EXECUTIVE INSIGHTS

IMPROVING CARE

DECREASING HOSPITAL-ACQUIRED CONDITIONS

Tools and Tactics for Success

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DECREASING HOSPITAL-ACQUIRED CONDITIONS: Tools and Tactics for Success

Nursing leaders prevented hospital-acquired conditions (HACs) during the recent pandemic patient surges with a combination of teamwork, data-driven technologies and enhanced safety protocols. This executive dialogue convened nurse executives to share their insights on developing a strong safety culture that will outlast the pandemic. Leaders also discussed the best ways to win staff buy-in for the new quality initiatives, a must for successful adoption.

KEY TAKEAWAYS

1. Hospital-acquired condition prevention should not fall solely on nurses. During COVID surges, **an all-hands-on-deck approach improved outcomes,** a teamwork mentality leaders want to keep.
2. Most nurse leaders worry about **patient falls and pressure injuries**.
3. Regular **safety meetings, checklists and improved accountability measures** help reduce HACs.
4. Virtual sitters, chair alarms, toilet alarms and automated patient monitoring systems also help to diminish harm. **Leaders also found value in artificial intelligence software,** used to identify high-risk patients.
5. **Hidden biases can affect treatment.** For example, some clinicians may turn obese patients less than they do others. Data can help reveal these biases.
6. Organizations can improve safety culture with a **consistent change management process** led by C-suite leaders.

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MODERATOR *(Terese Thrall, American Organization for Nurse Leadership)*: **Health care providers want to create better care and reduce hospital-acquired conditions (HACs). Have your experiences in caring for COVID-19 patients made reducing HACs a higher priority?**

LISA SMITHGALL *(Ballad Health)*: The pandemic has shown we experienced a higher rate of hospital-acquired conditions because our staff was stretched. We're now finally able to put more effort into those HAC-reduction activities we previously had in place.

THRALL: Has COVID made it hard to spend resources on reducing hospital-acquired pressure injuries (HAPIs)?

JILL STEWART *(UAB Hospital)*: During COVID, we hyper-focused on some of the quality pieces that we had long been working to improve, such as HAPIs.

We had already made great strides in reducing our hospital-acquired unstageable ulcers and overall HAPIs. The number of our proning patients grew, so we focused on teaching proning through simulations and other methods. We also brought in experts to ensure we were positioning the patients and offloading pressure points correctly. Our HAPIs ultimately decreased all throughout COVID, bringing our numbers to the lowest they've ever been.

KRISTI HARTWAY *(Multicare Good Samaritan Hospital)*: At one point in January, our ancillary services were critically short-staffed. We have great nurse educators, but there is a shortage. Our critical care nurses had to pick up the work of our respiratory therapists and even had to do lab work. There was a domino effect on patient care and our HAPIs tripled.

ADAM WINEBARGER *(Sinai Hospital of Baltimore)*: In January 2022, we deployed all our nonessential departments, including human resource and administration, to the hospital. Our patient experience scores for the month of January were the highest they've been in five years because we had so many people checking on the patients. Our falls decreased during that same time. Employees that usually are afraid to enter a patient's room were answering the call bells. It was eye opening how people in any position can support patient care and improve outcomes.

"It was eye opening how people in any position can support patient care and improve outcomes."

— Adam Winebarger — Lifebridge Health Sinai Hospital

PETA-ANN ANDERSON *(Jackson North Medical Center):* We had a similar model and it really worked for us. Especially our pressure injuries, which we reduced over 90% during our surge. We trained our perioperative staff to go to the med-surg units and to support our nursing staff. However, we saw a huge spike in our falls, especially on our COVID unit. We found virtual sitters more effective at reducing harm.

ANGELA WRIGHT *(Ascension Seton Williamson)*: In January, surgery volumes were up, COVID was up, everything was up. We had fewer resources, but we were able to capitalize on some of the lessons we learned in the first piece of it: a sense that everybody's in it together. It was common to see a physical therapist volunteer to help turn a patient. We've sustained that basic teamwork among disciplines. Our physical therapists, for example, do tasks without asking. We've seen a reduction in our HAPIs because of it.

THRALL: Which HAC worries you the most and why?

FRANCENE LUNDY *(Michigan Medicine)*: We've done a lot of evidence-based work to prevent falls. But my orthopedic patients believe once they've had their surgery and physical therapy, they're just fine. They get up, they go to the bathroom, they become lightheaded, and they fall. And they're the ones that are going to get hurt.

OCTAVIA WYNN *(Bon Secours Southside Medical Center)*: All the HACs worry me. We've been heavily focused on our culture because we've had so many traveling nurses and agency associates. We're proactively educating them and holding them to the same standards that we do the rest of our staff. We've seen a lot of improvements.

LUNDY: We're also working on accountability with our traveling nurses. We document their patient falls, ambulation, pressure injuries or even pain assessment.

WRIGHT: Falls are our biggest worry. Teamwork has helped. We do have chair alarms. One of our sites even has toilet alarms.

We realized that HACs are not the sole responsibility of nurses, although so many responsibilities fall on our shoulders. We've implemented education for every single associate in our organization, from security to biomed to food and nutrition, even physicians — all these associates are trained to answer a call. When you see a light going, you're expected to respond, even as a non-clinician.

We utilize our analytics, including real-time data that shows what safety measures have been implemented. So, a nurse manager can get it and say, "Hey, this person has not been turned." Most importantly, it sets expectations.

"I teach my nurse managers to notice more than the immediate task at-hand. When walking down the hall, they can spot the towels that need to be redone, a patient's fingernails — practicing with a sense of inquiry and looking for opportunities."

— Angela Wright —
Ascention Seton Williamson

I teach my nurse managers to notice more than the immediate task at-hand. When walking down the hall, they can spot the towels that need to be repositioned, a patient's fingernails — practicing with a sense of inquiry and looking for opportunities. Real-time coaching is important. Connecting with our patients also has been pivotal.

ANDERSON: I had to bring our fall rate down as well. We had a root cause analysis, where nurse and patient care technicians discussed how they could prevent future falls. We also have a safety committee with every department represented. Our entire team meets monthly so we're all aware of everything that we're doing related to preventing falls. And we've seen a significant drop; we're now down from 25 falls per month to single digits.

WINEBARGER: We had a high fall rate before my time at the system. The CNO, regardless of the time, required that the people call her when there was a fall, even at 3:00 AM, 4:00 AM. A couple of months in, the fall rate dropped, and we started using chair alarms.

THRALL: What are the barriers to reducing pressure injuries?

ROBIN GASPARINI *(Quality Mayo Clinic)*: There isn't much real-time data on what your culture is around turning patients or how well staff is performing the task. We're using the Leaf Patient Monitoring System and really have made a lot of headway. It gives you the visual cues that you need.

WINEBARGER: We have a significant pressure injury issue. And what we find is patients are classified as high risk. But then when you go and see the patient, there are certain interventions that just aren't in place that should be. Our clinical excellence team and our leaders will visit certain patients and will go through the patient's Braden scores, making sure that the bed alarms are on and working, that people have chair alarms in the rooms. It's helped.

GASPARINI: Unintended, unrealized biases about care delivery are a barrier. We want to provide unique and consistent care, but there are factors we're not always aware of that influence our ability to do that. We've seen inequities play out in our injury statistics.

The inability to individualize care for a patient is a barrier. Being able to say, "This patient is at more risk for these things than other patients" is important.

THRALL: Are there technologies that any of you have used that have helped with reducing pressure injuries?

ANDERSON: During admission, we have missed opportunities to document existing pressure injuries. So now our nurses use their phones to capture pressure injuries and they upload those photos directly into the medical record.

WRIGHT: The Leaf product has a visual cue to show if a patient hasn't been turned within a certain amount of time. It also measures the degree or the effectiveness of turns. Sometimes you've turned a patient, but it's not effective. When you have unstable ICU patients, you should know what the micro turn looks like, and how to offload pressure. It also provides valuable feedback, which we owe to our nurses when they're not following standards of care.

"Unintended, unrealized biases about care delivery are a barrier. . . We've seen inequities play out in our injury statistics."

— Robin Gasparini — Mayo Clinic

WINEBARGER: We just started using an artificial intelligence software to identify patients at high risk for pressure injury. It scours the medical record, looking at lab values and nursing documentation. Somehow, it creates predictive analytics. And similar to the Rothman Index, it'll tell clinicians who's higher risk and who's not. So physicians and nurses know who to prioritize.

WRIGHT: Nothing can take the place of basic communication, which I think we've gone away from. For example, everybody does multidisciplinary rounds. And it's interesting that we'll see pressure injuries and then you look at the patient's intake form and it's not documented. Or it hasn't been discussed that a patient is not getting enough nutrition. While technology is great, we must make sure that basic human communication is in place.

THRALL: Beyond COVID surges, is coordination with other staff necessary? What's the best way to get buy-in?

GASPARINI: With Leaf, it doesn't matter who you are or what discipline you are, there's a visual, and everybody knows what it means — red, yellow or green. Anybody can participate in that action if they're comfortable with the patient. We've even used it for our patients and families to say, "We shouldn't be doing this to you or for you. We're doing this with you."

With this system, we were able to see when our pressure injuries were occurring, if they were, and when our patient movements were. And we realized that we had some unfavorable practices (we had a culture of not turning in the evenings). We could directly correlate them with our protocols. We had a lot of data, unfortunately, that exposed unintended biases. We found that patients who are overweight or obese were turned less than other patients.

WINEBARGER: We found that many of our pressure injuries started in the ED because we have people boarding sometimes up to two days. Nine times out of 10, we'll get something that's acquired on day three. It started in the ED because there were no interventions. This is particularly complex when we have high boarding times, so the importance of frequent turning and moving patients from stretchers to regular hospital beds is very important.

SMITHGALL: You must have real-time HAC activity identification and then reinforcement back to the people involved. Because I don't think any nurse comes to work and thinks that they want to cause an injury to a patient.

"We found that the HAC occurrence often did not get back to the nurses who cared for the patient. We must evaluate any safety events in a timely manner . . . and communicate back to everyone who took care of that patient."

— Lisa Smithgall — Ballad Health

We found that the HAC occurrence often did not get back to the nurses who cared for the patient. They didn't know that when they cared for that patient, potentially their practice caused a harmful event. We must evaluate any safety events that we identify in a timely manner. We must identify all the people involved with a patient experiencing an HAC and communicate back to everyone who took care of that patient.

THRALL: What can leaders do to make this a priority for staff?

GASPARINI: Have a solid, consistent change management process. Good leadership comes from the top down. It can't just be a unit manager or a core group that wants to implement it. That's why our implementation was probably less successful initially; we didn't own the message.

We have improved our pressure injury rates. But an effective change management process is important for the success of any rollout. ●

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References: 1. National Scorecard on Hospital Acquired Conditions, Agency for Healthcare Research and Quality (AHRQ). June 2019 **2.** Pickham D, Berte N, Pihulic M, Valdez A, Mayer B, Desai M. Effect of a wearable patient sensor on care delivery for preventing pressure injuries in acutely ill adults: A pragmatic randomized clinical trial (LS-HAPI study). Int J Nurs Stud. 2018;80:12-19.

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