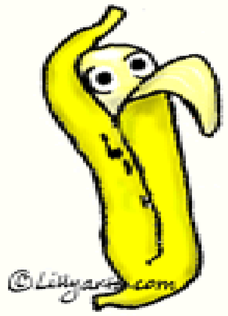

Reducing Hospital Acquired Pressure Ulcers on a TCAB Unit

4-Eyed Assessment Nurse and PCA Working Together

Sharnae Coakley, RN, BSN, Reva Klar, RN, MSN, GCNS-BC, Meghan C. Smith RN,BSN., CWOCN,
Elmira Nixon, RN, MHSA, Connie Hall Burke , RN, BSN, Judy Paull APRN, NEA-BC

DMC Sinai-Grace Hospital

Background

Pressure Ulcers

•Pressure ulcer prevalence and prevention are mounting concerns for healthcare entities.
•Pressure ulcers cause considerable harm to patients and hinder their functional recovery, cause pain, contribute to the development of serious infections and add to hospital length of stay.
•Early nursing interventions are associated with decreased incidence of hospital-acquired pressure ulcers.
•Pressure ulcers not identified within 24 hours of admission are considered hospital acquired and reimbursement for their care and treatment is in jeopardy

Transforming Care at the Bedside
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Transforming care at the bedside (TCAB) is a national program with the intended aim of improving care for patients served on medical-surgical units, where most inpatient care is delivered, and where most improvement is needed. It is estimated that 35%-40% of unexpected deaths occur on this unit type. The essential nature of teamwork and collaboration are critical components of the TCAB endeavor. The use of the Plan-Do-Study-Act (PDSA) methodology is directed at improving functionality in the following areas:
•Safe and Reliable Care
•Vitality and Teamwork
•Patient-Centered Care
•Value-Added Care Processes

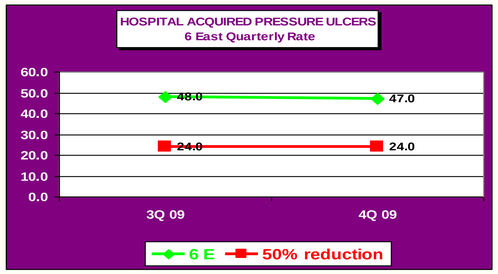
The Sinai-Grace TCAB Unit - 6EAST

•39 bed medical/surgical unit that has a sub-specialty focus of geriatrics and oncology. A high percentage of patients are admitted from nursing homes and many have multiple comorbidities. The hospital Case Mix Index (CMI) is 1.60
•Average daily census 37, Average Admits/day, 5.1.
• Modified team nursing model of care.
• Shared governance established in 2008.

Specific Aim

To decrease the incidence of hospital acquired pressure ulcers on 6 East by 50% during a 12 month period beginning Nov.2009.

Current Hospital Acquired Pressure Ulcer rate per 1,000 patient days is 34.7
The intended rate for the next 12 months is 16.8



Plan

•A Plan was initiated with the input of 6 East RNs/PCAs, Wound/Ostomy Care Nurses, Nursing Management and the CNS to reduce Hospital Acquired (HA) Pressure Ulcers. Small "Tests of Change" were implemented and evaluated by the staff on the unit. These included the following:

•4 Eyed Assessment – Completed on all patient admissions and patient transfers to 6 East that met the following criteria: **confusion (A & O 1-2) and non-ambulatory patients.** This paired an RN/PCA or other team member (resident or physician assistant) together at the bedside to assess the patient for altered skin integrity. A pressure ulcer not documented on admission is considered hospital acquired. The current 4 eyed assessment tool was changed x 3 since November 2009 with input from the staff as a Test of Change.

•Use of an Admission Checklist for Pressure Ulcers (as part of an admission folder) to prompt nurses regarding interventions to prevent pressure ulcers as well as those requiring actual management

•Education for RNs (using NDNQI concepts) and Education on Hygiene and Pressure Ulcer Prevention for Nursing Assistants (PCAs).

•Anatomical Locations placed on Wireless on Wheels for reference during documentation (hardware for computer system)

•Monthly Prevalence Survey of all 39 patients by CNS and Staff Nurse using NDNQI criteria

At the Detroit Medical Center, nursing documentation is completed in the Electronic Medical Record. Recently, additional space was added for pressure ulcer documentation.

References

Denby Abby, Rowland Altha. (2010). Stop Them at the Door: Should a pressure ulcer prevention be Implemented in the Emergency Department? *Journal of Wound and* Ostomy *Nursing*, *37*(1):35-38

Redlings MD, Lee NE, Sorvillo F. (2005) Pressure Ulcers: More Lethal than we Thought? *Advances in Skin & Wound Care, 18* (7). :367-372.

Rutherford,P. et al. Transforming care at the bedside., Cambridge, MA: Institute for Healthcare Improvement; 2004. IHI Innovation series white papers. http://www.ihi.org

Results

Since the inception of the TCAB unit (November, 2009), the Hospital Acquired Pressure Ulcer rate has decreased from 34.7/1000 patients days to 7.0/1000 patient days (Aug. 2010).

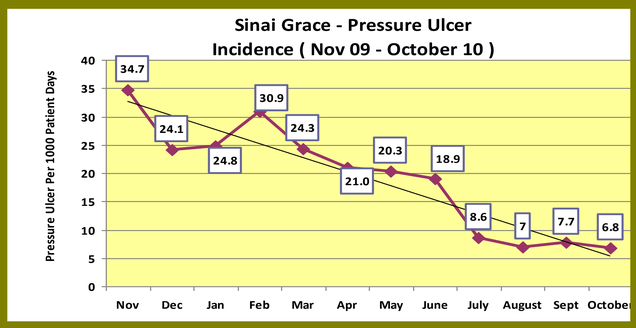
• 91% of the assessments were documented in the EMR within the required timeline, and 97% of the participants have found the process helpful

• Comments made by the staff completing the 4 eyed assessment include:

•"Helpful to have two people looking"

•"I can do my wound care immediately"

"Time saving, more accurate and provided better care"



Validation of Assumptions

With staff input and interventions chosen from small "Tests of Change", the staff of 6 East has improved their documentation on admission and reduced Hospital Acquired (HA) pressure ulcers.

Ongoing planning and interventions are now being discussed to reduced HA pressure ulcers that occur with patients with longer Length of Stays and a decreased Braden Score.

• To enhance communication, notification of all new admissions goes to both the RN and PCA who each receive a copy of the SBAR report sent from the ED for all admissions.

•The team continues to have bi-weekly TCAB meetings to review results and plan subsequent Tests of Change.