Multifaceted Approach to Decreasing Pressure Ulcers in the ICU

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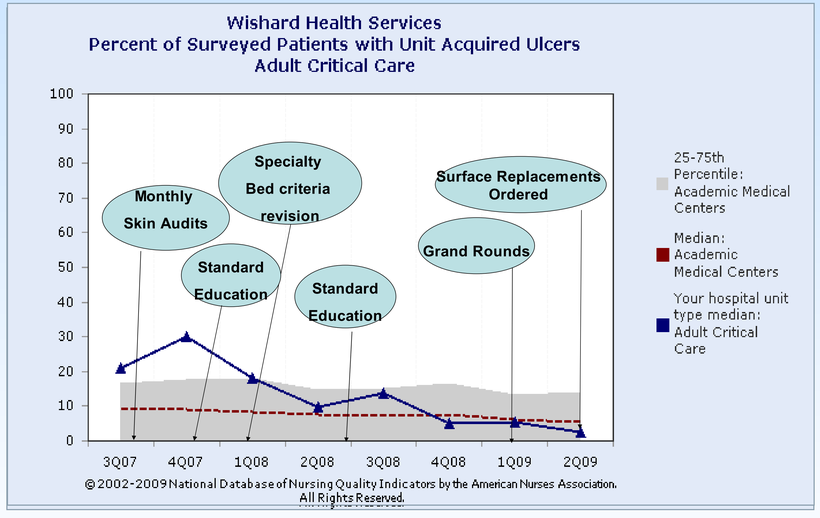
Purpose

To decrease pressure ulcers in the intensive care units (ICUs) to at or below NDNQI benchmarks, a multifaceted structured approach was implemented.

Significance

Pressure ulcer prevention has been a goal, yet a challenge in the intensive care environment. With a spike in the incidence of pressure ulcers in the Intensive Care Units, the organization mobilized resources in a different way. A skin care team was reorganized with the goal to decrease the incidence of hospital acquired pressure ulcers. A four-pronged structured approach was implemented which addressed routine rounding, specialty bed utilization, surface assessment and staff education.



Strategy and Implementation

4 Pronged Approach

Bed- surface analysis:

- Current bed surfaces were evaluated and found to be inadequate for basic pressure reduction.
- Surface alternatives available were evaluated and pricing explored.
- The skin care team made a recommendation for surface purchase.

Specialty bed utilization:

Current Specialty Bed Protocol was reviewed and revised:

- The existing guidelines required 2 or more current Stage II pressure ulcers or a Stage III/IV pressure ulcer to qualify for placement on a specialty bed.
- The Critical Care guidelines were adjusted to allow placement of patients on these beds based on risk assessment to support proactive prevention rather than reactive treatment only.
- Determination of increased risk included utilization of 2 or more vasopressors, low Braden scores, poor oxygenation status and use of neuromuscular blockers with the presence of increased intracranial pressure.

Rounding:

Focused rounding was implemented by the Certified Wound/Ostomy Nurse:

- Rounding to evaluate patient risk occurred daily in the ICUs.
- Rounding included discussion/coaching with bedside nursing staff on treatment plan
- Rounds included a ICU staff nurse, thus creating a unit champion with the focus to prevent pressures ulcers.

Education of staff

Ongoing education on skin care products, bed utilization, staging had been provided using standard methodologies.

A grand rounds mandatory education was provided to the ICU nursing staff. This interactive education included: a review of staging, preventative measures, risk factors, scoring of the Braden scale, nursing protocol for skin care management, available products, and pressure redistribution surfaces were reviewed. Case methodology was used to evaluate.

Evaluation

Wishard Health Services used the NDNQI prevalence study, but increased the frequency to monthly.

From the highest incidence of 40% in the 3rd quarter 2007, hospital-acquired pressure ulcers have decreased to meet or be below benchmark since 2nd quarter 2008 in the Intensive Care Units.

Implications for Practice

Multiple factors contribute to hospital acquired pressure ulcers and all must be addressed. Decreased incidence of pressure ulcers improves patient outcomes in many ways and decreases the cost of healthcare.

- By addressing identified issues simultaneously and intervening, measurable progress toward pressure ulcer prevention was achieved.
- Changing the methodology used for staff education to a case review and grand rounds format with a single in-depth focus on pressure ulcer prevention.
- Monitor progress frequently enough to enable timely interventions via daily rounds and monthly data review.
- Create opportunities for the staff to become actively engaged via rounding and education initiatives.