Confidential Information

SAINT MARY'S HEALTH CARE

Intensive Review of Hospital Acquired Pressure Ulcers (HAPU)
Pressure Ulcer Core Indicator Team

NDNQI survey Date: Intensive Review Date:

Members present: *please circle members present*
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Executive summary

During the intensive review there were _____ noted for this data review period. This data includes both incidence and prevalence data. The HAPU was Incidence data.

Note:
Only the prevalence data is forwarded for inclusion in data reporting to the appropriate bodies (Trinity-Health, NDNQI, Quality Committee of the Board, Nursing Dashboard).

Situation

Patient name:
FIN#: MR#:
Admit date:
LOS:

Background

Intensive Review Assessment / Determination
Evidence:

- Documented Evidence of Pressure Ulcer Prevention:
  - Was Sleep surface was appropriately used?
    - Comments:
  - What was the patient's activity level?
    - Turn / reposition q2h / activities / ambulation / chair
  - Were appropriate skin care products used?
    - Comments:

- Were the patient's heels elevated?
  - Comments:
- Was Moisture contained?
  - Comments:
- Were Friction and Sheer forces reduced?
  - Comments:

- Appropriateness of Nursing Care:

- The medical record reflected consistency of assessment, appropriate interventions and response to those interventions:

- The WOCN was consulted and involved in care:

Recommendation

After intensive Review, it was determined that this pressure ulcer is.

- Avoidable
- Unavoidable
- Unable to be determined / need further review

After investigation this HAPU should be "charged" to:

- Nursing Unit:

Final Action Plan

This is a example of an mock intensive review … no patient identifiers are included.

Situation

Patient name: Miami J. Collar
FIN#: 0000000 MR#: 00-12-34
Admit date: January 26, 2011
LOS: 3 days

Background

This 65 y/o male patient has a pertinent medical history to include, but not limited to: Gastric Cancer, arthritis, Esophageal CA, chemo treatment.

Significant course of treatment:

- Braden score was 17 on admission.
- Patient was NPO, insufficient protein, *see nutrition notes
- Patient started J tube feeds post op.
- ** Patient was in surgery for 11 hours ** (atypical of course)
- Documentation reflects this patient was considered to have a HAPU.
- WOCN consult 01/29/2011.
- Patient was mobile and Bradens were not considered low.

Intensive Review Assessment / Determination

- Documented Evidence of Pressure Ulcer Prevention:
  - Sleep surface was appropriately used
    - Total Care and Versacare pressure redistribution surfaces
  - Turn / reposition q2h / activities / ambulation / chair
    - Documentation was consistent on both nursing units
  - Appropriate skin care products used
    - Kept clean and dry and applied Sensicare
  - Heels elevated
    - Consistent documentation
  - Moisture contained
    - Moisture management was not an issue
  - Friction and sheering forces reduced
    - Support surfaces, turning and mobility to reduce were documented.

- Appropriateness of Nursing Care:
  - Documentation reflects appropriate nursing care was delivered. Consistent with standard of care. Assessments were initiated and interventions appropriate.
  - Appropriate consult to WOCN (although it was considered delayed due to inter-unit transfer)

- The medical record reflected consistency of assessment, appropriate interventions and response to those interventions:
  - Documentation supports pressure ulcer prevention measures were initiated and implemented.

- The WOCN was consulted and involved in care:

- WOCN consulted on 1/29/2011.
- Follow up was then done 1/30/2011
- Ongoing communication with staff, CNL and MD.
- Difficult assessment due to atypical appearance and extenuating issues.
- PLEASE see MD documentation as well as WOCN notes for specifics**

Recommendation

After intensive Review, it was determined that this pressure ulcer is

- Unable to be determined Avoidable vs. Unavoidable at this time until further review by OR.

After investigation this HAPU should be "charged" to OR.

Final Action Plan:

We chose this example because most times it is very clear if the HAPU is avoidable. We chose to define "avoidable" as:

1. Was the standard of care met?
2. Is there supporting documentation?
3. Did we know the patient was at risk? And were the appropriate interventions implemented?

The above fictitious example illustrates that sometimes it is unclear if the pressure ulcer is avoidable or unavoidable. In this mock example, because our Intensive Review Team does not have an OR expert (although we are familiar with the surgical standard of care: pressure ulcer prevention for surgical patients), we want to emphasize the importance of collaborating with experts beyond the Core Indicator Team's expertise. This case was referred to the surgical CNS for further view.

The questions for the surgical CNS are:

1. Was the standard of care met?
2. Does the documentation in the OR reflect that the correct positioning devices were used appropriately?
3. Did the care plan indicate this patient was at high risk for pressure ulcer development secondary to prolonged length of surgery?