

Culture of Safety: Moving to Accountability **An 8-Part Audio Conference Series**

When it comes to hospital-acquired conditions, many health care organizations are moving away from a “blame free” culture toward a culture of accountability. The Joint Commission has made addressing the problem of “blame free” a priority, and CMS is no longer reimbursing certain hospital-acquired conditions. OPSI’s 2010 teleconference will focus on how a culture of accountability can improve patient safety processes. Ohio Board of Nursing President, Lisa Klenke, MBA, RN, will kick off the eight-part series on Feb. 10 with a presentation on the importance of accountability in enhancing patient safety in Ohio hospitals. For more information or to register, visit OPSI’s Web site at <http://www.ohiopatientsafety.org>.

Post-surgical Infections Raise Costs and Readmission Rates

Researchers at Duke University examined the 90-day postoperative period for 659 patients in one tertiary care center and six community hospitals in the Duke Infection Control Outreach Network over five years and concluded that post-surgical infections raise readmission and mortality rates as high as \$60,000 per patient. The study observed readmission, mortality, duration of hospital stay and hospital charges for patients with methicillin-resistant *Staphylococcus aureus* (MRSA) or methicillin-susceptible *Staphylococcus aureus* (MSSA) and those with no infection.

Patients with surgical site infections due to MRSA were 35 times more likely to be readmitted and seven times more likely to die within 90 days compared to uninfected surgical patients. These patients required more than three weeks of additional hospitalization and accrued more than \$60,000 in additional charges.

2010 National Patient Safety Goals

The Joint Commission has revised the [2010 National Patient Safety Goals](#) (NPSGs). Some changes were made in response to concerns from the field about resources needed to comply with increasingly more specific and detailed NPSGs. The revisions include streamlining certain Elements of Performance, as well as deleting some requirements. Decreasing the number of NPSGs allows organizations to focus on the most important issues. While no new NPSGs have been developed for 2010, hospitals were expected to have fully implemented the requirements related to health care-associated infections (which were established with the 2009 NPSGs.) The Joint Commission is currently reviewing the role and development of NPSGs.

National Patient Safety Week March 7—13

Mark your calendars for National Patient Safety Week, March 7—13. Ohio’s theme this year, “Step up to Safety: What position are you playing?” emphasizes the team effort involved in patient safety. OPSI has developed posters for hospitals to use to announce Patient Safety Week. Visit OPSI’s [Web site](#) to access these resources. Share this site with other associates who work with patient safety issues, and don’t forget to recognize your own patient safety all stars.

OPSI Regional Conference May 12

Learn how human factors affect hospital-acquired conditions at OPSI’s regional conference, May 12, at MetroHealth in Cleveland. Keynote speaker Michael Leonard, MD, will focus presentations on effective reduction practices as they relate to pressure ulcers, wrong-site surgeries and multi-drug resistant organisms. Registration information will be available soon on OPSI’s Web site.

Face Masks and Hand Hygiene Limit Flu

Simple measures like hand hygiene and face masks reduce the transmission of flu-like illness, according to a study at the University of Michigan School of Public Health. More than 1,400 students in university residence halls were asked to either wear standard medical procedure masks or wear masks and use hand sanitizer for six weeks during the 2006-07 flu season. Both groups received basic hand-hygiene education. Participants were monitored for flu-like symptoms and compared with a control group that used neither masks nor sanitizer. Both the hand sanitizer/mask group and the mask-only group reported a significantly lower number of flu-like symptoms. Access the study [online](#) in The Journal of Infectious Diseases.

Poor Communication is Leading Cause of Wrong Surgeries

A recent Veterans Health Administration study published in the Archives of Surgery found poor communication among surgical team members to be the leading cause of wrong surgeries, including wrong procedures, patients, body parts and implants. About 20 percent of adverse events between 2001 and 2006 reported by the VA were caused by communication failures, such as poor handoffs of critical information. More than 15 percent were caused by problems with the perioperative timeout process, which involves redundant checks on patient’s identity, test results and other vital information. One in every 18,955 surgeries involves a wrong surgery, and the VA found 209 adverse events and 314 close calls in which mistakes were discovered before patients were harmed.

Quality Transformation Collaborative Saves Children's Lives

In October 2006, a group of 29 pediatric intensive care units (PICUs) in 27 children's hospitals across the country began working together to eradicate Catheter-associated blood stream infections (CA-BSIs) in PICU patients. Through a quality transformation collaborative formed by the [National Association of Children's Hospitals and Related Institutions](#) (NACHRI), these PICU teams have prevented 121 deaths, 1000 CA-BSI infections and saved \$35 million in infection-related costs, as of December 2009.

In a *Pediatrics* article on the NACHRI quality transformation collaborative's outcomes, lead author and NACHRI Quality Transformation Vice President Marlene Miller, MD, MSc, and her co-authors assert that reducing the risk of CA-BSIs in pediatric patients requires a different focus than what works for adult patients. Reducing events requires an approach which combines evidence-based guidelines for catheter insertion with daily maintenance care for central lines. The main driver in reducing CA-BSI infections by almost 50 percent in 12 months was the reliable use of the recommended daily maintenance care for central lines. According to faculty, successful outcomes depend upon the number of PICUs involved, as well as transparency, where every PICU shares not only rates of infection, but also rates of compliance with both the insertion and maintenance bundles.

Quality transformation efforts "offer the opportunity to learn from one another more quickly," says Richard Brill, MD, chief medical officer at Nationwide Children's Hospital in Columbus, co-chair of the NACHRI PICU CA-BSI quality transformation collaborative and co-author of the article in *Pediatrics*.

FDA Notice and Recommendations for Steris System 1

On Feb. 2, the U.S. Food and Drug Administration (FDA) notified health care administrators and infection control professionals that they have **18 months** to transition from Steris Corporation's modified System 1 processors (SS1), used primarily in surgical and endoscopy suites for disinfection or sterilization of medical devices, to alternative legally-marketed devices. The FDA announced in December that the Agency has not approved or cleared the SS1 for its labeled claims. Steris Corporation has chosen not to seek FDA clearance of this device and its use should be discontinued.

During a December stakeholder conference call, the FDA stated that health care facilities should be able to transition from the SS1 to alternative devices in three to six months. Since then, the FDA has heard from many health care providers and organizations that advise a longer period of transition to avoid adversely affecting patient care. Therefore, the FDA is extending the recommended transition time period to 18 months. At this time, the FDA expects that Steris Corporation will continue to support existing SS1 units throughout the extended transition period.

The FDA also does not expect to take regulatory action against health care facilities for failing to replace SS1 units within the 18-month period. This safety alert is not a recall; the FDA does not intend to disrupt an organization's provision of care, treatment or services. However, these facilities should be aware that the current SS1 is a misbranded and adulterated medical device because it has not been cleared by the FDA as safe and effective for its labeled claims. The full safety alert and updates are available on the [FDA's Web site](#).

Trustees Must Foster Culture of Safety

In the decade since the release of the groundbreaking "To Err is Human: Building a Safer Health System" report by the Institute of Medicine, hospitals have worked to eliminate medical errors, and Medicare has stopped reimbursing providers for additional costs associated with "never events." The Agency for Healthcare Research and Quality (AHRQ) says hospital trustees can do more by creating a culture of safety that emphasizes transparency and accountability from the highest levels throughout the organization. Hospitals need to educate staff and patients about care quality and adhere to evidence-based design to ensure healthcare quality and safety improvement. Teamwork, care coordination and capital investments fostering those values can ensure patient care is consistent and appropriate throughout the transition process from hospital to home.

Who to Contact About OPSI

Do you have questions or comments regarding OPSI or this bulletin? If so, please e-mail [Rosalie Weakland](#). If you would like to be added to the list to receive the bulletin please e-mail [Jennifer Edse](#).

Mission

The Ohio Patient Safety Institute is the **leader** and **catalyst** in transforming health care into a reliable safe delivery system.