

Summer 2009

## Introduction

Welcome to the Summer 2009 issue of IPRO's *Hospital Patient Safety News*.

In this our second issue, we present updates on the Centers for Medicare & Medicaid Services (CMS) 9<sup>th</sup> Scope of Work Patient Safety Initiative Projects, and share some compelling "Fast Facts" that highlight the importance of the work being done by you and your colleagues. Future issues will also include updates related to quality improvement (QI) activities and best practices, and links to project resources and reminders. **If you have a best practice that you would like for us to feature in a future issue**, please forward your information to Eloise Tate at [etate@nyqio.sdps.org](mailto:etate@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 Eloise Tate at [etate@nyqio.sdps.org](mailto:etate@nyqio.sdps.org).

## IPRO's Patient Safety Initiative Projects

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

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

**Pressure Ulcer Project:** Working collaboratively with local nursing homes to reduce the incidence of pressure ulcers in high-risk patients;

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

## MRSA Project

Throughout the MRSA Project, IPRO's Team will be in contact with participating providers via monthly conference calls, quarterly reports and annual site visits.

Monthly conference calls offer technical support for frontline and quality management staff, and education on current MRSA best practices developed through experiences, observations and information gathered during site visits.

Quarterly reports, to be used as learning tools for QI in individual organizations, contain individual facility data as well as de-identified aggregate data for facilities across New York State. The first report, distributed in June 2009, was based upon Q1 data. The second report will include Q1 and Q2 data, and is scheduled for distribution at the end of September 2009.

During site visits, the Project Team will share MRSA best practices, conduct a chart audit and data review, and review MRSA Infection Policies and Protocols with staff. Site visits will be completed by the MRSA Project Team by the end of this year.

## **MRSA Fast Facts**

- The Association for Professionals in Infection Control & Epidemiology reports that 46 of every 1,000 health care facility patients in its 2007 study were infected or colonized with MRSA. Of these, 77% were identified within 48 hours of hospital admission. This finding suggests that 35 of 46 patients walk into health care facilities with MRSA.
- There were over 94,000 invasive MRSA infections in the US population in 2005; about 19,000 of these patients (18%) died during initial hospitalization.
- In 2005, 368,600 hospital stays were due to MRSA infection; an increase of 30% from 2004.

## **Surgical Care Improvement/Heart Failure (HF) Project (SCIP)**

### **Regional Meetings to Feature Dale Bratzler, D.O., M.P.H.**

To prepare participating hospitals for the CMS SCIP re-measurement scheduled for Q1 2010, the SCIP Project Team will host regional meetings in late October and November 2009.

Monday, October 26<sup>th</sup> – Albany

Tuesday, November 10<sup>th</sup> – Lake Success

Wednesday, November 11<sup>th</sup> – Rochester

Each of these meetings will feature a presentation by Dale Bratzler, D.O., M.P.H., the national clinical leader for the SCIP Project. The meetings will review the clinical guidelines behind the project measures, provide updates on data, and feature best practices from hospitals participating in the project, as well as mentoring hospitals. The meetings will also provide an opportunity for hospital QI staff to discuss successes, best practices and challenges. CME and CEU will be offered.

Announcements with detailed meeting information will be sent to hospital staff participating in the SCIP Project.

For additional information, please contact Denise Faulkner-Cameron, MPA, Project Manager at 516 326-7767, ext. 676 or [DFaulkner@nyqio.sdps.org](mailto:DFaulkner@nyqio.sdps.org).

### **SCIP Fast Facts: Surgical Site Infections (SSIs)**

- The Centers for Disease Control and Prevention's National Nosocomial Infections Surveillance system reports that SSIs are the third most frequently reported nosocomial infection, accounting for 14-16% of all nosocomial infections among hospitalized patients. Among surgical patients, SSIs were the most common nosocomial infection, accounting for 38% of all such infections.

- A medical record review of 34,133 charts performed under the auspices of CMS demonstrated significant opportunity for improvement in surgical site prevention.<sup>1</sup> In the area of appropriate antibiotic use, the medical record review found the following:
  - Appropriate antibiotics were given within one hour of incision time to 55.7% of patients; and
  - Prophylactic antibiotics were discontinued within 24 hours of surgery end time for only 40.7% of patients.

<sup>1</sup>Bratzler. *Arch Surg.* 2005; 140: 174-182.

- Present on Admission Code: In August 2007, CMS announced the FY 2008 Inpatient Prospective Payment System Final Rule, which introduced three different categories of conditions that, when present, trigger a higher payment as either a complicating condition or major complicating condition. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present. SSIs are among these conditions.

### **Venous Thromboembolism (VTE) Prophylaxis**

- Over two million Americans suffer from a VTE episode each year. Over one half of VTEs are hospital-acquired or require re-hospitalization within 30 days after discharge. Most hospitalized patients have at least one risk factor for VTE. Without VTE prophylaxis, proximal deep venous thromboembolism (DVT) and clinical pulmonary embolism (PE) occur in around 20% of surgical patients in the highest risk category.
- DVT occurs after approximately 25% of all major surgical procedures performed without prophylaxis, and PE occurs in 7% of surgeries conducted without prophylaxis. More than 50% of major orthopedic procedures are complicated by DVT and up to 30% by PE, if prophylactic treatment is not instituted. Despite the well-established efficacy and safety of preventive measures, studies show that prophylaxis is often underused or used inappropriately.

### **Pressure Ulcer Project**

IPRO is developing materials for patients and caregivers about the importance of skin safety. "It's Time to Take the Pressure Off," an easy-to-understand flyer, identifies areas of the body most susceptible to pressure ulcers and offers simple measures and suggestions on how to prevent pressure ulcers. Available in English and Spanish, "It's Time to Take the Pressure Off" can be downloaded from JENY at <http://jeny.ipro.org/showthread.php?t=2657>. A version developed for hospital staff is also available in English and Spanish and can be downloaded from JENY via the same link.

## Pressure Ulcer Fast Facts

- Although pressure ulcers are preventable, their prevalence is increasing and an estimated 2.5 million patients are treated for pressure ulcers in acute-care facilities in the US each year. The incidence of pressure ulcers in hospitals ranges from 0.4% to 38%. In order to improve care of patients who are either at risk for developing or already have pressure ulcers, hospitals, nursing homes, physicians and other clinicians must align initiatives to improve and coordinate processes across settings.
- According to a 2007 article published in *The Joint Commission Journal on Quality and Patient Safety*, pressure ulcers cause considerable harm to patients, hindering functional recovery, frequently causing pain, and often serving as vehicles for the development of serious infections. The goal for pressure ulcer incidence should be zero.<sup>2</sup>
- Pressure ulcers have also been associated with extended length of stay, sepsis and mortality. Nearly 60,000 US hospital patients are expected to die each year from complications due to hospital-acquired pressure ulcers. The estimated cost of managing a single, full-thickness pressure ulcer is as high as \$70,000, and the total cost for treatment of pressure ulcers in the US is estimated at \$11 billion per year.<sup>3</sup>

<sup>2</sup>Duncan K: *Preventing Pressure Ulcers: The Goal is Zero. The Joint Commission Journal on Quality and Patient Safety.* 33:605-610, October 2007.

<sup>3</sup>Redelings, MD Lee, NE, Sorvillo F. *Pressure ulcers: More lethal than we thought? Advances in Skin & Wound Care.* 2005. 18(7):367-372.

## Medication Safety Project

### New York Warfarin Safety Series Continues

Join IPRO for the next installment of the free CME-accredited New York Warfarin Safety Series: Improving the Outcomes of Oral Anticoagulation, Home Monitoring of Warfarin Therapy, featuring Jack E. Ansell, MD, Chairman, Department of Medicine, Lenox Hill Hospital. This event will take place on Tuesday, September 22, 2009, 8:00–9:00AM EST. At the conclusion of this educational activity, participants should be able to:

- Describe the benefits of home international normalized ratio (INR) monitoring of warfarin therapy reported in clinical studies;
- Discuss the management of INR values from point-of-care instruments (both in range and out of range); and
- Understand how to implement a program of home INR monitoring.

To participate (via web and phone): Prior to September 22nd, please register at the QNet Exchange Event Center at <https://ifmcevents.webex.com>. For more information on this event, contact Dianne Roux-Lirange, PhD, MSRN at [drirange@nyqio.sdps.org](mailto:drirange@nyqio.sdps.org).

To improve the quality of warfarin management across New York, IPRO has developed a variety of educational resources and clinical tools for providers and Medicare beneficiaries. These complementary resources are updated regularly and available at:

<http://providers.ipro.org/index/swat-index> (PDF resources on IPRO web page)

<http://jeny.ipro.org/forumdisplay.php?f=164> (Additional resources and discussion board on JENY)

## Medication Safety Fast Facts

- Under New York law (effective December 3, 2008) and accompanying regulations (*see* 8 N.Y.C.R.R. §63.9), pharmacists may immunize persons 18 years of age and older against influenza or pneumococcal disease. Such immunizations may be provided under a patient-specific or non-patient specific order issued by a licensed physician or certified nurse practitioner. The New York State Department of Health encourages physicians and certified nurse practitioners that work in local health departments to coordinate with pharmacists in their counties and to sign non-patient specific standing orders enabling pharmacists to immunize.

## The Hospital Patient Safety Staff at IPRO

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