The Military Health System's

PARTNERSHIP FOR PATIENTS CAMPAIGN

SAFE CARE SAVES LIVES

Additional Resources

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

PARTNERSHIP FOR PATIENTS℠

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Contents

1. Implementation Process

- Knowledge Center: How to Improve uses the Model for Improvement, developed by Associates in Process Improvement, as the framework to guide improvement work. The model is a powerful tool for accelerating improvement intended to complement change models that organizations may already be using. (IHI)
- On The Cusp: Stop HAI is a joint effort sponsored by the Health Research and Educational Trust, the Johns Hopkins University Quality and Safety Research Group and the Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality, through a contract with the Agency for Healthcare Research and Quality, to dramatically reduce hospital-acquired infections in all 50 states, the Washington, D.C., and Puerto Rico.
- Society for Healthcare Epidemiology of America / Infectious Diseases Society of America (SHEA/IDSA) Compendium of Strategies to Prevent HAIs synthesizes best evidence for the prevention of heath care-associated infections, highlights basic HAI prevention strategies and recommends performance and accountability measures to apply to individuals and groups working to implement infection prevention practices.

2. Adverse Drug Events

- IHI Medication Reconciliation Guide provides guidelines for ensuring that patients are given the proper medication and dosage throughout their hospital stay as well as after their discharge. The guide also provides recommendations for instructing patients on adhering to their medication regimens after they return home. (IHI).
- AHRQ Medication Reconciliation Toolkit (MATCH Toolkit) provides tools to ensure that patients are given the proper medication and shows an effective process that can detect and avert most medication discrepancies. This toolkit can be used to avoid potential medication discrepancies and prevent ADEs by monitoring medication at all points of care and maintaining a structured system for monitoring patient medication (AHRQ).
- IHI High Alert Medication Safety Process provides guidelines for safe practices to prevent harm from use of specific powerful medications including anticoagulants, insulin, opiates and sedatives. The process map includes a list of high-alert medications for reference and lists specific references for each type of medication to allow for a more specific approach to improving medication safety (Institute for Healthcare Improvement).
- Institute for Safe Medication Practices Guidelines Self-Assessment Tool contains a safety assessment tool for hospitals and allows hospitals to take the assessment and compare their data to other similar institutions. The tool also contains a quality improvement workbook that has preliminary comparative data for hospitals. Hospitals can use this workbook to compare their findings with national aggregate results (ISMP).

- Reducing and Preventing Adverse Drug Events to Decrease Hospital Costs contains background information on the cost implications of ADEs and relationship between medication errors and ADEs. (AHRQ).

3. Catheter-Associated Urinary Tract Infections

- On The Cusp: Stop HAI is a joint effort sponsored by the Health Research and Educational Trust, the Johns Hopkins University Quality and Safety Research Group and the Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality, through a contract with the Agency for Healthcare Research and Quality, to dramatically reduce hospital-acquired infections in all 50 states, the Washington, D.C., and Puerto Rico.
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- How-To Guide: Prevent Catheter-Associated Urinary Tract Infections addresses specific health care interventions hospitals and/or entire health care systems can pursue to improve the quality of health care. These interventions align with several national initiatives of the Institute of Medicine, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, Joint Commission and CDC as well as HHS' "Partnership for Patients" initiative (IHI, 2011).
- Guideline for the Prevention of Catheter-Associated Urinary Tract Infections 2009 is based on a targeted systematic review of the best available evidence, with explicit links between evidence and recommendations (CDC).
- Guide to the Elimination of Catheter-Associated Urinary Tract Infections provides resources for the prevention of CAUTIs in acute and long-term care settings, including: problem identification, definitions, conducting a risk assessment, surveillance methodology, health care reimbursement, prevention of CAUTIs (Association for Professionals in Infection Control and Epidemiology, Inc., 2008).

4. Central Line-Associated Blood Stream Infections

- On The Cusp: Stop HAI is a joint effort of the Health Research & Educational Trust, the Johns Hopkins University Quality and Safety Research Group, and the Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality, through a contract with the Agency for Healthcare Research and Quality, to dramatically reduce hospital-acquired infections in all 50 states, the District of Columbia and Puerto Rico.

- SHEA and IDSA Compendium of Strategies to Prevent HAIs synthesizes best evidence for the prevention of HAIs, highlights basic HAI prevention strategies and recommends performance and accountability measures to apply to individuals and groups working to implement infection prevention practices.
- CDC Central-Line Associated Blood Stream Infection (CLABSI) in Non-Intensive Care Unit (ICU) Settings Toolkit provides background information, prevention strategies, and measurement tools for preventing CLABSIs. The toolkit also provides additional resources to further explore CLABSI prevention strategies.
- Johns Hopkins Quality and Safety Group Research Toolkit contains instructions on how to use the toolkit to prevent CLABSI incidences in the hospital setting. The toolkit also contains case studies as examples of how hospitals have used this toolkit to implement successful changes and reduce the number of CLABSIs in their institution.
- Using a Comprehensive Unit-based Safety Program to Prevent Healthcare Associated Infections demonstrates AHRQ's framework for improving safety and contains a checklist that can be used to reduce the prevalence of CLABSI in hospitals and improve overall patient safety.
- Central Line Insertion Practices (CLIP) Adherence Monitoring briefly describes the CDC's and Healthcare Infection Control Practice Advisory Council's evidence-based practices and provides guidance on surveillance.

5. Falls

- The Johns Hopkins Falls Risk Assessment Tool is used to asses an adult patient's risk of fall. The tool uses factors such as age, fall history, medications, patient care equipment, and cognition to determine a numeric value for each patient's fall risk. A caregiver can complete this assessment to determine the appropriate care level for patients to help reduce the risk of falls.
- The Humpty Dumpty Fall Tool (licensed) is used to assess a pediatric patient's risk of fall. The tool uses age, gender, diagnosis, cognitive impairments, and medication as factors to determine a patient's risk of falling. A caregiver can use this tool to assess a child's risk for falling and provide appropriate care.
- The National Center for Patient Safety Falls Toolkit contains information about falls and falls prevention, examples of media tools that can be used to prevent falls, and educational materials and extra resources to provide further information and proven research studies on falls prevention techniques.
- The AHRQ Innovations Exchange Step Up to Stop Falls Toolkit contains best practices for preventing falls in older adults. The toolkit contains resources for the patients as well as caregivers and health care professionals. Tools include prevention and risk assessment guides, professional screening and competency guides, and a home safety screening checklist.
- DoD Patient Falls Reduction Toolkit is designed to address four facets of a credible Patient Fall Reduction program: assessment and re-assessment of all patients for fall risk, interventions to prevent falls, education of the patient and family and data collection for continuous program

6. Obstetrical Adverse Events

- American College of Obstetricians and Gynecologists. Contains resources to prevent obstetrical adverse events and how to use simulation drills and debriefing to create high reliability care teams.
- OB Hemorrhage Toolkit. A comprehensive toolkit from the California Maternal Quality Care Collaborative (CMQCC) for health care providers to improve readiness, recognition, response and reporting of hemorrhage.
- Preparing for Clinical Emergencies in Obstetrics and Gynecology ACOG Committee Opinion. Patient care emergencies may periodically occur at any time in any setting, particularly the inpatient setting. To respond to these emergencies, it is important that obstetrician/gynecologists prepare themselves by assessing potential emergencies that might occur, creating plans that include establishing early warning systems, designating specialized first responders, conducting emergency drills, and debriefing staff after actual events to identify strengths and opportunities for improvement. Having such systems in place may reduce or prevent the severity of medical emergencies.
- A Quality Improvement Toolkit. "Elimination of Non-medically Indicated (Elective) Deliveries before 39 Weeks Gestational Age. A comprehensive toolkit from CMQCC. Offers best practices for prevention of early deliveries, and outlines the most effective strategies for health care providers in implementing those practices.
- Safe Deliveries: Reducing Elective Delivery Prior to 39 Weeks. A description of the work of the Washington State Hospital Association to reduce elective deliveries before 39 completed weeks of gestation.
- Elective Induction and Augmentation Bundles. IHI presents tips on successful implementation of the bundles based on the "all or nothing" strategy, under which teams must comply with all components of the bundle unless medically contraindicated.
- Shoulder Dystocia. Facts, Evidence and Conclusions. A comprehensive web site with an extensive bibliography on shoulder dystocia. Shoulder dystocia is an obstetrical complication that occurs in thousands of deliveries in the US each year. It has the potential for causing significant, lifelong injury to the newborns involved in such deliveries.

7. Pressure Ulcers

- The Braden Scale for Predicting Pressure Sore Risk determines a patient's risk for developing a pressure ulcer. The scale can be used to develop preventive strategies or to determine an individual patient's susceptibility to Pressure Ulcers (Prevention Plus).
- Patient Safety: An Evidence-Based Handbook for Nurses describes the risk factors and risk assessment options associated with pressure ulcers. It provides guidelines for implementing a pressure ulcer prevention plan including skin care, mechanical loading, support surfaces and nutrition. The guide also provides information surrounding the management of pressure ulcers including the cleansing, assessment, debridement, bacteria management, dressing, and monitoring of the ulcer (Agency for Healthcare Research and Quality)
- Preventing Pressure Ulcers and Skin Tears addresses nursing care strategies and interventions for pressure ulcers, discusses the Braden Risk Score and outlines the appropriate monitoring and care protocols for each risk level (AHRQ).
- Best Practices in Pressure Ulcer Prevention discusses the critical components in preventing pressure ulcers, including skin assessments, risk assessments and care planning. The toolkit includes resources such as the Pressure Ulcer Prevention Pathway Tool and provides guidance for conducting the assessments and collecting data (AHRQ).
- National Database of Nursing Quality Indicators Pressure Ulcers Module provides an overview of pressure ulcers and the classification and team training processes. The module also outlines best practices for creating and managing a team that improves safe practices surrounding pressure ulcers and how a team can collect data effectively (National Database of Nursing Quality Indicators)
- VA Handbook Prevention of Pressure Ulcers (1180.02) addresses prevention of pressure ulcers in numerous care situations such as acute and home care. The guide also includes a breakdown of the Braden Scale for predicting pressure ulcer risk and flow diagrams to outline different suggested care practices (VA).
- National Quality Forum Framework for Measuring Quality of Prevention and Management of Pressure Ulcers (in draft) includes standards and guidelines for measuring the quality of prevention and management efforts. The framework also outlines and defines the different categories for pressure ulcers and the appropriate standard of care for each stage. The framework finally outlines a wound management methodology to aid the healing process and prevent further complications.
- Pressure Ulcer Scale for Healing (PUSH) 3.0 is a quick, reliable tool to monitor the change in pressure ulcer status over time (NPUAP).

8. Readmissions

- Project RED, a research group at Boston University Medical Center that has developed a toolkit of strategies to improve the inpatient discharge process, improve patient safety and decrease readmission rates. Included in the toolkit is a training manual and sample discharge care plans.
- STAAR Protocol: The State Action on Avoidable Readmissions, is an approach to improve the delivery of effective care at a regional level. The protocol provides an overview of the implementation process, as well as the goals and objectives of this initiative. The initiative also includes implementation materials, including How-To guides, briefs, presentations, and videos to help teams use the protocol and become successful at reducing readmissions (IHI).
- Project BOOST: Better Outcomes for Older Adults through Safe Transitions, is a national initiative led by the Society of Hospital Medicine to improve the care of patients as they transition from hospital to home. The Tool to Address Risking: a Geriatric Evaluation for Transitions: TARGET includes a risk assessment screening tool which targets eight risk factors.
- MONAHRQ My Quality Improvement (MyQI) Guide on Readmissions, provides background information on readmissions, as well as case studies and lessons learned that can provide best practices and common misconceptions surrounding readmissions prevention. The guide also outlines the discharge process and provides a toolkit and checklist to provide a safe and successful patient discharge. Finally, the guide includes resources for care coordination and patient communication to ensure that the patient is fully equipped for their transition to home life and is prepared for their hospital discharge (AHRQ).
- IHI How-To Guide: Prevent Adverse Drug Events (Medication Reconciliation), provides guidelines for ensuring that patients are given the proper medication and dosage throughout their hospital stay, as well as after their discharge. The guide also provides recommendations for instructing patients on adhering to their medication regimens after they return home.

9. Surgical Site Infections

- On The Cusp: Stop HAI is a joint effort of the Health Research & Educational Trust, the Johns Hopkins University Quality and Safety Research Group, and the Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality, through a contract with the AHRQ, to dramatically reduce hospital-acquired infections in all 50 states, the District of Columbia and Puerto Rico.
- SHEA/IDSA Compendium of Strategies to Prevent HAIs synthesizes best evidence for the prevention of HAIs, highlights basic HAI prevention strategies and recommends performance and accountability measures to apply to individuals and groups working to implement infection prevention practices.

- Agency for Healthcare Research and Quality: National Quality Measures Clearinghouse: Prevention of Surgical Site Infections is a national recognized repository of evidence-based practices and guidelines that apply to all HAIs.
- Management of Multidrug-Resistant Organisms in Healthcare Settings, The CDC provides recommendations to guide the implementation of strategies and practices to prevent the transmission of MRSA, VRE, and other MDROs.
- Strategies to Prevent Surgical Site Infections in Acute Care Hospitals provides practical recommendations to assist acute care hospitals to implement and prioritize their surgical site infection (SSI) prevention efforts.
- Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 6: Prevention of Healthcare-Acquired Infections), published by: National Institutes of Health, National Center for Biotechnology Information. This report analyzes the impact that quality improvement strategies have had on interventions for prevention of surgical site infections (SSI), central line-associated bloodstream infections (CLABSI), ventilator-associated pneumonia (VAP), and catheter-associated urinary tract infections (CAUTI).
- Why Not The Best? Quality Improvement Resources for Healthcare Professionals. This site enables hospitals to learn from other hospitals about successful strategies to create safe, reliable health care processes through case studies.
- Using the National Surgical Quality Improvement Program and the Tennessee Surgical Quality Collaborative to Improve Surgical Outcomes. This study demonstrates how NSQIP can be used to improve surgical quality in hospitals and how the organization of data and scrutiny are vital to process improvement in surgical settings.

10. Ventilator-Associated Pneumonia

- On The Cusp: Stop HAI is a joint effort of the Health Research & Educational Trust, the Johns Hopkins University Quality and Safety Research Group, and the Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality, through a contract with the AHRQ, to dramatically reduce hospital-acquired infections in all 50 states, the District of Columbia and Puerto Rico.
- SHEA/IDSA Compendium of Strategies to Prevent HAIs synthesizes best evidence for the prevention of HAIs, highlights basic HAI prevention strategies and recommends performance and accountability measures to apply to individuals and groups working to implement infection prevention practices.
- CDC Guidelines for Preventing Ventilator Associated Pneumonia gives background information on the cause and epidemiology of VAP and provides a scientific explanation of its causation. The guidelines also provide standards for monitoring VAP as well as suggested practices for sterilizing and cleaning equipment and other safe practices (Center for Disease Control and Prevention).

- SHEA/IDSA/National Guideline Clearinghouse Strategies to Prevent Ventilator-Associated Pneumonia in Acute Care Hospitals provides guidelines and comprehensive recommendations for preventing Ventilator-Associated Pneumonia. The Guide outlines strategies for detecting VAP as well as prevention strategies. The guide provides recommendations for implementing these strategies in acute-care settings. Finally, it outlines measurement and reporting standards, and recommendations for hospitals to track data and report to leadership.
- IHI Guidelines on Implementing the VAP Bundle provides additional information for implementing the VAP bundle and further outlines each step in the bundle. The site also provides additional tools, such as a Ventilator Bundle Checklist and Daily Goals Worksheet to improve bundle compliance and implementation.
- IHI How-to Guide: Prevent Ventilator-Associated Pneumonia defines the problem of Ventilator-Associated Pneumonia and discusses the importance of prevention. The guide outlines five components of care, including Elevation of the Head of the Bed, Daily Sedative Interruption and Daily Assessment of Readiness to Extubate, Peptic Ulcer Disease (PUD) Prophylaxis, Deep Venous Thrombosis (DVT) Prophylaxis, and Daily Oral Care with Chlorhexidine.

11. Venous Thromboembolism

- ACOG Guidelines to Prevent Thromboembolic Events National Guideline Clearinghouse on prevention of DVT and pulmonary embolism (AHRQ).
- Why Not the Best? Quality Improvement Resources for Health Care Comparative performance data on surgical care, including VTE prevention published. (The Commonwealth Fund).
- Diagnosis and Treatment of Deep Venous Thrombosis and Pulmonary Embolism
- Published by AHRQ, this site includes information from AHRQ's Evidence-Based Practice Program on the diagnosis and treatment of DVT and Pulmonary Embolism.
- NICE Pathways: Venous Thromboembolism Overview Published by the National Health Service for the National Institute for Health and Clinical Excellence. NICE Pathways is an interactive tool for health and social care professionals, providing access to NICE guidance and associated products for VTE prevention
- Map of Medicine®: Venous Thromboembolism Risk Assessment (All Patients) Published by the National Health Service. Site includes a VTE risk assessment algorithm.