

Improving Pressure Ulcer Prevention through Electronic Medical Record Redesign

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change the outcome*

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Cincinnati Children's Hospital Medical Center

- 511 Registered Beds
- 11,000 Employees; Over 3,000 RN's
- Ranked 2nd in NIH Pediatric Funding
- Top 10 Pediatric Hospitals U.S. News & World Report 2005, 2006, 2007, 2008, 2009, 2010
- Received the 2008 Picker Award for Excellence in honor of significant achievements in family-centered care
- Awarded Magnet Designation February 2009



Objectives

- Describe EMR redesigns to improve skin assessments and reduce the patient risk of pressure ulcers.
- Describe how EMR alerts help nurses add a skin plan of care for patients at risk for pressure ulcers.

The Improvement Model

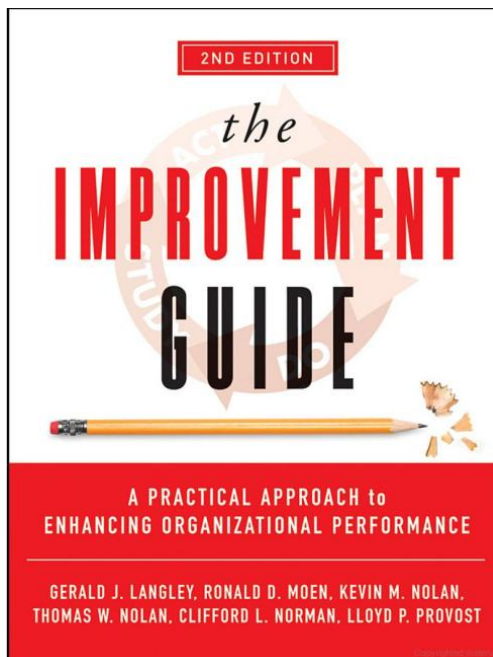
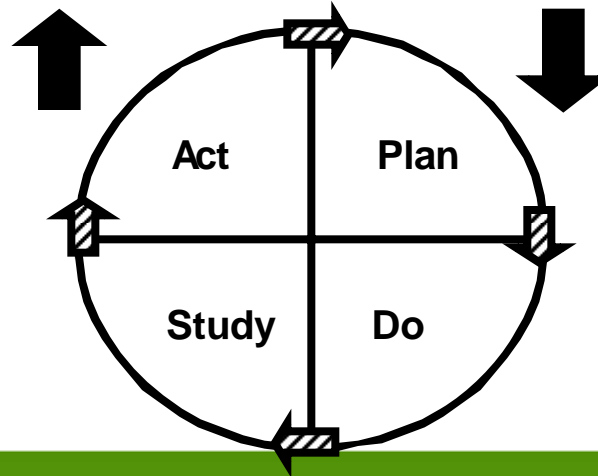
What are we trying to accomplish?



How will we know that a change is an improvement?



What changes can we make that will result in improvement?



The Improvement Model

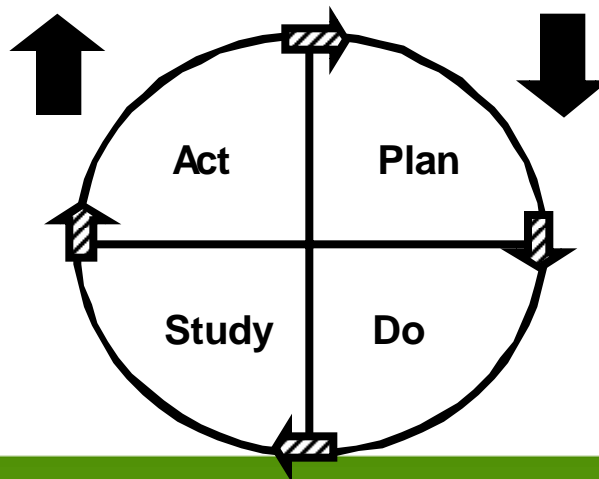
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Aim Statements

To increase compliance with skin assessments to 90% or higher through redesign of the EMR and staff education

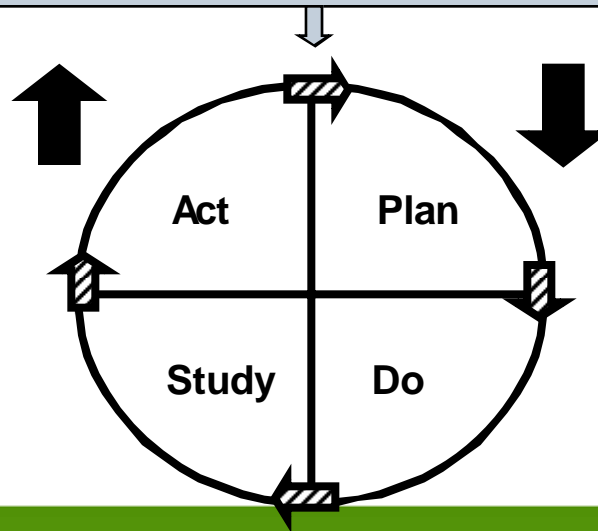
Overall to reduce pressure ulcer prevalence to $\leq 2.7\%$

The Improvement Model

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?



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Admission Process Metrics

- Compliance with documenting Braden Q score
- Compliance with documenting a Skin Assessment
- Compliance with documenting a Medical Device Assessment

Quarterly Outcome Metrics

- Facility Acquired Pressure Ulcer Prevalence



Medical Devices

found to be related to
pressure ulcer
development



The Improvement Model

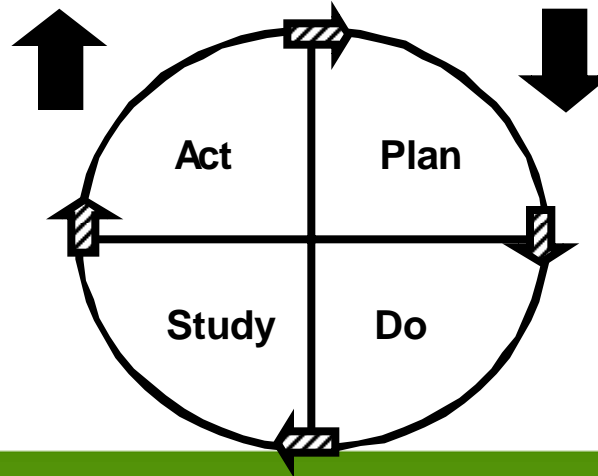
What are we trying to accomplish?



How will we know that a change is an improvement?



What changes can we make that will result in improvement?



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An Outline of Design Concepts for Improving Reliability

Level 1. Vigilance and hard work

(1, or 2, failures out of 10 opportunities or 80 – 90%)

- Awareness and training
- Feedback of data
- Personal reminders by an expeditor
- Standardization (broad, general)

Level 2. Human factors and reliability engineering

(5, or less, failures out of 100 opportunities or 95%)

- Redundancy
- Checklists and reminders (built into the process)
- Differentiation such as color coding
- Real time identification of failures such as drug interactions
- The default is the desired action, for example standard order sets
- Standardization of essential tasks

Level 3. Sophisticated behavioral designs

(5, or less, failures out of 1,000 opportunities or 99%)

- Take advantage of habits and patterns
- Make the system visible
- Clear and unambiguous communication
- High reliability organization Weick
 - *Preoccupation with failure*
Example - Study the circumstances leading to each hospitalization for an asthma exacerbation
 - *Reluctance to simplify*
"Dangerous until proven safe rather than safe until proven dangerous"
 - *Sensitivity to operations*
Moment by moment monitoring of the front line rather than the big picture;
Example - Red/yellow/green system for monitoring stress levels in patient care units
 - *Commitment to resilience*
Example - Contingency plans for maintaining access,
scheduling of unpredictable surgery cases into separate rooms, or code teams
 - *Deference to expertise* wherever it can be found
Example - Patient or parent involvement in design

OLD EMR

Clinical Documentation [Patient Menu] - Windows Internet Explorer provided by CCHMC

http://mcicisnetstage/50k0-ntat-bin/webcptun.exe/PRD/1?KEY=WD-INVISIONLP-INV-5-0-A3N:O:35875:1290016509

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Favorites CenterLink

OAS/Gold Version 25.0 Clinical Documentation [P... x]

Home RSS Print Page Safety Tools ? >>

Patient: **Laryngitis, Loretta** User: **CD4** Log Off

****Train/Test** Master Menu**

- Unit Census
- A3N
- Patient Menu**
 - Reminders
 - Rounds Report
 - Rounds Rpt - W/O Ord
 - Admission Info
 - IPOC
 - Patient Orders
 - Allergies
 - Blood Consent
 - Assessments
 - Assessments
 - Fall Risk
 - Wound/Skin Assessment
 - Respiratory Therapy
 - Pain
 - Med/IV Charting
 - Document
 - Chemotherapy
 - Med Reconciliation
 - Display WebMAR
 - Med Order/Chart
 - Vital Signs/HT/WT
 - I&O
 - Hourly Checks
 - Bedside Testing
 - Worklist/Reports

DOB: 2/5/2006 Sex: F Adm Dt: 11/22/2009 Scale WT: KG Dosing WT: KG
 Loc: A3N / 323A1 MR#: 11000711
 Allergies:
 Attn Dr: ABONIA, J.

Wound Skin Assessment

Previous Assessment:

Skin Assessment

Location 1: Problem area due to pressure: ☐ Yes ☐ No ☐ Unsure
 Comment: Is the area moist: ☐ Yes ☐ No
 Blanches: ☐ Yes ☐ No

Location 2: Problem area due to pressure: ☐ Yes ☐ No ☐ Unsure
 Comment: Is the area moist: ☐ Yes ☐ No
 Blanches: ☐ Yes ☐ No

Location 3: Problem area due to pressure: ☐ Yes ☐ No ☐ Unsure
 Comment: Is the area moist: ☐ Yes ☐ No
 Blanches: ☐ Yes ☐ No

Additional Locations/Wounds and Comments:

Wound/Incision Assessment

Location:	Dressing	Dressing Type	Drainage Amount	Drainage Color
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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OLD EMR

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 Atn Dr: ABONIA, J.

Wound Skin Assessment ClinDoc Feedback

Previous Assessment:

Modified Braden Q Scale

Mobility: ☐ Completely Immobile ☐ Very Limited ☐ Slightly Limited ☐ No Limitations

Activity: ☐ Bedfast ☐ Chairfast ☐ Walks Occasionally ☐ Walks Frequently

Sensory: ☐ Completely Limited ☐ Very Limited ☐ Slightly Limited ☐ No Impairment

Perception: ☐ Completely Limited ☐ Very Limited ☐ Slightly Limited ☐ No Impairment

Moisture: ☐ Constantly Moist ☐ Very Moist ☐ Occasionally Moist ☐ Rarely Moist

Friction/Shear: ☐ Significant Problem ☐ Problem ☐ Potential Problem ☐ No Problem

Nutrition: ☐ Very Poor ☐ Inadequate ☐ Adequate ☐ Excellent

Tissue Perfusion

% Oxygenation: ☐ Extremely Compromised ☐ Compromised ☐ Adequate ☐ Excellent

Score: Risk Severity:

22-25 = Mild 17-21 = Moderate < 16 = High

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 Loc: A3N / 323A1 MR#: 11000711 Allergies:
 Atn Dr: ABONIA, J.

Wound Skin Assessment

Previous Assessment: ☐ WNL

Device Assessment

Device 1: Problem area due to pressure: ☐ Yes ☐ No ☐ Unsure
 Comment: Is the area moist: ☐ Yes ☐ No
 Blanches: ☐ Yes ☐ No

Device 2: Problem area due to pressure: ☐ Yes ☐ No ☐ Unsure
 Comment: Is the area moist: ☐ Yes ☐ No
 Blanches: ☐ Yes ☐ No

Device 3: Problem area due to pressure: ☐ Yes ☐ No ☐ Unsure
 Comment: Is the area moist: ☐ Yes ☐ No
 Blanches: ☐ Yes ☐ No

Device 4: Problem area due to pressure: ☐ Yes ☐ No ☐ Unsure
 Comment: Is the area moist: ☐ Yes ☐ No
 Blanches: ☐ Yes ☐ No

Additional Devices and Comments:

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Loc: A3N / 323A1 MR#: 11000711 Allergies:
Attn Dr: ABONIA, J.

Wound Skin Assessment ClinDoc Feedback

Previous Assessment:

Interventions

Positioning	Manage Devices
<input type="checkbox"/> Turn / reposition Q 2 hrs (mod/high risk)	<input type="checkbox"/> Mepilex/Mepilex Lite under GTube, CPAP, BiPAP, Trach flanges & ties, IV hubs, & PICC wings
<input type="checkbox"/> Turn / reposition Q 3 hrs	<input type="checkbox"/> Tubing off patient
<input type="checkbox"/> Turn / reposition Q 4 hrs	<input type="checkbox"/> Patient off tubes / wires
<input type="checkbox"/> Out of bed	<input type="checkbox"/> Oximeter site change every 12 hrs
<input type="checkbox"/> zFlo (mod/high risk)	
<input type="checkbox"/> Gel pillow	

Splints/Casts/Collars/Braces	Chairs
<input type="checkbox"/> Petal with Moleskin	<input type="checkbox"/> Specialty seat cushion (not a pillow)
<input type="checkbox"/> Splint schedule followed	<input type="checkbox"/> Weight shift Q 15-30 min

Comment:

RCNIC or <28 Days of Age Interventions Interventions for Modified Braden Q Bundle

Review Complete Previous

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By clicking on these the nurse could see the interventions & bundle

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OLD EMR

 Interventions for the Modified Braden Q Mild 22-25 / Moderate 17-21 / High Risk 16 or Less		
	MILD RISK	MODERATE AND HIGH RISK FOLLOW ALL INTERVENTIONS & ADD
MANAGE MOISTURE	<ul style="list-style-type: none"> check diapers Q2hrs, change as needed do not use chux or other products with a plastic backing add moisture barrier to diaper area as necessary with diaper change, no need to completely remove barrier completely remove barrier once a day 	
DEVICE PROTECTION AND ASSESSMENT	<ul style="list-style-type: none"> check under GTubes, Trachs and other devices for moisture Mepilex / Mepilex Lite under GTubes, CPAP, BiPAP, Trach flanges & ties use 1 finger rule for trach ties prop tubing off patient do not lay patient on tubes and wires check ID band site with assessment change and evaluate oximeter site at least every 12 hours 	
SPLINTS CASTS COLLARS BRACES	<ul style="list-style-type: none"> keep skin dry and clean use all straps petal with moleskin as needed assess often for redness, irritation, or tightness evaluate pain for potential skin compromise 	

 Interventions for the RCNIC & Patients <28 days		
	SKIN CARE	
MANAGE MOISTURE	<ul style="list-style-type: none"> minimize use of adhesives check diapers Q2 to 4 hrs, change as needed do not use chux or other products with a plastic backing add moisture barrier to diaper area as necessary with diaper change, no need to completely remove barrier completely remove barrier once a day 	
DEVICE PROTECTION AND ASSESSMENT	<ul style="list-style-type: none"> assess GTube, NG, Replogle, and ETT for pressure areas check under GTubes, Trachs and other devices for moisture may use Mepilex or Mepilex Lite under GTubes, CPAP, Trach flanges or ties, IV hubs, and PICC wings use 1 finger rule for trach ties prop tubing off patient do not lay patient on tubes and wires check ID band site with assessment change and evaluate oximeter site at least every 12 hours 	
SPLINTS CASTS COLLARS BRACES	<ul style="list-style-type: none"> keep skin dry and clean use all straps petal with moleskin as needed assess often for redness, irritation, or tightness evaluate pain for potential skin compromise 	
REPOSITION Q 2 TO 4 HRS	<ul style="list-style-type: none"> only need a 15° shift to make a difference in a neonate supplement with small shifts in position document position change don't forget the head 	

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Pediatric Pressure Ulcer Prevention Bundle

Comprehensive Assessment				
<p>Risk Assessment</p> <ul style="list-style-type: none"> ▪ > 28 days of age, use modified Braden Q upon admission and daily ▪ ≤ 28 days of age, treat as high risk ▪ All RCNIC patients, treat as high risk <p>Skin Assessment</p> <ul style="list-style-type: none"> ▪ Daily head-to-toe <p>Device Protection Assessment</p> <ul style="list-style-type: none"> ▪ Every shift 				
Interventions				
Positioning	Moisture	Surface	Nutrition	Family
Based on the modified Braden Q assessment, reposition patients at moderate to high risk a minimum of every 2 hours. Reposition patients at low risk a minimum of every 4 hours.	Manage and minimize moisture by checking common moisture sites every 2 to 4 hours, and intervening as needed.	Use pressure reduction surfaces for beds and chairs.	Good nutrition is the first line of defense for prevention of pressure ulcers.	Involve and educate families in pressure ulcer prevention strategies and treatments.

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OLD EMR

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 Vital Signs/HT/WT
 I&O
 Hourly Checks
 Bedside Testing
 Worklist/Reports
 MD VO
 Inactive Orders
 Document Event
 Erroneous Orders
 Display
 Documentation
 Display/Print Orders
 Patient Results
 Pt Classification
 Pediatric Summary
 Patient Info
 Impact SIIS
 (Immunizations)
 CCHMC Formulary

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 Loc: A3N / 323A1 MR#: 11000711 Allergies:
 Attn Dr: ABONIA, J.

Active Interdisciplinary Plan of Care (IPOC) ClinDoc Feedback

Review Focus of Care

Review Focus and Select Items to Be EXCLUDED from Plan of Care

FOCUS A5 SKIN INTEGRITY
 (GL) MAINTAIN OR IMPROVE HYDRATION STATE ***
 (I) DAILY WEIGHTS AS ORDERED
 (I) IV/TPN AND LIPIDS/ENTERAL FEEDS AS ORDERED
 (GL) PATIENT COMFORT ***
 (I) NON PHARMACOLOGICAL PAIN MANAGEMENT
 (I) SOC PAIN MANAGEMENT
 (GL) PATIENT WILL BE FREE OF SKIN BREAKDOWN ***
 (I) APPLY LOTIONS TO DRY SKIN AS ORDERED
 (I) APPLY SKIN BARRIERS
 (I) ASSESS ALL SKIN SURFACES EVERY SHIFT AND PRN
 (I) CHANGE DIAPERS EVERY COUPLE HOURS
 (I) DO NOT USE LOTIONS/CREAMS PRIOR TO TOTAL BODY IRRADIATION
 (I) ENCOURAGE DAILY FLUID INTAKE
 (I) ENCOURAGE PATIENT TO GET OUT OF BED
 (I) KEEP TUBES AND WIRES OFF SKIN
 (I) REPOSITION/TURN PATIENT EVERY COUPLE HOURS
 (I) SITZ BATHS AS ORDERED

Return Continue

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EMR Skin Documentation

Old

vs

New

- Each type of assessment on a separate screen
 - Not part of the body system assessment screens
 - Unable to view previous assessments on same screen
 - Limited # of characters for description of skin issues
- All three assessments on same flow sheet (screen)
 - All are a part of the body systems assessments flow sheet (screen)
 - Can view multiple assessments from previous times on same screen
 - Ability to add comments and more room for detailed descriptions

EMR Skin Documentation

Old vs New

- Two separate areas of the EMR, one to document skin problems & another for other skin assessments
 - Perceived as double documentation
 - Interventions appeared by manually clicking on buttons
- One area to document all skin findings
 - Satisfied nurses who were documenting it all at one time & place
 - A high risk assessment automatically generated a “Best Practice Alert” that would visually prompt the nurse to consider adding the Skin Care Plan

NEW EMR

Doc Flowsheets ? Resize

File Add Row Add Group Add LDA Cascade Add Col Insert Col Device Compact Hide Comp'd Last Filed Graph Details More

Flowsheet: Body System Assess Vital Signs **Body System Assessment** IV Fluid/Med Intake Intake/Output

Category	Admission (Current) 10/05/10	11/17/10	1143	1510	1649	Last Filed Value
Reproductive						
Musculoskeletal						
Skin						
Braden Q > 28 Days...						
Braden Skin Assess...						
Braden Skin Assess...						
Braden Skin Assess...						
Device Assessment 1						
Device Assessment 2						
Device Assessment 3						
Device Assessment 4						
Device Assessment 5						
Interventions						
Wound / Incision # 1						
Wound / Incision # 2						
Wound / Incision # 3						

Category	Admission (Current) 10/05/10	11/17/10	1143	1510	1649	Last Filed Value
Skin						
Skin (WNL)	X					Exceptions to ...
Description	Pink					Pink
Temperature / Condition	Warm					Warm
Integrity	Pressure ...					Pressure Ulcer
Location	bila heels					bila heels
Additional Details	mepilex in...					mepilex intact
Braden Q > 28 Days of Age (If < 29 days Treat as High Risk)						
Mobility						very limited
Activity						chairfast
Sensory Perception						slightly limited
Moisture						occasionally m...
Friction Shear						potential probl...
Nutrition						adequate
Tissue Perfusion & Oxygenation						adequate
Score						(No Value)

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NEW EMR

Doc Flowsheets ? Resize

File Add Row Add Group Add LDA Cascade Add Col Insert Col Device Compact Hide Comp'd Last Filed Graph Details More

Flowsheet: Body System Assess Vital Signs Body System Assessment IV Fluid/Med Intake Intake/Output

Category	Value	Comment	Time Taken	Time Recd	User Taken	User Recd	Show Audit
Reproductive	<input checked="" type="checkbox"/>						
Musculoskeletal	<input checked="" type="checkbox"/>						
Skin	<input checked="" type="checkbox"/>						
Braden Q > 28 Days...	<input checked="" type="checkbox"/>						
Braden Skin Assess...	<input checked="" type="checkbox"/>						
Braden Skin Assess...	<input checked="" type="checkbox"/>						
Braden Skin Assess...	<input checked="" type="checkbox"/>						
Device Assessment 1	<input checked="" type="checkbox"/>						
Device Assessment 2	<input checked="" type="checkbox"/>						
Device Assessment 3	<input checked="" type="checkbox"/>						
Device Assessment 4	<input checked="" type="checkbox"/>						
Device Assessment 5	<input checked="" type="checkbox"/>						
Interventions	<input checked="" type="checkbox"/>						
Wound / Incision # 1	<input checked="" type="checkbox"/>						
Wound / Incision # 2	<input checked="" type="checkbox"/>						
Wound / Incision # 3	<input checked="" type="checkbox"/>						

Admission (Current) 10/05/10		11/17/10		Last Filed Value
1143	1510	1649		
Braden Q > 28 Days of Age (If < 29 days Treat as High Risk)				
Mobility				very limited
Activity				chairfast
Sensory Perception				slightly limited
Moisture				occasionally m...
Friction Shear				potential probl...
Nutrition				adequate
Tissue Perfusion & Oxygenation				adequate
Score				(No Value)
Braden Risk				Moderate Risk
Braden Skin Assessment 1				
Skin Assessment (WNL)	X			Exceptions to ...
Skin Assessment Location 1	Heels			Heels
Problem Area Due to Pressure	Yes			Yes
Is the area moist?	No			No
Blanching?				No

Value Comment Time Taken Time Recd User Taken User Recd Show Audit File

change the outcome*

NEW EMR

Primary		Admission (Current) 10/05/10				
Reproductive	<input checked="" type="checkbox"/>	11/17/10				Last Filed Value
Musculoskeletal	<input checked="" type="checkbox"/>	1143	1510	1649		
Skin	<input checked="" type="checkbox"/>	Device Assessment 1				
Braden Q > 28 Days...	<input checked="" type="checkbox"/>	Device Assessment (WNL)	WNL			within normal li...
Braden Skin Assess...	<input checked="" type="checkbox"/>	Device 1	Brace/ca...			Brace/cast #1
Braden Skin Assess...	<input checked="" type="checkbox"/>	Problem Area Due to Pressure	No			No
Braden Skin Assess...	<input checked="" type="checkbox"/>	Is the area moist?	No			No
Device Assessment 1	<input checked="" type="checkbox"/>	Blanches?	Yes			Yes
Device Assessment 2	<input checked="" type="checkbox"/>	Device Assessment 2				
Device Assessment 3	<input checked="" type="checkbox"/>	Device Assessment (WNL)	WNL			within normal li...
Device Assessment 4	<input checked="" type="checkbox"/>	Device 2	ID band si...			ID band site
Device Assessment 5	<input checked="" type="checkbox"/>	Problem Area Due to Pressure	No			No
Interventions	<input checked="" type="checkbox"/>	Is the area moist?	No			No
Wound / Incision # 1	<input checked="" type="checkbox"/>	Blanches?	Yes			Yes
Wound / Incision # 2	<input checked="" type="checkbox"/>	Device Assessment 3				
Wound / Incision # 3	<input checked="" type="checkbox"/>	Device Assessment (WNL)	WNL			within normal li...
		Device 3	Diaper			Diaper
		Problem Area Due to Pressure	No			No

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NEW EMR

Doc Flowsheets ? Resize

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Braden Skin Assess...			
Braden Skin Assess...			
Device Assessment 1			
Device Assessment 2			
Device Assessment 3			
Device Assessment 4			
Device Assessment 5			
Interventions			
Wound / Incision # 1			
Wound / Incision # 2			
Wound / Incision # 3			



Category	Admission (Current) 10/05/10	11/17/10	Last Filed Value
Positioning	Out of bed		Out of bed
Splints / Casts / Collars / Braces	Splint sch...		Splint
Protect Heels	Heels flo...		Heels floated
Manage Moisture	Check dia...		Check diapers
Manage Devices	Check ID ...		Check ID band ...
Chairs	Shift weig...		Shift weight ev...
Beds	Accumax ...		Accumax matr...
Manage Friction & Shear	Draw she...		Draw sheet to r...
Wound / Incision # 1			
Location	Foot		Foot
Orientation	Left		Left
Wound / Incision Type	Pressure ...		Pressure ulcer
Wound/ Incision First Identified Date			
Wound/ Incision Resolution Date			
Site Closure Method	None		None

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NEW EMR

BestPractice Alert - Stream,Canary

Based on the Modified Braden Q assessment OR the patient is less than 29 days of age, patient is considered to be at Moderate / High risk for developing pressure ulcers. Consider adding the Skin Care Plan template.

Acknowledge Reason:  

[Jump to Patient Plan of Care](#)

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NEW EMR

Display: ☒ Description ☐ Detail ☒ Goals ☒ Interventions

Actual/potential impaired skin integrity

Resolve

 Modify Problem

Goal: Patient will develop or maintain clean and intact skin.

Indicators of Progress Towards Goal:

Skin is clean and intact, with lack of redness, excoriation, or lesions

- 1 = Unstable; immediate intervention(s) required
- 2 = Variable; frequent intervention required
- 3 = Manageable; requires close monitoring
- 4 = Stable; with current therapy
- 5 = Normal/at baseline; problem resolved

Initial Rating: 1 = Unstable; immediate intervention(s) required

Outcome Target Rating: 4 = Stable; with current therapy

Interventions

1. Identify contributing factors
2. Utilize Braden interventions as appropriate
3. Minimize injury from friction
4. Reposition patient as needed
5. Keep skin dry
6. Refer to specialty skin resources as needed
7. Assess need for pressure relieving devices

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- + (Neuro-rehab) Receptive Language Impairment
- + (Neuro-rehab) Expressive Language Impairment
- + (Neuro-rehab) Secondary Language Impairment
- **IP Speech: Older Feeding**
 - (Older Feed) Swallowing Dysfunction
- **Skin**
 - Actual/potential impaired skin integrity
 - Patient will develop or maintain clean and intact skin.
 - Assess circulation and sensation of restrained body part
 - Assess skin around devices (i.e cooling blanket, tubes, splints, restraints) (2)
 - Perform routine skin assessments utilizing Braden and/or Braden Q as (2)
 - Utilize Braden interventions as appropriate (2)
 - Assess incisions/wounds for signs/symptoms of infection
 - Minimize injury from friction (2)
 - Reposition patient as needed (2)
 - Keep dressings intact.
 - Measure wound changes daily as indicated.
 - Assess need for pressure relieving devices (2)
- **OT - IP**
 - + (OT - IP) RANGE OF MOTION IMPAIRMENT
 - **(OT - IP) Abnormal Muscle Tone**

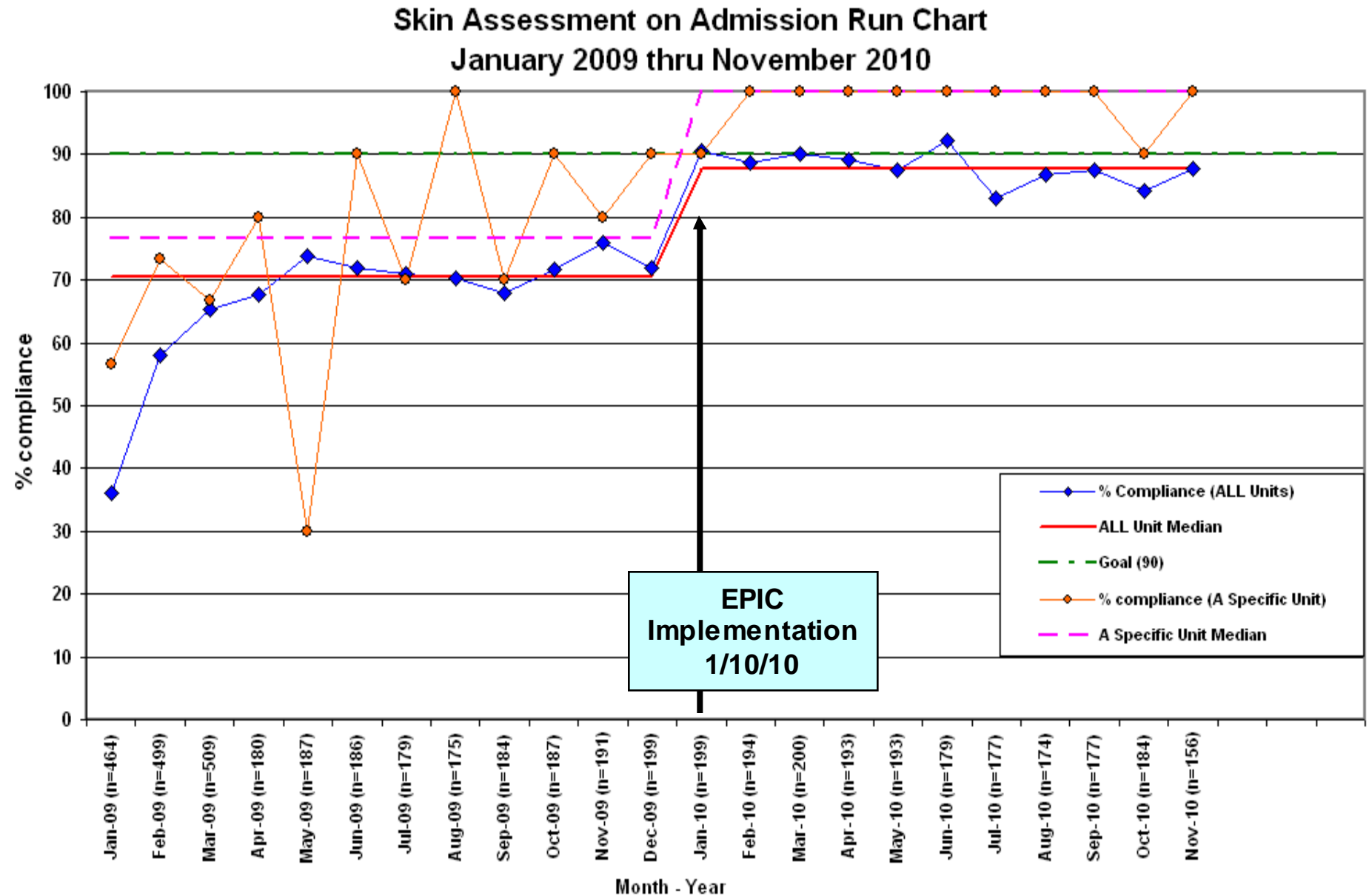
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NEW EMR

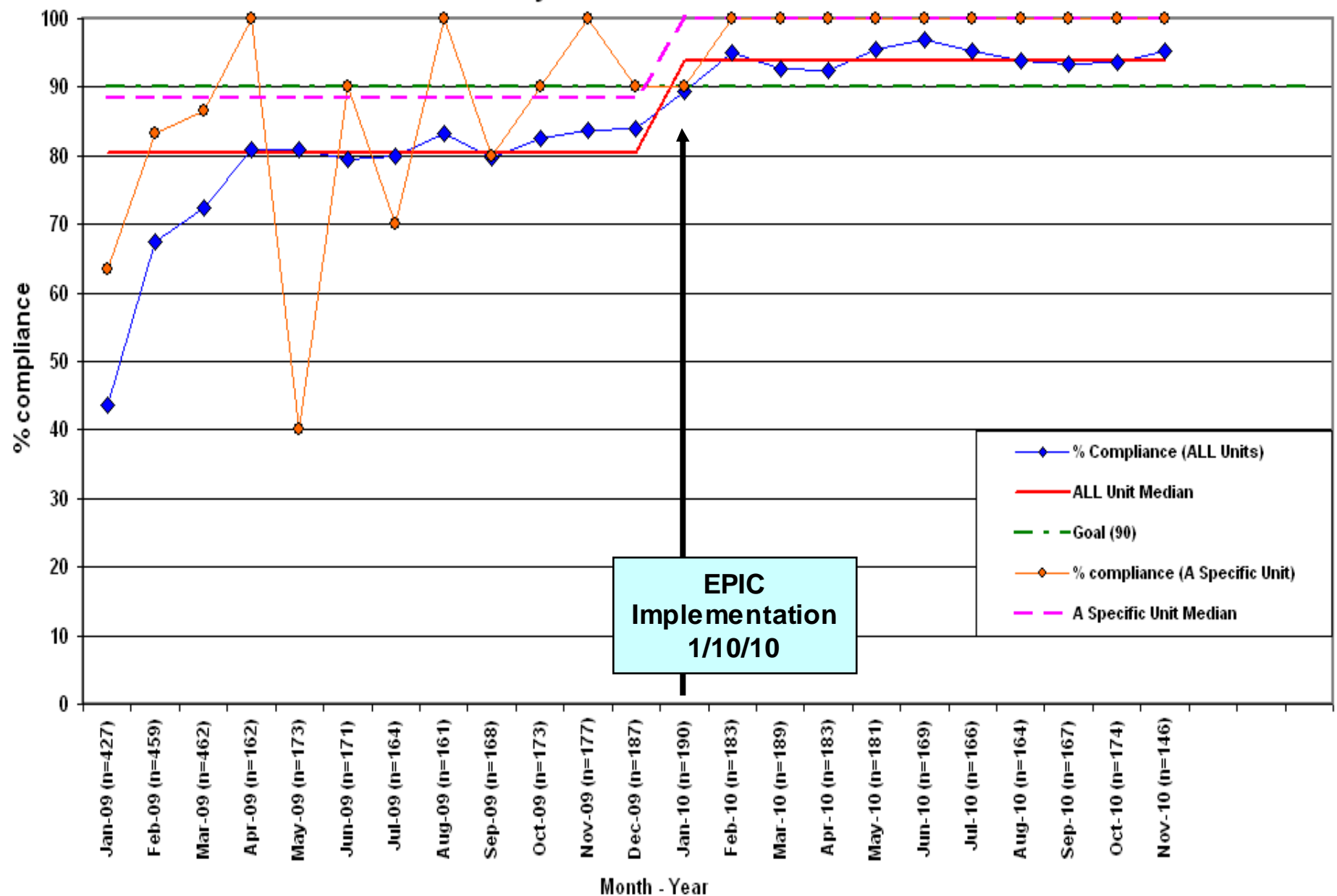
Display:	<input checked="" type="checkbox"/> Description	<input checked="" type="checkbox"/> Web Links	<input checked="" type="checkbox"/> Detail	<input type="checkbox"/> Interventions	<input checked="" type="checkbox"/> Outcomes	<input checked="" type="checkbox"/> Notes
Documented on 11/14/10 1320 <input type="text"/>						
Goal: Patient will develop or maintain clean and intact skin.						
Outcome: Goal Ongoing						
Mepilex border to both heels-dry and intact. Up in wheelchair throughout day, being turned at night.						
Mepilex also on right achilles intact and no drainage noted.						
Documented on 11/09/10 1102 <input type="text"/>						
Goal: Patient will develop or maintain clean and intact skin.						
Outcome: 3=Progress towards goal						
Patient has 2 pressure ulcers at this time, to bilateral heels. Mepilex border dressings intact and will continue to be monitored.						
Documented on 11/07/10 0352 <input type="text"/>						
Goal: Patient will develop or maintain clean and intact skin.						
Outcome: 4=Progress towards goal						
Pt. Has no further skin breakdown to date. Monitoring bilateral pressure ulcer heels by keeping heels floated, changing dressing everyday, turning q2hrs, minimize injury from friction and using pressure relieving devices.						
Documented on 10/29/10 0413 <input type="text"/>						
Goal: Patient will develop or maintain clean and intact skin.						
Intervention: Assess need for pressure relieving devices						
z flo's positioned to float heels off bed						

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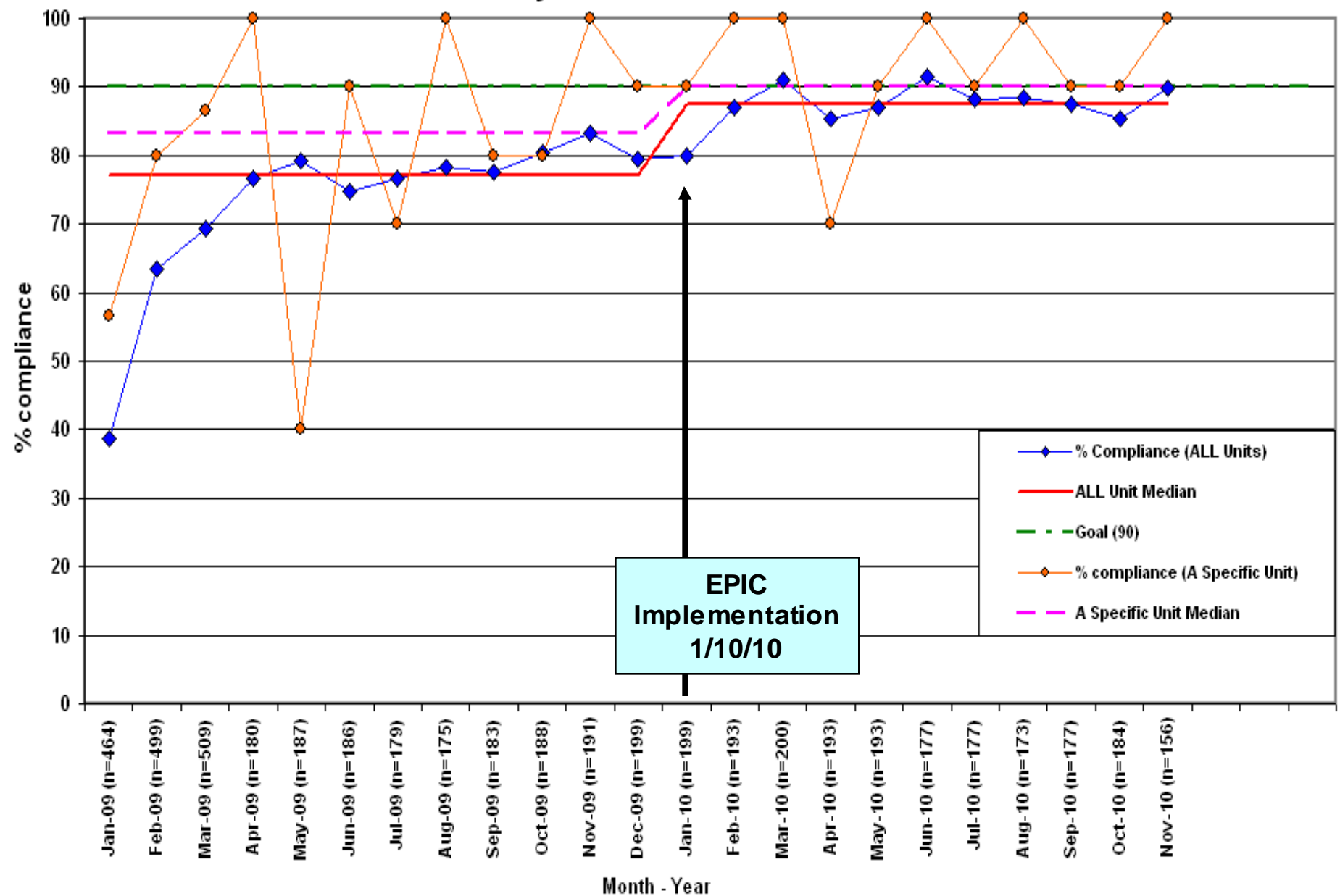
Sharing Housewide Process Measures with Unit Leaders & Staff

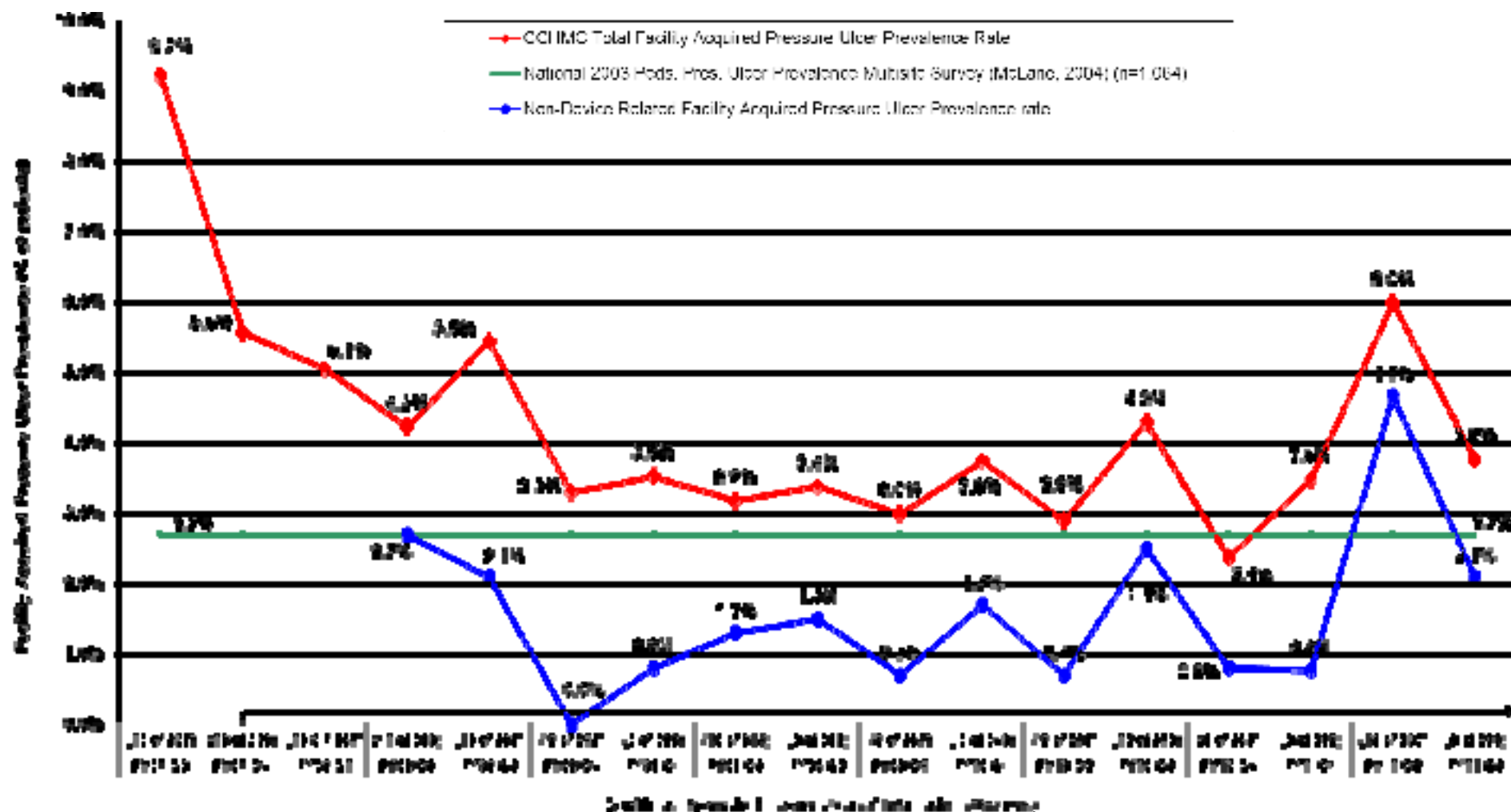


Risk Assessment on Admission Run Chart January 2009 thru November 2010



Device Assessment on Admission Run Chart January 2009 thru November 2010





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Questions?



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