Title:
Clinical Nurses and Executive Leaders Collaborating at the Bedside to Eliminate Hospital-Acquired Pressure Injuries

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Session Title:
Developing Nurse Leaders
Slot:
R 01: Monday, 31 July 2017: 10:15 AM-11:30 AM
Scheduled Time:
10:15 AM

Keywords:
Employee Engagement, Executive Leaders and Pressure Injury Prevention

References:

Aydin, C., Donaldson, N., Stotts, N. A., Fridman, M., & Brown, D. S. (2014). Modeling hospital-acquired pressure ulcer prevalence on medical-surgical units: Nurse workload, expertise, and clinical processes of care. Health Research and Educational Trust. Retrieved from http://onlinelibrary.wiley.com.laneproxy.stanford.edu/store/10.1111/1475-6773.12244/asset/hesr12244.pdf?v=1&t=i2zs0r1h&s=19d8d1f5b1055eb9d987d1b5d4542b7d319fb379. doi: 10.1111/1475-6773.12244

Demarre, L., Verhaeghe, S., Hecke, A. V., Clays, E., Grypdonck, M., & Beeckman, D. (2014). Factors predicting the development of pressure ulcers in at-risk population who receive standardized preventive care: secondary analyses of a multicenter randomized controlled trial. Journal of Advanced Nursing, 5(1). doi: 10.1111/jan.12497

Samuriwo, R., & Dowding, D. (2014). Nurses' pressure ulcer related judgments and decisions in clinical practice: A systematic review. International Journal of Nursing Studies, 51 (12), 1667-1685.

Abstract Summary:
Bedside staff and executive leaders took a collaborative approach through shared decision-making to eliminate hospital-acquired pressure injuries while inspiring self-motivation, accountability, employee engagement, and improved outcomes.
Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
The learner will be able to utilize the wound care algorithm to assist with pressure injury	The algorithm simplifies pressure ulcer staging by utilizing simple descriptors such as, color,

treatment and identify barriers to implementation.	drainage, and wound base to help guide bedside nurses to the right treatment protocol.
The learner will be able use the HAPI Alert process as an example of how Executive Leaders and Bedside Staff can work together to reach a common goal.	The HAPI Alert process was designed to assist Executive Leaders in creating work environments and work conditions that encourage employees to be self-motivated, assume responsibility for their job role, and provide opportunities for growth and development. Employees who are most likely to engage in their jobs are the ones that believe their jobs have meaning and they are provided with the tools to be successful.

Abstract Text:

Background: Hospital acquired pressure injury (HAPI) rates have not changed in the last eight quarters despite a large investment made in equipment and supplies, as well as education and training at a large academic teaching hospital. Clinical Nurses Leaders who pay close attention to work conditions and work environments give employees access to sufficient resources to be able to do their work effectively and have better organizational outcomes (Rich, LePine, & Crawford, 2010). Leaders that create work environments and work conditions that encourage employees to be self-motivated, assume responsibility for their job role, and provide opportunities for growth and development will have a higher level of productivity. Employee engagement is a key factor that helps to match the employee's values and beliefs with the organizational values and goals. Employees who are most likely to be engage in job performance are the ones that believe their jobs have meaning and they are provided the tools to be successful (Joo, Jeung, & Yoon, 2010).

A**im:** The goal of this project was to reduce the incidence of HAPI using a collaborative, shared-decision making approach between executive leaders, nursing managers, wound experts, and clinical nurses**.**

Methods: The Nursing Quality department's initial assessment revealed variability in structure, and variability in process of initial identification, reporting, assessment, and documentation of HAPI's. Clinical nurses, executive leaders, wound experts, and nurse managers formed a workgroup to identify the root cause of the current state problem, develop counter measures, design future state, and develop an implementation plan. A collaborative process called HAPI alert and Pressure Injury Prevention (PIP) Alerts was created. The purpose of the PIP alert was to assist the clinical nurses with diagnosing, staging, and implementing a treatment plan for Stage I/II, or Suspected Deep Tissue Injury (sDTI) pressure injuries. A communication algorithm was followed, alerting the unit manager, charge nurse, and clinical nurse specialist to respond to the bedside to determine treatment options. A HAPI Alert is activated when a stage III, IV, or unstageable PU is suspected. The team, consisting of the clinical nurse, unit manager, Chief Nursing Officer (CNO), Unit Director, Quality Manager, and Wound Ostomy Certified Nurse (WOCN) meets at the bedside to discuss the mechanism of injury, prevention strategies in place, the current condition of the patient, and any barriers to success.

Results: Since May 2014, 52% reduction in PU incidence and prevalence, virtual elimination of Stage III/IV PU, a potential cost savings of $3,000,000.

Conclusion: Pressure injury prevention takes a collaborative approach from all levels of nursing. Continuous evaluation and individualization of processes are essential to delivering safe and effective patient-centered care. It is clear that implementing change in an organization is not an easy task but must be planned and calculated to be successful. Leaders who allow staff to be part of the decision making process are often successful with managing resistance to change. Implementing the HAPI alert team

encouraged organizational leaders to work with the bedside workforce to come up with solutions collaboratively to reduce HAPI. When employees have a clear understanding of their job roles and responsiblilites, accountability can be placed on performance and increased engagement occurs. This inturn motivates the staff to practice excellence and improve outcomes. This collaborative process is a best practice that is replicable in any health care organizations.