Collaboration At Its Finest:

MARKEDLY REDUCING PRESSURE ULCERS BELOW NATIONAL STANDARDS

Hahnemann University HOSPITAL

ABSTRACT

Patient discomfort from pressure ulcers in combination with the financial burden imposed by high treatment costs and the elimination of CMS reimbursements made prevention of facility-acquired pressure ulcers a top priority at our hospital. In response, we embarked on a comprehensive, multi-pronged program in May of 2008 to decrease prevalence and incidence rates.

At the time of inception, both our prevalence rate of 16.8% and incidence rate of 2.4% were above the national average for acute care facilities. This made our ultimate goal a challenge, but certainly attainable.

We identified the education of all staff in recognizing at-risk patients and applying appropriate prevention interventions as the most significant factor in the prevention of facility-acquired pressure ulcers. Under the leadership of our WOCN, we instituted a comprehensive educational plan for all staff members. This included scheduling educational opportunities within the classroom, on the various units, and in individualized learning situations at the bedside. Family and caregivers were also instructed in prevention measures that can be employed at home to prevent skin issues in the future.

Unit-based Skin Champions were appointed as advocates of continual improvement. We also established a multidisciplinary Save on Skin taskforce, developed clinical practice guidelines, moved all reporting online, and conducted a Skin Fair, Grand Rounds on preventing skin injury and more.

The result over two years has been spectacular: we reduced facility-acquired prevalent from 12.6% in May 2008 to 2.9% in May 2010 and brought the incidence rate to an astounding 0%. Furthermore, the year to date facility-acquired prevalence rate for 2010 is currently at 2.6%.

BASELINE DATA

Prevalence, the number of patients with at least one pressure ulcer existing at a given point in time, ranges from 10.1% to 17% in an acute care setting (NPUAP, 2001). Our prevalence data is collected quarterly from inpatients on adult units with the exception of the Mother Infant Unit and inpatient Medical Psych. Incidence, the number of patients who were initially ulcer-free and then developed a pressure ulcer within a particular time frame, ranges from 0.4% to 38% in acute care facilities (NPUAP 2001). Incidence data is collected biannually.

GOALS

In 2008, we recognized a need for a hospital-wide initiative to prevent facility-acquired pressure ulcers. This was sparked by the elimination of CMS reimbursements and a cost associated with a single stage 2 pressure ulcer of $43,000. More importantly, we saw a high personal cost to our patients, including increased risk of nosocomial infection, pain, greater length of stay, and premature mortality. Therefore, we embarked on a multi-pronged program to decrease prevalence and incidence rates.

INTERVENTIONS

Education – The education of all staff in recognizing at-risk patients and applying appropriate prevention interventions is foremost in the prevention of facility-acquired pressure ulcers.

- **Classroom-Based Education** –
  - *Pressure Ulcer Staging:* Includes instruction on how to properly stage pressure ulcer, documentation and assessment of risk factors.
  - *Preventing Skin Injury:* Includes assessment of risk factors, implementing interventions to prevent pressure ulcer formation, and using a multidisciplinary team in prevention.
- **Unit-Based Education** – Annually, our Wound Care Nurse (WOCN) conducts unit-based competency lectures on pressure ulcer prevention and treatment geared to the specific unit's needs. For example, a unit with a high number of bariatric patients may require education on preventing skin breakdown within skin folds. Quarterly sessions on recognizing, preventing and managing pressure ulcers are also held for the department of PT/OT.
- **1:1-Focused Education** – Each time our WOCN consults with a patient, it is used as a learning opportunity for the attending nurse. Our focus on assessment, staging of pressure ulcers, interventions for prevention, and treatment has improved the knowledge and confidence of our nursing staff.
- **Patient/Family Education** – Every patient encounter is viewed as a chance to educate. When possible, our WOCN includes the patient's family/caregivers in education regarding prevention of pressure ulcers, treatment for any current pressure ulcers, and interventions that can be employed at home to prevent skin issues in the future.
- **Grand Rounds** – Over the last year, our WOCN has presented a Nursing Grand Rounds open to all staff on Preventing Skin Injury. Topics include interventions to prevent pressure ulcers, how to use the Braden scale to identify at-risk patients, skin care, positioning and moisture management.
- **Internal Medicine Monthly Conference** – Attended by all internal medicine residents and medical students doing internal medicine rotations, this conference covers CMS guidelines for pressure ulcer prevention, the importance of documenting pressure ulcers present on admission, staging of pressure ulcers, and an update on our current prevalence rates.

Unit Champions – Our unit-based skin champions act as change agents to promote the integration of evidence-based practice into daily nursing practice.

Revision of nursing flow sheet – Includes a "skin man" diagram and check-off boxes for pressure ulcer stage, size, appearance and treatment. The "skin man" is a front and back body image where nurses circle areas of skin breakdown. This improved overall daily documentation of skin assessments, as well as communication for patient transfers.

SOS Taskforce/Interdisciplinary Approach – The Save Our Skin (SOS) taskforce is a multidisciplinary group consisting of bedside nurses, nurse educators, physical therapists, nutritionists, WOCN, nursing administrators and other departments that may be needed to address issues at any given time. Meeting monthly, the taskforce is charged with increasing awareness of skin breakdown throughout the hospital, educating on preventive measures for skin breakdown, and developing treatment processes for skin breakdown utilizing evidence-based practice.

Joint Commission Project – The Joint Commission Resources Pressure Ulcer Prevention Project (JCR PUPP) is a 3-year project designed to advance the translation of safe patient care from evidence to the bedside with a focus on the successful implementation of pressure ulcer prevention protocols in the acute care setting. As one of the four member hospitals, we have engaged a multidisciplinary team to identify the current impediments to successfully implementing pressure ulcer prevention protocols within our facility. Over the past year, our focus has been on the need for unit-specific initiatives to ensure that all at-risk patients are turned at prescribed intervals. Additionally, we are working to re-educate all staff on the hospital's Save Our Skin Program. This project will continue for an additional 18 months.

Clinical Practice Guideline Development – Clinical Practice Guidelines (CPGs) help aid the nurse in proper evidence-based practices and techniques, including the prevention of skin breakdown and treatment modalities.

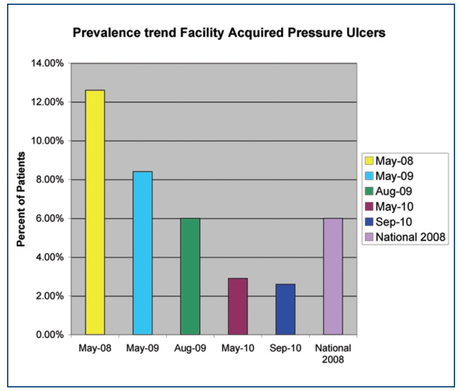
Online Incident Reporting – Moving from a paper incident reporting system to an online method has dramatically improved the rate of reporting and timeliness of reports.

Wound Care Consult Form – This addresses wound assessment, treatment and prevention strategies and allows both nursing and medical staff easy access to recommendations for proper prevention strategies and treatment recommendations for patients.

Skin Fair – An interdisciplinary committee of nurses, physicians, physical therapists and nutritionists developed a Skin Fair conducted on June of 2009 that centered on maintaining healthy skin. Games, prizes and educational information were available for staff and hospital visitors.

RESULTS

	May 2008	May 2009	August 2009	May 2010	September 2010
Prevalence	16.8%	14.5%	14.2%	6.6%	6.7%
Facility-acquired Prevalence	12.6%	8.4%	6%	2.9%	2.6%
Incidence	2.4%	2.3%	N/A	0%	N/A



DISCUSSION

Equally important to reaching our goal is a plan for sustaining our efforts. In the future, we plan to have preprinted wound care order sets for both physicians and nurses, easily accessible product reference lists to ensure the correct product is applied each time, development of a patient/family handout on prevention, and continued education for staff.

Our hospital's innovative approaches to decreasing hospital-acquired pressure ulcer rates can be created and implemented by any acute care organization. A strong commitment to patient safety and evidence-based patient care will ultimately result in positive patient outcomes and cost savings for both the patient and the hospital.

REFERENCES

- Comprehensive Hospital-Based Program Significantly Reduces Pressure Ulcer Incidence and Associated Costs. AHRQ, Mar 2008
- Jackson, K & McCubbin, L. (2007). Empowering Nursing Autonomy with Skin Care. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice*, Vol 21(2).
- Champions Improve Staff Education and Compliance with Pressure Ulcer Prevention Strategies. IHI.Org
- Harrison, M., Mackey, M., & Friedberg, E. (2008). Pressure ulcer monitoring: a process of evidence-based practice, quality, and research. *Joint Commission Journal of Quality and Patient Safety*, 34(6):355-9.