Strategies for predicting and preventing hospital-acquired conditions (hacs) and ...

According to patient safety experts, prediction and prevention are the two main goals for avoiding adverse events and reducing the incidence of hospital-acquired conditions (HACs) (Bresnick, 2018). Hospital-acquired conditions (HACs) are preventable; never events are more serious and can be deadly. Higher-staged pressure ulcers are both. They are among the most prevalent and dangerous medical errors (Gaffney, Hatcher, Milligan, & Trickey, 2016). A valuable tool for information is the electronic medical record (EMR). When it is used wisely, it can become a valuable resource, such that the data can help to catch human error and prevent adverse events (Bresnick, 2018). Understanding the history and social aspects that HACs and never events present, realizing that prevention and recovery efforts provide patient care strategies, becoming well adept at the agencies involved and the protocols they put in place to follow, and engaging in the importance of incident reporting finalizes strategies for predicting and preventing HACs and Never Events.

Introduction

With every medical error, there is causation (WHO, 2016). Medical error causation places patient death at the number three spot on the list of patient deaths nationally (n. a., 2016). Factors that may influence medical errors, are those associated with health care professionals, patients, work environment, medications, tasks, computerized information systems, and primary-secondary care interface (WHO, 2016). There are many areas to research, but fully understanding causation will lead to a better understanding on how to strategize a resolution. Error prevention is reliant on a fundamental approach of error reporting (Wolf & Hughes, 2008). We

rely on statistical data to show us the level of severity and the ranking of causation. When medical errors occur, as in the case of HACs, healthcare documentation and incident reporting is key to prevention and future occurrence.

Historical and Social Perspective

The term " Never Event" was first introduced in 2001 by the former CEO of the National Quality Forum (NQF). Although an initial list of never events was established in 2002, multiple revisions have been undertaken and now consists of 29 serious reportable events grouped into 7 categories. Under the heading of Care Management Events, pressure ulcers at stage 3, stage 4, or those unstageable, that are not present on admission to a health care facility, are considered one of the listed seriously reportable never events (PSNet, 2018).

Following the release of the Institute of Medicine's (IOM) report To Err Is Human: Building a Safer Health System, much focus was placed on the depth of this report. This report centered on adverse events and findings from the Harvard Medical Practice Study suggested that the national leading cause of hospital death was preventable. More than 70 percent of these errors were secondary to negligence, while more than 90 percent were deemed preventable adverse events. Based on this data, the IOM continued their focus on the reporting of such errors to measure provider performance accountability with the intent of increasing and improving patient safety (Wolf & Hughes, 2008).

Pharmacist-led medication review was shown to reduce hospital admissions. Medication reconciliation via electronic systems reduced discrepancies as well as adverse drug events (potential and actual) (WHO, 2016). Patient safety is top of mind and critical to prevention. Over time, medical error reduction strategies have been implemented and still increase in administrative efforts.

Prevention and Recovery Efforts

When a death certificate states " sepsis, secondary to decubitus ulcers," healthcare facilities and providers are looked at for the reasons behind such an event. Family members who are not expected to be as knowledgeable as the providers they trusted will start to question the actions of the health care team. There are always going to be contributing factors, such as the underlying causation for a patient's hemodynamically unstable condition; however, even if, and when, this condition exists, there are prevention measures to avoid never events and recovery measures in place for expediency when a previously unnoticed " hot spot" is finally noticed. From a nursing standpoint, prevention is important but recovery efforts are of equal importance.

A study was performed to introduce the concept of error recovery and the important role medical-surgical nurses provide to patients to enhance patient safety. Nurses are a key factor in safeguarding their patients, but little is known about their role in medical error recovery. This recovery process includes medical error identification, acting to interrupt the process, and then correcting the error to mitigate patient harm. We think about

prevention; we also need to think about recovery. Error recovery is the process which occurs before patient harm ensues. Nurses who " fully use their education, expertise, and role to identify, interrupt, and correct medical errors," will embody a safer healthcare system. Recovery efforts are dependent upon human intervention, requiring professional decision-making and critical clinical reasoning. When system safeguards fail, human intervention must take over (Gaffney, Hatcher, Milligan, & Trickey, 2016).

After analysis of the 155 surveys within this study, the results demonstrated that expert nurses (those with advanced education) were better equipped to identify, interrupt, and recover errors. Advanced education is not only achieved at the graduate level as experiential expertise via certifications and/or lifelong learning contributes as well. A safer healthcare system is dependent and reliant on the ability of nurses to utilize their full capabilities and expertise to perform recovery efforts. Nursing workload contributes to patient safety and it is recommended that nurse advocacy and participation in policy at the organizational and legislative level take place to adjust a better workload. Recovery efforts were found more so in nurses with self-reported expertise than self-reported novice nurses. When a system failure occurs, nurses provide the human intervention necessary replacing the latest trends in computerized safeguards. Reliance on nurses is crucial to ensuring patient safety (Gaffney, Hatcher, Milligan, & Trickey, 2016).

Ethical Implications and Consequences

The depth of clinical documentation, or lack thereof, creates ethical or legal implications not to mention financial implications for the entity providing

care. Two organizations provide us guidance: Centers for Medicare and Medicaid Services and the National Pressure Ulcer Advisory Panel.

Centers for Medicare and Medicaid Services (CMS)

The Deficit Reduction Act (DRA) of 2005, signed presidentially in 2006, requires the Centers for Medicare and Medicaid Services (CMS) to consider two conditions that qualify for adjustment in hospital payments: never events or hospital-acquired conditions. If these conditions were not " present on admission," then no payment will be provided to the entity (HMSA, 2009). Because of this ruling, there lies the legal implication that CMS's reimbursement determination leads the way to a compelling argument of negligent behavior in the level of care provided to the patient (O'Rourke & Hershey, 2009).

The National Pressure Ulcer Advisory Panel

The *National Pressure Ulcer Advisory Panel (NPUAP)* , through public policy, education, and research, is an authoritative voice for improvement in patient outcomes with respect to the prevention and treatment of pressure injuries (n. a., 2018). They have six position statements concerning pressure ulcers:

Pressure Injury Staging – 2017 Clarifications (New). This is a recent position statement from 2017. Its premise was to appoint a multi-disciplinary Staging Task Force for the preparation of refined definitions from the 2007 staging definitions. The task force reviewed scientific literature and proceeded with the adoption of the following seven updates: (1) The diagnosis of a " pressure injury" does not mean that the health care provider(s) " caused"

the injury. (2) Some pressure injuries are unavoidable despite the provision of evidence-based care by the healthcare team. (3) The numerical staging system does NOT imply liner progression of pressure injuries from Stage 1 through Stage 4, nor does it imply healing from Stage 4 through Stage 1. (4) The NPUAP Staging System classifies pressure injuries based on the type of tissue loss that can be visualized or directly palpated. (5) The pressure injury may be more extensive than initially apparent. The wound base and surrounding tissue should be assessed for variations in sensation, temperature, firmness, color and any expression of drainage from surrounding tissues when palpated. (6) Deep Tissue Pressure Injury (DTPI) may evolve into a full thickness wound despite optimal care. (7) Any pressure injury should be treated in accordance with current evidence-based practices and monitored closely for changes that require re-evaluation of treatment strategies (n. a., 2018).

Hand Check Method: Is it an Effective Method to Monitor for Bottoming Out?: A National Pressure Ulcer Advisor Position Statement: June 2015. This position statement has to do with the method of determining support for mattresses and does not relate to my topic; however, its premise is to limit the use of a techniques used to check support mattresses called the hand check (n. a., 2018).

Pressure Ulcers with Exposed Cartilage Are Stage IV Pressure Ulcers. Its premise is that Stage IV pressure ulcers were defined as having full-thickness tissue loss with exposed bone, tendon, or muscle. An update would be to include that cartilage, line bone, would serve the same anatomical

function and, therefore, should also be staged as a Stage IV pressure injury (n. a., 2018).

National Pressure Ulcer Advisory Panel Position Paper on Staging Pressure Ulcers. Its premise is that pressure ulcers that reach the Stage III or IV staging, or those that are unstageable, are ones that have reached full thickness, which are considered " never events." Documentation accuracy is imperative to note the staging level to differentiate these injuries as less than or at the level of consideration as a never event. As nurses are the first professional to likely examine the patient, it is the responsibility of the nurse to identify, stage, document, and develop a care plan. The NPUAP supports the education for nurses to acquire advanced skills in this regard (n. a., 2018).

Mucosal Pressure Ulcers: An NPUAP Position Statement: August 2008. This form of pressure injury does not relate to my topic of interest; however, its premise is that mucosal surface pressure injuries exist but are not to be stages using the pressure ulcer staging system as they do not have observable characteristics to be able to use the staging tool (n. a., 2018).

The Facts about Reverse Staging in 2000: The NPUAP Position Statement. This is from 2000. Its premise is that when a pressure ulcer reaches a certain stage, it remains that stage after healing. Healing will not replace lost muscle, subcutaneous fat, or dermis and, therefore, the ulcer will always be considered the level of injury staging its reached. " Once a Stage IV always a Stage IV" (n. a., 2018).

Incident Reporting

Incident reports are fully documented reports describing adverse incidents that have occurred during a patient's hospital stay during their time receiving patient care. In addition to the incident report being fully documented, the patient record must also include a recording of the incident. This multi-purpose incident report aides the risk management department by helping to identify situations that may place the entity at risk for litigation, looking for ways to prevent future incidents from happening by educating health-care personnel, and monitoring the number and types of incidents via the creation of a database. Documentation and identification of high-risk areas are part of the traditional risk management methodology, while educating staff within these risk areas is part of the guidance of the entity's quality assurance program. Identifying high-risk areas, followed by educating and alerting staff to these identified risk areas, is only as good as the documentation provides (McWay, 2010).

The incident report must be thorough. If information is not documented, or if not clear and concise, there lies potential legal liability. This report is crucial to any loss prevention program. The extrapolated information from this document, when placed into the database, will be used for the purpose of prevention and, therefore, it becomes quite critical to not only ensure accuracy, but timeliness as well. Timeliness becomes very important, as the memory of the incident is very clear in mind; however, it is not the only reason because availability of the report is of equal importance. When a report is completed in a timely fashion, it becomes readily available to an attorney, insurance company, and even quality assurance departments for review and scrutiny. Timeliness and availability become determinant factors

in whether the incident report becomes discoverable and admissible in the case of litigation (McWay, 2010).

Conclusion

Recommendations as to how to prevent potential future breaches may sometimes be a difficult task. Without previous documented incidents, risk management would not be able to identify high-risk areas. Without these identified areas, quality assurance departments would not be able to effectively educate their healthcare workers to the potential risk. It is unfortunate to have to rely upon previous incidents as collateral damage for the purpose of identification and education; however, as they are available, they should be used wisely. For every incident report, a wrong has been done to an individual and it would be unfortunate to have more wrongdoing. In order to prevent future breaches, a culture of safety must be top of mind. The appropriate departments must ensure that their staff is fully aware of potential future risk. Briefing them on the importance of documentation, not only how to fully document and the elements of such, but also the reasoning of why becomes crucial. When someone fully understands the reasons behind something, they are more apt to oblige with the task at hand. Staff must be fully informed on how to fully document, in a timely fashion, in clear and concise language, so that the information in their report can be utilized to further the work of those appropriate departments in furthering their alert database and education systems. Because of the DRA of 2005, we now have advanced standards where payment is rescinded or void when pressure injuries occur from what is considered withholding a level of care congruent

with ethical health care. The NPUAP provides position statements. Continued education and awareness must be a standard requirement.

Performing a full assessment of a patient's condition, inclusive of any existing pressure ulcers or hot spots, is not only an expected duty as a nurse but also an ethical behavior. Documenting integumentary assessment when it was not done holds legal implications, as well as not documenting at all, and may be considered negligent. A never event is much like it is stated—an event that is never to occur. A historical and social perspective provides a background, prevention and recovery efforts provide patient care actions, information about the ethical implications and consequences provide agency protocols, and details of the importance of incident reporting finalizes strategies for prediction and prevention.

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