EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

EQIC HOSPITAL SUCCESS STORIES

SEPTEMBER 2024

Introduction

Over the course of the Eastern US Quality Improvement Collaborative's contract, participating hospitals achieved many quality improvement successes that were shared in affinity workgroup presentations and with CMS. To celebrate those achievements, teams submitted stories of QI, patient safety and care transition initiatives with measurable success. EQIC published the submissions from these hospitals in the areas of falls, health equity, infections, opioids, patient and family engagement, pressure injuries, readmissions and sepsis via *EQIC News*. We are proud to share these successes here with you.

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Falls

FALL PREVENTION AND REDUCTION

Bertrand Chaffee Hospital

Submitted by Lexi Wilson, BSN, RN, Nurse Manager, Med-Surg

Background

In late 2022, the nurse manager, administration and staff at Bertrand Chaffee Hospital were determined to find a way to decrease the number of falls on the medical-surgical floor. The team found the 25 falls in 2022 unacceptable and decided to work together to prevent patient harm.

Approach and collaboration

The team realized they needed to identify the cause of most patient falls and make necessary changes to help prevent them. Intervention planning took place from September to December 2022.

The first priority was to interview the staff. Nurses and nursing assistants were interviewed individually since they are a direct line to the patients. Knowing and understanding what they see daily is important for recognizing trends and issues in current processes. Through this work, the team was able to determine the common causes of patient falls and how to help staff better recognize patients at high risk for falls.

Interventions included:

- updates to current policies;
- bimonthly staff education;
- updating signage, including new visual cues attached to the improved “fall leaves” visual fall-risk tool for staff recognition prior to entering the patient’s room (such as why the patient might fall, e.g., confusion);
- implementing a fall-risk assessment for each patient; and
- circulating screen savers on monitors to remind staff of patient fall interventions.

The team launched the new initiatives in January 2023 and provided regular data updates to staff so they could see how their efforts were helping. The team also provided a final update at year-end to show how staff efforts, knowledge and care reduced patient falls.

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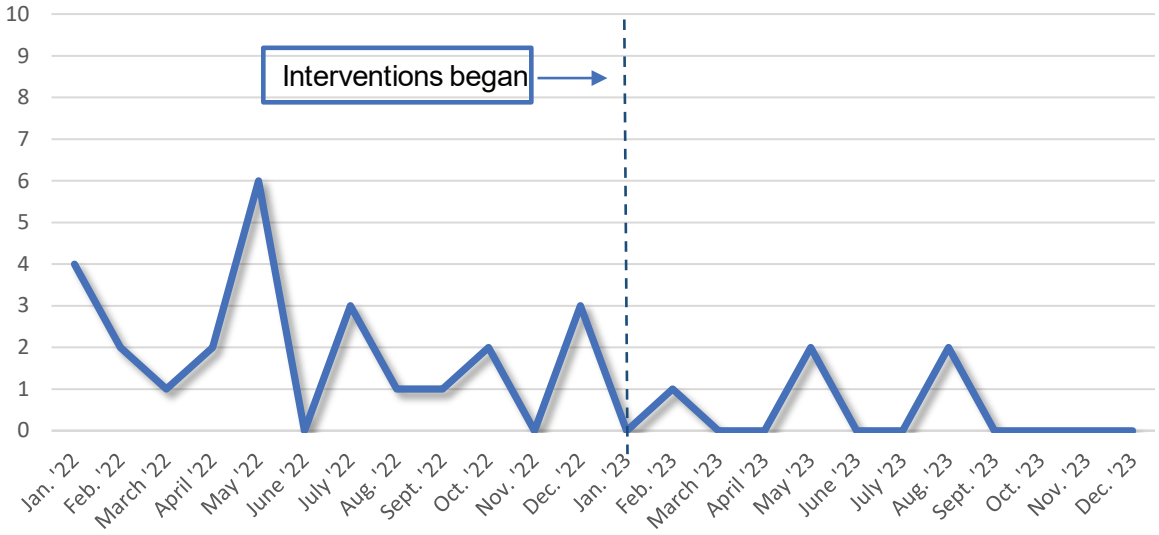
Results and impact

Falls were reduced from 25 in 2022 to five in 2023; a 77% reduction. The hospital also went four consecutive months without any falls.

Staff expanded their knowledge regarding the reasons patients fall and their morale improved as they continued to see their work pay off and falls reduced.

The next steps are to recognize if any of the falls in 2023 were caused by issues not previously identified when the improvement process began. Education will also continue to be updated and reinforced. Each month, fall numbers will be shared so that the team can identify what caused the fall and adjust workflows, as needed. The team will continue to give praise and credit where it is due.

Bertand Chaffee Hospital Falls Reduction Project Data



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Falls

FALL PREVENTION PROGRAM

Carthage Area Hospital

Submitted by Emmylu Stevens, Director, Quality

Background

In 2020, Carthage Area Hospital identified fall reduction as an organizational priority and developed a robust fall review committee to create a successful fall reduction program. The committee includes members of the nursing, therapy and quality teams. As the committee chair, Cheryl Tousant, PT, DPT, GCS, championed the project and applied a high-reliability approach to the program. Through her engagement and leadership, the organization developed a focus on zero harm related to patient falls.

Dr. Tousant and the fall review committee immediately identified a need for more meaningful, clear and transparent falls data, and selected the medical-surgical floor as a primary focus area.

Approach and collaboration

After establishing benchmarks and goals, the team engaged with frontline staff to collaboratively identify areas contributing to patient falls. Through focus group meetings, they identified potential influencing factors, including a large swing-bed population and care trends occurring during night shifts, at shift changes and those resulting from a full census.

The team developed a post-fall audit tool, and by 2021, every fall was immediately evaluated using the PFAT. This approach enabled the team to make real-time, immediate interventions while providing the quantifiable data needed to identify more impactful, thoroughly planned interventions, including:

- posting color-coded signs outside each patient room indicating the Morse fall risk level and recommended level of assistance for each patient;
- displaying a “fall board” in the nurses’ station, which transparently shared past fall trends to frontline clinical staff; and
- upgrading the chair alarm monitoring system to a wireless device system integrated into the existing nurse call system.

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At the end of 2021, Dr. Tousant and her team conducted a comprehensive review of the data and found they were mostly incorrect about the contributing factors impacting patient falls. The team regrouped and instituted a "please call, don't fall" campaign. In 2022, interventions were implemented around the use of safety companions or "sitters" and the proper use of chair and bed alarms.

In 2023, Carthage formed a subcommittee to focus more strategically on frontline clinician critical thinking and barriers to alarms. The most recent prevention strategies include:

- a med-surg unit shift-change safety huddle;
- a standardized nurse-to-nurse reporting sheet that includes bed and chair alarms;
- bed and chair alarm signage outside of each patient room;
- nurse leader census rounding;
- quality census rounding; and
- a standardized charge nurse checklist.

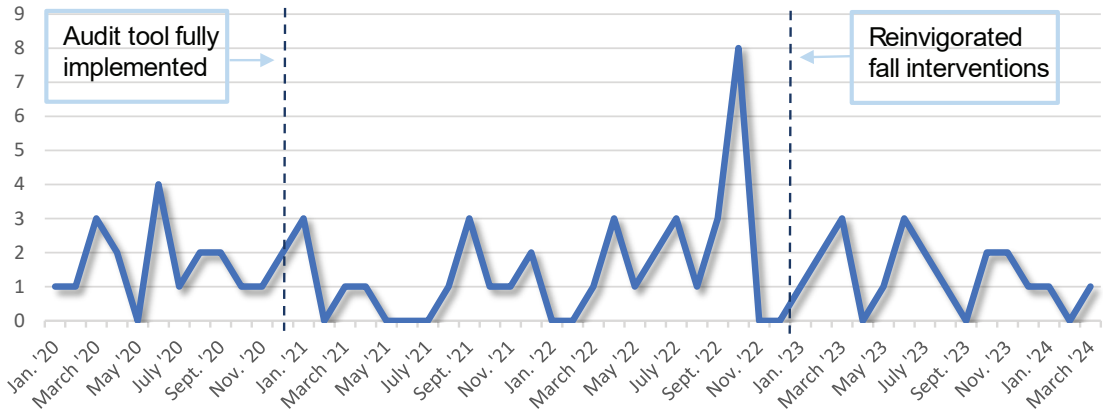
Since implementing these interventions, the med-surg floor has gone 87 days without a fall!

Results and impact

The fall prevention journey at Carthage improved the staff's understanding of fall influences, specifically in the med-surg unit. Given the program's success, the organization now uses the PFAT for parking lot and sidewalk falls and anticipates similar success. Additionally, the fall review committee has expanded to include a safe patient handling and mobility program.

The fall prevention program developed and maintained by Dr. Tousant and her team is a true value to patients at Carthage. Without a process improvement champion with the dedication and leadership to remain engaged, the same success would not have been achieved.

Carthage Area Hospital Falls Data



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Health Equity

ADDRESSING HEALTH EQUITY THROUGH HEALTHY FOOD EDUCATION IN THE SBH BRONX SCHOOL COMMUNITY

SBH Health System

Submitted by Alvin Lin, Vice President, Ambulatory Care Transformation and Innovation

Background

The Bronx has one of the highest rates of food insecurity in the country, affecting more than 35% of local children. Limited access to nutritious food leads to unhealthy diets and contributes to chronic diseases like diabetes. Even when food intake is not reduced, food-insecure households often buy cheaper, less nutritious foods due to tight budgets.

Educating the community about the importance of a healthy diet and subsidizing healthy meals can promote sustained healthy choices. SBH Health acknowledged this need among its patient population and pursued a multifaceted approach to educate Bronx youth on nutrition and healthy eating.

Approach and collaboration

In partnership with the New York City Department of Education, the team engaged students in the following activities:

- **Urban rooftop farming:** Students had practical, hands-on experiences that connected them directly with the food production process. They took part in planting, weeding, spacing and harvesting fresh food onsite at the SBH rooftop farm. They saw the direct link between the food they grew and its nutritional benefits, developing a positive attitude toward fresh, healthy foods. Several students posted on their social media accounts about how much fun they had on the rooftop farm.
- **Culinary center and teaching kitchen:** Students were provided with fundamental life skills that empowered them to prepare their own meals. This independence can lead to healthier eating habits because they have greater control over ingredients and cooking methods. Students learned knife skills and kitchen safety and prepared several healthy dishes for a family-style meal in a state-of-the-art commercial kitchen.

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- **Education:** Students learned how to read nutrition labels and make informed decisions about their food choices based on their nutritional needs. They also learned how to identify foods lower in saturated fats, sugars and sodium and higher in beneficial nutrients like fiber and vitamins. Students discussed the importance of understanding serving sizes, sugar content in drinks and the differences in how their bodies digest processed versus whole foods.
- **Meal prep at home:** The program sought to instill lifelong habits of preparing and enjoying healthy meals at home. Students are more likely to continue cooking for themselves and their families as they age, promoting better long-term health outcomes. SBH distributed "STEM" food kits containing healthy meal recipes and a week's supply of fresh, healthy food for students to prepare at home with their families.

Results and impact

The team assessed its three-month program through pre- and post-program surveys and used the Plan-Do-Study-Act methodology.

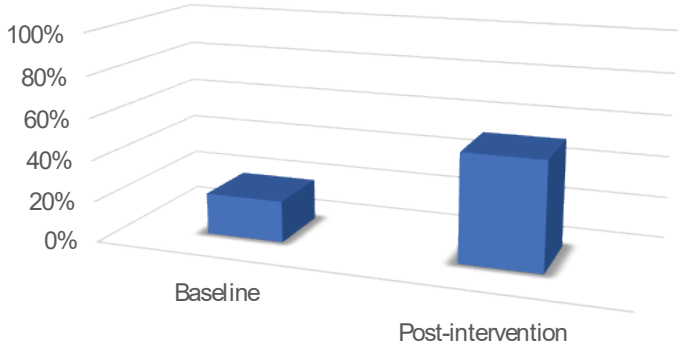
The program was a success, exceeding the goal of a 20% improvement in understanding and choosing healthy foods and how to read nutrition labels. Quiz scores increased post-intervention.

Students reported significant behavioral changes:

- 52% now often choose healthy supermarket ingredients (160% increase);
- 60% frequently prepare meals with vegetables (275% increase); and
- 48% regularly consume prepared fruits or vegetables (500% increase).

This program effectively enhanced nutritional knowledge and promoted healthier eating habits among Bronx youth, addressing critical community health challenges.

How often would you select healthy ingredients at the supermarket (2 or more times per week)?



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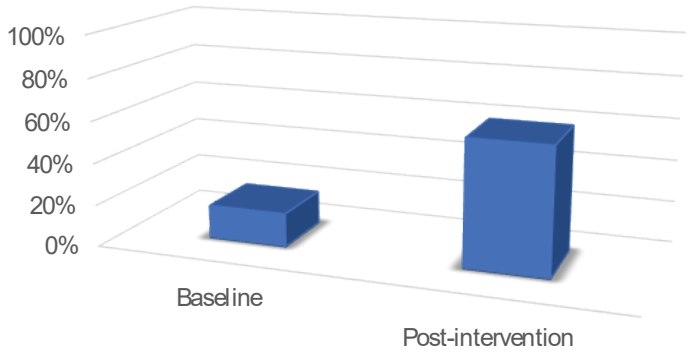
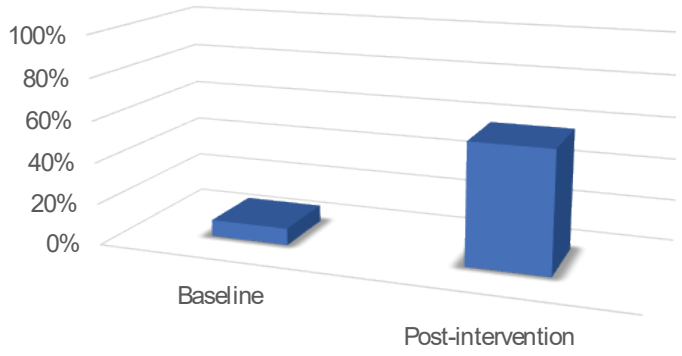
How often would you make a meal with vegetables (2 or more times per week)?



How often would you prepare fruits and vegetables to eat (2 or more times per week)?



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Infections

REDUCING CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

Bassett Medical Center

Submitted by Laura Palada, RN, BSN, MSMHA, Director, Quality

Background

At Bassett Medical Center, the number of catheter-associated urinary tract infections, the CAUTI rate and the CAUTI standardized infection ratio were increasing and above national benchmarks. In 2019, 2020 and 2021, there were 25, 22 and 27 CAUTI events, respectively. Bassett prioritized bringing the CAUTI rate down.

Goals

1. Improve the hospital CAUTI rate (CAUTIs per 1,000 patient days) year over year:
    a. 2021 baseline of 2.35 to 1.5 by December 2021
    b. 2022 baseline of 1.5 to 1.0 by December 2022
    c. 2023 baseline of 1.0 to 0.79 by December 2023
2. Eliminate all process failures that cause CAUTIs.
3. Decrease indwelling urinary catheter days by 10% within two years.

Assessment process

In early 2021, the team performed a CDC CAUTI Targeted Assessment for Prevention, which identified gaps and potential opportunities, including:

- poor compliance with documenting and applying medical necessity requirements and indications for use, including using bladder scanners for assessment;
- poor compliance with daily indwelling urinary catheter care bundle completion;
- inconsistent use of evidence-based practices for management of chronic indwelling urinary catheter use and indications/process for obtaining urine cultures (infection vs. colonization); and
- inconsistent CAUTI bundle compliance.

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Approach and collaboration

In 2021, the team developed a strategic A3 Plan-Do-Study-Act cycle to guide the work. The project was considered a high priority, with active involvement and support from organizational leadership. A CAUTI workgroup was created with representatives from nursing, nursing leadership, infection control and prevention, medical staff, administration, residents, quality, education, clinical information technology and urology.

The CAUTI workgroup, led by the infection control practitioner and the vice president of medical affairs, met every two weeks beginning in February 2021. The workgroup took a multifaceted approach and applied the following interventions:

- used a standardized review process (hot wash) for all CAUTI events and near-miss events;
- identified a physician champion to assist with clinical reviews, CAUTI analysis and engaging medical staff;
- identified nurse champions who engaged in each nursing unit to systematically observe bundle compliance, coach newly hired nurses and educate RN staff about the nurse-driven protocol;
- established a nurse-driven protocol for performing a daily necessity determination on all patients with indwelling catheters (supported by infection prevention staff);
- developed a partnership with the medical supply vendor to review current supplies and provide education on how to use the silver-coated indwelling urinary catheters and external catheters the team chose;
- a multidisciplinary team educated the medical staff, medical and surgical residents, and nurses via grand rounds;
- infection control staff conducted daily checks for necessity documentation and sent TigerText communications (a collaboration platform) to clinical staff for follow-up and removal;
- developed a non-closed systems catheter cart with urology and emergency department staff to standardize the processes across the hospital. A non-closed catheter has breaks in the tubing with various ports and valves. This can be a preferred catheter for specific, complicated patients. The non-closed systems cart has everything the team might need readily available for insertion and maintenance. This approach allows for standardization, sterility and efficiency;
- leveraged the EPIC electronic record for optimization:
  - best practice alerts prompt nurses to change indwelling urinary catheters if more than four days prior to urine collection;
  - best practice advisories built into the EPIC system are set up for all inpatients with indwelling urinary catheters each time a urinalysis with reflex is ordered; the alerts pop up and must be acknowledged before one can go forward;

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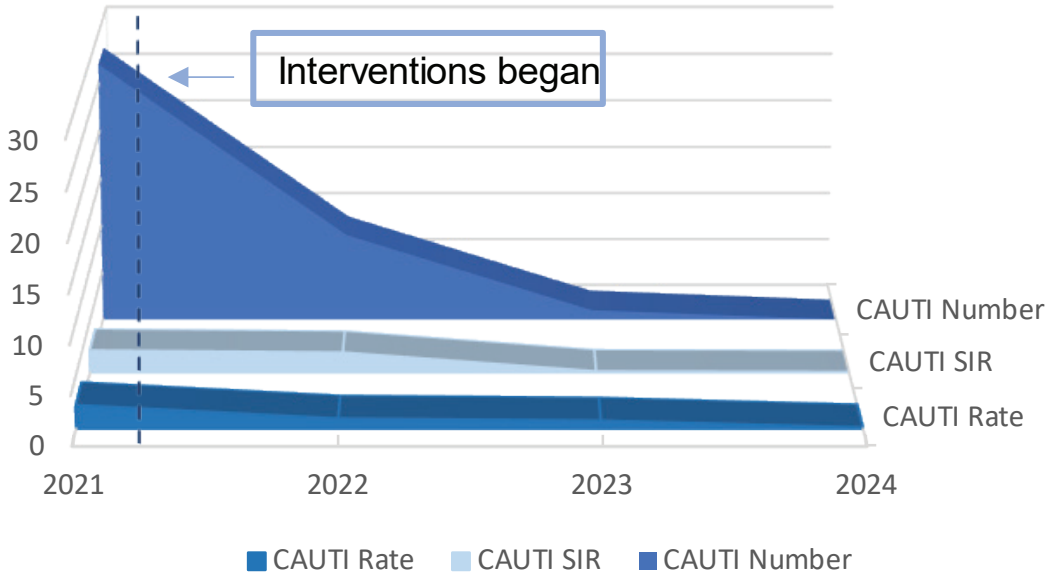
- modified the system to require a documented reason when a urine culture is ordered;
- introduced new peri-care wipes and a standardized approach to peri-care based on CDC guidelines;
- implemented new nurse-driven protocols that were provided as part of the medical and nursing staff education and are updated as necessary:
  - nursing bladder management guides the administration and identification of residual urine and assesses the necessity of a urinary catheter; and
  - nurse-driven urinary catheter removal protocol for discontinuation.

Results and impact

- The number of CAUTIs decreased from 27 in 2021 to nine in 2022 and to one in the first quarter of 2023. There have been zero CAUTIs for 14 months.
- Rates decreased from 2.35 in 2021, to 1.0 in 2022, to 0.79 in 2023 and to 0.1 in 2024.
- The standard infection ratio decreased from 2.234 (baseline) to 2.024 for 2021, to 0.0682 for 2022 and to 0.00 for 2023.
- Foley catheter days decreased by 20.7% by the end of 2023 (6,294 days to 4,987 days).
- CAUTI bundle compliance has been hardwired and sustained.

This project resulted in significant ownership of and engagement with both the medical and nursing staff. The next steps include maintaining processes by conducting periodic audits to ensure continued compliance.

Bassett Medical Center CAUTI Data



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Infections

A HUDDLE A DAY KEEPS THE MICROBES AWAY

Guthrie Corning Hospital

Submitted by Cynthia Whitaker, Vice President, Operations and Chief Nursing Officer

Background

Corning Hospital experienced a marked increase in catheter-associated urinary tract, central line-associated bloodstream and *Clostridioides difficile* infections in fiscal year 2022. The hospital was not meeting the benchmark CAUTI rate of less than one, CLABSI rate of zero or CDI rate of less than three.

In February 2022, the chief nursing officer examined the current hospital-acquired infection management structure and collaborated with the infection preventionist and quality improvement specialist to make necessary changes for improvement. The CNO hypothesized that implementing a more purposeful team huddle with a whole hospital team approach focused on communication and increased awareness would reduce HAIs.

Approach and collaboration

In March 2022, the CNO collaborated with the quality team to implement a daily device huddle, a best practice to review indwelling catheters, central venous catheters and uncollected CDI orders. The huddle enabled staff to assess indications for the device/order, review appropriate care, discuss plans for alternative devices and review the CDI algorithm.

Nurse managers come to the huddle prepared to discuss patients with devices/open orders and report any barriers to device removal and order cancellation. The hospital president, chief medical officer and CNO support the team to mitigate these barriers.

Results and impact

Daily device huddles have reduced CAUTI and CDI rates to less than one and maintained a CLABSI rate of zero. This success has been sustained for FYs 2023 and 2024 to date. The team approach to HAI reduction has increased engagement and positively impacted the culture of safety. The project outcomes reduce harm and keep patients safe.

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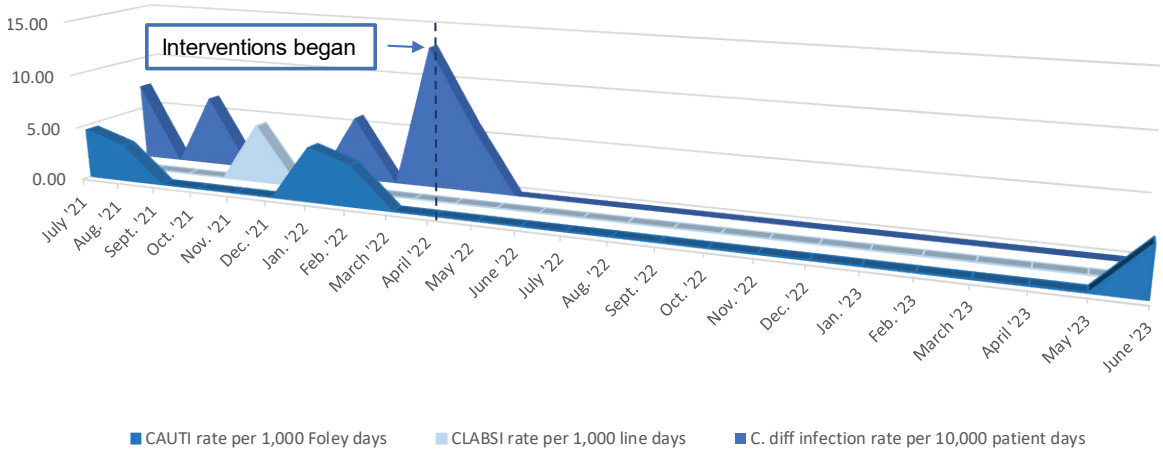
Executive leader involvement has been effective and necessary to improve the culture of safety within the organization, and Guthrie Corning Hospital continues to use a collaborative team approach to sustain HAI reduction.

Guthrie Corning Infection Data



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Infections

IV THERAPY INFECTION REDUCTION PROJECT

UVM Health Network CVPH Medical Center

Submitted by Jonathan J. Verseput, RN, IV Therapist

Background

In 2022, Champlain Valley Physicians Hospital had seven central line-associated bloodstream infections and identified the need to eliminate or dramatically reduce CLABSIs for patient safety. CVPH's team began meeting in September 2022 to develop a quality improvement plan for reducing CLABSIs.

The team pursued the initiative in conjunction with the IV therapy department and included several improvement strategies across different hospital units. The timeline for research, implementation and change was calendar year 2023 with a goal of zero CLABSIs.

Approach and collaboration

CVPH developed a plan in January 2023 and implemented strategies in March 2023. Working with EQIC and the CDC, the team began gathering information. A gap analysis determined the need to build leadership support, compliance audits, policies and procedures, and staff knowledge/education.

Leadership support: With leadership support, the hospital invested in staffing for IV therapy. Having a fully staffed IV therapy department is critical to patient care.

Compliance audits: Best practice initiatives instituted by the team included:

- daily central line monitoring, dressing monitoring and IV tubing system monitoring, with a goal of 100% compliance;
- instead of adding any reinforcement to the existing dressings, sterile dressing changes were completed to ensure adhesion; and
- during daily IV therapy rounds, the IV tubing system was examined. This included any IV tubing lines and ports attached or present in patient rooms. Any open-ended IV line or line with no sterile needleless connector was discarded. Any IV tubing "looped back" to the first port was discarded.

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Policies and procedures: CVPH updated its CLABSI prevention policies and procedures to comply with those of the Infusion Nurses Society and Association for Vascular Access, two highly respected authoritative bodies.

Staff knowledge/education: CVPH held monthly CLABSI meetings, in which the team:

- reviewed best practices;
- audited findings; and
- consistently re-evaluated training needs and education gaps.

Through these discussions, the team also discovered a need to include more nursing unit members in the CLABSI prevention compliance meetings.

The IV therapy unit rolled out staff education in March 2023 via an IV therapy newsletter, email and shoulder-to-shoulder training at the bedside with floor staff nurses and clinical assistants. Education focused on best practices found in the Infusion Nurses Society guidelines. Staff discarded more than 50 IV tubing sets within the first three weeks due to non-compliance with best practices. Within a few months, the amount of improper IV tubing care dropped to only a handful a month.

In April 2023, the IV therapy staff provided day-long grand rounds education to all staff and shared actual CVPH patient case study data.

The team sent monthly IV therapy newsletters to all clinical units and staff throughout 2023 to reinforce best practices, highlight bad practices and show current successes. Unit champions for IV therapy helped guide daily practice in the respective units. Previously, only one staff IV therapist provided all education. Now, the entire IV team has the authority to educate staff, broadening access to clinical staff.

Results and impact

- CLABSI incidents dropped from seven in 2022 to one in 2023. The team maintains tight standards, including education updates and tracking bloodstream infection rates hospital-wide.
- Staff education continues beyond the initial rollout with the monthly newsletter and face-to-face training on evidence-based practices. By including the operating room clinical staff, the IV team and infection control in the meetings, a better working relationship and engagement were established.
- Unit leaders now provide training on the updated policies and procedures.

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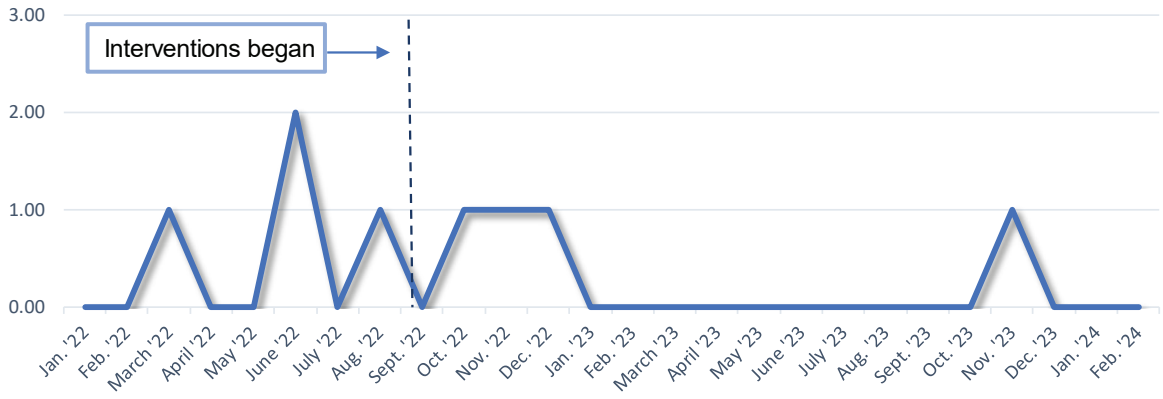
Champlain Valley Physicians Hospital CLABSI



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Opioids

IMPROVING OPIOID SAFETY WITH NARCAN PRESCRIPTIONS AND EDUCATION

WVU Medicine Summersville Regional Medical Center

Submitted by Jerri Kirkland, Director, Quality Risk and Compliance

Background

The CDC determined that fatal overdoses in West Virginia claimed more than 1,400 lives in 2021, with more than 1,200 attributed to opioids. Because these deaths can trend much higher in rural communities, WVU Medicine Summersville Regional Medical Center identified the need for education and prevention within its patient population. In January 2023, Summersville partnered with the emergency department and the inpatient Critical Access Hospital to initiate a performance improvement project in the rural health clinic.

The goal was to ensure that all patients with a daily morphine dose greater than 50 morphine milligram equivalents have a Narcan prescription added to their medication regimen (order). This initiative targeted patients who were either recently discharged from the inpatient setting and prescribed opioids or were seen in the ED on opioids and then followed up at the medical center's rural health clinic.

Approach and collaboration

The team conducted a Plan-Do-Study-Act cycle:

- **Plan:** The team reviewed opioid prescription data for patients with an MME >50 without a Narcan prescription to determine the baseline. Then, the team developed a plan for provider and patient education to ensure all patients who met that threshold received a Narcan prescription.
- **Do:** The team met with clinic managers, ED staff and hospitalist providers to set parameters and discuss adding Narcan prescriptions to the medication regimens of eligible patients.
- **Study:** Patients with MME >50 were audited monthly and the team focused on ensuring patients had a coinciding Narcan prescription on their next clinic visit and providing education at the time the Narcan prescription was written. Audit results were shared with the clinic.

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- **Act:** Patient and provider education relating to safe medication practices and medication adherence was provided as part of the clinic's performance improvement project for 2024. The clinic has adopted a plan to monitor Narcan prescription data monthly to ensure eligible patients receive prescriptions. The electronic medical record allows the staff to see what prescriptions are filled to monitor for continuous improvement.

Results and impact

1. Compliance with Narcan prescriptions provided for patients with an MME >50 increased from a baseline of 72% to 94% within a one-year period, from the first to the fourth quarter of 2023.
2. Conversations about Narcan were sensitive due to the stigma associated with opioids. During this initiative, physicians and staff became more comfortable having difficult conversations with patients, and patients became more comfortable filling prescriptions after receiving education on high-dose opioid risk.
3. Summersville continues to monitor the number of Narcan prescriptions in the rural health clinic quarterly and has expanded this project to all primary care clinics in 2024.

Summersville Narcan Prescription with an Opioid Compliance 2023

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Patient and family engagement

ADDRESSING THE HUMAN EXPERIENCE IN HEALTHCARE

SBH Health System

Submitted by Joan Dauhajre, LCSW, MS, Assistant Vice President and Chief Experience Officer

Background

SBH Health System has implemented numerous patient experience initiatives to enhance quality and patient satisfaction. As a Planetree-designated facility, SBH emphasizes person-centered care, focusing on empathy, patient engagement and a healing environment.

Approach and collaboration

In recent years, SBH implemented various programs to directly improve patient outcomes, such as patient satisfaction, as measured by Hospital Consumer Assessment of Healthcare Providers and Systems scores.

Key initiatives include:

- **National Research Corporation experience platform:** 100% of patients receive discharge phone calls to address real-time concerns and staff perform service recovery for outstanding concerns and issues.
- **Adopt-a-unit:** Weekly leadership rounds to monitor performance and address patient concerns on specific units.
- **Patient experience physician liaison:** This new role educates clinical staff on patient engagement skills, participates in family meetings and focuses on clinical HCAHPS domains.
- **Emergency department patient representative coverage:** The representative provides proactive rounding and serves as the voice of ED patients.
- **Pre-health student ambulatory care and ED rounding:** Daily student rounding addresses patient concerns and facilitates waiting room communication.
- **Patient television services:** Complimentary TV services provide patients with distraction, socialization and pain management.
- **"GNITE" rounds:** Hospitalist rounds are conducted daily to discuss medications, treatment plans and patient expectations.

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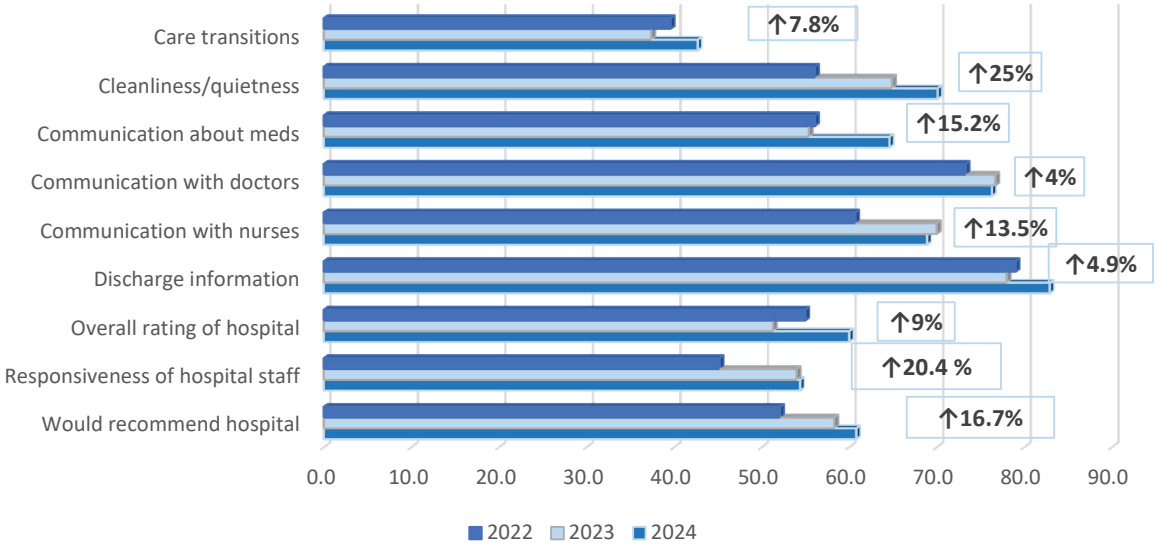
- **Medication management/meds to beds program:** A multidisciplinary approach to patient medication education provided by nursing and pharmacists. Pharmacists dispense medications to patients and review each medication and any potential side effects at discharge.
- **Patient/family advisory council:** Gathers feedback from patients and community constituents on existing and newly proposed initiatives.

Results and impact

The impacts of the patient experience and patient satisfaction initiatives are reflected in SBH's HCAHPS survey results, which have progressively improved in all areas over the last several years.

SBH Improvement Outcomes | HCAHPS Comparison Q1 2022, 2023 and 2024



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Pressure injuries

REDUCING HOSPITAL-ACQUIRED PRESSURE INJURIES WITH A UNIT-BASED TEAM APPROACH

BronxCare Health System

Submitted by Darcy Reefer, Director, Nursing Performance Improvement

Background

BronxCare identified the need to reduce hospital-acquired pressure injury rates and promote safe, quality care. Although the organization used multiple evidence-based HAPI prevention nursing interventions, compliance with these measures was not closely monitored or quantified.

The organization implemented a quality improvement project to decrease the overall HAPI rate by 20% over three months. The project was implemented in May 2023 on 10 inpatient units including medical/surgical, step-down and critical care units. Additional medical/surgical units were included in August 2023.

Approach and collaboration

Interventions included implementing unit-based teams comprised of:

- the nurse manager;
- the unit lead physician;
- frontline staff (registered nurses and patient care technicians);
- the wound care ostomy nurse; and
- the PI nursing team.

Unit-based teams were created on each inpatient unit and schedules were established. The UBTs met weekly for focused discussions on HAPI reduction/prevention and to promote interdisciplinary collaboration. This approach heightened awareness of HAPI reduction efforts.

The team developed and implemented care facilitation tools. This involved peer-to-peer monitoring of nursing practices using a tool to measure compliance with evidence-based HAPI prevention measures. Care facilitation allowed for real-time audits, feedback delivery and correction of nursing practice.

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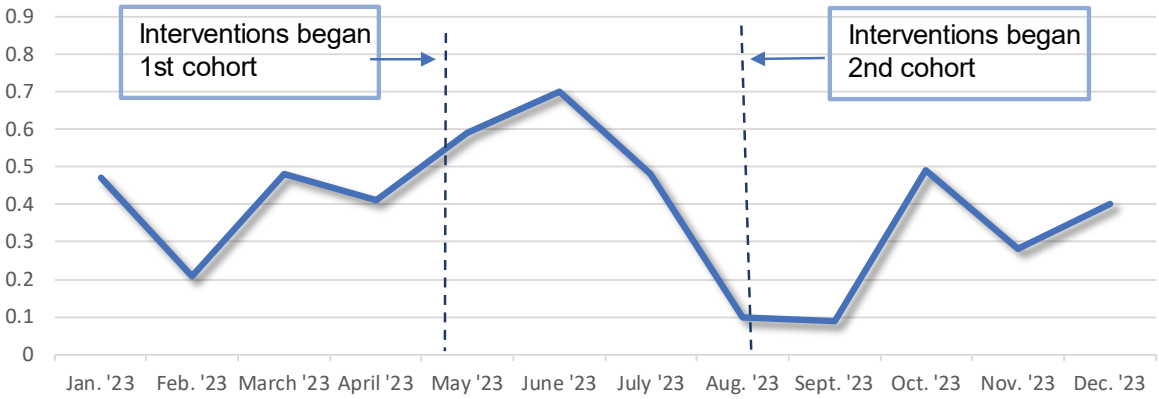
Results and impact

The overall HAPI rate in the second quarter of 2023 was 0.57 per 1,000 patient days and 0.36 per 1,000 patient days in Q3. This was a 37% decrease in the HAPI rate within one quarter. The Q4 rate was 0.29, a 19% decrease.

The UBT meetings and care facilitation effectively decreased HAPIs. Weekly UBT meetings encouraged bidirectional communication of organization priorities, best practices and data dissemination. Care facilitation allowed the UBTs to identify HAPI prevention measures that needed further follow-up, education opportunities and barriers to compliance.

Next steps include continued UBT meetings and care facilitation. The inpatient units continue to conduct weekly UBT meetings and monthly regional meetings where multiple UBTs collaborate to share lessons learned and recommendations. BronxCare continues to monitor HAPI incidence rates and conduct quarterly prevalence studies.

Bronxcare Hospital-acquired Pressure Injuries Rate



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Pressure injuries

REDUCING HOSPITAL-ACQUIRED PRESSURE INJURY RATES

Canton-Potsdam Hospital, St. Lawrence Health

Submitted by Sarah Horan, BSN, RN, Inpatient Wound Care Nurse

Background

Canton-Potsdam Hospital at St. Lawrence Health System identified the opportunity to reduce hospital-acquired pressure injuries. The team partnered with EQIC to better understand the system's specific needs, assess current practices in comparison to best practice standards and develop an approach to address the needs identified. The timeline was set for one year.

Approach and collaboration

In the second quarter of 2023, CPH assembled a multidisciplinary team of representatives from administration, unit leadership, respiratory therapy, environmental services, nursing, nursing professional development and physical therapy.

Through the EQIC rapid-cycle improvement program assessment and in conjunction with a hospital data analysis and policy and procedure review, the team identified three primary improvement areas:

1. The need for further PI prevention education for patients and families. The team planned to develop and disseminate a brochure for patients and families with information on staff PI prevention efforts, how those might look and what the patient can expect during their stay. The brochure also describes strategies to continue PI prevention after discharge. The goal was to have environmental services place the brochure in all newly cleaned patient rooms beginning in Q4 2023.
2. Create a skin care champion pilot program on one of the medical-surgical units. At the end of Q3 2023, a staff nurse volunteered for this role and was provided PI-specific education to act as a clinical resource for staff, supported by the wound care nurses.
3. Hold quarterly PI prevention meetings with nursing leadership, quality and clinical nurses. These meetings enable staff to discuss documentation, address unit-specific trends in PI occurrences and assess current and developing QI needs.

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Results and impact

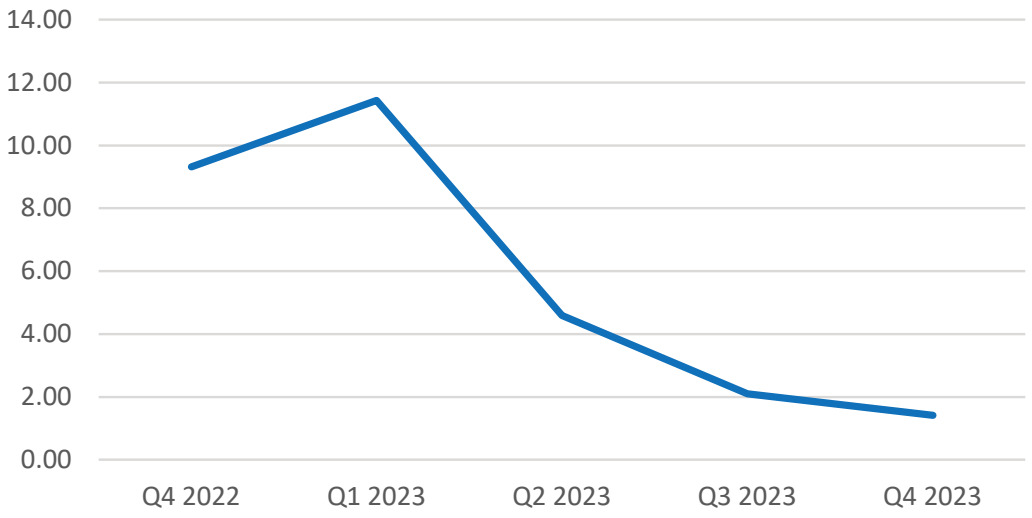
CPH's skin care champion program has resulted in more consistent PI prevention strategies used by nursing and ancillary staff, as evidenced by monthly chart audits and rounding by wound care nurses. More patients consistently have specialty surfaces and off-loading equipment, such as heel off-loading boots and PI prevention pillows for chairs. The goal is to expand this skin care champion program to all units at CPH and all three St. Lawrence Health hospitals by the end of 2024.

The quarterly PI prevention meetings have increased communication with wound care, leadership and quality, allowing the team to quickly identify trends and potential areas for QI and make timely necessary changes to practice and policy. The committee's goal is to continue to grow membership and encourage more direct care nurses to join so that open and effective communication between leadership, direct care nursing and wound care is maintained, and any areas of opportunity are addressed quickly and cooperatively.

The patient and family PI education brochures are not yet in full circulation, but the team expects to see a continued reduction in HAPI rates by educating patients and families on the importance of turning and repositioning patients throughout their stay. The goal is to have every clean patient room contain a PI prevention brochure for each new patient and family by June 2024.

In conjunction with the addition of two full-time wound care nurses at three system hospitals for education and clinical support, these initiatives have reduced HAPIs.

Canton-Potsdam HAPI Prevalence Rate



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Pressure injuries

PRESSURE INJURY REDUCTION INITIATIVE

Catholic Health Good Samaritan University Hospital

Submitted by Lilian Apurillo, Director, Performance Improvement

Background

Pressure injuries can result in extensive harm, including chronic wounds and as many as 60,000 deaths each year in the United States. Care of hospital-acquired pressure injuries places a substantial financial burden on healthcare systems. Previous estimates of the national cost of treating HAPIs ranged from $3.3 billion to $11 billion annually. A single HAPI episode could cost anywhere from $500 to more than $70,000.

In 2022, Good Samaritan University Hospital performed a gap analysis on PI prevention and treatment using the National Pressure Injury Advisory Panel Guidelines for Prevention and Treatment and recognized a need for sweeping change.

In the fourth quarter of 2022, corporate leaders and the new chief nursing officer charged the team to make sustained change. The CNO, vice president of quality management and director of PI nursing met daily to ensure process metrics were improving and leaders were accountable for outcomes. Additionally, any potential cases were reviewed to ensure no new trends or a re-emergence of former trends.

Approach and collaboration

Based on the gap analysis, GSUH implemented:

- an executive skin steering committee with critical care and medical/surgical subgroups;
- a 12-week wound care associate specialized educational program for acute care bedside nurses that focuses on wound assessment, Braden scoring and interpretation, implementation of preventive practices and accurate staging; this program aids in developing a nursing team with clinical expertise to promote a culture of knowledge and awareness of current wound care standards; 52 nurses participated in the program in 2022 and 2023;
- standardized education during orientation, including hands-on application of preventive dressings and appliances;
- ongoing support for all staff, including in-services by vendors on proper use and placement of dressings;

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- nurse-driven prevention bundles/protocols;
- enhanced assessment tool (Braden) to include intensive care unit-specific risks;
- focused emergency department strategy to ensure identification of wounds present on admission and an aggressive approach to prevention;
- increased frequency of scheduled capturing of all wounds in Tissue Analytics to twice a week;
- standardized skin rounds using the Cypher tool by leadership to ensure adoption and adherence to nurse-driven prevention bundles/protocols; and
- promotion of daily review of wound prevention care plans at huddles.

GSUH's wound care team promoted a culture of knowledge, awareness and improved confidence to facilitate the current wound care standards. They empowered nurses to focus on delivering high-quality, holistic and patient-specific care to improve wound-related outcomes for PI patients.

Results and impact

Focusing on preventive strategies has led to improved patient outcomes. GSUH had a 69.5% decrease in wounds based on a comparison of the 2020 to 2023 Nursing Quality Indicators Database facility incidence rate. Prevention remains a priority as education is currently being expanded to focus on prevention in procedural areas including the operating rooms.

Early identification of at-risk patients is a key driver of successful outcomes. In January 2023, 71.6% of Braden scores were documented within 12 hours of admission for all inpatients. Further review of the data showed that only 33.7% of admitted patients who remained in the ED within 12 hours of being admitted had the Braden score documented. By December, documentation improved to 94.5% overall and 89.5% within the ED.

Early identification of wounds present on admission has also improved, and GSUH believes it has contributed to the prevention of wound progression. In January 2023, documentation of a skin assessment by two registered nurses occurred within 12 hours of admission for 43.7% of inpatients. This decreased to 7.7% for admitted patients in the ED. By December 2023, this improved to 77.0% overall and 62.4% for the ED.

GSUH continues to be diligent in promoting prevention and the best outcomes for patients.

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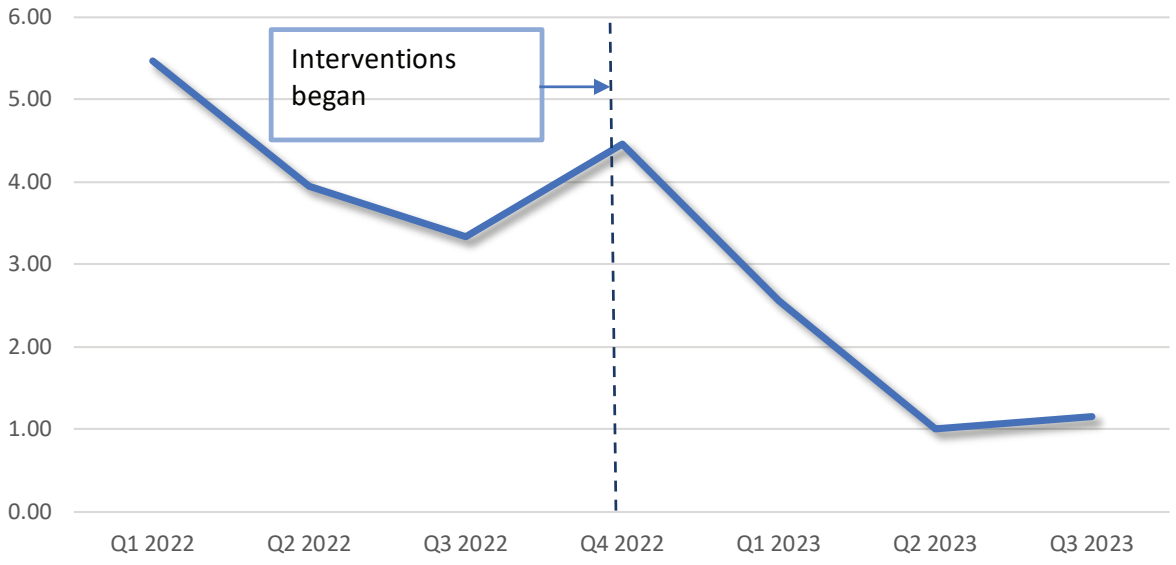
Good Samaritan Pressure Injury Prevalence Rate Stage II or Greater



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Pressure injuries

PRESSURE INJURY PREVENTION: ZERO HARM

Community Memorial Hospital

Submitted by Tamara Young, BSN, RN, CWOCN, WOC, Nurse/Educator

Background

Community Memorial Hospital developed and implemented a pressure injury prevention program based on best-practice research and innovative advances in prevention techniques. The PIP quality improvement program used a multidisciplinary approach including early risk identification and comprehensive data collection methods to guide prevention and treatment decisions.

A gap analysis conducted by the wound ostomy continence nurse (a new position at CMH) in the spring of 2023 identified three main areas where processes or supplies were lacking:

- **People:** No skin and wound care committee, interdisciplinary approach or PIP awareness and education.
- **Products:** No pressure redistribution devices, evidence-based practices or standardized care and formulary.
- **Process:** Outdated PIP policy, need for electronic medical record updates and new data collection methods.

Approach and collaboration

Adding the WOC nurse was the impetus for this change, but it required a culture shift to get everyone on board with the new PIP program. As the project lead, the WOC nurse fostered that culture change by being visible on the unit, providing support to frontline staff, acting as a resource and seeing 100% of patients at risk of or currently having PI.

This approach fostered buy-in from nursing staff and facilitated the program's rollout as staff were eager to seek guidance and learn more about PI prevention and treatment.

The creation of a Skin and Wound Care Committee provided an interdisciplinary approach to program development, bringing together the various levels of expertise necessary to address the multifaceted nature of PIP.

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The committee instituted various educational approaches to ensure staff understood the "why" behind prevention. These included real-time bedside education, five-minute unit huddles, product in-services, clinical orientation and annual education.

The PIP program focused on six basic components: skin inspection, risk assessment, pressure redistribution and offloading, maintaining skin health, nutrition and hydration, and patient and family education. To address these components, the team emphasized awareness and accountability for PIs and implemented device selection algorithms, standardized formularies, Braden Scale interventions and prophylactic dressings.

Comprehensive skin and Braden Scale assessments are now completed within 12 hours of admission, twice daily on shift changes and any time a patient transfers between units or if their condition changes.

CMH invested in Skin Health Solutions and Lippincott Solutions to support training and education needs, standardize care and stay updated with evidence-based practice. The electronic medical record was updated to make the Braden assessment mandatory and supportive interventions and patient education on PIP available. These practices ensure consistent documentation that accurately reflects the care provided.

As any QI program requires ongoing evaluation, EQIC performed a rapid-cycle improvement program assessment and identified areas for improvement. For any hospital-acquired PI, the WOC nurse conducts a root cause analysis, starting with a post-PI bedside huddle with real-time education then a daily PI incident review at each shift for one week and a review of the incident at the morning leadership safety meeting.

Results and impact

CMH significantly reduced the incidence of PI by fostering a culture that values prevention, educates staff and patients, encourages collaboration and uses data to drive improvement. The PI prevalence rate has been maintained at zero and the incidence rate has declined by 50%. Notably, the hospital did not have a PI from Sept. 9, 2023, to Feb. 2, 2024.

As of 2024, wound ostomy is an official department at CMH participating in the hospital's performance improvement program.

The organization maintains the PIP program by reevaluating the process, staying up to date with best practices and conducting ongoing staff training and data collection and analysis. The WOC nurse collects and presents quality data to improve care quality and patient outcomes. The Skin and Wound Care Committee meets regularly to review PI prevalence and incidence rates, identify trends and barriers to care, review products and identify education needs.

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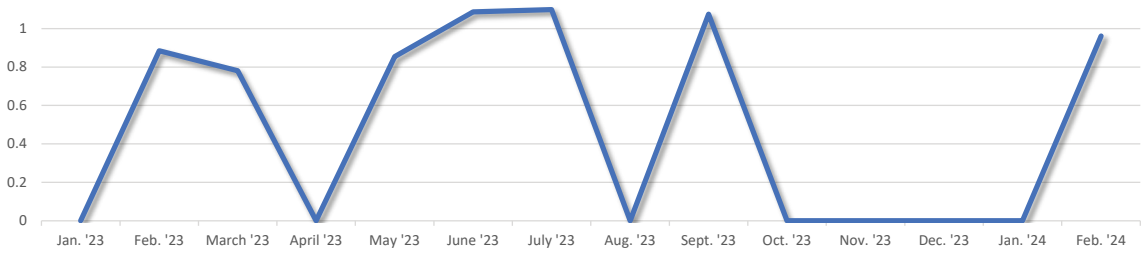
Community Memorial Rate of Facility-acquired Pressure Injuries Stage II or Greater



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Pressure injuries

PRESSURE INJURY PREVENTION COMMITTEE

Rutland Regional Medical Center

Submitted by Liza Eddy, MHA, BSN, RN, RN Manager, Patient Safety

Background

Pressure injuries are associated with extended hospital stays, sepsis and mortality. An estimated 60,000 U.S. hospital patients die each year from complications due to hospital-acquired pressure injuries. Unstageable, Stage 3 and Stage 4 HAPIs are serious, reportable events — and preventable if assessments and interventions occur regularly.

Rutland Regional Medical Center instituted a pressure injury prevention committee to improve care quality for patients in all clinical departments by reducing the overall incidence of serious, reportable HAPIs. The PIP committee worked with affected departments to decrease their incidence of HAPIs by 5% over a six-month period to help RRMC reach its fiscal years 2023 and 2024 goal of reducing HAPI incidence to zero.

The project focused on supporting and improving the day-to-day activities of bedside staff, including care interventions directly related to skin condition, injury prevention, wound identification and wound treatment. The project did not focus on medical equipment or processes that do not impact skin integrity (e.g., intravenous pumps and bed frames).

Critical success factors include reduced incidence of serious, reportable HAPIs and the development of improved tools and resources for bedside staff.

Desired outcomes

- **Education and training**
  - Develop/provide educational content for bedside staff that improves their understanding of PI staging and management.
- **Supportive tools and resources**
  - Examine existing policies and procedures to ensure they align with best practice standards.
  - Provide algorithms to assist in PI management and prevention.
  - Ensure that documentation in the electronic health record reflects best practice standards and improves workflows for bedside staff.

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Approach and collaboration

Formed in early 2023, RRMC's multidisciplinary PIP committee is comprised of wound, ostomy and continence nurses, representatives from all nursing units, physical/occupational therapy, hospitalists, general surgery, case management, information technology, education, quality and safety, and biomed. Participants include staff RNs, frontline employees, managers, directors and senior leadership.

One of the initial challenges of the project was a lack of baseline and current data. The organization had a robust system in place to complete once-monthly skin checks and submit the results to the National Database of Nursing Quality Indicators®. Frontline staff entered patient safety event reports for any serious reportable PI. To ensure no data point was missed, a process was developed to run monthly reports based on diagnosis codes. All data sources were then filtered through a central location (RN manager of patient safety). As data then became available, information was regularly shared with the PIP committee, inpatient units and RRMC leadership.

Through the PIP committee and a root cause analysis process for reportable PI, system deficiencies were identified in the areas of policies, documentation, education, resources, staffing and equipment. The RCAs suggested that many HAPIs had been present on admission but were incorrectly staged. With the new "4 Eyes in 4 Hours" process change, RRMC improved the ability to accurately record and document any skin abnormalities that are present on admission, identify patients at risk for PIs and use teamwork and critical thinking with RN partners to improve patient care.

Results and impact

In April 2023, RRMC's HAPI rate was 3.7%. In March 2024, the rate improved to zero. Two hospital departments have maintained a HAPI rate of zero for five months and every department's HAPI rate has improved. While additional efforts are still needed, staff and leaders are encouraged by the overall improvement and are committed to continuing PIP.

- **Data collection**
  - The two existing processes to report HAPIs left gaps in data collection. Centralizing the reporting and data collection and developing a regular monthly report based on diagnoses helped ensure data were complete, accurate and thorough.
- **Education**
  - The Wound Ostomy Care NDNQI Pressure Injury and Skin Care modules were assigned to every RN and new hire RN. The modules are now required annually to ensure staff stay informed of any updates to best practice recommendations. The WOC nurse also reviewed and updated the skin and wound care resources and training materials available in each unit.

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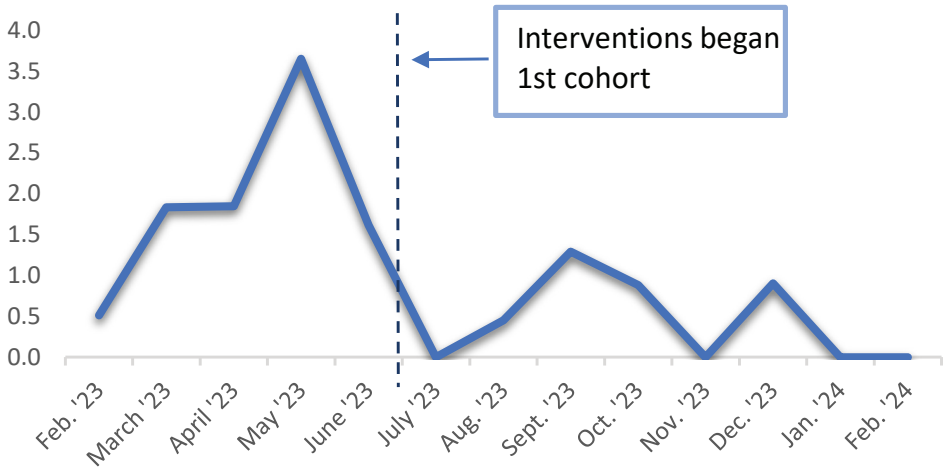
- The education rollout helped set the stage for the 4 Eyes in 4 Hours project. When the organization updated its policy to require that two RNs complete the admission skin assessment, there was an immediate and drastic improvement in documentation of skin abnormalities present on admission and improvement in HAPI prevention.

- **Support surfaces**
  - During the RCAs, it became clear that low air-loss mattresses ("KCI overlay") were inconsistently ordered and often not used when indicated. The process of putting the KCI overlay in place was cumbersome and required a maintenance ticket to request the pump and new bed with the overlay in place. The quality and safety department worked with the WOC team to develop a support surface algorithm and support RN clinical decision making.
  - A mattress assessment was completed in May 2023, identifying deficiencies related to the integrity of the mattresses. A new fleet of mattresses and bed frames was put in place in March and April 2024. The new integrated mattress surfaces offer improved low air-loss systems and eliminate the need to change a patient's bed or mattress.

Rutland Regional Medical Center HAPI Rate per 1,000 Patient Days



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Pressure injuries

REDUCING THE RATE OF HOSPITAL-ACQUIRED PRESSURE INJURIES

Valley Regional Hospital

Submitted by Katharine Bak, RN, MSN, Director, Nursing and
Rachel Noyer, RN, WCC, Interim Inpatient Nurse Manager

Background

Valley Regional Hospital had three hospital-acquired pressure injuries in the first quarter of 2023 and subsequently completed a root cause analysis.

The RCA team included members from quality, risk/compliance, nursing leadership and staff RNs directly involved in patient care. The team identified gaps, including:

- staff failure to recognize/stage pressure-related wounds;
- lack of knowledge related to mandatory reporting of HAPIs;
- lack of a defined process for recognition/documentation/reporting;
- lack of education upon orientation and ongoing competency validation;
- inconsistent handoff processes between shifts;
- lack of individual responsibility and accountability around PI prevention; and
- lack of a hospital policy or any other supportive tool for nurses to reference.

Approach and collaboration

The team used the Institute for Healthcare Improvement's Plan-Do-Study-Act cycle tool to guide a performance improvement project to address these gaps.

For the "Plan" phase, the team asked, "How can we reduce HAPIs on the inpatient unit?" They predicted that increased awareness, education and knowledge of the contributing factors related to PI development would reduce rates. The team collected PI data before implementing interventions.

The team involved nursing staff from the inpatient unit, emergency department and nursing leadership to assess current knowledge using the National Database of Nursing Quality Indicators Module 1, direct observations and discussions.

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Based on results from the assessment, during the "Do" phase, VRH:

- completed the nursing quality checklist;
- incorporated a monthly chart review of skin assessments;
- created a PI identification and wound care process map to outline the necessary steps for staff to take;
- assessed staff knowledge;
- provided education/mandatory skills day, hospital policies and wound care resources;
- tracked PI with a quality dashboard; and
- implemented wound care nursing consults.

Results and impact

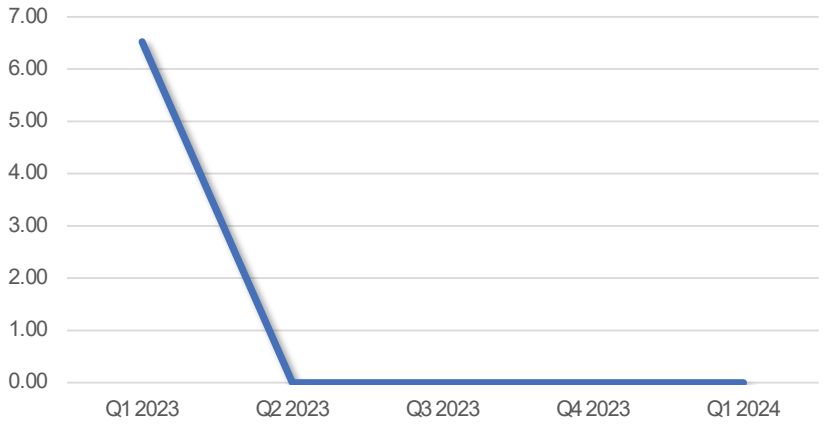
For the "Study" phase, the team analyzed the impact of these interventions on their predictions and found that increased awareness, education and knowledge of the contributing factors related to PI development did reduce HAPI rates.

The hospital increased its attention and focus on PI prevention and treatment and provided tools to support staff's roles in preventing, assessing and treating PI and other wounds.

As a result, staff demonstrated more knowledge of PI staging, communication and documentation.

For the "Act" phase, the team implemented a prevalence study tool, included hospital-acquired injuries and infections in clinical staff orientation and continues to monitor staff competencies. VRH is also planning for the next PDSA initiative using data from a rapid-cycle improvement program.

Valley Regional Hospital HAPI Rate



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Pressure injuries

REDUCING PRESSURE INJURY USING THE LEAF PATIENT MONITORING SYSTEM

WVU Medicine United Hospital Center

Submitted by Stephanie Constable, BSN, RN, CWOCN, Wound and Ostomy Care Nurse

Background

WVU Medicine United Hospital Center has always strived to reduce patient harm events, with pressure injuries being a top priority. WVU closely monitors hospital-acquired pressure injury rates and evaluates each instance independently. The goal is to determine the root cause and improve processes to prevent HAPI recurrence.

In 2021, a slight increase in the number of HAPIs prompted the team to evaluate wound care protocols, enhance the PI prevention team and re-educate nurses at the bedside. Despite these interventions, the number of HAPIs increased even further in 2022. The team began to look for other resources and decided to pilot the LEAF patient monitoring system.

Approach and collaboration

With the support of nursing leadership and the quality improvement department, the wound care team requested permission from the value analysis committee to pilot the LEAF system in the critical care unit, which has patients at the highest risk of developing a HAPI. The team also wanted to trial the technology on a medical-surgical unit to determine the estimated monthly usage in this patient population and identify any complications of initiation/use. The team was hoping to see a reduction in the number of HAPIs in the CCU compared to the 11 that developed between January and February of 2022.

The team completed a month-long LEAF system pilot in the CCU and on a medical-surgical unit in March 2022. The goal was to determine the nurses' ability to initiate the technology on the appropriate patients using a pre-determined decision tree to achieve an overall turn score of at least 85% compliance. After the successful completion of the pilot, the hospital's new goal became greater than or equal to a 10% reduction in the number of HAPIs after hospital-wide LEAF system implementation.

The team began the pilot with bedside nurse education and training and identified a super user group for each unit. The pilot was a success on both units according to the pre-determined goals. After seeing the results, the value analysis committee voted to move

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forward with hospital-wide implementation. It took several months to install all the necessary technology and provide hospital-wide nursing education; the LEAF patient monitoring system went live on Nov. 1, 2022.

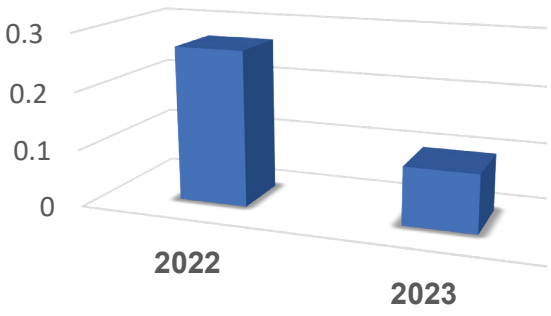
Results and impact

The LEAF system had a positive impact on the number of HAPIs from 2022 to 2023, with a 46% reduction in the number of patients developing a HAPI and a 62% reduction in the number of total PI.

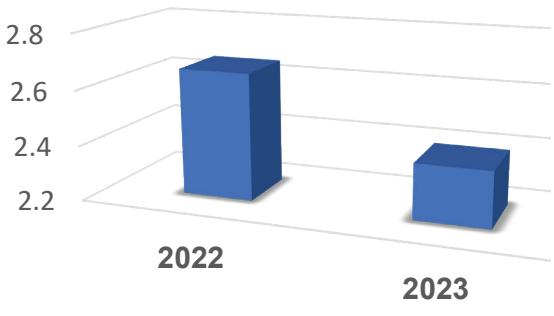
In 2023, the hospital's HAPI prevalence rate was 2.4% and the incidence rate was 0.1%. Throughout this process, the team identified inconsistencies in the number of HAPIs identified by wound care and those captured by coding and MountainZERO, WVU's systemwide patient safety initiative to increase communication and eliminate preventable harm events. Implementing the LEAF system improved the bedside nurses' ability to identify patients at risk for skin breakdown early and implement appropriate preventive measures. Hospital-wide focus on this patient population, coupled with the LEAF decision tree, drove an increase in early identification by nursing.

Through LEAF technology and reporting, the hospital identified and improved upon the typical turn pattern of nursing to decrease the time patients spend on their backs. Previously, patients were typically turned to their back between every right and left turn. The team educated nurses and nursing assistants on proper turn techniques and schedules (i.e., turn rotations should be back/right/left repeat unless a patient has a restricted side). With continuous re-education and oversight, this change has reduced the average patient time spent on the back from 55% to around 46%.

United Hospital Center Pressure Injury Incidence Rate



United Hospital Center Pressure Injury Prevalence Rate



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Readmissions

IMPACT OF IMPLEMENTING A CARE PARTNER PROGRAM ON HOSPITAL-WIDE READMISSION

Maimonides Medical Center

Submitted by Deidre Grant, MSN, RN AHN-BC, Performance Improvement Specialist and Ilya Goldstein, MPH, Performance Improvement Specialist

Background

Maimonides Medical Center, a 711-bed, community-based, acute care tertiary hospital in Brooklyn, New York, launched its Care Partner program in June 2019 to align with the New York state Caregiver Advise, Record, and Enable Act's mandate for hospitals to allow patients to designate a caregiver upon admission.

A CP serves as a compassionate companion for patients and can be a family member, friend or individual actively involved in the physical, emotional or logistical aspects of caregiving. Their involvement with activities of daily living and healthcare advocacy can enhance a patient's quality of life. Studies have shown improvements in patient outcomes, including readmission reduction and patient satisfaction, when a CP is integrated into care.

After the initial launch of the CP program, unforeseen challenges during the COVID-19 pandemic stalled operations. In late 2022, MMC set out to reinvigorate and refocus the initiative using the EQIC Care Partner "Commit, Identify, Include and Prepare" framework. A multidisciplinary task force spearheaded the work using the Plan-Do-Study-Act quality improvement methodology.

The patient care changes made in conjunction with the EQIC framework earned MMC recognition as an EQIC Care Partner Hospital in August 2023.

Approach and collaboration

The journey began with creating the multidisciplinary task force comprised of senior leadership, nursing, physician, patient relations, case management, information technology, legal and quality management staff. The task force collaborated to identify areas of opportunity, understand sources of variation, use the PDSA cycle and execute an action plan.

In the "Plan" phase, the task force used process mapping to determine the current state and create a desired future state. In the "Do" phase, the patient relations and admission

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nurse's initial patient interaction workflow was changed to include electronic health record documentation. This new step captures the identified CP in the Patient Self-Determination Act form and nurse admission note, which auto-populates into the discharge summary, discharge instructions and clinical summaries. The task force added CP as a learner option in the education record.

MMC customized the HANYS EQIC care partner brochure and included it in patient admission packets and hospital-wide education lectures to leadership, nursing, residents and case management staff. CP program information was also shared in a hospital-wide advertisement via MMC's marketing department.

With each cycle, data checks, communication of ongoing efforts and improvement actions are reported regularly to the multidisciplinary task force, the hospital-wide quality improvement committee and the board of trustees.

Results and impact

MMC's IT department generates a CP report, which pulls electronic health record data on patients who identify a CP, those who decline and those who defer, and combines these data with the monthly patient readmit report.

MMC conducted a time series analysis from January through December 2023. During the baseline period in 2022, an average of 3.9% of patients identified a CP. Implementation changes occurred in January 2023, and 50.8% of patients identified a CP in June and 75.2% in December. MMC concluded its 2023 results with a total average of 53.8% of patients identifying CPs, compared to 3.9% the previous year, exceeding the goal of a 20% increase within six months.

After program implementation, MMC studied the impact of the CP program on its 30-day readmission rate. The team also examined patients with a CP and their Readmission Risk Assessment Score and used the Chi Squared test to determine if a difference between the observed and expected data was due to chance or a relationship between the variables. The results showed that patients who identified a CP had a significantly lower readmission rate (10.0% compared to 18.2%) than those who did not.

These outcomes underscore the positive influence of CPs on effective communication, collaboration and adherence to treatment plans, with potential implications for broader healthcare improvement. The results also revealed that patients with any risk assessment score who identified a CP had a significantly lower readmission rate than those without a CP (4.9% vs. 10.3% for low risk, 12.7% vs. 23.4% for intermediate risk and 30.9% vs. 49.1% for high risk). The P-value was <0.001 for all three risk assessment scores.

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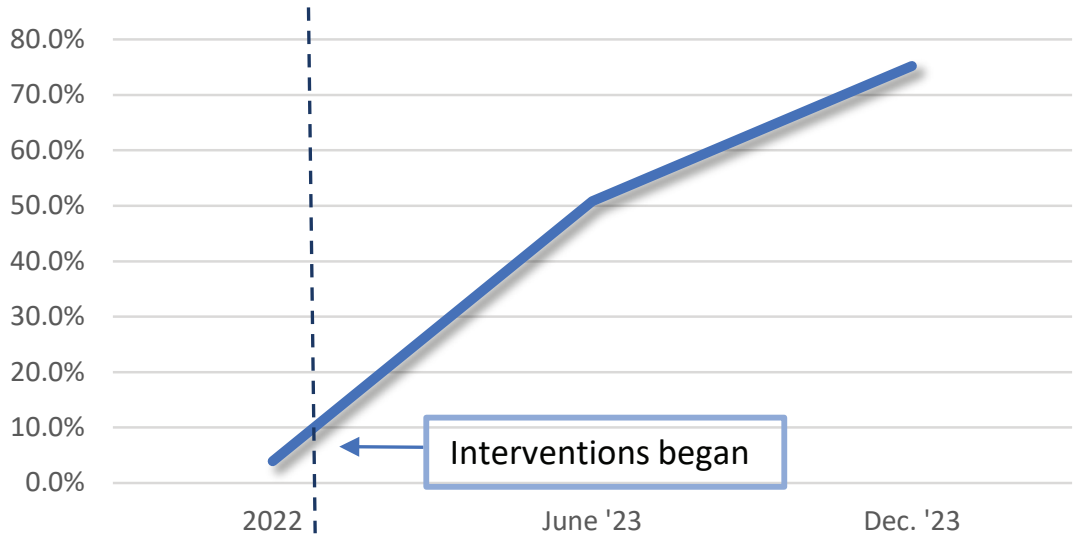
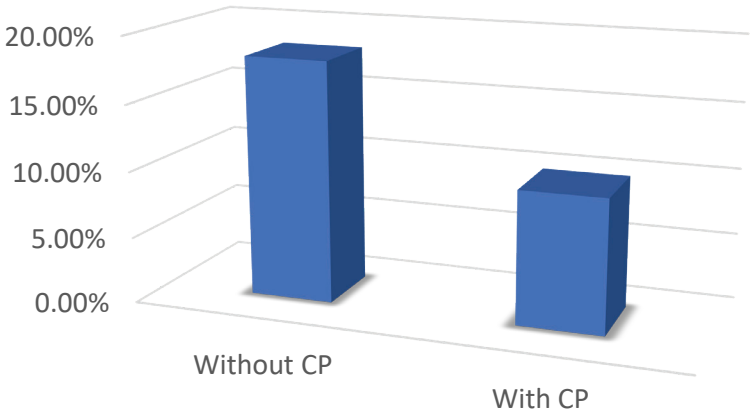
Care partners not only enhance effective communication and collaboration between patients and care teams but also positively influence healthcare outcomes by ensuring better adherence to treatment plans and medication regimens. Through this program, MMC showed that patients who identified a CP had a lower 30-day readmission rate than those who did not. MMC's next study will examine the effect of CPs on patient satisfaction. Every attempt should be made to identify a CP for all MMC patients and involve them in the plan of care.

Patients Who Have Identified a Care Partner



Rate of Readmissions for Patients with a Care Partner and Without in 2023



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Sepsis

SEPSIS IMPROVEMENT JOURNEY

Lewis County Health System

Submitted by Rebecca Keefer, RN, Clinical Information Liaison

Background

The team at Lewis County Health System acknowledged the need to improve sepsis care. Sepsis recognition was low, and bundle compliance was inconsistent. Under new leadership and with support from the chief executive officer and chief nursing officer, the staff development department initiated a mission-driven sepsis improvement campaign using evidence-based best practices and innovative new technology to facilitate early identification and sepsis patient management.

Approach and collaboration

The foundation for improvement was creating the right team with key stakeholders. These included frontline nursing staff from every department, a pharmacist, an emergency department nurse manager, the ED medical director and the staff development coordinator. The clinical informatics liaison nurse, who abstracts sepsis data, was assigned the role of sepsis coordinator. A charter guided the team with meeting dates, problems, goals, objectives and deliverables.

The team created a nurse-driven sepsis alert process in which all nurses and nursing supervisors were educated and empowered to call a sepsis alert upon recognizing systemic inflammatory response syndrome plus suspected or known infection. The sepsis coordinator or nursing supervisor responded and reviewed the chart to ensure all protocols were followed appropriately in real-time.

In a three-month period, 70 sepsis alerts were called, 35 of which met severe sepsis or septic shock criteria. This sepsis alert process has led to rapid sepsis recognition and the potential for preventing further deterioration.

Notably, the team collaborated with the information services department to implement a Meditech system upgrade that allowed for program surveillance. The surveillance tool works in the background of the electronic health record to give real-time, meaningful information to evaluate and determine if a patient meets the criteria for sepsis. If so, the information

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is pushed to the physicians' patient tracker using an early warning system as a "possible sepsis" alert. This process augments nursing communication with the providers, and the sepsis coordinator also receives messages on any patients who meet systemic inflammatory response syndrome criteria.

With goals of 100% compliance with three- and six-hour bundles, and 100% compliance with shock fluid bolus and documentation, LCHS put into place a plan that included:

- data collection and planning: bundle compliance dashboard;
- policy review and a sepsis training plan, including:
  - sepsis training during skills day;
  - forming a sepsis team;
  - reviewing the sepsis policy;
  - working on "Code Sepsis;"
  - using a failure modes and effects analysis to identify and address potential problems or failures and their resulting effects on the system or process before an adverse event occurs;
  - conducting ongoing Plan-Do-Study-Act cycles to run small tests of change;
- ongoing improvements included:
  - initiating a sepsis alert;
  - using Meditech for sepsis surveillance;
  - continuing sepsis education through skills days; and
  - creating sepsis training tools.

Results and impact

The sepsis improvement initiative's results showed overall compliance climbing from below 40% to consecutive months of 100%. For ten months, compliance was greater than the New York state and national average.

Use of the surveillance program has decreased the number of charts audited, thereby increasing competency and accurate recognition.

Compliance with the three-hour sepsis bundle for three months following the training was 93%, 100% and 100%. Compliance for the six-hour sepsis bundle for three months was 100%, 100% and 100%.

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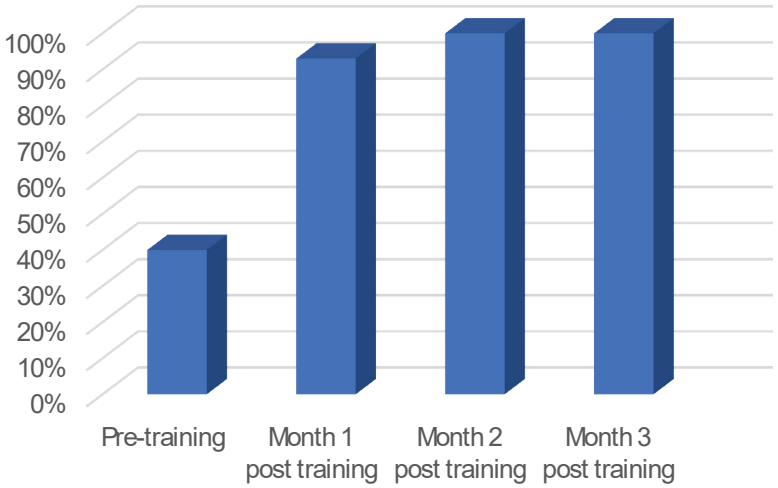
Lewis County Three-hour Bundle Compliance



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