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HAI Resource Guide

DOMAIN	DESCRIPTION SOURCE
ANTIMICROBIAL STEWARDSHIP	
Antimicrobial Stewardship	**American Association of Nurse Anesthetists** Infection Control Guide for Certified Registered Nurse Anesthetists http://www.aana.com/resources2/professionalpractice/Documents/PPM%20Infection%20Control%20Guide.pdf
Antimicrobial Stewardship	**American Society for Anesthesiologists** Recommendations for Infection Control for the Practice of Anesthesiologist (Third Edition). Developed by the ASA Committee on Occupational Health Task Force on Infection Control http://www.asahq.org/For-Healthcare-Professionals/~/media/For%20Members/About%20ASA/ASA%20Committees/Recommendations%20for%20Infection%20Control%20for%20the%20Practice%20of%20Anesthesiology.ashx
Antimicrobial Stewardship	**CDC - Why Inpatient Stewardship?** The Centers for Disease Control and Prevention has launched *Get Smart for Healthcare*, a new campaign focused on improving antimicrobial use in inpatient healthcare settings such as acute-care facilities, and long-term care through the implementation of antimicrobial (or antibiotic) stewardship programs. These antimicrobial (or antibiotic) stewardship programs are interventions designed to ensure that hospitalized patients receive the right antibiotic, at the right dose, at the right time, and for the right duration. http://www.cdc.gov/getsmart/healthcare/inpatient-stewardship.html
Antimicrobial Stewardship	**Greater New York Hospital Association (GNYHA)** GNYHA, in partnership with the United Hospital Fund and with support from the New York State Department of Health, helped a group of acute and long term care health facilities implement and test a set of evidence-based guidelines to create effective and sustainable antibiotic stewardship programs across the continuum of care. http://www.gnyha.org/whatwedo/quality-patient-safety/
Antimicrobial Stewardship	**Society for Healthcare Epidemiology of America and Infectious Diseases Society of America Joint Committee on the Prevention of Antimicrobial Resistance**: Guidelines for the Prevention of Antimicrobial Resistance in Hospitals

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	http://www.idsociety.org/uploadedFiles/IDSA/Guidelines-patient_Care/PDF_Library/Antimicrobial%20Resistance.pdf
Antimicrobial Stewardship	**SHEA/IDSA Guidelines for Developing an Institutional Program to Enhance Antimicrobial Stewardship** This document presents guidelines for developing institutional programs to enhance antimicrobial stewardship, an activity that includes appropriate selection, dosing, route, and duration of antimicrobial therapy. http://cid.oxfordjournals.org/content/44/2/159.full#AntimicrobialStewardship
Antimicrobial Stewardship	**SHEA - Guidelines for Developing an Institutional Program to Enhance Antimicrobial Stewardship** This document presents guidelines for developing institutional programs to enhance antimicrobial stewardship, an activity that includes appropriate selection, dosing, route, and duration of antimicrobial therapy. http://www.shea-online.org/View/ArticleId/9/Guidelines-for-Developing-an-Institutional-Program-to-Enhance-Antimicrobial-Stewardship.aspx
CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI)	
Catheter Associated Urinary Tract Infection (CAUTI)	**APIC - Association for Professionals in Infection Control and Epidemiology, Inc** Guide to the Elimination of Catheter-Associated Urinary Tract Infections (CAUTI's) Developing and Applying Facility-Based Prevention Interventions in Acute and Long-Term Care Settings http://www.apic.org/Resource_/EliminationGuideForm/c0790db8-2aca-4179-a7ae-676c27592de2/File/APIC-CAUTI-Guide.pdf
Catheter Associated Urinary Tract Infection (CAUTI)	**CAUTI Challenge** The CAUTI Challenge website provides comprehensive resources for preventing CAUTI and reducing indwelling urinary catheter use. http://cautichallenge.com/
Catheter Associated Urinary Tract Infection (CAUTI)	**Catheterout.org** This website gives you an array of potential options for reducing CAUTI and indwelling urinary catheter use. Some potential options can include: tools for physician and nurse engagement, ideas for nurse-led 'catheter patrols' to assess patients for Foleys and initiate removal for those that are non-indicated, Foley-stop orders, and brochures for patients and

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	their families that are requesting a Foley without a true medical indication. http://catheterout.org/
Catheter Associated Urinary Tract Infection (CAUTI)	**Centers for Disease Control and Prevention (CDC)** A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney. UTIs are the most common type of healthcare-associated infection reported to the National Healthcare Safety Network (NHSN). Among UTIs acquired in the hospital, approximately 75% are associated with a urinary catheter, which is a tube inserted into the bladder through the urethra to drain urine. Between 15-25% of hospitalized patients receive urinary catheters during their hospital stay. The most important risk factor for developing a catheter-associated UTI (CAUTI) is prolonged use of the urinary catheter. Therefore, catheters should only be used for appropriate indications and should be removed as soon as they are no longer needed. http://www.cdc.gov/HAI/ca_uti/uti.html
Catheter Associated Urinary Tract Infection (CAUTI)	**Healthcare Infection Control Practices Advisory Committee (HIICPAC) **** Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009, Gould, et al http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf
Catheter Associated Urinary Tract Infection (CAUTI)	**IHI Catheter-Associated Urinary Tract Infection** Urinary tract infections account for approximately 40 percent of all hospital-acquired infections annually, with fully 80 percent of these hospital-acquired urinary tract infections attributable to indwelling urethral catheters. It is well established that the duration of catheterization is directly related to risk for developing a urinary tract infection (UTI). With a catheter in place, the daily risk of developing a UTI ranges from 3 percent to 7 percent. Among the ten hospital-acquired conditions selected by the Centers for Medicare & Medicaid Services, catheter-associated UTI received a high priority due to its high cost and high volume, and because it can be reasonably prevented through application of accepted evidence-based prevention guidelines. http://www.ihi.org/explore/CAUTI/Pages/default.aspx
Catheter Associated Urinary Tract Infection (CAUTI)	**Journal of General Internal Medicine - Loeb et al June 2008: 23(6:816-820** 'Stop Order to Reduce Inappropriate Urinary Catheterization in Hospitalized Patients: A Randomized Controlled Trial'

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	To assess whether stop orders for indwelling urinary catheters reduces the duration of inappropriate urinary catheterization and the incidence of urinary tract infections. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517898/
Catheter Associated Urinary Tract Infection (CAUTI)	**Infection Control and Hospital Epidemiology - Huang, et al, 2004 Nov;25(11) 974-8** This study demonstrated that a simple measure instituted as part of a continuous quality improvement program significantly reduced the duration of urinary catheterization, rate of CAUTI, and additional costs of antibiotics to manage CAUTI. http://www.ncbi.nlm.nih.gov/pubmed/15566033
Catheter Associated Urinary Tract Infection (CAUTI)	**Partnership for Patients** Catheter-Associated Urinary Tract Infections http://partnershipforpatients.cms.gov/p4p_resources/tsp-catheterassociatedurinarytractinfections/toolcatheter-associatedurinarytractinfectionscauti.html
Catheter Associated Urinary Tract Infection (CAUTI)	**The Pennsylvania Patient Safety Authority** The Pennsylvania Patient Safety Authority was established under Act 13* of 2002, the Medical Care Availability and Reduction of Error ("Mcare") Act, as an independent state agency. It operates under an 11-member Board of Directors, six appointed by the Governor and four appointed by the Senate and House leadership. The Authority is charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety. http://www.patientsafetyauthority.org/EducationalTools/PatientSafetyTools/cauti/Pages/home.aspx
Catheter Associated Urinary Tract Infection (CAUTI)	**SHEA/IDSA Practice Recommendations** Strategies to Prevent Catheter-Associated Urinary Tract Infections in Acute Care Hospitals http://www.jstor.org/stable/10.1086/591066
CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION (CLABSI)	
Central Line	**APIC - Association for Professionals in Infection Control and Epidemiology, Inc**

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Associated Blood Stream Infection (CLABSI)	Guideline for the Prevention of Intravascular Catheter-Related Infections, 2011 ** http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf
Central Line Associated Blood Stream Infection (CLABSI)	**Centers for Disease Control and Prevention (CDC)** Healthcare Associated Infections Modern healthcare employs many types of invasive devices and procedures to treat patients and to help them recover. Infections can be associated with the devices used in medical procedures, such as catheters or ventilators. These healthcare-associated infections (HAIs) include central line-associated bloodstream infections, catheter-associated urinary tract infections, and ventilator-associated pneumonia. Infections may also occur at surgery sites, known as surgical site infections. Additionally, *Clostridium difficile* can cause gastrointestinal infection; patients can be exposed to this bacterium through contaminated surfaces or the spores can be transferred on unclean hands of others. Central line-associated bloodstream infections, catheter-associated urinary tract infections, and ventilator-associated pneumonia account for roughly two-thirds of all HAIs. CDC works to monitor and prevent these infections because they are an important threat to patient safety. http://www.cdc.gov/HAI/bsi/bsi.html
Central Line Associated Blood Stream Infection (CLABSI)	**Healthcare Infection Control Practices Advisory Committee (HICPAC) - Published April 1, 2011 **** Guidelines for the Prevention of Intravascular Catheter-related Infections, O'Grady, et al This report was prepared by a working group comprising members from professional organizations representing the disciplines of critical care medicine, infectious diseases, healthcare infection control, surgery, anesthesiology, interventional radiology, pulmonary medicine, pediatric medicine, and nursing. http://www.idsociety.org/uploadedFiles/IDSA/Guidelines-Patient_Care/PDF_Library/Prevention%20IV%20Cath.pdf
Central Line Associated Blood Stream Infection (CLABSI)	**Implement the IHI Central Line Bundle** The IHI Central Line Bundle is a group of evidence-based interventions for patients with intravascular central catheters that, when implemented together, result in better outcomes than when implemented individually. **http://www.ihi.org/knowledge/Pages/Changes/ImplementtheCentralLineBundle.aspx**
Central Line Associated Blood Stream Infection	**Infection Control and Hospital Epidemiology** - Vol. 29, No. S1, October 2008 ** Strategies to Prevent Central Line-Associated Bloodstream Infections in Acute Care Hospital - Marshall, et al. Previously published guidelines are available that provide comprehensive recommendations for detecting and preventing

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(CLABSI)	healthcare-associated infections. The intent of this document is to highlight practical recommendations in a concise format designed to assist acute care hospitals in implementing and prioritizing their central line–associated bloodstream infection (CLABSI) prevention efforts. Refer to the Society for Healthcare Epidemiology of America/Infectious Diseases Society of America "Compendium of Strategies to Prevent Healthcare-Associated Infections" Executive Summary and Introduction and accompanying editorial for additional discussion. http://www.jstor.org/stable/10.1086/591059
Central Line Associated Blood Stream Infection (CLABSI)	**Journal of the American Academy of Pediatrics** Statewide NICU Central-Line-Associated Bloodstream Infection Rates Decline After Bundles and Checklists *Pediatrics published online February 21, 2011: DOI: 10.1542/peds.2010-2873* The online version of this article, along with updated information and services, is located on the World Wide Web at: http://pediatrics.aappublications.org/content/127/3/436.abstract Dr. Schulman's contact information is: Joseph Schulman, MD MS, Systems of Care Division, California Department of Healthcare Services, 1515 K Street Suite 400 Sacramento, CA 95814 Office ph: 916-327-2487 email: Joseph.Schulman@DHCS.ca.gov
Central Line Associated Blood Stream Infection (CLABSI)	**Journal of Infusion Nursing - January/February 2011, Volume 34- Issue 1** Pediatric Central Line: Bundle Implementation and Outcomes http://journals.lww.com/journalofinfusionnursing/Abstract/2011/01000/Pediatric_Central_Line__Bundle_Implementation_and.5.aspx
Central Line Associated Blood Stream Infection (CLABSI)	**The Pennsylvania Patient Safety Authority** The Pennsylvania Patient Safety Authority was established under Act 13* of 2002, the Medical Care Availability and Reduction of Error ("Mcare") Act, as an independent state agency. It operates under an 11-member Board of Directors, six appointed by the Governor and four appointed by the Senate and House leadership. The Authority is charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety.

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	http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/clabsi/Pages/home.aspx
Central Line Associated Blood Stream Infection (CLABSI)	**University of Rochester Medical Center** Web-based Training on: "*Preventing Central Line Associated Blood Stream Infections*" This program was created by the following individuals: Ghinwa Dumyati, MD Cathy Concannon http://www.urmc.rochester.edu/community-health/central-line-education/
CENTRAL LINE INSERTION PRACTICES (CLIP)	
Central Line Insertion Practices (CLIP)	**Centers for Disease Control and Prevention (CDC) - National Healthcare Safety Network (NHSN)** Central Line Insertion Practices (CLIP) Adherence Monitoring, O'Grady, et al The CDC's Healthcare Infection Control Practices Advisory Committee (CDC/HICPAC) *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011 recommends evidence-based central line insertion practices known to reduce the risk of subsequent central line-associated bloodstream infection. http://www.cdc.gov/nhsn/PDFs/pscManual/5psc_CLIPcurrent.pdf
***CLOSTRIDIUM DIFFICILE* (C-DIFF, CDI)**	
Clostridium Difficile (C-Diff, CDI)	**Agency for Healthcare Research and Quality (AHRQ)** *Clostridium difficile* infection (*C. difficile*) is a serious public health problem that has recently increased in both incidence and severity. Taking steps to reduce *C. difficile* is a major health and public health imperative. Antimicrobial stewardship targeted to *C. difficile* reduction shows promise, because increased rates of *C. difficile* are associated with inappropriate antibiotic use. An antimicrobial stewardship program (ASP) is a systematic approach to developing coordinated interventions to reduce overuse and inappropriate selection of antibiotics, and to achieve optimal outcomes for patients in cost-efficient ways. This toolkit assists hospital staff and leadership in developing an effective ASP with the potential to reduce *C. difficile*. http://www.ahrq.gov/qual/cdifftoolkit/cdifftoolkit.pdf
Clostridium Difficile (C-	**APIC - Association for Professionals in Infection Control and Epidemiology, Inc**

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Diff, CDI)	Guide to Preventing *Clostridium difficile* Infections http://apic.org/Resource_/EliminationGuideForm/59397fc6-3f90-43d1-9325-e8be75d86888/File/2013CDiffFinal.pdf
Clostridium Difficile (C-Diff, CDI)	**Centers for Disease Control and Prevention (CDC)** *Clostridium difficile* is a bacterium that causes infection, most often related to the use of antibiotics during healthcare treatment. *Clostridium difficile* infections cause diarrhea and more serious intestinal conditions such as pseudomembranous colitis. CDC provides guidelines and tools to the healthcare community to help prevent *Clostridium difficile* infections and resources to help the public understand these infections and take measures to safeguard their own health when possible. http://www.cdc.gov/HAI/organisms/cdiff/Cdiff_infect.html
Clostridium Difficile (C-Diff, CDI)	**Medscape CME Activity** Medscape, LLC is pleased to provide online continuing medical education (CME) for this journal article, allowing clinicians the opportunity to earn CME credit. This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Medscape, LLC and Emerging Infectious Diseases. Medscape, LLC is accredited by the ACCME to provide continuing medical education for physicians. Medscape, LLC designates this Journal-based CME activity for a maximum of 1 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. All other clinicians completing this activity will be issued a certificate of participation. To participate in this journal CME activity: (1) review the learning objectives and author disclosures; (2) study the education content; (3) take the post-test with a 70% minimum passing score and complete the evaluation, (4) view/print certificate. http://www.medscape.org/viewarticle/758703
Clostridium Difficile (C-Diff, CDI)	**SHEA-IDSA Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA)** This guideline is designed to improve the diagnosis and management of *Clostridium difficile* infection (CDI) in adult patients. A case of CDI is defined by the presence of symptoms (usually diarrhea) and either a stool test positive for *C. difficile* toxins or

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	toxigenic *C. difficile,* or colonoscopic or histopathologic findings revealing pseudomembranous colitis. In addition to diagnosis and management, recommended methods of infection control and environmental management of the pathogen are presented. http://www.jstor.org/stable/10.1086/651706
Clostridium Difficile (C-Diff, CDI)	**SHEA/IDSA Practice Recommendations **** **Strategies to Prevent *Clostridium difficile* Infections in Acute Care Hospitals, Dubberke, et al** Previously published guidelines are available that provide comprehensive recommendations for detecting and preventing healthcare-associated infections. The intent of this document is to highlight practical recommendations in a concise format designed to assist acute care hospitals in implementing and prioritizing their *Clostridium difficile* infection (CDI) prevention efforts. http://www.jstor.org/stable/pdfplus/10.1086/591065.pdf
COMPREHENSIVE UNIT BASED SAFETY PROGRAM (CUSP)	
Comprehensive Unit Based Safety Program (CUSP)	**Agency for Healthcare Research and Quality (AHRQ) - Using a Comprehensive Unit-based Safety Program to Prevent Healthcare-Associated Infections**. The Agency for Healthcare Research and Quality (AHRQ) supports numerous projects that are helping hospitals in all 50 States, the District of Columbia, and Puerto Rico to employ a Comprehensive Unit-based Safety Program (CUSP) to reduce healthcare-associated infections (HAIs). The CUSP approach can be applied to patient safety problems, including various types of preventable infections, such as central line-associated blood stream infections (CLABSIs), catheter-associated urinary tract infections, and ventilator-associated pneumonia, in intensive care units (ICUs) and other hospital units. This page provides an overview of CUSP and links to useful resources on the Web. http://www.ahrq.gov/qual/cusp.htm#Resources
Comprehensive Unit Based Safety Program	**Journal of Critical Care Medicine - 2008 June;23(2): 207-21**** Improving Patient Safety in Intensive Care Units in Michigan

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(CUSP)	Pronovost PJ, Berenholtz SM, Goeschel C, et al. Improving patient safety in intensive care units in Michigan. J Crit Care. 2008; 23 (2): 207-21 [PubMed] http://www.ncbi.nlm.nih.gov/pubmed/18538214
Comprehensive Unit Based Safety Program (CUSP)	**On the CUSP: Stop HAI** On the CUSP: Stop HAI is a joint effort of the Health Research & Educational Trust (HRET), the Johns Hopkins University Quality and Safety Research Group (JHU QSRG), and the Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality (MHA Keystone). Through a contract with the Agency for Healthcare Research and Quality (AHRQ), they look to dramatically reduce hospital-acquired infections in all 50 states, the District of Columbia and Puerto Rico. http://www.onthecuspstophai.org/
DISCHARGE PLANNING	
Discharge Planning	**Centers for Medicare and Medicaid Services (CMS) Discharge Planning Checklist** The CMS discharge planning checklist is available at https://www.medicare.gov/pubs/pdf/11376.pdf
HEALTHCARE ASSOCIATED INFECTIONS (HAIS)	
Healthcare Associated Infections (HAIs)	**Association for Professionals in Infection Control and Epidemiology (APIC)** **Cost Calculator** This tool is designed to demonstrate the costs of infection and the savings inherent in preventing them. It will also provide you with tables and graphs that describe the financial impact of infections at your hospital. You have the ability to customize the report using your own data. For infection prevention and control professionals who cannot find a financial partner or identify the excess costs per each infection type, we have provided data from national studies to estimate economic endpoints. The more of your own data you provide, the closer the estimated costs will reflect the financial impact of infections at your institution.

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	http://apic.org/Resources/Cost-calculators
Healthcare Associated Infections (HAIs)	**Association for Professionals in Infection Control and Epidemiology (APIC)** **Implementation Guides** APIC's Implementation Guides provide practical, evidence-based best practices for the surveillance and the elimination of infections. Each guide includes online tools and resources. http://apic.org/Professional-Practice/Implementation-guides
Healthcare Associated Infections (HAIs)	**California Department of Public Health** The Healthcare Associated Infections (HAI) Program is one of three programs in the Center for Health Care Quality of the California Department of Public Health. The Program is responsible for the surveillance, reporting, and prevention of infections in California's general acute care hospitals as mandated by Senate Bills 739, 1058, and 158. The Program was authorized in December 2009. HAIs are the most common complication of hospital care and are listed among the top ten leading causes of death in the United States. It is estimated that each year there are more than 1.7 million infections, 99,000 deaths, and $3.1 billion dollars in excess healthcare costs in acute care hospitals alone. Based on this data it is estimated that approximately 200,000 patients develop infections in California hospitals each year with an annual cost of about $600 million. The vision of the HAI Program is to eliminate HAIs for California patients. http://www.cdph.ca.gov/programs/hai/Pages/default.aspx
Healthcare Associated Infections (HAIs)	**Campaign Zero – Families for Patient Safety** In 2008 Medicare published a list of preventable hospital hazards which often result in harm to patients — or death. Medicare called these hazards "Never Events" because they should *never* happen to you or someone you love in the hospital. Hospitals everywhere responded with safety campaigns to improve their processes, protocols and attitudes to zero out Never Events. You can campaign for patient safety too! Here at campaignZERO, learn what you can do to help safeguard your loved ones in the hospital when they need you most. http://www.campaignzero.org/

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Healthcare Associated Infections (HAIs)	**Centers for Disease Control and Prevention (CDC) **** Healthcare Associated Infections (HAIs) remain major patient safety issue in healthcare. HAIs result in devastating complication for patients with twice the mortality rates; longer hospital stays; and higher healthcare cost. All of the complications create a vast drain on the healthcare system. Therefore, strategies for infection preventions are a number one priority. In this spirit, the CDC has compiled a set of toolkits to assist in addressing issues to reduce HAIs. http://www.cdc.gov/hai/state-resources/index.html **Inter-facility Infection Control Transfer Form** This example Inter-facility Infection Control patient transfer form can assist in fostering communication during transitions of care. This concept and draft was developed by the Utah Healthcare Associated Infection (HAI) working group and shared with Centers for Disease Control and Prevention (CDC) and state partners courtesy of the Utah State Department of Health. This tool can be modified and adapted by facilities and other quality improvement groups engaged in patient safety activities. http://www.cdc.gov/HAI/toolkits/InterfacilityTransferCommunicationForm11-2010.pdf
Healthcare Associated Infections (HAIs)	**Infection Control and Hospital Epidemiology** **A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals** Included information pertaining to CLSBSI's, VAP's, CAUTI's, SSI's, MRSA, and C-difficile. http://www.jstor.org/stable/10.1086/593984
Healthcare Associated Infections (HAIs)	**Texas Medical Institute of Technology (TMIT)** The HCUP HAI Cost Calculator is a predictive software model that provides more targeted estimates of HAI incidence, cost, and length-of-stay impact based on hospital size, geographic location, teaching status, and patient admissions. It uses single-source data for the HCUP NIS data set and a series of linear regressions to calculate the impact of six HAIs (CLABSI, CAUTI, CDI, MRSA, SSI, and VAP). http://www.safetyleaders.org/downloads/TMITCostCalculator.xlsx
IMMUNIZATION	

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Immunization	**The Advisory Committee on Immunization Practices (ACIP)** The Advisory Committee on Immunization Practices (ACIP) consists of 15 experts in fields associated with immunization, who have been selected by the Secretary of the U. S. Department of Health and Human Services to provide advice and guidance to the Secretary, the Assistant Secretary for Health, and the Centers for Disease Control and Prevention (CDC) on the control of vaccine-preventable diseases. In addition to the 15 voting members, ACIP includes 8 *ex officio* members who represent other federal agencies with responsibility for immunization programs in the United States, and 26 to 30 non-voting representatives of liaison organizations that bring related immunization expertise. http://www.cdc.gov/vaccines/acip/index.html
Immunization	**Adult Vaccination.org** This website is supported by unrestricted educational grants (EG) from GlaxoSmithKline, Merck & Co., Inc., Pfizer Inc and Sanofi Pasteur. The National Foundation for Infectious Diseases' EG policy is that funders do not control program content. The National Foundation for Infectious Diseases (NFID) is a non-profit, tax-exempt (501c3) organization founded in 1973 and dedicated to educating the public and healthcare professionals about the causes, treatment and prevention of infectious diseases. Visit www.NFID.org for more information. http://www.adultvaccination.org/default.aspx
Immunization	**Centers for Disease Control and Prevention - Vaccines and Immunizations** Materials to help you better understand vaccines and immunizations and why they are an important part of staying healthy. http://www.cdc.gov/vaccines/default.htm **Vaccine Information for Adults:** http://www.cdc.gov/vaccines/adults/resources.html
Immunization	**Flu.gov** This is a federal government website managed by the U.S. Department of Health and Human Services and provides information on flu basics including types of flu, prevention, symptoms, treatment, and vaccination for infants, children, adults, pregnant women, and travelers.

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	http://www.flu.gov/index.html
Immunization	**The Immunization Action Coalition (IAC)** The Immunization Action Coalition (IAC) works to increase immunization rates and prevent disease by creating and distributing educational materials for health professionals and the public that enhance the delivery of safe and effective immunization services. The Coalition also facilitates communication about the safety, efficacy, and use of vaccines within the broad immunization community of patients, parents, health care organizations, and government health agencies. For more than a decade, the Centers for Disease Control and Prevention (CDC) has worked in concert with and provided financial support to IAC for the purpose of educating health professionals about U.S. vaccine recommendations. CDC recognized IAC's accomplishments in 1997 by awarding it the prestigious Partners in Public Health Award for efforts "instrumental in achieving high levels of routine infant hepatitis B immunization."Physicians, nurses, and other healthcare professionals at every level of the immunization community, including both the public and private sectors, rely on many of the following projects in their daily work to increase immunization rates across the lifespan. http://www.immunize.org/
Immunizations	**Vaccine Information Statements (VIS)** The National Childhood Vaccine Injury (NCVI) Act requires that all healthcare providers give parents or patients copies of VIS before administering each dose of the vaccines listed in the schedule. http://www.cdc.gov/vaccines/pubs/default.htm#vis
NATIONAL HEALTHCARE SAFETY NETWORK (NHSN)	
National Healthcare Safety Network (NHSN)	**National Healthcare Safety Network (NHSN)** The National Healthcare Safety Network (NHSN) is a secure, internet-based surveillance system that integrates and expands legacy patient and healthcare personnel safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at CDC. NHSN also includes a new component for hospitals to monitor adverse reactions and incidents associated with receipt of blood and blood products. Enrollment is open to all types of healthcare facilities in the United States, including acute care hospitals, long term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities

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	http://www.cdc.gov/nhsn/
National Healthcare Safety Network (NHSN)	**NHSN - Patient Safety Component** The Patient Safety Component of NHSN includes surveillance methods to identify and track device-associated infections, procedure-associated infections, medication–associated issues that impact infection rates or treatment, multidrug-resistant organism and *Clostridium difficile* incidence and prevalence, as well as administration of influenza vaccine to high-risk inpatient populations before and during the influenza season. Within the Patient Safety Component, like-types of surveillance are grouped into modules. Instructions and standardized surveillance methods and definitions for each module are provided in specialized protocols. http://www.cdc.gov/nhsn/settings.html
ROOT CAUSE ANALYSIS	
Root Cause Analysis	**IPRO Root Cause Analysis Tool Kit** In order to prevent HAIs, a process is needed to define the problem, investigate the cause, and develop actions for minimizing and preventing future infections. Root cause analysis (RCA) is a process, which is used to investigate and categorize the root cause of events. The RCA tool helps to define what happened, how it happened and why it happened, allowing practitioners to understand and prevent future occurrences. http://qio.ipro.org/wp-content/uploads/2012/12/7_1-12-14_RCA_Toolkit_final.pdf
Root Cause Analysis	**Minnesota Department of Health** Root Cause Analysis Toolkit: For facilities that are new to conducting root cause analysis - and even for those who are more experienced - it can sometimes be difficult to establish a process that runs smoothly, is comfortable for participants, and leads to meaningful, focused discussions of system issues that may have contributed to events. This online RCA toolkit is designed to be a resource for any facility that would like to establish or improve their RCA process. It contains sample policies, position descriptions and agendas, graphic organizers and visual aids, question guides, invitations and ground rules, case studies and other documents that facilities can use to educate their staff, their RCA facilitators, or their leaders about this process. You are welcome to make use of anything in this toolkit, or to adapt it for your own purposes. Where appropriate, please cite the organization that is the source of the tool

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	http://www.health.state.mn.us/patientsafety/toolkit/index.html
Root Cause Analysis	**The Joint Commission (TJC)** A framework for a root cause analysis and action plan in response to a sentinel event. http://www.jointcommission.org/Framework_for_Conducting_a_Root_Cause_Analysis_and_Action_Plan/
SURGICAL SITE INFECTION (SSI)	
Surgical Site Infection (SSI)	**Association of PeriOperative Registered Nurses (AORN)** The AORN Comprehensive Surgical Checklist was created to support a facility's need to use a single checklist that includes the safety checks outlined in the World Health Organization's (WHO) Surgical Safety Checklist, while also meeting the safety checks within The Joint Commission's Universal Protocol in order to meet accreditation requirements. It is useful in all facility types -- hospital ORs, ASCs and physician offices. http://www.aorn.org/Clinical_Practice/ToolKits/Correct_Site_Surgery_Tool_Kit/Comprehensive_checklist.aspx#axzz2HglkborQ
Surgical Site Infection (SSI)	**APIC - Association for Professionals in Infection Control and Epidemiology, Inc** Guide to the Elimination of Orthopedic Surgical Site Infections http://www.apic.org/Resource_/EliminationGuideForm/34e03612-d1e6-4214-a76b-e532c6fc3898/File/APIC-Ortho-Guide.pdf
Surgical Site Infection (SSI)	**APIC - Association for Professionals in Infection Control and Epidemiology, Inc** Guide for the Prevention of Mediastinitis Surgical Site Infections Following Cardiac Surgery http://www.apic.org/Professional-Practice/Implementation-guides
Surgical Site Infection (SSI)	**Centers for Disease Control and Prevention (CDC)** A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place. Surgical site infections can sometimes be superficial infections involving the skin only. Other surgical site infections are more serious and can involve tissues under the skin, organs, or implanted material. CDC provides guidelines and tools to the healthcare community to help end surgical site infections and resources to help the public understand these infections and take measures to safeguard their own health when possible.

HAI Resource Guide

DOMAIN	DESCRIPTION SOURCE
	http://www.cdc.gov/HAI/ssi/ssi.html
Surgical Site Infection (SSI)	**Delmarva Foundation for Medical Care **** National Patient Safety Initiative Surgical Care Improvement Project (SCIP) Community of Practice Handbook http://www.mdqio.org/docs/DFMC_SCIP_Handbook.pdf
Surgical Site Infection (SSI)	**IHI Prevent Surgical Site Infection** Surgical site infection (SSI) continues to represent a significant portion of healthcare-associated infections. The impact on morbidity, mortality, and cost of care has resulted in SSI reduction being identified as a top national priority in the US Department of Health and Human Services Action Plan to Prevent Healthcare-Associated Infections. The majority of SSIs are largely preventable and evidence-based strategies have been available for over ten years and implemented in many hospitals, as nationally recognized by SCIP and SHEA in the US. Worldwide attention to safer surgery including prevention of SSI led to the development of the WHO Surgical Safety Checklist demonstrating the importance of teamwork and communication in addition to evidence-based care for preventing SSI. http://www.ihi.org/explore/SSI/Pages/default.aspx
Surgical Site Infection (SSI)	**New York State Department of Health - Protocols to Enhance Safe Surgical Care** The New York State Department of Health released recommendations from its Pre–Operative Protocols Panel as part of a statewide effort to further safeguard patients care during surgical procedures. (02/08/2001) http://www.health.ny.gov/press/releases/2001/preop.htm
Surgical Site Infection (SSI)	**QualityNet - Specifications Manual for Hospital In-patient Quality Reporting Program** The *Specifications Manual for National Hospital Inpatient Quality Measures* (Specifications Manual) is the result of the collaborative efforts of the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission to publish a uniform set of national hospital quality measures. Over time, it will be necessary to present more than one version of the manual on this Web page so that a specific data collection time period (i.e., based on hospital discharge dates) can be associated with the applicable manual. Find the appropriate data collection period below and select the associated Specifications Manual.

** CMS Primary Reference

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DOMAIN	DESCRIPTION SOURCE
	https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099
Surgical Site Infection (SSI)	**The Joint Commission (TJC) - Universal Protocol** The Universal Protocol applies to all surgical and nonsurgical invasive procedures. Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Organizations can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure. http://www.jointcommission.org/standards_information/up.aspx Facts about the Universal Protocol: http://www.jointcommission.org/assets/1/18/Patient_Safety1.PDF
Surgical Site Infection (SSI)	**World Health Organization (WHO) Surgical Safety Checklist** The goal of the Safe Surgery Saves Lives Challenge is to improve the safety of surgical care around the world by ensuring adherence to proven standards of care in all countries. The WHO Surgical Safety Checklist has improved compliance with standards and decreased complications from surgery in eight pilot hospitals where it was evaluated. http://www.who.int/patientsafety/safesurgery/en/
Ventilator-Associated Events – VAE	
Ventilator-Associated Events (VAE)	**Centers for Disease Control and Prevention (CDC)** The CDC has a site on VAP that includes fact sheets and other resources. http://www.cdc.gov/hai/vap/vap/html

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