Zeroes are for Heroes

One Hospital's "Blueprint for Action" to Reduce and Prevent Pressure Ulcers

Karen Hartley, BSN, RN, CWOCN, CPHQ

Nursing Performance Improvement Coordinator

Andrea Stanley, MSN, RN, NEA-BC

Chief Nursing Officer

Tewksbury Hospital, Tewksbury, MA

Objectives

Describe a successful action plan to rapidly decrease HAPU's.

Identify successful nurse oriented strategies and methods used to improve patient outcomes by dramatically reducing HAPU's.

Tewksbury Hospital

State facility; established in 1854 as an almshouse with a census of 3000 patients.

The administration was placed in the hands of a Superintendent, a Physician, and a Chaplain of the 14 additional employees only 1 was a Nurse.

Salaries per anum:	
Dr. Jonathan Brown, Physician	\$400.00
Rev. Jacob Coggin, Chaplain	\$300.00
Thomas Hale, Clerk	\$250.00
George Pearl, Cook & his wife	\$350.00
Mary Pearl, Seamstress	
Parker Tisbury, Farmer & his	\$350.00
wife, Ermeline	
Mary Ann Gay, Nurse	\$200.00
	Dr. Jonathan Brown, Physician Rev. Jacob Coggin, Chaplain Thomas Hale, Clerk George Pearl, Cook & his wife Mary Pearl, Seamstress Parker Tisbury, Farmer & his

Tewksbury Hospital

- 360 bed long term acute care hospital
- 7 medical units
- 4 psychiatric units
- The primary mission of Tewksbury Hospital
 - is to provide comprehensive treatment, care and comfort to adults with chronic medical and mental illness.



Tewksbury Hospital



- Medical units census 240 patients
- 70% of our patients are at risk for skin breakdown
- 75% are non ambulatory requiring a wheelchair or mobility device
- 90% are dependent in ADLs
- 72% are dependent in toileting
- 50% are incontinent for bowel and bladder

The skin issue: June 2009

- Joined NDNQI Q2-08
 - Provided standardized methodology in collecting data and benchmarking ability
- Between Q2-08 and Q1-09 our data of percent of surveyed patients with hospital acquired pressure ulcers placed us between the 50th and 75th percentile.
- By Q2- 09 our HAPU rate had exceeded the NDNQI 90th percentile, indicating an urgent need to improve nursing clinical practice and patient outcomes.
- A total of 57 HAPU's were noted in the June 2009 prevalence study with several stage 3 and 4 ulcers.

Significance

Several patients had significant complications from HAPUs including multiple surgeries, invasive procedures, and pain, as well as an overall reduction in their quality of life.

Costs associated with these events were significant and directly reflected nursing clinical practice issues.

Purpose

Vision:

 Improve organizational performance in the area of pressure ulcer prevention.

Goal:

Reduction of the Hospital Acquired
 Pressure Ulcer (HAPU) rate from
 17.3% in 6/2009 to 3.5% by 3/2010.

Strategy

- "Blueprint for Action"
- Rapid cycle performance improvement initiative.
- Addressed
 - People
 - Practice
 - Products
 - Processes
 - Performance
 - Education

"Blueprint for Action" People

- Bedside nurses took ownership of improving patient outcomes through active participation in an aggressive pressure ulcer prevention and treatment initiative described in the "Blueprint for Action".
- An interdisciplinary Wound Team was established that included a Skin Resource Nurse from each medical unit, physical therapy, pharmacy, medicine, nutrition and infection control.
- Intensive education in skin care concepts to this group was conducted by the team facilitator, an experienced and knowledgeable CWOCN.

The Team

- Culture
- Share
- Communicate



"Blueprint for Action" Practice

- A review of the literature and best practices were conducted, leading to a full revision of the current guidelines for wound care at Tewksbury Hospital.
- Evidence based practice guidelines for pressure ulcer prevention and management were developed and integrated into day to day online documentation, MD order sets and treatment records.

"Blueprint for Action" Products

- Revisions to skin care practices included changing the hospital formulary for approved skin products achieving the best in skin protection, healing and cost effectiveness.
- An evaluation of innovative products on the market to protect the skin, reduce pressure and maximize healing has led to acquisition of the right products for the nurse to have in her arsenal in the fight to protect each patient's skin.

"Blueprint for Action" Processes

- Incorporated a complete daily skin assessment into the nursing routine.
- Initiated "Hourly Rounding" requiring repositioning and toileting for all patients every hour.
- Improved risk assessment and nurse care planning monthly by utilizing an enhanced NDNQI collection tool.

"Blueprint for Action" Performance

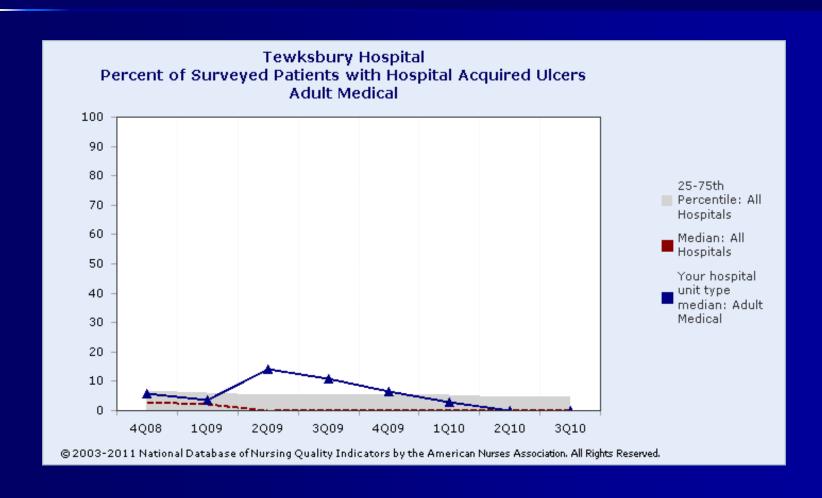
Pressure Ulcer Prevalence studies were increased from quarterly to monthly and conducted by the unit based Skin Resource Nurses.

Every HAPU is thoroughly reviewed with an emphasis on the how and why. This analysis is utilized in determining prevention strategies.

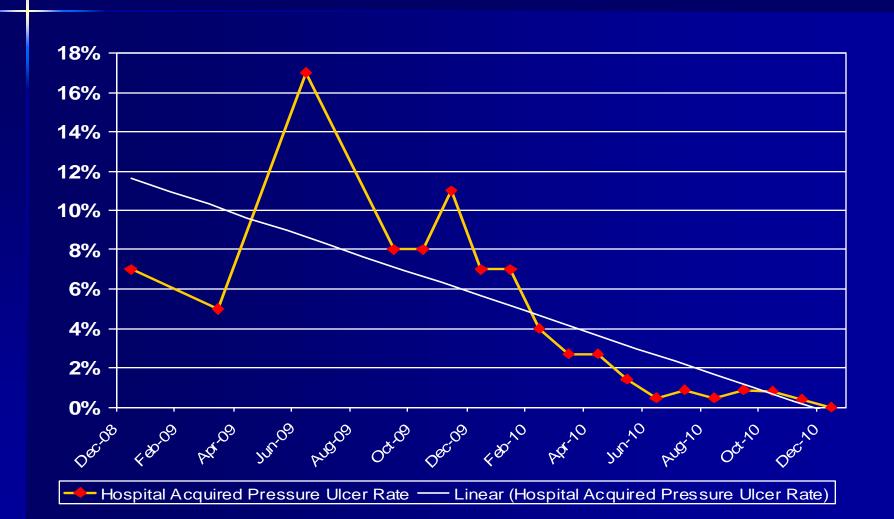
"Blueprint for Action" Education

- Intensive two hour education sessions are required for all nursing assistants, a group of unlicensed staff that plays a tremendously important role in the day to day skin care given to our patients.
- Focusing on this group has enhanced use of best practices and products, thus improving patient outcomes.
- Licensed nursing staff have also been educated on skin assessment, pressure ulcer prevention and treatment.

Results



Results



"Blueprint for Action" Success!

Units were recognized through a "Zeroes are for Heroes" Campaign in which units achieving a 0% hospital acquired pressure ulcer rate are celebrated.

Currently all units have achieved Zeroes!

Zeroes are for Heroes

12/14/10

UNT	CENSUS	# RISK PTS	% AT RISK PTS	#PTS ê PU	TOTAL# PU	TOTAL PU RATE	# PTS ê CA PU	TOTAL# CA PU	TOTAL CA PU RATE	# PTS ĉ HA PU	TOTAL # HA PU	TOTAL HA PU RATE	
A3	30	20	67%	2	2	6.7%	2	2	6.7%	0	0	0%	
C3	35	28	80%	3	4	8.6%	3	4	8.6%	0	0	0%	
D2	36	20	56%	0	0	0%	0	0	0%	0	0	0%	
D3	32	28	88%	0	0	0%	0	0	0%	0	0	0%	
E2	35	31	89%	2	3	5.7%	2	3	5.7%	0	0	0%	
E 3	31	27	87%	4	4	12.9%	4	4	12.9%	0	0	0%	
E4	33	9	27%	2	2	6%	2	2	6%	0	0	0%	
TOTAL	232	163	70%	13	15	5.6%	13	15	5.6%	0	0	0%	

Conclusion:

A pressure ulcer prevention program that is driven by bedside nurses and founded on Evidence Based Practice decreases the rate of hospital acquired pressure ulcers, thereby improving patient care and safety.

Questions?

■ E-mail: <u>Karen.Hartley@state.ma.us</u>