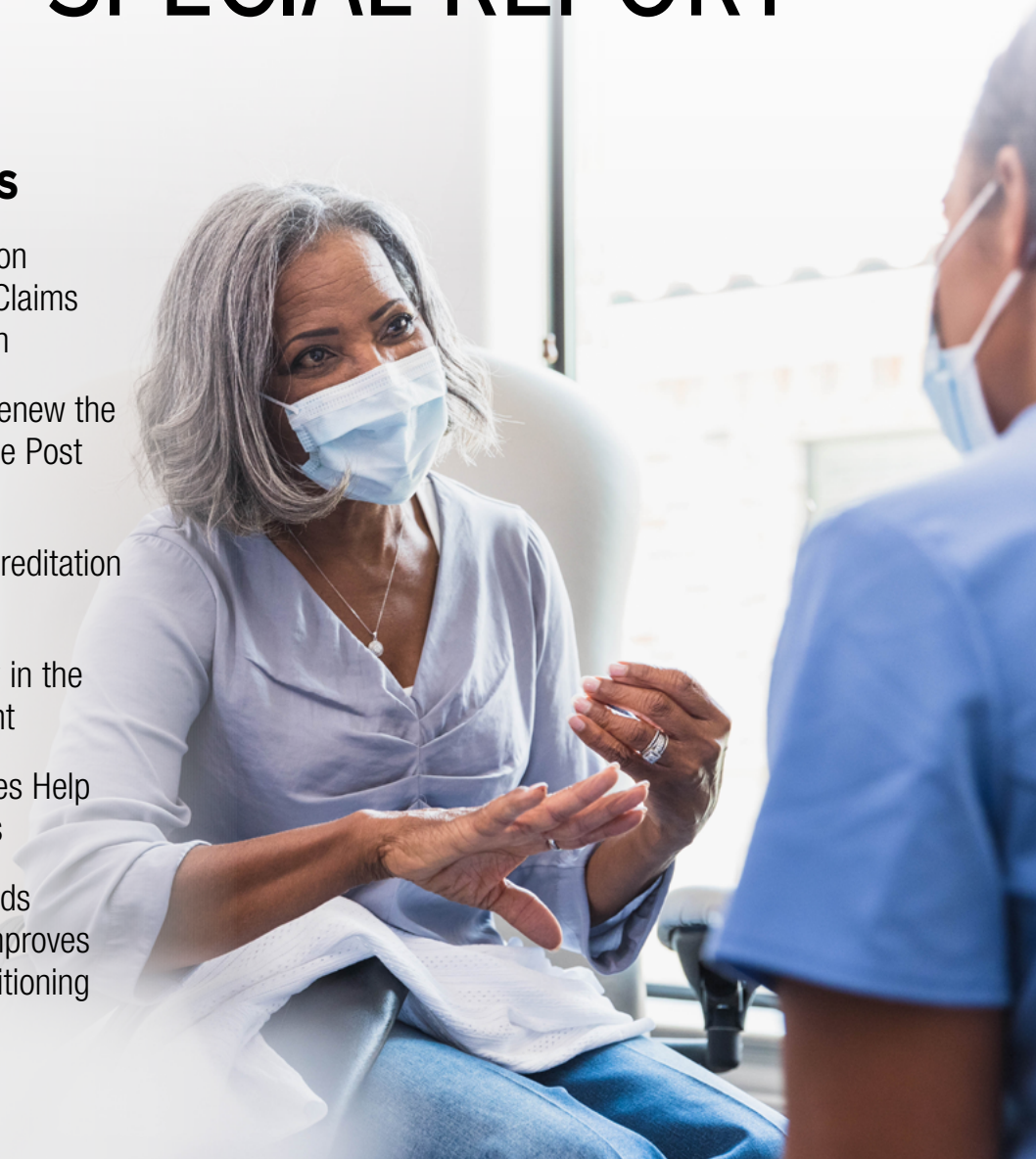


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Patient Safety Awareness Week SPECIAL REPORT

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Study Shows Correlation Between Malpractice Claims and Miscommunication

By Matt Phillion

The healthcare industry has known about the challenge of patient handoffs and communication for some time. But recently, a study from the [Journal of Patient Safety](#) examined a random sample of malpractice claims to determine how often communication failures were involved in those claims.

The study found that:

- Communication failures accounted for nearly half (49%) of all claims reviewed, posing a significant patient safety threat as well as a substantial financial burden to healthcare systems
- Roughly 40% of cases that involved communication failures included handoffs in care
- Interventions to improve transmission of critical patient information could substantially reduce malpractice expenditures

“For a number of years, we’ve known miscommunications are major players in the epidemic of medical errors. But prior studies of malpractice claims in particular have typically under-recognized how important miscommunications are in claims.”

— Christopher Landrigan, MD, MPH,
chief of general pediatrics at Boston Children’s Hospital

Christopher Landrigan, MD, MPH, is chief of general pediatrics at Boston Children’s Hospital and one of the co-authors of the journal article. He is also co-founder of the [I-PASS Patient Safety Institute](#).

“For a number of years, we’ve known miscommunications are major players in the epidemic of medical errors,” he says. “But prior studies of malpractice claims in particular have typically under-recognized how important miscommunications are in claims. Our study evaluated claims from systems nationwide, across all clinical areas, demonstrating the key role of miscommunications in malpractice claims.”

From the patient perspective, Landrigan says, safe and reliable care

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is top of mind, which has driven many improvements throughout the healthcare space. “But it’s often difficult for hospitals and insurance carriers to prioritize things unless they can really understand what the financial bottom line is,” he says. “There’s a lot of competing demands on hospitals and healthcare systems, always something clamoring for attention any given day. If you demonstrate both the human toll and how financially punishing an issue is, it helps motivate them to fix it.”

“One of the most interesting things we took from the study is the scope of the problem. The fact that nearly half of all malpractice incidents involve communication failures was really striking.”

— Christopher Landrigan, MD, MPH, chief of general pediatrics at Boston Children’s Hospital

In speaking with healthcare leaders, Landrigan notes, most say they are driven to improve patient safety because they truly see it as part of their mission. It’s rare for finances to be a primary motivator. Without an understanding of the financial impact of a patient safety problem and the potential savings generated by addressing it, however, it’s tough to push a particular patient safety intervention strategy to the top of the heap of competing issues. This study helps in that regard.

The scope of the problem

Communication failures play a major role in malpractice claims. “One of the most interesting things we took from the study is the scope of the problem,” says Landrigan. “The fact that nearly half of all malpractice incidents involve communication failures was really striking.”

Prior research had shown communication to be a big factor, but not to this extent, he says. “It turns out communication failures really are this incredibly common problem when disasters happen in the healthcare system,”

says Landrigan. This is consistent with analyses of sentinel events reported to organizations like the Joint Commission and the Department of Defense, he notes.

Part of the challenge, Landrigan says, is that communication failures are hidden beneath the surface. Because malpractice claims are so often analyzed in siloes, as surgical claims, medical

claims, and so forth, these analyses don’t think of the common themes across all those areas, such as miscommunication.

“The fact that miscommunication has been hidden has resulted in a lack of investment in communication solutions,” says Landrigan. “It’s not something that has been top of mind until recently for patient safety. Even though we’ve been developing tools and procedures, most systems haven’t seriously invested in those solutions until now.”

Change in this area requires evolution in the field. “It’s one thing to recognize miscommunication as a problem, but if you don’t have the right tools and processes, there’s not much you can do about it,” says Landrigan. “Fortunately, over the last 10 years or so, we have been gradually building a bundle of tools that can help.”

Now, tools like I-PASS are mature and ready to be scaled across healthcare systems, he says. “This study suggests that the financial ramifications of implementing handoff solutions could be profound.”

Justifying the expense

Patient safety is the first priority, but initiatives become easier to implement when they can save money in the long run. “This added information about the financial toll shows it’s really worth investing in,” says Landrigan.

A structured communication process in place for patient handoffs, together with a robust rollout process, can consistently lower medical error rates, he says.

“Despite the evidence, it’s been very difficult to garner the resources to make something like I-PASS the standard for communication across an organization, using it for every handoff every time,” he says. “The system has to be deeply committed to making it work.”

When strong handoff communication is implemented, though, the feedback is positive. “One of the things we’ve heard consistently from physicians and nurses when this is rolled out, especially from less experienced providers trained in this method, is that they feel much better going home at the end of their shift knowing they’ve effectively passed information off in a way that things won’t get dropped,” says Landrigan. “It enables them to hand off information in a more robust way.”

Overcoming existing challenges

There currently isn’t a perfect system for tracking malpractice and adverse events, but multiple large studies estimate the numbers of patients who die because of medical errors at more than 250,000 per year.

“It’s a controversial number and there’s a lot of debate back and forth, but any way you slice it, the number of patients harmed or killed by errors is enormous,” says Landrigan. “We know that half or more of those injuries are in part due to miscommunications. The toll on human lives is vast.”

It’s not just the human toll that is overwhelming, though. “There’s an enormous financial toll as well, billions of dollars every year,” says Landrigan.

Errors are a universal experience among physicians, he says. “Every clinician has a story they can

Patient Safety Awareness Week



tell you about a failed communication they received, and we're all aware of our own mistakes as well," he says. And this creates a burden on the providers as the weight of worry drags them down.

"The psychological well-being of the providers themselves is an incredibly important piece of this," says Landrigan. "Better systems, more reliable systems, have an enormous personal benefit for physicians and nurses. Tools that help improve care and avoid errors impact how we feel about our jobs, because at the end of the day, we all entered healthcare to help people."

Now, there's opportunity to further invest in and improve these systems. "Financially, it's the right thing to do. Healthcare systems are doing the best they can with limited resources," says Landrigan. "This study helps demonstrate that an investment in a more

reliable communication system up front could pay huge downstream dividends."

Good communication is all the more pivotal given the staffing challenges the nation faces. "All of these things are intertwined—as healthcare providers are stressed, as time pressures increase, as we face the physical toll of working at this grueling pace in the midst of COVID, with an end that seems like it's never going to arrive," Landrigan says. "When you're moving quickly, it's easy to make mistakes, and it's difficult to

connect with patients at this pace. We need to do anything we can do to help connect our colleagues and patients."

Malpractice claims involving miscommunication tend to be expensive to resolve. "When professionals who are experts in their field have a communication breakdown, those kind of events are often indefensible in court," says Landrigan. "This speaks to the importance of high-quality communication between clinicians, and between clinicians and patients. It reflects the really simple message that we can't afford to not communicate with each other." *

Matt Phillion is a freelance writer covering healthcare, cybersecurity, and more. He can be reached at mattthew.phillion@gmail.com.

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Using Technology to Renew the Focus on Hand Hygiene Post Pandemic

By Lori Moore, MPH, BSN, RN, CPPS; Clinical Educator, Healthcare; GOJO Industries

The COVID-19 pandemic confirmed the importance of primary tenets of infection prevention, chief among them hand hygiene.

With the pandemic came unprecedented challenges to healthcare facilities, and some quality metrics like hand hygiene performance were difficult or impossible to obtain.

Published reports of hand hygiene performance during the pandemic showed that initial performance increased followed shortly thereafter by a return to baseline or below.^{1,2} Furthermore, many quality improvement initiatives were also placed on hold during the pandemic, and it's still probably unclear the extent to which patient safety and quality have suffered. Be that as it may, quality metrics like hand hygiene are essential during both times of stability and times of crisis.³

The goal of any quality metric is to obtain reliable data to improve patient safety, yet hospitals relying on direct observation alone are likely insufficiently allocating and deploying valuable resources for improvement efforts based on the scant information obtained.

The challenges of direct observation have been described at length, including capturing only a small portion of hand hygiene opportunities and the Hawthorne effect.^{4,5} Quality and safety leaders readily acknowledge that a gap exists between reported compliance rates and hand hygiene behaviors taking place on a 24/7 basis and are questioning whether this gold standard is sufficient to manage risk in the wake of the growing burden of healthcare-associated infections.

Over the past decade, healthcare facilities have been introduced to automated hand hygiene monitoring systems that have been designed to provide standardized collection of data across multiple units and facilities on a 24/7 basis.^{4,6} PURELL SMARTLINK™ AMS was developed to serve as a metric for capturing hand

hygiene data and managing risk associated with hand hygiene behaviors.

However, data alone is not enough to improve hand hygiene, and implementing an automated hand hygiene monitoring system without also initiating complementary interventions may not result in sustained behavior change.⁷ Therefore, an important part of the solution is to provide the tools and support needed to build and sustain improvement.

PURELLSM Clinician-Based Support can assist customers in achieving the full potential of the system, increase organizational learning, and build improvement across complex systems.

As SARS-CoV-2 becomes a less formidable disruptor and there is a renewed focus on quality in healthcare, implementing technology to efficiently generate large volumes of standardized hand hygiene data can provide a more complete picture of hand hygiene practices, leading to better resource allocation and improved patient care.

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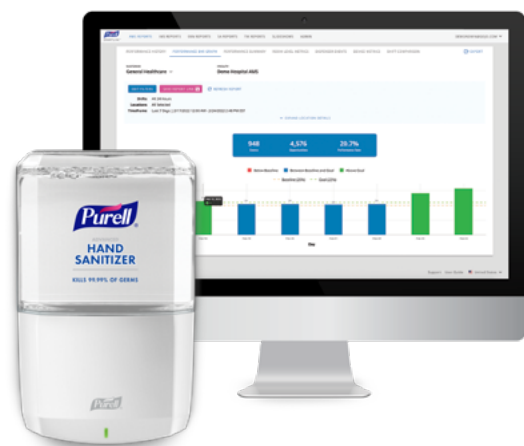
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The Link Between **Accreditation** and **Patient Safety**

Now more than ever, patients are seeking quality and safety in their health care settings.

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Advocating on Behalf of Patients

In 2022, IAC appointed Rosemary Gibson to its Board of Directors as its first public member. A nationally esteemed champion for patient rights, Ms. Gibson's charge is to advocate on behalf of the patient in the accreditation process, offering an outside perspective to represent the voice of accreditation's ultimate stakeholder, the patient.



In my new role as public member, I look forward to bringing expertise to the board and staff to deepen the patient perspective and highlight how IAC-accredited facilities work to improve the quality of care patients receive.

- Rosemary Gibson



What is IAC Accreditation and How Does it Affect Patient Safety?

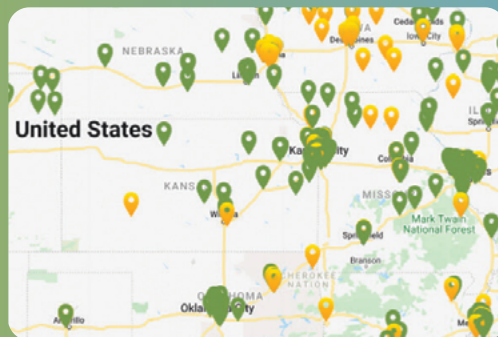
The Intersocietal Accreditation Commission (IAC) is a nonprofit, nationally recognized accrediting organization. The IAC was founded by medical professionals to advance appropriate utilization, standardization and quality of diagnostic imaging and intervention-based procedures. The IAC programs for accreditation are dedicated to quality improvement and patient safety and all support one common company mission: **Improving health care through accreditation**[®]. Since its inception in 1991, the IAC has granted accreditation to more than 14,000 sites. IAC offers accreditation in the following areas:

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- **Echocardiography**
- **Nuclear/PET**
- **MRI**
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- **Carotid Stenting**
- **Cardiac Electrophysiology**
- **Cardiovascular Catheterization**

Private offices, clinics and departments within hospitals that are accredited by the IAC submit to a review of their daily operations. By participating in the accreditation process, these medical facilities demonstrate a commitment to the performance of quality patient testing and procedures and strive to meet nationally recognized standards. During the accreditation process, applicant facilities must submit documentation on every aspect of their daily operations. While completing the application, facilities are required to identify and correct potential problems, revising protocols and validating quality improvement programs. Accreditation is granted only to those facilities that are found to be providing quality patient care, in compliance with the IAC **Standards**. Once granted, IAC accreditation is valid for a period of three years, after which time the facility must undergo a repeat evaluation.

Learn more at intersocietal.org/patients.

Resources



Accredited Facility Locator

IAC offers an online tool (intersocietal.org/iac-accredited-facility-locator) to assist patients or referring physicians in locating an IAC-accredited facility. When scheduling a procedure, patients are encouraged to research the accreditation status of the facility. Each online listing verifies the facility's accreditation status, what areas the facility is accredited in and the date accreditation is granted through.



IAC Seal of Accreditation

An accredited facility may have the Seal of Accreditation or their official IAC Certificate of Accreditation proudly on display or on their website as an indicator you are receiving the highest level of care. Referring physicians may also find the Seal of Accreditation on reports.



Improve patient safety in the emergency department

A 2020 study by Newman-Toker, et al. identified that 15 diseases account for about half of all serious misdiagnosis-related harms. The research focused on the “Big Three” categories of vascular events, infections, and cancers and found that 10% of patients with a “Big Three” disease are misdiagnosed. A likely explanation for this result is that practitioners encounter these conditions infrequently, are not familiar with the variable presentations, and are prone to cognitive errors in the diagnostic process.

These diseases require a consistent, thorough evaluation that focuses on the history and exam’s diagnostic features that should prompt the practitioner to include the condition in the differential diagnosis. The authors of this study concluded succinctly that their findings allow us to “target diagnostic improvement initiatives to diseases with the highest error and harm rates.” Additional studies outline the failure to diagnose profile demonstrates omission of elements in history taking, physical exams, and medical decision-making.

In emergency medicine

According to industry statistics, failure to diagnose accounts for 60% of medical errors and malpractice claims in emergency medicine, with 76% of ED physicians stating they experience diagnostic uncertainty on a daily basis. Regarding patient safety, failure to evaluate and diagnose potential adverse events is driving high rates of medical errors and malpractice claims in the emergency department. A recent study from Johns Hopkins highlights the challenges around failure to diagnose and evaluate and concludes that when focus and investment are applied to this challenge, lower error and harm rates are seen.

Reducing diagnostic error

Leveraging 30 years of data into the root causes of the failure to diagnose, Nuance partnered with The Sullivan Group to develop ED Guidance for Dragon Medical Advisor, an AI-based decision support tool. ED Guidance for Dragon Medical Advisor specifically targets the most common diagnosis-related errors. The advice and resources provided by ED Guidance are focused on the most common and impactful patient safety and risk issues in emergency medicine. ED Guidance for Dragon Medical Advisor drives clinical alignment around elements in the history, physical exam, and medical decision-making that improve diagnostic certainty. Additionally, the algorithms help identify possible high-risk conditions and passively notifies the practitioner of a “Risk Identified.” ED Guidance for Dragon Medical Advisor also fits comfortably within the practitioner workflow. This real-time clinical feedback helps physicians avoid medical errors before they become an adverse event or malpractice claim.



Patient Safety

Cognitive burden makes it difficult to avoid potential diagnostic errors.

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Physician Burnout

Risk Mitigation

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Improve patient safety

- Automatically identify failure to diagnose errors
- Identify appropriate differential diagnoses



Reduce physician burnout

- Improve efficiency through in-workflow guidance
- Improve recall assistance



Drive financial impact

- Mitigate the cost of risk
- Improve E/M coding impact



Improve risk mitigation

- Achieve accurate and complete documentation
- Reduce malpractice claims
- Reduce medical errors

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in documentation deficiencies in 120 days¹

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¹ Nuance E/M Impact Study 2021

* Nuance has partnered with the Sullivan Group, leader in patient safety content and training in the ED for over 20 years, to cover the most common chief complaints related to high-risk conditions.

How Simple Visual Cues Help Prevent Medical Errors



Learn more about the simple cues that play a vital role in patient safety

Medical errors not only affect patient safety, but can also impact a hospital's efficiency, patient reviews, average length of patients' stay, and in-hospital death rate. **There are over 7,000 deaths per year in US hospitals* from medication errors alone.** Patient safety advocates and professionals are consistently seeking new measures to reduce errors, and The Joint Commission continues to include "Improve staff communication" in its National Patient Safety Goals. Visual cues have been found to be an effective and simple method to improve communication.

So what are visual cues?

Visual cues quickly communicate important information, such as a warning, reminder or action needed at a glance. Visual cues come in different formats, including labels, flags, tags, wristbands or anything that is highly visible. They should be seen at the right time and in the right context of the information provided. Even as technology plays an increasingly heavier role in the healthcare setting, simple visual cues continue to play a vital role in clear communication and preventing medical errors.

Let's explore some widely-used and powerful visual cues and what they contribute to increasing patient safety.

Alert at a Glance



[Color-coded alert wristbands](#) are one of the most common visual cues found in hospitals. The highly visible wristbands are placed onto patients with special risks—in addition to their primary identification wristbands—to alert caregivers of special precautions. The wristbands are particularly effective for communication because of the bright colors and easy-to-read text. The colors and primary alert types have been adopted by the majority of state hospital associations, as well as the American Hospital Association.

For example, when a nurse sees a patient with a yellow "Fall Risk" wristband, they immediately understand the extra precautions required.

Monitor Blood Temperature in Real Time

[Timestrip® Blood Temp 10](#) are cues that do more than just visually alert staff. With the press of a button, these indicators monitor the real-time temperature of blood in bags to enhance the quality control process for blood transportation. They clearly indicate when the temperature has been breached to ensure regulatory compliance of AABB Standards for Blood Banks and Transfusion Services and the FDA's CFR 600.15(a) for monitoring temperature of whole blood.

"The Blood Temp 10 indicators help us know that our blood supply is being properly used in the safest way for our patients."

— Blood Bank Supervisor at Decatur Memorial Hospital

The indicators give the healthcare personnel the peace of mind they need to focus their attention on patient safety. "These temperature indicators save us time during trauma codes when time is everything," a Blood Bank Supervisor at Riverside Health Systems added.

Command Attention, Communicate Clearly

Communication labels are used throughout the hospital for a wide variety of applications. The general purpose, however, is the same: Get someone's attention and communicate important information. Simple, yet effective, risk reduction.

For the pharmacy, regulatory compliance and reducing medication errors are a top priority. Bright and bold communication labels command attention to clearly communicate important instructions, information and alerts with the pharmacists and between departments.

Throughout the hospital, STAT labels, biohazard labels and allergy labels are visually calling for attention to alert staff of risks.



*Fekadu T, Teweldemedhin M, Esrael E, Asgedom SW. Prevalence of intravenous medication administration errors: a cross-sectional study. *Integr Pharm Res Pract.* 2017; 6:47-51. Published 2017 Jan 31. doi:10.2147/IPRP.S125085

86% of Nursing Leaders Agree That Visual Reminders Are Effective in Prompting Nurses to Take Action



Source: TechValidate survey of 112 hospital nurse managers, directors, and CNOs

Remind Nurses to Take Action

Visual cues can also remind busy nurses when to take action for tasks that have a patient safety component, such as changing IV tubing. Some hospitals use simple colored labels that indicate the day and time to change IV tubing, while others are turning to the innovative [TimeAlert™ IV](#) time-indicating reminder labels. TimeAlert IV allows any caregiver to know at a glance how much time has elapsed since the last tubing change and when it is time to change it. With the push of a button the indicator is activated, using color-changing technology to indicate when the IV tubing needs changing.



Shake Out of a Routine

In the operating room, patient safety stakes are high and there's no margin for error. While alert wristbands are used in the OR, they can be hidden from view when the patient is draped for surgery. Aside from the typical risks of surgery, anesthesia poses other risks and anesthesiologists must often respond quickly to ensure the safety and comfort of the patient. As such, anesthesiologists regularly administer medication directly into IV ports.

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Dr. Christopher Walters is a practicing anesthesiologist who came up with the idea for the visual alert at the IV port. [Ident-Alert® IV Port Clips](#), the newest innovation in visual cues, are designed specifically for IV injection ports to act as a last step visual cue and reminder for medication warnings or allergies. The color-coded clips help prevent medication administration errors by alerting the anesthesiologist right at the site of the drug injection.



“Anesthesiology is a very unique field where we’re taking medication from the vial and going right to the port where there’s no physical reminder. Visual cues are highly important to shake you out of any routine, and stop you from making an error.”

— Dr. Christopher Walters

These clips have a huge potential for use outside the OR as well, such as in the ICU, where multiple IV lines are being used simultaneously.

Make No Mistake

Visual cues help promote a “make no mistake” culture. Even with technological advancements and strictly regulated protocols, the human factor in healthcare is not perfect. Visual cues provide extra aid and support for people to prevent errors and improve patient safety.

Get free samples of these featured visual cues!





PSQH Innovation Awards Winner: SCL Health Improves Process for Prone Positioning of COVID-19 Patients

By Jay Kumar

Editor's note: The fourth annual PSQH Innovation Awards recognize healthcare organizations who overcame patient safety or quality improvement challenges. In this article, we highlight the winning submission selected from SCL Health in Superior, Colorado. Thanks to Patricia McGaffigan, RN, MS, CPPS, vice president of safety programs at the Institute for Healthcare Improvement, for her help in evaluating the submissions.

As the COVID-19 pandemic took hold in 2020, healthcare organizations had to look for creative solutions to new problems that arose as a result. SCL Health in Superior, Colorado, found that it needed to come up with a better way to conduct patient proning, which involves placing patients with acute respiratory distress syndrome (ARDS) on their stomachs to allow better distribution and air volume in their lungs. SCL's process transformation has been selected as the winner of the fourth annual PSQH Innovation Awards.

The challenge

In SCL's award submission, Nancy McGann, PT, CSPHP, CPPS, manager of clinical associate safety at SCL Health, detailed the steps taken to respond to this issue.

"In April 2020, we noted a large increase in hospital-acquired pressure injury (HAPI) in our COVID-19 patients that were vented and prone for the treatment of ARDS. We had 28 HAPIs systemwide related to proning in March and April 2020 and only

**"ANOTHER CONCERN WAS THAT PRONING
REQUIRED FIVE TO SEVEN CAREGIVERS
AND SIGNIFICANT PPE THAT WAS IN
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IS OFTEN A LIFE-SAVING TREATMENT, YET
IT TAKES CONSIDERABLE RESOURCES
AND TIME FOR AN ALREADY STRETCHED
CRITICAL CARE WORKFORCE."**

— Nancy McGann, PT, CSPHP, CPPS,
manager of clinical associate safety at SCL Health

one proning-related HAPI in all of 2019. We also noted two patient-handling overexertion injuries to our critical care nurses while proning patients during the same timeframe," she wrote. "Another concern was that proning required five to seven caregivers and significant PPE that was in limited supply worldwide. Proning is often a life-saving treatment, yet it takes considerable resources and time for an already stretched critical care workforce. To further complicate this problem, patients with high BMI have a higher risk of hospitalization and mortality from COVID-19. This makes all of the aforementioned risks of proning higher. We want to ensure we can offer this life-saving treatment to patients with high BMI while protecting and sustaining our workforce."

SCL saw the use of proning grow quickly, but it involved health risks for staff, McGann wrote.

"With the onset of COVID-19, the use of proning increased

PSQH Innovation Awards Winner

exponentially. Prone positioning is an evidence-based clinical practice used to improve oxygenation in patients who require mechanical ventilation for the management of ARDS. In a pivotal clinical trial, Guerin et. al. (2013) provided strong evidence that oxygenation improves when patients are in the prone position for at least 16 consecutive hours. Mortality at 28 and 90 days was shown to be lower among the patients who were in the prone position

healthcare system at one hospital but noted a large variation in proning methods at our eight hospitals. This variation included proning with bed sheets, friction reducing devices (FRD) and ceiling lifts. We needed to determine how to provide this treatment in a manner that is safe and efficient for both our patients and our workforce,” wrote

treated the vast majority of COVID-19 patients requiring mechanical ventilation in the spring surge in Colorado. The team included, critical care nurses, wound care nurses, respiratory therapists, Safe Patient Handling & Mobility Leads, performance improvement specialists, nurse researchers, nurse practice leaders, and supply chain professionals,” wrote McGann. “We met virtually and for an in-person half-day facilitated meeting in June of 2020. All barriers, current practices and potential solutions were identified by clinicians through brainstorming sessions. We then created action items for all team members to perform over the summer. The clinicians worked with supply chain staff to identify all possible solutions to the known barriers and risks to the physical movement of proning and swimming patients, and how to best position them once prone. Several items came from OR spine procedures where proning had been performed for years.

“WE HAD EXPERIENCED SUCCESS IN PRONING USING CEILING LIFTS IN OUR HEALTHCARE SYSTEM AT ONE HOSPITAL BUT NOTED A LARGE VARIATION IN PRONING METHODS AT OUR EIGHT HOSPITALS..”

— Nancy McGann, PT, CSPHP, CPPS, manager of clinical associate safety at SCL Health

compared to the control (supine) group ($p < 0.001$,” she wrote. “Best practice from literature is proning 16 hours/day with swimming position changes every two hours (Bamford et al., 2019; Drahnak & Custer, 2015; Mitchel & Seckel, 2018). A recent study implied that there is an increased risk of skin injury and caregiver injury risk from the lateral transfers needed for proning unless lifts or air-assisted devices are used (Wiggerman et. al. 2019). Literature and internal data showed that 27%-50% of patient handling injuries occur from repositioning in bed (AON, 2018, SCL Health Internal Patient Handling Data).”

In May 2021, SCL performed an extensive literature search to explore proning techniques and determine if there was information already existing about how to prevent HAPI in this patient population. It returned 24 articles, primarily discussing manual proning techniques with no mention of skin injury.

“We had experienced success in proning using ceiling lifts in our

McGann. “It was clear that the traditional manual way of proning required significant time and resources and carried an increased risk of pressure injury to our patients and overexertion injury to our caregivers. Therefore, we applied for an internal safety grant to improve the proning process.”

The resolution

To resolve the challenge, SCL reached out to colleagues across the country to learn from their experiences, including those from New York City with the highest volumes of COVID-19 patients at that time. McGann wrote that this did not yield solutions for these problems, but they received an internal SCL Health Safety Grant.

“We pulled together an interdisciplinary team that

After trialing and researching all summer, the team met in late August for an eight-hour simulation session with all of the proning and positioning equipment identified, McGann wrote.

“Three simulation rooms were used at Saint Joseph Hospital (SJH). One used a mobile lift, one had a ceiling lift and one used a variety of FRD systems. Each room had access to all of the additional positioning needs,” she wrote. “Each participant needed to be both a patient and a caregiver for every technique. We then immediately met to reach a consensus on the best method to prone since each site was using different equipment and processes and felt confident they had developed the most ideal process. Surprisingly, consensus was extremely easy to reach. The caregivers were especially surprised how much better they felt as the patient using both the ceiling or mobile lift and a FRD to prone. The vote was 100% for this method with other defined tools for positioning and securing the endotracheal tube.”

McGann wrote that the team developed a toolkit that included a three-tiered flow diagram so sites without ceiling lifts in their ICU had other options and supply chain ensured all items were available systemwide. Positioning equipment included wedges, fluidizers, foams, tape, aerated mats, and OR prone positioners. The toolkit also included videos, job aids, and a proning checklist that was then

PSQH Innovation Awards Winner

disseminated systemwide in September 2020 prior to the second surge in Colorado.

“SJH with 100% ceiling lift coverage completely adopted the change to a ceiling lift method by the fall-winter surge. In the spring surge, they used a FRD proning system,” McGann wrote. “Good Samaritan (GSMC) added in the FRD after only using ceiling lifts in the spring surge. A DNP student at SJH extracted several data points from Epic to compare outcomes before and after the significant proning practice change.”

The results

Pressure injury:

Total HAPI reduction at SJH was 46% after the initial practice change from spring 2020 to fall-winter 2020 and was 70% in sustainment (January-June 2021). Facial HAPI was reduced 80% in sustainment. Time between pressure relief turns decreased 47 minutes

from 3 hours and 8 minutes in the spring to 2 hours and 20 minutes in the fall-winter, and then to 2 hours and 9 minutes during January-June of 2021. This improvement was realized despite increased length of stay; 337 hours, 365 hours, 383 hours respectively and higher

acuity measured by mortality; 27%, 52% and 31% respectively.

Time and staff savings:

Time study performed at GSMC showed an 83% decrease in the time needed to prone. The number of staff to prone was reduced from six to three, and minutes to prone from sixty to 20 contributing to the 83% overall reduction.

“SJH WITH 100% CEILING LIFT COVERAGE COMPLETELY ADOPTED THE CHANGE TO A CEILING LIFT METHOD BY THE FALL-WINTER SURGE. IN THE SPRING SURGE, THEY USED A FRD PRONING SYSTEM.”

— Nancy McGann, PT, CSPHP, CPPS, manager of clinical associate safety at SCL Health

Honorable Mentions

The following submissions were selected as honorable mentions:

Guam Memorial Hospital Authority, Tamuning, Guam

Dealing with a staffing shortage during the height of the COVID-19 pandemic, the Guam Memorial Hospital Authority created a telemedicine program to connect physicians who were off-site with patients in the intensive care unit. With limited resources on an isolated island in the Pacific, GMHA was able to improve the quality of healthcare for its patients and reduce burnout for the physicians on site.

The Johns Hopkins Health System, Baltimore

Johns Hopkins Health System found that its electronic voluntary event reporting system was lacking and developed a new system called Hero that reimagines processes and workflows. The mobile-friendly application allows easier reporting with a single, simplified submission form and robust interfaces. It includes a chat function to allow reviewers and reporters to communicate about risks identified within the event report and mitigation strategies being implemented.

Creedmoor Psychiatric Center, Queens Village, New York

Creedmore Psychiatric Center began a systemwide effort to reduce violence and improve safety. Using evidence-based review, leadership led the initiative to reduce patient aggression and staff injuries from patient assault by brainstorm causes of violence and soliciting improvement suggestions from staff. Progress was slow when the changes began in July 2018, but by mid-2021, staff injuries have decreased dramatically and patient aggression is trending downward.

NYC Health + Hospitals, New York City

NYC Health + Hospitals—a system with 11 hospitals, five post-acute facilities, and more than 70 outpatient centers—developed a High Value Care initiative designed to eliminate unnecessary testing and treatment that result in patient harm. NYC Health + Hospitals implemented interventions that included the utilization of behavioral nudges that helped establish a norm of appropriate testing and treatment and discouraged overuse that could cause harm. More than 120 projects were initiated over a 2.5-year period from July 2019 to December 2021, saving an estimated \$19 million per year (based on a combination of publicly reported charge costs and an analysis of prevented adverse events and downstream services).



Staff injury:

No patient handling overexertion injuries were reported proning patients when ceiling or mobile lifts were used.

Conclusion

“Moving to this three-tiered proning strategy allowed us to improve the safety and efficiency of proning regardless of ceiling lift coverage by using mobile lifts. This significantly reduced pressure injury and allowed us to prone pregnant patients and patients that were 400+ pounds with BMI in the 60s,” McGann wrote. “This life-saving technique may not have been physically possible without this approach. Sites with ceiling lift coverage in their ICUs

reduced the time to prone by 83% per patient. This process has been fully adopted at both SJH and GSMC even with the passing of time, stress, turnover, and travel nurses. The time savings for this alone allows our staff to be able to perform other vital patient needs while keeping them healthy and at work. The patient and workforce safety benefits of this enhanced method of proning demonstrates that the patient lifts initially purchased to prevent workforce injury, also prevents patient injury

and improves both the safety and efficiency of care delivery. This body of work also led to the recommendation to cohort ICUs during COVID-19 surges in areas with ceiling lifts when possible.

SCL has shared this work nationally on several occasions. It won a best poster award in March 2021 at the Association of Safe Patient Handling Professionals Conference and was presented via webinar in September 2021. It was again presented as a poster at a Rocky Mountain Evidence-Based Practice Conference in October 2021 and then presented to over 500 attendees on December 15, 2021, for an American Hospital Association (AHA) webinar. This information can also be seen on demand by [registering for the free AHA webinar](#). *

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