

Infection Prevention in Arizona CAHs— Managing Systems to Improve Quality

Learning & Action Session 1: Hardwiring Your System's Changes

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Information for Health Care Improvement



Introductions

- Name and Title
- Hospital
- How long in your current position?
- Who is your strongest supporter at the hospital?

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Information for Health Care Improvement



Objectives

- Identify Lessons Learned (from CVRMC's journey to an effective infection control team and SAMC's efforts to sustain leadership engagement) that could be transferred to your hospital's infection prevention program and propose how you might apply them.

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Objectives

- Select at least one of the materials from the APIC website related to the CMS HAI initiatives, that you might share with members of your hospital's team, and plan how and when you will share the material(s).

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Objectives

- Decide on one measure that could be tracked in all participating IPC hospitals (in addition to hospitals' individual measures) to evaluate the overall impact of the Collaborative and identify who needs to help you determine the feasibility of collecting the data.

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Lessons Learned

- CVRMC's ongoing journey to an effective Infection Control Team
- SEAMC's efforts to obtain and sustain leadership engagement
 - What were some of the challenges and barriers?
 - What worked well?
 - What didn't work well and why not?

CMS Update on HAIs

- MRSA
- CLABSI
- C Diff
- CA-UTI
- SSI

HAI Resources

- [APIC Materials](#)
- [APIC Hand Hygiene Music Video](#)
- [Maryland Hospital Hand Hygiene Collaborative](#)

Possible Measures to Evaluate IPC

- # of patient days without an HAI
- Hand hygiene compliance
- MDRO transmission
- ??

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Over 1 million drug-related injuries occur every year in health care settings. The Institute of Medicine estimates that at least a quarter of these injuries are preventable.

To find out how to prevent medication errors, go to <http://www.hsag.com/drugsafety/>.



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