

# Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 6 - Prevention of Healthcare-Associated Infections: Evidence Report/Technology Assessment Number 9



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## ***Reviews***

*Very good e-book and helpful one. It is among the most awesome publication we have read. Its been developed in an remarkably simple way in fact it is simply right after i finished reading this book through which basically transformed me, affect the way i really believe.*

*(Prof. Kacey O'Hara)*

## **CLOSING THE QUALITY GAP: A CRITICAL ANALYSIS OF QUALITY IMPROVEMENT STRATEGIES: VOLUME 6 - PREVENTION OF HEALTHCARE-ASSOCIATED INFECTIONS: EVIDENCE REPORTTECHNOLOGY ASSESSMENT NUMBER 9**

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Createspace. Paperback. Book Condition: New. This item is printed on demand. Paperback. 172 pages. Dimensions: 11.0in. x 8.5in. x 0.4in. Healthcare-associated infections (HAIs) are considered to be the greatest risk patients face in the hospital environment. HAIs can occur in any patient care setting, but infections in hospitalized patients account for the vast majority of HAIs. Hospitalized patients are additionally susceptible to experiencing serious consequences of HAIs due to comorbid illnesses. According to estimates from the Centers for Disease Control and Prevention (CDC), up to two million patients (nearly one in 20 hospitalized patients) experience a healthcare-associated infection every year in the U. S. , leading to approximately 88, 000 deaths and 4. 5 billion in extra costs per year. Moreover, the incidence of HAIs appears to have increased over the last three decades, despite the fact that the majority of HAIs are thought to be preventable. Efforts to monitor and prevent HAIs have existed for decades. These efforts have followed the public health methodology of surveillance and prevention. The effectiveness of such methods was provided by the Study of the Effectiveness of Nosocomial Infection Control study, which demonstrated that hospitals with structured infection control programs achieved sustained reductions in HAI rates, whereas hospitals with less comprehensive programs saw increased infection rates. The growing focus on improving patient safety over the past few years has catalyzed even greater efforts to curb HAIs. Public reporting of infection rates has been proposed as a means of educating patients and encouraging preventive efforts; currently, six states require reporting of HAIs, and legislation requiring some type of reporting has been proposed in the majority of states. Within the hospital, surgical site infections (SSI) and three types of infections common in intensive care unit patients are particularly prevalentcentral-line associated bloodstream infections, ventilator-associated pneumonia, and catheter-associated urinary...



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