4-21-2023

A HAPI Reduction QI Project: Don't Leave Your Patient in S.H.A.M.B.L.E.S

Anissa Guzman
Providence WA/MT

Ashlee Garcia

Valerie Lindsay

A HAPI Reduction QI Project:
Don't Leave Your Patient in S.H.A.M.B.L.E.S

Anissa Guzman, MBA, PhD, RN, NEA-BC, NPD-BC, CNE (Providence-Central Division; Ashlee Garcia, *MSN, APRN, AGACNP-BC, CWOCN CFCN (TMC Health); Valerie Lindsay, RN, MSN-Ed, CV-BC (TMC Health)*

Background

Hospital-acquired conditions are challenging, complicated issues and they carry a high price for patients and healthcare organizations.

- HAPIs affect approximately 2.5 million people annually in the U.S. with associated loss of revenue.
- The estimated financial repercussions of Hospital-acquired Pressure Injuries (HAPIs) range from $14,000 to $70,000 per event and can result in revenue loses in the millions of dollars.
- Many payers do not cover the costs if incurred as the result of hospitalization.
- The cost to healthcare, but most importantly, the cost to patients through the effect on mortality and quality of life make prevention of HAPIs imperative (Vitale & Dzioba, 2021).

Purpose

- Use QI methodology, PDSA, and quality metrics data to create interactive education content, specifically for HAPI prevention, to be used in real-time rounding on patient care units to decrease the incidence of HAPI for inpatients
- Implement similar process for other hospital-acquired conditions (HACs) to positively influence decreased incidence

Methods

A collaborative effort between NPDs and WOC nurses ed to the development of the 'SHAMBLES' education program to decrease HAPIs.in Feb 2022

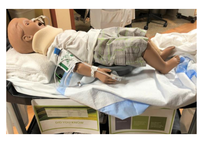
- WOC nurses and NPDs brainstormed about what influences HAPI occurrence and prevention
- Team identified an acronym to use for the project-S.H.A.M.B.L.E.S.
- The catch phrase of 'Don't leave your patients in S.H.A.M.B.L.E.S' became the centerpiece of the collaborative effort.

NPDs and WOC nurses completed online and in-person QI education

- 'Intro to Quality Improvement' and 'How to do a QI Project '

NPDs and WOC nurses worked together to develop the education rounding content and plan for delivery

- Quality data used to create the plan and target problem areas, such as device use and repositioning – PDSA cycles were used
- Mobile' teaching units with interactive teaching strategies - standard patient approach, simulation with a mannequin , and gaming
- Daily rounding with content changes every 2 weeks targeting different interventions
- 'Badge Buddies' and stickers were created and distributed to nurses, CNAs, and patientcare technicians.

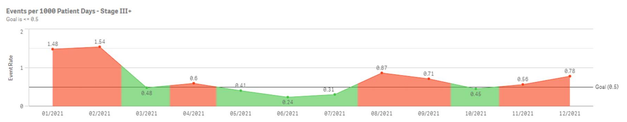


Results

HAPI prevention improved on several units

- HAPI incidence decreased during the period of rounding
- HAPI incidence stayed below the 'target' even during recurrent COVID surges

2021 HAPI Data by Month



2022 HAPI Data by Month

Discussion

A QI Project at a 596-bed community hospital led to a decrease in HAPI events across inpatient setting

- Interdisciplinary collaboration with key stakeholders and ***recurrent training sessions to keep 'SHAMBLES 'on the forefront of the staff's mind***
- ***Modifying education content every 2 weeks*** to ***address real-time practice gaps kept learners engaged***
- Partnership with three departments ***enhanced teamwork and built trust and rapport***
- The collaborative QI project ***used best practice education strategies***
- Consider ***implementing the same principles to target decreasing other HACs***

Implications for Practice

- This collaborative approach for a QI project can be replicated in other organizations to achieve the same or possibly better outcomes for HAPIs and other hospital acquired conditions (HACs)
- Use of quality metrics data can be leveraged to create education and training plans to improve HACs
- Collaboration across specialties can be successful in decreasing HAPIs, and other HACs in the future

References

Vitale, N.A. & Dzioba, D.A. (2021). Why investing in hospital-acquired pressure injury prevention technology makes financial sense. https://www.hfma.org/topics/hfm/2021/february/why-investing-in-hospital-acquired-pressure-injury-prevention-te.html

Rondinelli, J. Zuniga, S., Kipnis, P. Najib Kawar, L. Liu, V. & Escobar, G.J. (2018). Hospital-acquired pressure injury: Risk-adjusted comparisons in an integrated healthcare delivery system. Nursing Research, 67(1), 16-25.

Gupta, P., Shiju, S., Chacko, G., Thomas, M., Abas, A., Savarimuthu, I., Omari, E., Al-Balushi, S., Jessymol, P., Mathew, S., Quinto, M., McDonald, I., & Andrews, W. (2020). A quality improvement programme to reduce hospital-acquired pressure injuries. BMJ Open Quality, 9(3) doi: 10.1136/bmjoq-2019-000905

Acknowledgments

Special thanks to the NPDs, WOC nurses, Cam Dyman, Clinical Informatics Applications Training Manager, Diandra Andrews, Director Quality & Accreditation, and Joy Upshaw, CNO at Tucson Medical Center for continuing to strive for clinical excellence and improving quality patient care using QI methodologies.

Please use the QR code above to view the electronic poster online.