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A HAPI Reduction QI Project:

Don't Leave Your Patient in S.H.A.M.B.L.E.S



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Background

Hospital-Acquired Conditions (HACs) are challenging, complicated issues and they carry a high price for patients and healthcare organizations.

- Hospital-Acquired Pressure Injuries (HAPIs) affect approximately 2.5 million people annually in the U.S. with associated loss of revenue.
- The estimated financial repercussions of HAPIs range from \$14,000 to \$70,000 per event and can result in revenue losses 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 HACs to positively influence decreased incidence

Methods

A collaborative effort between NPDs and WOC nurses led 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.

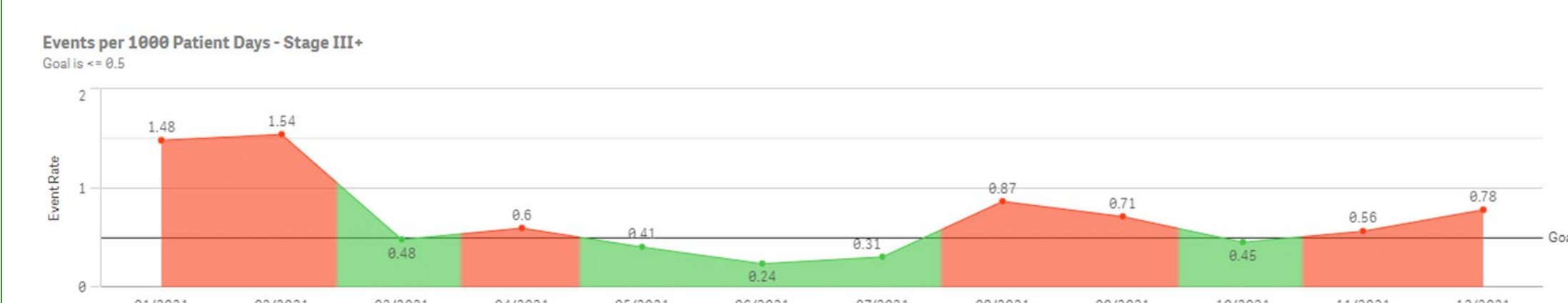


Results

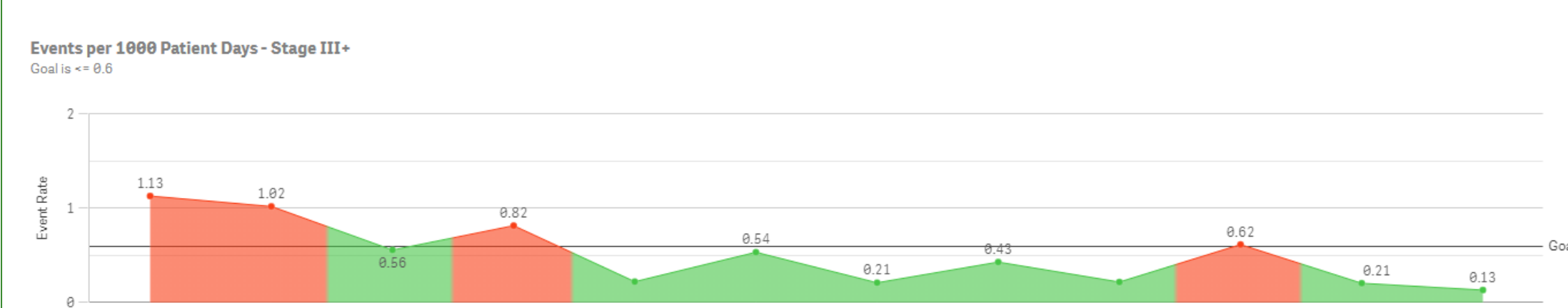
HAPI prevention improved on several units

- HAPI incidence decreased during the period of rounding
- HAPI incidence stayed below the 'target' even during recurrent COVID surges
- HAPIs decreased from 107 in 2021 to 86 in 2022

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 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

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