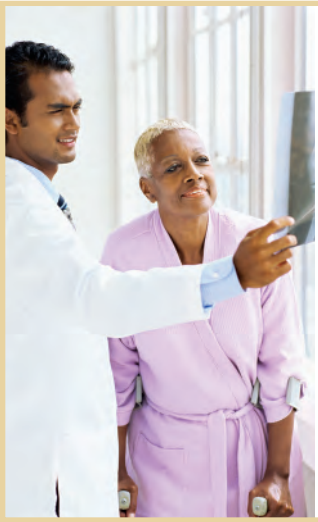
Hospital Patient Safety News

Fall 2012

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

www.ipro.org



Welcome to the Fall 2012 issue of IPRO's *Hospital Patient Safety News.* In this edition, we present 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 email to Susan Ulmer at sulmer@nyqio.sdps.org.

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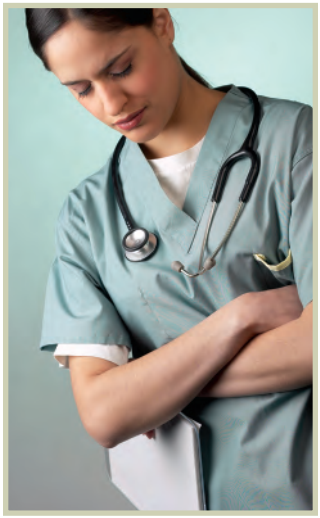
CAUTI and SSI Linked to Nurse Understaffing



July 2012. *FierceHealthcare* reported that higher rates of healthcare-associated infections (HAI) are linked to nurse burnout, according to a new *American Journal of Infection Control* (AJIC) study. Researchers from the University of Pennsylvania's School of Nursing found that nurse burnout can be caused by understaffing and can be detrimental to patient safety. The study looked at more than 7,000 registered nurses at 161 hospitals to see how nurse burnout affected the two most common HAIs: catheter-associated urinary tract infections (CAUTI) and surgical site infections (SSI). Researchers found that more than one-third of nurses reported they had an emotional exhaustion score of 27 or greater on the Maslach Burnout Inventory-Human Services Survey, meeting the definition for healthcare personnel burnout. On average, nurses were charged with taking care of 5.7 patients. The study found that for every additional patient assigned to a nurse, there was about one extra CAUTI per 1,000 patients. Researchers reported that if nurse burnout could be reduced from 30 percent to 10 percent, hospitals could prevent an estimated 4,160 HAIs each year. Read more: www.fiercehealthcare.com/story/nurse-burnout-understaffing-linked-hospital-infections/2012-07-30. To access the *AJIC* article: www.ajicjournal.org/article/S0196-6553(12)00709-2/fulltext.

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FLU SEASON IS COMING

Visit **Patient Corner** on page 4 for important resources.

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News You Can Use

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Stopping *Clostridium difficile* Infections

August 2012. *USA Today* provides results of an investigation into efforts to reduce *Clostridium difficile* infections (CDI) in healthcare settings. This investigation was conducted through interviews, federal and state data reviews, and assessments of government and academic studies. The article describes the slow reduction in CDI rates, while telling the stories of patients who have suffered with CDI. One patient, 14-year-old Bailey Quishenberry, was recovering from a brain tumor when she developed CDI. Her toxic megacolon was treated with multiple rounds of fecal transplant until her health was restored six months later. The online article is accompanied by a five-minute video documenting Bailey's victory over her illness. CDI is the only U.S. Department of Health and Human Services' (HHS)-identified high-priority infection that remains

Bailey Quishenberry

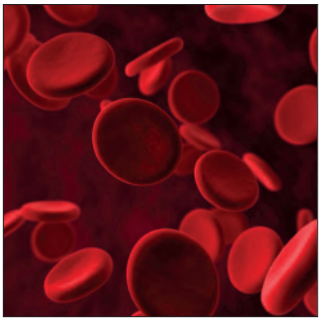
at historically high levels. Efforts to reduce CDI include a new federal data reporting rule scheduled to begin in 2013, implementation of antimicrobial stewardship programs to reduce inappropriate use of antimicrobials, stricter cleaning protocols, improved identification of infected patients, better adherence to isolation practices, and the institution of multidisciplinary teamwork. Barriers to controlling CDI rates cited in the article include: increasing costs of infection control methods in the face of diminishing Medicaid and Medicare reimbursements; misleading labels on Environmental Protection Agency (EPA)- approved hospital disinfectants falsely claiming they are effective against *C. difficile;* staffing concerns due to facilities cutting costs; and challenges faced when building effective multidisciplinary teams. Bailey's video and the complete article on CDI control challenges can be accessed at: www.usatoday.com/news/health/story/2012-08-16/deadly-bacteria-hospital-infections/57079514/1.

Clinical Trial Studies Fecal Transplant as CDI Treatment

August 2012. *Medical Xpress* reports that the Center for Women's Gastrointestinal Medicine at the Women's Medicine Collaborative in Providence, Rhode Island has been funded by a new National Institutes of Health research grant to conduct a study testing the use of fecal bacteriotherapy, or fecal transplantation, as an effective treatment for relapsing *C. difficile*. Fecal transplantation has been available as an unconventional treatment with a low rate of complications for over 50 years, but few physicians are aware of it. Researchers hope to develop standard treatment protocols for the procedure and raise awareness and availability to patients with CDI. The transplant, which can be performed as an outpatient colonoscopy, infuses healthy donor stool mixed with saline into the colon. The donor stool, which is obtained the morning of the procedure, helps replace the healthy bacteria missing from the patient's colon and combats the overgrowth of *C. difficile*. Application of this procedure can provide relief for patients with recurring CDI that is unresponsive to antibiotics, a cost saving benefit to patients with CDI and medical systems, and help to avoid development of drug-resistance associated with long-term antibiotic usage. For the full article, see: http://medicalxpress.com/news/2012-08-groundbreaking-clinical-trial-fecal-transplant.html.

Infection Prevention Collaborative

August 2012. Hemodialysis-related central line associated blood stream infections (HD-CLABSI) continue to be a significant cause of rising hospitalization rates in hemodialysis patients. Dr. Priti Patel, Medical Officer for the Centers for Disease Control and Prevention's (CDC) Division of Healthcare Quality Promotion discusses in her latest Safe Healthcare blog how the CDC Dialysis Bloodstream Infection Prevention Collaborative has been proven to lower bloodstream infections among hemodialysis patients. The CDC Dialysis Bloodstream Infection Prevention Collaborative was established in 2009 as a partnership among dialysis facilities in the United States. This collaborative has seen



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News You Can Use

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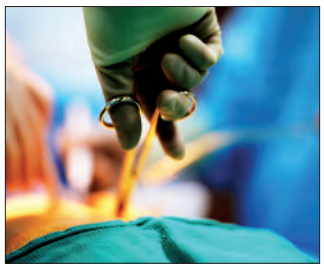
an impressive 31 percent decrease in bloodstream infections, and a 53 percent decrease in access-related bloodstream infections when CDC prevention guidelines are implemented. The CDC has also developed additional catheter connection/disconnection and site care audit tools, checklists, and new protocols intended to promote CDC recommended practices for infection prevention in hemodialysis facilities. These tools, provided at no cost by the CDC, serve as a resource for facilities to promote best practices and implement quality improvement strategies for hemodialysis patients. To read more about the CDC Dialysis Blood Stream Infection Prevention Collaborative and gain access to the audit tools and checklists, please visit: www.cdc.gov/dialysis/collaborative. CDC also provides a one-hour self-guided continuing education course on infection prevention in dialysis settings at: www.cdc.gov/dialysis/provider/CE/infection-prevent-outpatient-hemo.html.

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.

CUSP Helps Reduce Surgical Wound Infections

July 2012. *Infection Control Today* reports that implementing a surgical patient safety program effectively reduces the number of surgical site infections (SSI) in patients who undergo colorectal procedures. A recent study published in the *Journal of the American College of Surgeons* applied a CUSP strategy to empower front-line staff to identify problems in the operating room. The program includes: antibiotic selection and dosing, skin preparation, maintenance of normal body temperature, and intra-operative sterile technique. The study monitored 278 colorectal surgery patients in the 12-month, pre-intervention period and 324 patients in the 12-month post-intervention period. After a year, researchers found that the overall SSI rate fell from 27.3 percent to 18.2 percent. "Changes evolved over one year - it was not a bundle, it didn't happen all at once. Therefore, it's hard to figure out what specifically led to our wound infection reduction. But interestingly, as soon as we got this team together and engaged, our wound infection rate dropped," said lead study author Dr. Elizabeth Wick. Read more: www.infectioncontroltoday.com/news/2012/07/surgical-patient-safety-program-lowers-ssis-by-onethird-following-colorectal-operations.aspx.



House Staff Quality Council Increases Patient Safety

June 2012. *Becker's Clinical Quality & Infection Control* reports that forming house staff quality councils to engage residents in quality improvement efforts could increase patient safety, according to a study published in the *Joint Commission Journal on Quality and Patient Safety*. Leadership at New York-Presbyterian Hospital, the site of the study, created a resident-led house staff quality council to engage stakeholders in

quality and patient safety activities. Its members are determined to decrease or minimize adverse events by facilitating multimodal communication, ensuring smart workflow, and measuring outcomes to determine best practices. The council collaborated on two quality improvement projects, focused on medication reconciliation and the use of electronic medical records. These projects led to significant improvements and the introduction of other quality improvement projects, including hand hygiene compliance, infection prevention, and patient hand-offs. Read more: www.beckersasc.com/asc-quality-infection-control/study-reveals-impact-of-housestaff-quality-council-on-healthcare-quality.html.

Five Steps of CUSP

1. Educate staff on the Science of Safety
2. Identify defects in the system
3. Assign an executive to adopt unit
4. Learn from one defect per specified time period
5. Implement teamwork tools

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

Patient Corner

National Diabetes Month and the Flu Vaccine

November is National Diabetes Month, and November 14th is World Diabetes Day. This occasion offers an opportunity to raise awareness about diabetes control and prevention, and to remind people with diabetes to protect themselves during the upcoming influenza season by receiving the 2012-13 influenza vaccine. People with either type 1 or type 2 diabetes are at increased risk of developing serious flu-related complications that may result in hospitalization and even death. People living with diabetes should also be sure that their pneumococcal vaccines are up to date in order to help prevent severe secondary-infections such as pneumococcal pneumonia. The start of flu season is often difficult to predict, so it is best to get the vaccine before the peak of the flu season in February, when many people are already sick. For more information on "Diabetes & Flu: What You Need to Know and Do," visit: www.cdc.gov/diabetes/news/flu.htm. To find promotional materials for National Diabetes Month, go to: www.diabetes.org/in-my-community/programs/american-diabetes-month/.

Small Steps to Success

Healthcare Associated Infections (HAI) Workgroups

As part of the ongoing HAI initiative, IPRO hosted a series of support calls that offered hospitals an opportunity to share with other project participants their successes and challenges in preventing catheter-associated urinary tract infections (CAUTI). Participating hospitals were randomly split into two groups to facilitate an open discussion. Hospital representatives shared various improvement strategies that ranged from programming an automatic 48-hour urinary catheter discontinuation order into newly implemented electronic health records (EHR), to implementing multidisciplinary educational modules on CAUTI prevention. Other successful methods include:

- Conducting annual nursing competency trainings and demonstrations on urinary catheter insertion and maintenance;
- Implementing a urinary catheter insertion bundle, which includes an insertion checklist, verification of placement order, and confirmation of indication for catheter use;
- Programming into the EHR an indications checklist for urinary catheter placement orders;
- Conducting real-time root cause analyses for every CAUTI;
- Implementing nurse driven protocols for catheter removal; and
- Using photographs of real-life errors as a teaching tool and displaying educational posters as a reminder of proper use and maintenance of urinary catheters.

The workgroups also identified areas that may require additional attention. These include:

- Physician engagement.
- Adaptation of root cause analysis practices to evaluate CAUTI causes.
- Identifying and avoiding practices like tipping the catheter tubing backwards before draining it during an assessment of urinary output. This common practice may cause a backflow of urine and subsequently introduce harmful bacteria from the tubing into the bladder.
- Staff competency training on obtaining sterile specimens to avoid contamination errors.
- Raising awareness and gathering input on new policies and procedures among frontline staff.
- Reviewing older policies and procedures to make sure that they translate into everyday practice.
- Integrating and translating inpatient hospital protocols into emergency department practices to reduce urinary catheter utilization and contamination.

Summaries of each workgroup's recommendations are posted on IPRO's HAI website: http://hai.ipro.org in the CAUTI section under Prevention Tools and Resources.

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.

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SPECIAL COMMENTARY

Hospital Inpatient Quality Reporting (IQR) Program and Healthcare Associated Infections

By Karen O'Leary, Project Manager and Vicky Agramonte, RN, MSN, Project Manager

One of the clinical requirements for the Hospital Inpatient Quality Reporting Program is the submission of quarterly HAI data for CLABSI, CAUTI, SSI (colon/hysterectomy) via the National Healthcare Safety Network (NHSN). These data are then transmitted by NHSN to CMS. Failure to enter data timely and accurately into NHSN can jeopardize a hospital's annual payment update (APU) consideration. Although Q2 2012 (April, May and June) data are not due to CMS until November 15, 2012, it is important to submit data on a monthly basis for use in quality improvement. Submitting data monthly will also permit additional time to make corrections, if necessary, prior to the CMS Warehouse lock date. For more information on these critical CMS reporting requirements, as well as upcoming submission deadlines, click on these hyperlinks: CLABSI (www.cdc.gov/nhsn/PDFs/FINAL-ACH-CLABSI-Guidance.pdf); CAUTI (http://library.constantcontact.com/download/get/file/1103416423628-129/FINAL-ACH-CAUTI-Guidance.pdf); SSI (for Hysterectomy & Colon) (http://library.constantcontact.com/download/get/file/1103416423628-130/FINAL-ACH-SSI-Guidance.pdf), contact Karen O'Leary (koleary@nyqio.sdps.org) or Vicky Agramonte (vagramonte@ipro.org), or go to www.ipro.org/index/qio-hpri for more information on these and other requirements under the quality data reporting project.

Healthcare Associated Infections and Patient Safety Research

Cevasco, M., Borzecki, A.M., Chen, Q., and others (2011). "Positive predictive value of the AHRQ Patient Safety Indicator 'Postoperative Sepsis': Implications for practice and policy." (AHRQ Contract No. 290-04-0020). *Journal of the American College of Surgery,* 212(6), pp. 962-967.

Researchers performed medical record reviews for events that Patient Safety Indicator 13 (postoperative sepsis), flagged at Veterans Administration and nonfederal hospitals. They found that Patient Safety Indicator (PSI) 13 was not effective in identifying postoperative sepsis cases. As a result, the authors assert PSI 13 is not ready to be used for safety profiling, public reporting, and pay-for-performance measures.

Clancy, C. (2011, January). "Checking in about innovation." *Healthcare Informatics* 28(2), pp. 48-64. Reprints (Publication No. 12-R056) are available from the AHRQ Publications Clearinghouse.

Carolyn Clancy, MD, Director of the Agency for Healthcare Research and Quality, discusses the strategic use of information technology to improve care delivery, quality, patient safety, and efficiency. Topics include: learning in a systematic way from off-label use of medications, the pace of information technology advances, patient-centered care, and physician engagement in performance measurement.

Clancy, C. (2011, September). "Protocol for all. Smaller hospitals can adopt proven tools for reducing central-line infections." *Modern Healthcare,* p. 20. Reprints (Publication No. 12-R059) are available from the AHRQ Publications Clearinghouse.

The director of the Agency for Healthcare Research and Quality discusses use of the Comprehensive Unit-Based Safety Program (CUSP) in reducing central line-associated bloodstream infections. The CUSP protocol uses a checklist of evidence-based safety practices that both small- and mid-sized hospitals can use. The article describes how the initial program, developed for Michigan, has been adopted by hospitals in all 50 states.

Young, M.J., Brown, S.E.S., Truog, R.D., and Halpern, S.D. (2012). "Rationing in the intensive care unit: To disclose or disguise?" (AHRQ grant HS18406). *Critical Care Medicine* 40(1), pp. 261-266.

The authors consider the conceptual and practical complexities surrounding the disclosure of rationing decisions to patients and surrogates and the ethical justifications for and against disclosure. They conclude that disclosure will often be consistent with clinicians' professional obligations. Systematic disclosure of prevailing intensive care norms for making allocation decisions can promote transparent, professional, and effective healthcare delivery.

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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.

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Upcoming Events

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

Tuesday, October 9 • 12:00PM EST: **National CUSP Call: Learning from Defects**

Tuesday, November 13 • 12:00PM EST: **National Content Call: Preparing for the Future - Setting up for Sustainability**

Tuesday, December 11 • 12:00PM EST: **National CUSP Call: Engaging Senior Leadership**

Conferences

October 11-12: **Meeting of Healthcare Infection Control Practices Advisory Committee**
Centers for Disease Control and Prevention (CDC-HICPAC)
Washington, DC
www.cdc.gov/hicpac/eCalender.html

October 27-31: **140th Annual Meeting & Exposition**
American Public Health Association (APHA)
San Francisco, CA
www.apha.org/meetings/AnnualMeeting/

November 12-13: **Patient Engagement Forum- Nurses' Contributions to Fostering Successful Patient Engagement**
Nursing Alliance for Quality Care (NAQC)
Washington, DC
www.gwumc.edu/healthsci/departments/nursing/naqc/

December 9-12: **24th Annual National Forum on Quality Improvement in Health Care**
Institute for Healthcare Improvement (IHI)
Orlando, FL
www.IHI.org/24Forum

Special thanks to Karen O'Leary, Vicky Agramonte, and Crystal Isaacs for their contributions to the Fall 2012 *Hospital Patient Safety News.*

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About IPRO

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

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

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