EXECUTIVE INSIGHTS

HIGH-QUALITY CARE

# REDUCING HOSPITAL-ACQUIRED CONDITIONS

## Initiatives to Improve Outcomes

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# REDUCING HOSPITAL ACQUIRED CONDITIONS: Initiatives to Improve Outcomes

**Preventing hospital-acquired conditions (HACs) continues to be a high priority for nursing executives.** Staff turnover has made prevention of HACs more challenging, especially after the pandemic. Quality improvement projects may be difficult to standardize among an influx of new and contract hires. This executive dialogue convened nurse executives to discuss how organizations can improve HAC prevention efforts through collaborative approaches, education, shared governance and technology.

## KEY TAKEAWAYS

1. Nurses who entered the profession during the pandemic may lack hands-on training and experience, leading to an increase in hospital-acquired conditions (HACs). **Targeted education and mentorship programs** can help bridge the knowledge gap.

2. Staff turnover and the presence of contract staff can impact HAC initiatives. Strategies such as **extensive orientation, consistent education and residency programs for contract staff** can help ensure adherence to HAC prevention protocols.

3. **Identifying and addressing specific HAC concerns in different units or departments** is crucial. Falls, pressure injuries, central line-associated bloodstream infections (CLABSIs), catheter-associated urinary tract infections (CAUTIs), and Clostridium difficile (C. diff) infections are common HACs that require targeted interventions.

4. **Engaging staff in HAC-reduction initiatives** can be achieved through shared governance, committee participation and educational approaches such as quizzes and case studies.

5. Inadequate staffing contributes to HACs, but other factors, such as **nursing tenure and supply shortages**, also create challenges.

6. **Technologies such as artificial intelligence and mobility-sensing systems** can aid in fall deterrence, pressure injury prevention and proactive management of patient conditions.

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**MODERATOR** *(Terese Thrall, American Organization for Nursing Leadership)*: **Have your experiences caring for patients in a post-COVID environment made reducing hospital-acquired conditions (HACs) a bigger priority? Has it been difficult to obtain C-suite support for initiatives to prevent or reduce HACs?**

**MARI LYNN ROSS** *(Franciscan Health):* HACs have always been important. I don't think that the pandemic changed that. In fact, we saw more HACs during the pandemic, especially issues like ventilator-associated events. As nurses, one of our main goals is to prevent patient harm. Because safety is a top priority, I have never had any difficulty – if I have a return on investment – to get approval for a product or initiative that shows its worth.

**VONDA LUCERO** *(Medical Center Health System)*: I completely agree. HACs have always been a priority, but in our county hospital and rural community, many nurses entering the workforce during the pandemic had only simulation training. They needed to gain experience through clinical rotations. We are getting licensed vocational nurses just out of school. They sometimes need help understanding what it takes to prevent HACs.

**MONICA DAVILA** *(Stanford Health Care Tri-Valley)*: We are also seeing an increase in HACs; we have noticed that our new RN grads need more elbow-to-elbow support to identify and address HACs. Our grad nurses were COVID trainees; some were just coming out of school. They had limitations to their clinical rotations and training; the exposure to the clinical environment and hands-on was minimal. To address this knowledge gap, we have implemented a tiered mentorship with skilled-based competency training to help them find their confidence and empower their practice.

**"We wouldn't have spent time and money training a contract person pre-pandemic, but we do now."**

— Terry Seik —
Hays Medical Center

**THRALL: How are staff turnover and the high levels of contract staff affecting your HAC initiatives?**

**ROXANNE WICKLUND** *(IU Health Arnett)*: The new grads are coming off of their graduation with less clinical experience. So we've hired nursing professional development specialists, educators who work with recent grads and contract staff to acclimate them to our safety efforts, such as bed alarms and central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infection (CAUTI) prevention. They get an extensive orientation to ensure we care for all our patients consistently. Our nursing professional development specialists are dedicated to units and are joined at the hip – or elbow – with nurse managers.

**THRALL:** Is it hard to get contract staff to follow protocols?

**TERRY SIEK** *(Hays Medical Center)*: We wouldn't have spent time and money training a contract person pre-pandemic, but we do now. We ensure that we go over all of our HAC prevention with contractors and that they attend all the same classes as our staff. We've had success with most of our travelers, especially our international nurses. Like brand-new grads, they go through our residency program, a year of supported practice.

**THRALL: Which HAC, such as such as falls, CLABSIs, pressure injuries, worries you the most?**

**MARIETTA ABERNATHY** *(Atrium Health Stanly)*: Falls, because making sure patients don't get up without assistance is a constant battle. We hired a mobility technician whose sole purpose is to assist and ambulate patients whenever they need help getting out of bed, especially post-surgical or high-risk patients. This minimizes the risk of pressure ulcers and deep vein thrombosis after

surgery. It's been a big help. We have seen a reduction in falls, especially falls with injuries.

**MARY LINDSAY** *(Duke University Hospital):* The prevention process depends upon the department. In the ICU, improving physician partnerships may result in increased compliance with CLABSI prevention protocols. An example is the concept of a boot camp to ensure that physicians receive consistent education and adhere to standardized procedures, specifically regarding insertion and maintenance bundles for central line care. Falls are our primary concern in our step-down units because patients tell us they don't want to bother nurses because "they are so busy." Revisions to our cardiac monitoring procedures has alerted staff pertaining to a potential fall. When the lead sensors are removed, this triggers a critical alarm, which is sometimes a precursor to a patient getting out of bed. Quite often, the nurses can catch patients before their falls.

**ALICIA POTOLSKY** *(El Camino Health)*: Currently, we're challenged by C. diff. We have a high number of traveling and newly hired nurses. At the same time, we need to work with physicians and take a multidisciplinary approach. This approach aims to ensure all clinicians comprehend and adhere to the guidelines, rather than relying solely on the bedside nurse.

**"We … take a multidisciplinary approach … to ensure all clinicians comprehend and adhere to the guidelines, rather than relying solely on the bedside nurse."**

— Alicia Potolsky — El Camino Health

To address this issue, we are partnering with our quality team and are encouraging unit-based interventions to better identify patients for possible C. diff. infection. We are standardizing processes for when to collect stool samples, and learning how to effectively collaborate across departments. While we already have protocols in place to reduce C. diff cases, our current focus is improving identification of existing C. diff infection within the first three days of admission.

Partnering with our quality team has sparked inspiration within our units, leading to several interventions and even the creation of a video. Recently, we finished a fun campaign about hand washing. Overall, this challenge has caused us to collaborate across disciplines and reevaluate our processes.

**MICHELE STENBECK** *(Essentia Health)*: We also had an issue with C. diff protocols. We put a stop-point in the medical record to order stool samples. Orders went right to our infectious disease department so the experts could help assess our physicians' timing and protocol and educate them. Because we had so many newer nurses, they decided not to order stool samples during night shifts. These interventions reduced our C. diff cases.

**THRALL: What is an easy way for staff to understand and participate in HAC-reduction initiatives? And how do you get buy-in from different departments?**

**LUCERO:** We use committees. We have a CAUTI committee, a CLABSI committee, and a fall committee. We've introduced a point system to get nurses involved on those committees. Nurses who participate in multiple committees are eligible for bonuses. This helps us gather diverse perspectives and ideas from nurses actively working at the bedside and who have firsthand experience with patients. It encourages ownership and we get practical ideas to improve care.

**WICKLUND:** We paired advanced practice nurses with hospitalists to help patients avoid unnecessary central lines and reduce CLABSIs. They use an ultrasound guided IV insertion when IV sticks are difficult. It lowered our CLABSI rates significantly just in the past couple of months.

**DAVILA:** We leveraged our professional governance structures with our councils and clinical ladder to incentivize nurses to participate. As part of the Stanford Healthcare System, we've aligned with our Palo Alto colleagues to ensure that bedside nurses are at the table for practice discussions.

**THRALL: Many of you are using shared governance to engage staff with quality practices. What are the ways that you help your team understand what needs to be done in terms of preventing HACs?**

**POTOLSKY:** Instead of simply sending out a tip sheet or posting information something on our intranet, our exceptional education team developed a weekly quiz sent out to all staff. These quizzes were designed to be challenging, and they incorporate interactive case studies, thereby promoting critical thinking among clinicians.

**LINDSAY:** We purchased a fluorescent substance visible under certain lighting. It helped the nurses and staff see areas that they missed when cleaning and disinfecting. This highlighted the opportunities when cleaning high-touch surfaces.

**THRALL: What barriers do you face when reducing hospital-acquired pressure injuries?**

**DAVILA:** The post-pandemic initiatives to bring our organization back to our new norm came so fast our front-line staff and our department leaders struggled to keep up with the growing demands between growing volumes and organization operational plan strategies and initiatives. We are still triaging demands and expectations while balancing patient care. Our main priority is patient-centeredness and our focus is zero harm. Everything else is noise.

**LINDSAY:** Our biggest challenge is the workforce's lack of experience. For example, in the critical care areas with the highest acuity, new nurses are task-focused which aligns with Benner's model, and they need to learn to take a comprehensive approach to care, such as remembering to turn patients regularly. The experience complexity gap further highlights the learning opportunities.

**"Hospital-acquired pressure injuries were a big focus for us in getting back to our pre-COVID numbers."**

— Vonda Lucero — Medical Center Health System

**POLTOSKY:** We had a considerable number of employees working extra shifts and overtime during the pandemic. Since then, several staff members have expressed feelings of burn out, and managers are focused on working to rebuild their resilience and inspire them.

**THRALL: Is there a relationship between staffing levels and the occurrence of pressure injuries?**

**ROSS:** Yes. Although, it wasn't just staffing. We also have to remember that during the pandemic, we saw pressure injuries we never saw before, such as on patients' faces where they came into contact with ventilators.

**LUCERO:** We realized we had a knowledge gap. Hospital-acquired pressure injuries were a big focus for us in getting back to our pre-COVID numbers. When we instituted Smith + Nephew's Leaf product at the facility, Smith + Nephew visited and taught us about turning. Some nurses were unaware that using a pancake pillow did not effectively relieve pressure and offset the risk of pressure injuries, even though they turned patients every two minutes. It was eye-opening for our staff. We ended up using wedges and other materials and realized that our three single-use pillows were not cutting it.

**STENBECK:** Staffing is just part of the problem. You might have the numbers of staff that you need, but their experience and knowledge may vary.

**WICKLUND:** To everybody's point, it's not just nursing. We have ancillary support vacancies and nurses have also picked up those duties.

**LUCERO:** Nurses also have to draw their own blood cultures now. We were so used to the phlebotomists doing it, and then we didn't have any phlebotomists. We ended up having to reteach the nurses to obtain blood cultures correctly.

**THRALL: What process do you use to implement a quality initiative at your organization?**

**SIEK:** We did well in preventing CAUTIs, CLABSIs, hospital-acquired pressure injuries and other HACs. But we were struggling to prevent aspiration pneumonia. Our quality and mortality committees helped us delve deeper and find ways to prevent it.

**LINDSAY:** Within 24 to 72 hours of a safety event, we try to get everybody involved through a "swarm." A swarm is not needed for every event, but we do swarm for specific conditions such as CAUTIs, CLASBIs, pressure injuries and falls with injury. If the event involves a pressure injury related to a respiratory device, the respiratory and wound care teams would be involved. We then review documentation to identify missed opportunities or areas for improvement.

Sometimes HAC issues are related to medical materials, especially during the pandemic. In these cases, we engage our medical materials team.

We conduct tiered huddles, including internal huddles within service lines, and each huddle reports up to the entire hospital. This allows us to share findings and identify recurring issues. Champions engage with the units and will investigate and address areas of concern. We have different champions, including hospital-acquired infection and pressure injury champions. The champions will help educate staff on what was learned and determine the following steps, either approved as hospital-wide practices or will go through additional hospital- and committee review and approval.

**"I think that we will see artificial intelligence helping to prevent HACs in many ways."**

— Mari Lynn Ross — Franciscan Health

**LUCERO:** Product substitutions for products also were a tremendous issue for us.

**WICKLUND:** We also hold daily huddles to discuss supply issues and HACs. The information discussed in these huddles is then shared with the entire team, and nurses further communicate it during daily huddles on the floor. It's hit or miss due to part-time staff and communication gaps. But you can't over-communicate when it comes to these issues.

**THRALL: What new technologies can contribute to preventing HACs?**

**ROSS:** We are working with a company using artificial intelligence to sense the patient's movements to prevent falls. It gives the nurse 15 to 30 more seconds to get in the room. Companies are also starting to work on artificial intelligence for patient repositioning, sepsis detection and understanding pressure ulcer probability. I think that we will see artificial intelligence helping to prevent HACs in many ways. ●

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**References: 1.** Schutt SC, Tarver C, Pezzani M. Pilot study: Assessing the effect of continual position monitoring technology on compliance with patient turning protocols. Nurs Open. 2017; 207:1–8.

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