Strategies to Reduce Hospital-Acquired Conditions

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Disclosures

• Board Member, American Association of Critical Care Nurses
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Objectives

1. Identify key elements of high reliability organizations within your current practice environment.

2. Describe strategies you can implement within your personal practice/unit to reduce hospital acquired conditions.
Goal: Provide Exceptional Care

Challenges
Healthcare should be:
- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

In 2010, the Institute of Medicine provided a vision that all clinical decisions would be evidence based by 2020.

Health Care Reform

- Improved Quality Care (outcomes)
- Improved Access
- Improved Efficiency
- Improved Safety
Hospital Value-Based Purchasing Quality Domains

<table>
<thead>
<tr>
<th>Year</th>
<th>Domain Details</th>
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</table>
| 2019 | Clinical Processes of Care (15%)  
Patient Experience of Care (20%)  
Outcome (60%)  
Efficiency (10%) |
| 2017* | Patient and Family-Centered Experience of Care/Care Coordination (25%)  
Safety (25%)  
Clinical Care (15%)  
Clinical Care – Outcomes (25%)  
Clinical Care – Processes (15%)  
Efficiency and Cost Reduction (25%)  
Patient and Family-Centered Experience of Care/Care Coordination (25%)  
Safety (25%)  
Clinical Care (15%)  
Efficiency and Cost Reduction (25%) |

* Beginning with FY 2017, CMS realigned the quality domains to align more closely with CMS’ National Quality Strategy (NQS) and serves as a standard for health care organizations across the country and around the world. The NQS is a collaborative effort to improve health and health care across nations by increasing awareness of the importance of quality improvement.

National Quality Forum (NQF)

Acknowledges progress is being made

However,
- ~ two million HACs occur annual in the US
- ~90,000 deaths
- > $4.5 billion in healthcare costs

Where are we today??
1 in 25 hospitalized patients experience a hospital acquired infection or condition (HAI or HAC)
- CAUTI and CLABSI
- While still a problem, C-diff and MRSA rates are decreasing
~ 1.5 million medication errors annual
- Wrong drug, wrong dose, wrong combination, adverse reaction
Practice bundles and technology are reducing CLABSI, VAP, and CAUTI

Growing List of “Serious Reportable Events”

Using Evidence to Guide Practice
- Saves time
- Saves $n
- Improves care....

Choosing Wisely Campaign
- American Board of Internal Medicine (ABIM), American Academy of Nursing and AACN

Don’t:
- order routine diagnostic tests at regular intervals
- transfuse red blood cells in hemodynamically stable, non-bleeding critically ill patients with Hgb ≥ 7 mg/dL
- let older adults lie in bed or only get up into a chair during their hospital stay
- deeply sedate mechanically ventilated patients without a specific indication and daily attempts to lighten sedation
- continue life support for patients at high risk for death or severely impaired functional recovery without offering patients and their families the alternative of care focused entirely on comfort

Ingredients for Improving Quality of Health Care
- Leadership prioritizes quality and safety in a meaningful way
- Measure WHAT you are doing as well as outcomes
- Know what works CLINICALLY and ensure you are doing it (EBP)
- Analyze organization of care delivery at a micro (person, unit) and macro (team, system, service) for process change opportunities

Innovations In Patient Safety
- Technology Advances; EBP translation
- Continuous Quality/Process Improvement
- High Reliability Organization Principles


What is a High Reliability Organization
- A high reliability organization is a social system that has developed a culture sensitive to safety that makes it possible for employees to cope with uncertain and time-dependent threats. (Roberts et al. 2004)
- HROs embrace two competing approaches to maintain a culture of safety: prevention and resilience

EBP and HRO compliment

- EBP
- Patient
- HRO
- Culture
What is a High Reliability Organization?

At the core of high reliability organizations (HROs), are five key concepts, which we believe are essential for any improvement initiative to succeed:

- **Sensitivity to operations.** Preserving constant awareness by leaders and staff of the state of the systems and processes that affect patient care. This awareness is key to noting risks and preventing them.
- **Resilience to simplify.** Simple processes are good, but simplistic explanations for why things work or fail are risky. Avoiding overly simple explanations of failure (unqualified staff, inadequate training, communication failure, etc.) is essential in order to understand the true reasons patients are placed at risk.
- **Preoccupation with failure.** When near-misses occur, these are viewed as evidence of systems that should be improved to reduce potential harm to patients. Rather than viewing near-misses as proof that the system has effective safeguards, they are viewed as symptomatic of areas in need of more attention.
- **Defensive to expertise.** If leaders and supervisors are not willing to listen and respond to the insights of staff who know how processes really work and how it affects patients really face, you will not have a culture in which high reliability is possible.
- **Resilience.** Leaders and staff need to be trained and prepared to know how to respond when system failures do occur.

Highly Reliable Organizations

- Provide care that minimizes errors
- **Care processes are consistent and predictable**
- System can quickly adapt to system failures to prevent harm
- Care processes are efficient
- Care outcomes are measurable

Highly Reliable Organization Culture of Safety

- **Goals are patient centered**
- Practice is informed by current best evidence
- Leadership and staff believe in the evidence
- Teamwork and collaborative practice is a norm
- Asking questions is encouraged
  (communication effectiveness; culture of inquiry)
- Learning is never ending

Sammer et al, 2010; Melnyk 2012; Sutcliffe et al. 2011
- Individualized care based on patient needs
- Application of best evidence
- Consistency in protocol adherence
- Predictability in care
- Resiliency to adapt care interventions based on patient needs/assessment
- Excellence in outcomes
- Safe and effective care

**EBP Implementation AND High Reliability Organizations**

The 5 A’s Model of Evidence Based Practice (Richardson, 2005)

**EBP and HRO and HAC reduction**
1st, evaluate your practice and “routines” in practice

Summary Sacred Cows: Decade Long Journey

Makic & Rauen. CCN 2016, 36(2): 1-6

Question Process
Strategies to Reduce HACs

› Label the clinical outcome/goal
› Audits: Data
› Bedside observations: Validate Data
› ENGAGE the team
› Listen to the teams “voice”
› Significant Events: Root Cause Analysis to LEARN
› Team Communication
› Patient/Family Members Engagement and Feedback

Know Your Unit’s Outcomes

› Outcomes should be readily available to help identify where targeted interventions are needed
› Nurses should be knowledgeable about the measurement, the improvement, benchmarking, clinical costs (Gallagher)
› Focus on structure and process of outcomes
› Keep the patient at the center of focus

“...change occurs when those who are providing the care are included in the exploratory and improvement process.” (Gallagher)
Know Other Unit’s Outcomes

- Connect with a unit who is exceeding benchmarks where you are struggling
- Ask to learn from their success
- Replicate learning gained
- Can be more formal through Nursing Grand Rounds, seminars or formal mentoring

Frontline Staff Have the Best “Feel”

- “Listen” when staff say “xyz isn’t working”
- Ask: “Why”
- Ask: “Suggestions for best practice change”
- Brainstorm: “Changes to process for success”

Identifying Barriers

- Listen to the chatter
**Motivators**

- **Carrot**
- **Stick**

**Avoid Over Simplifying**

- Patients are complex
- HC systems can be more complex
- When identifying practice opportunities:
  - Variance from standard expectations?
  - Why?
  - How could the process change to avoid patient harm?
  - Team approach

**The answer cannot always be to ask for more resources – think about it another way...**

- Transportation
- Intellect
- Inventory
- Processing

- Waiting
- Overproduction
- Rework
- Motion
Know Where You’re Going

- Processes impact on outcomes
  - Proactive vs Reactive
- Explore and operationalize data in a meaningful way
- Communicate the importance of the practice outcome: preventable harm

Healthy Work Environment

Optimal Patient Outcomes

Clinical Excellence

Healthy Work Environment

So what if we changed our focus from Never Events to Always Events?

Work Smarter – Not Harder

No thanks!

We are too busy

Where do you need help?

<table>
<thead>
<tr>
<th>ABCDE Bundle</th>
<th>AACN – Implementing the ABCDE Bundle at the Bedside</th>
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<tbody>
<tr>
<td>Alarm Fatigue</td>
<td>AACN – Strategies for Managing Alarm Fatigue</td>
</tr>
<tr>
<td>CAUTI</td>
<td>AHRQ – Toolkit for Reducing CAUTI in Hospitals</td>
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<tr>
<td>CLABSI</td>
<td>AHRQ – CLABSI tools</td>
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<tr>
<td>Sepsis</td>
<td>CDC – CLABSI Prevention</td>
</tr>
<tr>
<td>Ventilated Patients</td>
<td>AHRQ – Safety Program for Mechanically Ventilated Patients (In progress)</td>
</tr>
</tbody>
</table>

- Patient Focused
- Empower Staff
- Effectively Translate EBP into Practice
- Embrace technology
- Systematically Measure Outcomes
- “Nimble”
Fostering Transparency in Outcomes, Quality, Safety, and Costs
A Vital Direction for Health and Health Care

Peter J. Pronovost, Johns Hopkins Medicine; J. Matthew Austin, Johns Hopkins Medicine; Christine B. Cassel, Kaiser Permanente School of Medicine; Suzanne F. Delbanco, Catalyst for Payment Reform; Ashish K. Jha, Harvard T.H. Chan School of Public Health; Bob Kocher, Merrill; Elizabeth A. McClynn, Kaiser Permanente; Louis G. Sandy, UnitedHealth Group; John Santa, formerly of Consumer Reports

September 19, 2015

Healthcare Value

\[ V = \frac{Q + S}{S} \]

VALUE

QUALITY

SERVICE

COST

https://www.google.com/search?site=&tbm=isch&source=hp&biw=1280&bih=899&q=head+in+sand+picture
Patients!

Always Event: Preventable Harm

You can make a difference

Thank you~
Selected References