevent Unsafe Injections in Healthcare

By, Mary Beth Wenger, Health Communications Specialist at the New York State Department of Health

If spreading a dangerous illness were entirely preventable, would you take steps to do so? Surely you would do whatever it takes to protect the health and safety of patients.

Sadly we continue to hear stories about disease outbreaks resulting from transmission of bloodborne pathogens via unsafe injections. Some examples: thousands of patients being notified they may have been exposed to infection due to the re-use of insulin pens; a multi-state investigation of alleged provider drug “diversion;” and more than 50,000 endoscopy/colonoscopy patients receiving notification that they required testing for hepatitis C.

“Wait a minute,” you’re probably saying, “Doesn’t every healthcare provider understand and follow safe injection practices?” Unfortunately, the answer is “no.” You might be surprised to learn that the U.S. Centers for Disease Control and Prevention (CDC) has conducted a number of investigations that reveal that many providers who believed they were following correct injection procedures were, in fact, making mistakes. The CDC and the Safe Injection Practices Coalition (SIPC)—a group of healthcare-related organizations formed to promote safe injections in all healthcare settings—report that since 2001, more than 150,000 patients in the US have been told they might have been exposed to bloodborne pathogens because healthcare providers failed to follow basic infection control procedures. The correct procedures are outlined in CDC’s “Standard Precautions” issued in 2007. www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Also since 2001, 48 outbreaks of disease related to unsafe injections were investigated by the CDC. That number, however, represents only the incidents reported to the CDC. The numbers cited could just be a fraction of the real cases, as many episodes of exposure risk to hepatitis B virus (HBV), hepatitis C virus (HCV) and HIV are difficult to trace back to a healthcare setting.

Patients have been exposed not only to viral infections but also to serious bacterial infections due to unsafe injection practice, as outlined in a 2012 *Morbidity and Mortality Weekly Review* (MMWR) article. www.cdc.gov/mmwr/preview/mmwrhtml/mm6127a1.htm?s_cid=mm6127a1_w.

In a handful of cases, unsafe provider practices include reusing needles/syringes from patient to patient. More commonly however, are instances of indirect disease transmission, where a healthcare provider inserts a used syringe (even if the needle

has been changed) back into a multi-dose vial of medication, thus contaminating the entire vial of medicine if it is used for subsequent patients. This practice is commonly referred to as “double-dipping.” Additionally, some providers mistakenly believe it is safe to reuse syringes if the injection is administered through an intervening length of tubing. In still other instances, a provider mishandles a single-dose vial, typically free of preservatives, in order to administer doses to multiple patients.

Concern about these practices led to the creation of the “One & Only” Campaign (“One Needle, One Syringe, Only One Time”), www.oneandonlycampaign.org. Led by the CDC and SIPC, the Campaign is a public health education initiative aimed at raising awareness among patients and healthcare providers about safe injection practices, with an ultimate goal of eradicating outbreaks resulting from unsafe injection practices. New York is a Campaign “partner state.” The New York One & Only Campaign is funded by the CDC and overseen by the New York State Department of Health (DOH). Healthcare providers are urged to sign on to the Campaign and use the many educational materials including videos, staff trainings, posters and brochures. Moreover, the campaign encourages patients to ask their providers questions, including “What steps are you taking to ensure my injection is a safe one?”



New “One & Only” materials, including a Bloodborne Pathogen Training module, a “How To Do It Right” injection safety animated video and a podcast by the President of the American Association of Nurse Anesthetists, can be found within the New York One & Only Campaign’s recent Injection Safety Newsletter. www.oneandonlycampaign.org/content/new-edition-ny-one-only-campaign-newsletter-december-2012.

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SPECIAL ARTICLE 2

Prevention of Surgical Site Infections

By Michael Bosta Pharm. D Candidate 2013

Between 2006–2008 the Centers for Disease Control and Prevention’s (CDC) National Health Safety Network found that 1.9% of all operative procedures resulted in a surgical site infection.¹ According to the Nationwide Inpatient Sample (NIS), a component of the Agency for Healthcare Quality and Research (AHRQ) and Healthcare Cost and Utilization Project (HCUP), 6,891 cases of SSI during hospitalization were identified in the United States in 2005.² This finding was used to project a nationwide estimate of 406,730 additional hospital days costing \$991 million due to SSI’s.² Readmission for treatment due to an SSI projected an additional 521,933 hospital days costing \$674.4 million.² Overall, an estimated 928,663 additional days of hospital care, an average extension of stay of 9.7 days, and \$1.6 billion in hospital costs were attributed to surgical site infection.²

Surgical site infections can be limited to the skin (superficial infection) or can be serious and life-threatening due to their impact on vital organs. Usual signs and symptoms are redness/pain at surgery site, drainage of fluid from the wound, and fever.² The causative pathogens are microorganisms, necessitating antimicrobial prophylaxis and post-operative treatment. Improvement in quality of patient care and decreased institutional costs can be realized by implementing surgical site infection preventative measures (see Figure 1) and antimicrobial prophylaxis. The most commonly encountered

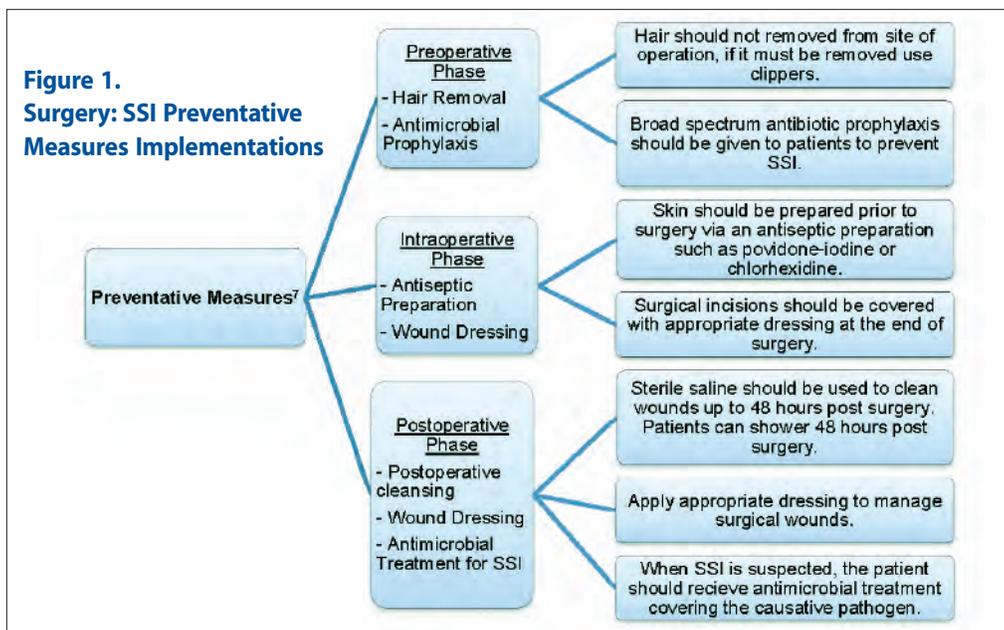
Table 1. Common SSI Causative Pathogens⁴

- Staphylococcus aureus
- Coagulase-Negative Staphylococci
- Enterococcus Spp.
- Escherichia coli
- Pseudomonas aeruginosa
- Enterobacter Spp.
- Candida Spp
- Klebsiella pneumoniae

Table 2. Risk Factors for SSI⁵

- Extremities of Age
- Diabetes
- Obesity⁶
- Nicotine Use
- Malnutrition
- Recent Surgery
- Increased Hospital Stay

causative pathogens are listed in Table 1; antimicrobial prophylaxis is directed at eliminating these pathogens, keeping in mind that the type of procedure influences the choice of antimicrobial used (see Table 3). Certain factors can play a major role in the risk and development of an SSI, as seen in Table 2. Some risk factors such as obesity and nicotine use are modifiable. Elimination of these risk factors will not only benefit the patient’s quality of life, but also aid in preventing bacterial infection development. Through staff education and patient awareness, surgical site infections can be minimized.



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Prevention of Surgical Site Infections

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Table 3. Antimicrobial Prophylaxis for SSI⁸

Procedure ^A	Antimicrobial Treatment	Initiation of Antimicrobial (minutes prior to procedure)	Recommended Re-dosing Interval (hours after initial dose)
Cardiac <ul style="list-style-type: none"> • Coronary artery bypass • Cardiac device insertion procedures (e.g., pacemaker implantation) • Ventricular assist devices 	Cefazolin	60	4
	Cefuroxime	60	4
	Clindamycin*	60	6
	Vancomycin*	120	N/A
Thoracic <ul style="list-style-type: none"> • Noncardiac procedures, including lobectomy, pneumonectomy, lung resection, and thoracotomy • Video-assisted thoracoscopic surgery 	Cefazolin	60	4
	Ampicillin-Sulbactam	60	2
	Clindamycin*	60	6
	Vancomycin*	120	N/A
Gastroduodenal <ul style="list-style-type: none"> • Procedures involving entry into lumen of gastrointestinal • Procedures without entry into gastrointestinal tract 	Cefazolin	60	4
	Clindamycin* OR	60	6
	Vancomycin* +	120	N/A
	Gentamicin* OR	60	N/A
	Aztreonam* OR	60	4
	Moxifloxacin* OR	120	N/A
	Levofloxacin*	120	N/A
Orthopedic <ul style="list-style-type: none"> • Spinal procedures with and without instrumentation • Hip fracture repair • Implantation of internal fixation devices • Total joint replacement 	Cefazolin	60	4
	Clindamycin*	60	6
	Vancomycin*	120	N/A

^A Not an exclusive list of procedures. Selection was based on prevalence of surgery as indicated by the CDC.⁹

* Indicated when allergy to beta-lactam present

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Prevention of Surgical Site Infections

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Helpful Links

IPRO

www.ipro.org/index/hai-ssi

Quality improvement healthcare strategies and resources for the prevention of SSI.

Center of Disease Control and Prevention

www.cdc.gov/HAI/pdfs/ssi/SSI_tagged.pdf

Patient information regarding SSIs including frequently asked question and answers.

Institute for Healthcare Improvement

www.ihi.org/explore/ssi/pages/default.aspx

Tools and guides directed towards the prevention of SSI.

Sources

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Healthcare-Associated Infections and Patient Safety Research

Arriaga, A.F., Bader, M. A., Wong, J.M., and others. (2013). "Simulation-Based Trial of Surgical-Crisis Checklists." *The New England Journal of Medicine* 368, pp. 246-253.

Doctors, nurses and other hospital operating room staff who follow a written safety checklist to respond when a patient experiences cardiac arrest, severe allergic reaction, bleeding followed by an irregular heartbeat or other crisis during surgery, are nearly 75 percent less likely to miss a critical clinical step, according to a new AHRQ-funded study that appeared in the *New England Journal of Medicine* on January 16. Investigators simulated multiple operating room crises and assessed the ability of 17 operating room teams from three Boston-area hospitals—one teaching hospital and two community hospitals—to adhere to life-saving steps for each simulated crisis. In half of the crisis scenarios, operating room teams were provided with evidence-based, written checklists. In the other half of crisis scenarios, the teams worked from memory alone. While the use of checklists is rapidly becoming a standard of surgical care, the impact of their use during a surgical crisis has been largely untested.

Litvin, C.B., Ornstein, S.M., Wessell A. M., Nemeth, L.S., and Nietert, P.J. (2012). "Adoption of a Clinical Decision Support System to Promote Judicious Use of Antibiotics for Acute Respiratory Infections in Primary Care." *International Journal of Medical Informatics* 81(8), pp. 521-526.

A recent AHRQ-funded study examined facilitators and barriers to the use of a clinical decision support system (CDSS) that targeted inappropriate antibiotic prescribing. Researchers determined adoption rates and explored providers' attitudes associated with the clinical decision support tool that was adopted at nine primary care practices. Beliefs associated with successful adoption of the CDSS included the perception that the systems helped in the decision-making process and facilitated conversations with patients about appropriate

antibiotic use. Other factors that influenced success included the engagement of non-physician staff and using an iterative, customizable CDSS. Barriers to adoption included providers' discomfort with CDSS recommendations, inability to use the CDSS at the point of care, and the perception that the CDSS had limited value for decision making.

Groves, P.S., Finfgeld-Connett, D., and Wakefield, B.J. (2012). "It's Always Something: Hospital Nurses Managing Risk." *Clinical Nurse Research*, pp. 1-18.

In this AHRQ-funded study, nurses at a 274-bed Midwest academic medical center describe the challenges of keeping their patients safe amid constraints within their institution's patient safety culture. The findings helped develop a new framework to manage risk that recognizes the ongoing challenges for nursing staff to better manage patient safety. A more in-depth understanding of how nurses view and manage risk can help to improve their hospital's patient safety efforts, according to the authors.

Taylor, E.F., Machta, M.R., Meyers, S.D., Genevro, J., and Peikes, D.N. (2013). "Enhancing the Primary Care Team to Provide Redesigned Care: The Roles of Practice Facilitators and Care Managers." *The Annals of Family Medicine* 11, pp. 80-83.

Efforts to redesign primary care require multiple supports. Two potential members of the primary care team — the practice facilitator and care manager — play distinct roles in redesigning and improving care delivery, according to a new AHRQ study. Facilitators, also known as quality improvement coaches, help coordinate practices' quality improvement activities and build capacity for those activities. Care managers coordinate care and help patients navigate the system, improving access and overall communication.

Article summaries from the Agency for Healthcare Research and Quality (AHRQ) Electronic Newsletter January 18, 2013, Issue #364

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<http://hai.ipro.org>

IPRO's online portal to information and resources on HAI prevention

- Tools and articles by infection prevention and patient safety experts,
- Information on dates and times for upcoming webinars,
- Recorded webinars, and presentations,
- Patient education materials,
- and more.

Visit us today.

Upcoming Events

IPRO HAI Webinars www.ipro.org/index/hai-hplinks

Thursday, April 18 • 7:00 AM EST: **SSI through Partnership for Patients: Essentials for Successfully Implementing an Effective Brief, Debrief, or Timeout**

Monday, May 13 • 1:00 PM EST: **C. Difficile Overview**

Wednesday, June 19 • 7:00 AM EST: **SSI through Partnership for Patients: The Role of the Surgical Team in Reducing Harm for Surgical Patients**

Thursday, June 20 • 1:00 PM EST: **National HAI Virtual Conference**

On the CUSP Webinars www.onthecuspstophai.org/on-the-cuspstop-cauti/educational-sessions

Tuesday, April 9 • 12:00 PM EST: **Patient and Family Engagement**

Conferences & Training Sessions

April 7–9 **IHI's 14th Annual International Summit on Improving Patient Care in the Office and Community**
Institute for Healthcare Improvement (IHI)
Scottsdale, AZ
www.ihl.org/offering/Conferences/Summit2013/Pages/default.aspx

May 1–4: **SHEA Spring 2013 Conference: Advancing Healthcare Epidemiology and the Role of the Environment**
Society for Healthcare Epidemiology of America (SHEA)
Atlanta, GA
<http://shea2013.org>

June 7–10: **APIC 40th Annual Conference: Advancing Infection Prevention Education**
Association for Professionals in Infection Control and Epidemiology (APIC)
Fort Lauderdale, FL
<http://ac2013.site.apic.org>

June 12–13: **2013 TeamSTEPPS National Conference**
Agency for Healthcare Research and Quality (AHRQ)
Dallas, TX
<http://teamstepps.ahrq.gov/nationalconference.htm>

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About IPRO

Through its work as the Medicare Quality Improvement Organization for New York State, IPRO works to improve the quality of healthcare provided to more than three million Medicare beneficiaries. An independent, not-for-profit organization, IPRO supports providers across the state with evidence-based, clinical interventions and objective expertise to improve patient care.

For more information about IPRO, please visit www.ipro.org.

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