

Key Nursing Innovations that Drive Down Prevalence of Hospital Acquired Pressure Ulcers

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Waterbury Hospital

- Average Daily census 150 patients
- Teaching hospital
- 13,000 admissions yearly
- Accredited by Joint Commission





Our Journey

- October 2007: 11 patients out of 147 surveyed had a hospital acquired pressure ulcer
- Prevalence rate of 7.4%
- The hospital administration believed we could do better
- The hospital's goal was to prevent pressure ulcers from developing during their hospital stay but to also improve the treatments used for pressure ulcers

First Step: Develop a team to review current processes

- Advanced Practice Nurse/WOCN certified
 - Staff Nurses
 - Dietician
 - Respiratory Therapist
 - Physical Therapy
 - Physician Champion
 - Clinical Informatics
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- Role of the team is to review, implement and disseminate evidence based care to the hospital community

Team focused on three main areas

- Products: what was carried, how it was stocked and how it got to staff
- Treatments: what was staff using to treat wounds, how they were using the products and staff's knowledge of the products
- Documentation: consistency, accuracy and ease of use

Second Step: Sub-committees formed

- Protocols and Products
 - Focused on standardization of products and creation of protocols for pressure ulcers and skin tears
- Information Systems
 - Focused on redesign of computer documentation

Step 3: Standardization of treatments and products

- Reviewed literature for evidence based treatments
- Trialed various products
- Narrowed down the products we carried
- Process changed from central storage to unit storage
- Standardized products on all units
- Protocols developed for Stage I, II, III, IV, Unable to Stage Pressure Ulcer and Suspected Deep Tissue injuries
- Protocol developed for Partial Thickness Skin Tear

Step 4: Get our documentation to work for us

- Goal: simplify the process
- Braden Score documentation triggers prevention measures based on score
- Consults electronically triggered based off of staff documentation
- “Wound Measurement Tuesday”
- System generated daily report to WOCN and nursing management listing patients with documented pressure ulcers

Braden Assessment

Braden Assessment			
Sensory Perception	<input type="radio"/> Completely limited <input type="radio"/> Very limited <input type="radio"/> Slightly limited <input type="radio"/> No impairment	Moisture	<input type="radio"/> Constantly moist <input type="radio"/> Very moist <input type="radio"/> Occasionally moist <input type="radio"/> Rarely moist
Activity	<input type="radio"/> Bedfast <input type="radio"/> Chairfast <input type="radio"/> Walks occasionally <input type="radio"/> Walks frequently	Mobility	<input type="radio"/> Completely limited <input type="radio"/> Very limited <input type="radio"/> Slightly limited <input type="radio"/> No limitations
Nutrition Options of "Very Poor" and "Probably Inadequate" will automatically fire a Nutritional Consult.	<input type="radio"/> Very poor <input type="radio"/> Probably inadequate <input type="radio"/> Adequate <input type="radio"/> Excellent	Friction and Shear	<input type="radio"/> Problem <input type="radio"/> Potential problem <input type="radio"/> No apparent problem
Skin Integrity Risk Score	<input type="text"/>		
A score of less than or equal to 18 will automatically enter preventative intervention orders.			




Braden Score Tasks

Pending	11/22/2011	16:00 EST	Pressure Redistribution Surface to bed	11/22/11 16:00:00 EST Pressure redistribution accumax pump to bed. Ordered secondary to documenting ...
Pending	PRN		Barrier Cream as needed	Barrier Cream PRN 11/22/11 13:17:09 EST, PRN order Order entered secondary to documenting a Braden Score of 18 or less. [BCC_SKIN...
Pending	11/22/2011	17:00 EST	Document percentage of meal consumed	11/22/11 17:00:00 EST Order entered secondary to documenting a Braden Score of 18 or less. [BCC_SKIN...
Pending	11/22/2011	17:17 EST	Elevate Affected Area	Area: Heels, 11/22/11 17:17:00 EST Order entered secondary to documenting a Braden Score of 18 or less. [BCC_SKIN...
Pending	11/22/2011	17:17 EST	Turn and/or Reposition Patient	11/22/11 17:17:00 EST Order entered secondary to documenting a Braden Score of 18 or less. [BCC_SKIN...

Braden Score and Assessment Consults

Consults			
<input checked="" type="checkbox"/>	Consult Dietary Braden	Ordered	11/22/11 13:21:04 EST, Routine Order entered secondary to documenting Nutrition status as "very poor" or "probably inadequate" on ...
<input checked="" type="checkbox"/>	Consult Enterostomal Therapist	Ordered	11/22/11 13:26:54 EST, Routine Ordered secondary to documentation of wound classification of III, IV, Deep tissue injury, or Unable t...

Care Sets

Wound/SkinCare Orders (Initiated)					
Last updated on: 11/22/2011 13:28 EST by: Nichols RN, Brenda A					
Activity					
<input checked="" type="checkbox"/>		Activity (008)	Ordered	Activity: to Chair, Minimum of: BID, PRN order, with chair cushion, 11/22/11 13:28:00 EST	with chair cushion
Nursing					
<input checked="" type="checkbox"/>		Bed: Specialty	Ordered	q8hrATC, 11/22/11 13:28:00 EST	
<input checked="" type="checkbox"/>		Static Air Boots	Ordered	q8hrATC, 11/22/11 13:28:00 EST	

Step 4: Get our documentation to work for us

- Simplified our documentation to only include what needed to be there for a full assessment
- Our motto became “less is best”

Integumentary Assessment

Integumentary

Menu

Skin Abnormality

Site A

Site B

Site C

Site D

Site E

Site F

Site G

Site H

Site I

Site J

Site K

Site L

Site M

Integumentary Assessment

Integumentary Assessment

- Assessment norms met
 Exceptions noted

Integumentary Assessment Norms

- Mucous membranes pink and moist
 Skin color normal for ethnicity
 Skin warm and dry
 Skin intact without abnormalities
 No surgical incisions
 No wounds, ulcers or skin tears

Skin Color

- Pink
 Red
 Normal for ethnicity
 Cyanosis
 Slight jaundice
 Jaundice
 Pale
 Ruddy
 Other:

Skin Description

- Blotchy
 Bruising
 Dry
 Clammy
 Diaphoretic
 Fragile
 Itching
 Moist
 Mottled
 Other:

Skin Temperature

- Warm
 Cold
 Cool
 Hot

Skin Turgor

- Elastic
 Non-Elastic
 Tenting
 Tight
 Other:

Mucous Membrane Color

- Pink
 Cyanotic
 Dusky
 Pale
 Red
 White
 Other:

Mucous Membrane Description

- Moist
 Cracked
 Dry
 Tear
 Ulcerated
 Other:

Does the patient have an Incision/Wound, Ulcer or Skin Tear?

- No Yes

Does the patient have a Skin Abnormality?

- No Yes

Does the patient have a Surgical drain/tube?

- No Yes

Incision/Wound Menu

Incision/Wound Menu

STOP: This menu is intended for viewing specific information on all documented wounds. Click 'DOCUMENT' to be taken to that site and proceed with documentation.

	Type	Location	POA	Healed	Status & last updated date/time	Need to document?
Site A	Ulcer-Pressure	Sacrum	Yes	No	11/22/11 13:22	<input type="radio"/> Document
Site B						<input type="radio"/> Document
Site C						<input type="radio"/> Document
Site D						<input type="radio"/> Document
Site E						<input type="radio"/> Document
Site F						<input type="radio"/> Document
Site G						<input type="radio"/> Document
Site H						<input type="radio"/> Document
Site I						<input type="radio"/> Document
Site J						<input type="radio"/> Document
Site K						<input type="radio"/> Document
Site L						<input type="radio"/> Document
Site M						<input type="radio"/> Document

IMPORTANT INFO ON THIS MENU SECTION:

Information documented on the site section will not appear on this menu until after the entire form has been signed. It will be available here next time this form is accessed.

Incision/Wound Care- Site

Incision/Wound Care-Site A

Type

- Burn Skin graft recipient Ulcer-Arterial Other:
 Friction/shear injury Skin tear Ulcer-Diabetic
 Radiation burn Surgical incision Ulcer-Pressure
 Skin graft donor Traumatic wound Ulcer-Venous Stasis

Location

- Head Abdomen Leg, right
 Face Lower back Knee, left
 Neck anterior Coccyx Knee, right
 Neck posterior Sacrum Ankle, left
 Arm, left Buttock, left Ankle, right
 Arm, right Buttock, right Heel, left
 Shoulder, left Scrotum Heel, right
 Shoulder, right Hip, left Foot, left
 Elbow, left Hip, right Foot, right
 Elbow, right Ischium, left Toe(s), left
 Hand, left Ischium, right Toe(s), right
 Hand, right Groin Other:
 Upper back Perineum
 Chest Leg, left

Description

- Closed Slough
 Epithelization
 Granulation tissue
 Necrotic tissue
- Bone Sutured
 Tendon Other:
 Tunneling
 Undermining
 Dehisced
 Edges approximated
 Edges separated
 Stapled

Present on Admission?

Is Site A Healed?

Past charted measurements:

No qualifying data available

L: cm W: cm D: cm Depth is <0.25 cm

Measurements to be documented Q Tuesday

L X W Calculation & Range in cm squared

Drainage

Drainage Amount

Drainage Odor

Pink Percentage

Yellow Percentage

Red Percentage

Black Percentage

PUSH Score

Pressure Ulcer Staging

Past charted stages/classification:

No qualifying data available

Surrounding Tissue

Treatments, Dressings & Interventions

Dressing

- Intact Wound Vac
 Reinforced Other:
 Apply
 Changed
 Dressing discontinued
 Open to air
 Dressing changed by other discipline

Dressing Orders

No active orders available.

If Wound vac was selected, the surgical/drain section will appear in order to continue documenting the Wound vac

Skin Abnormality Documentation

Integumentary Detailed Assessment

Skin Abnormality

Location	Abnormality	*Status	Comment
<Alpha>	<MultiAlpha>	<Alpha>	

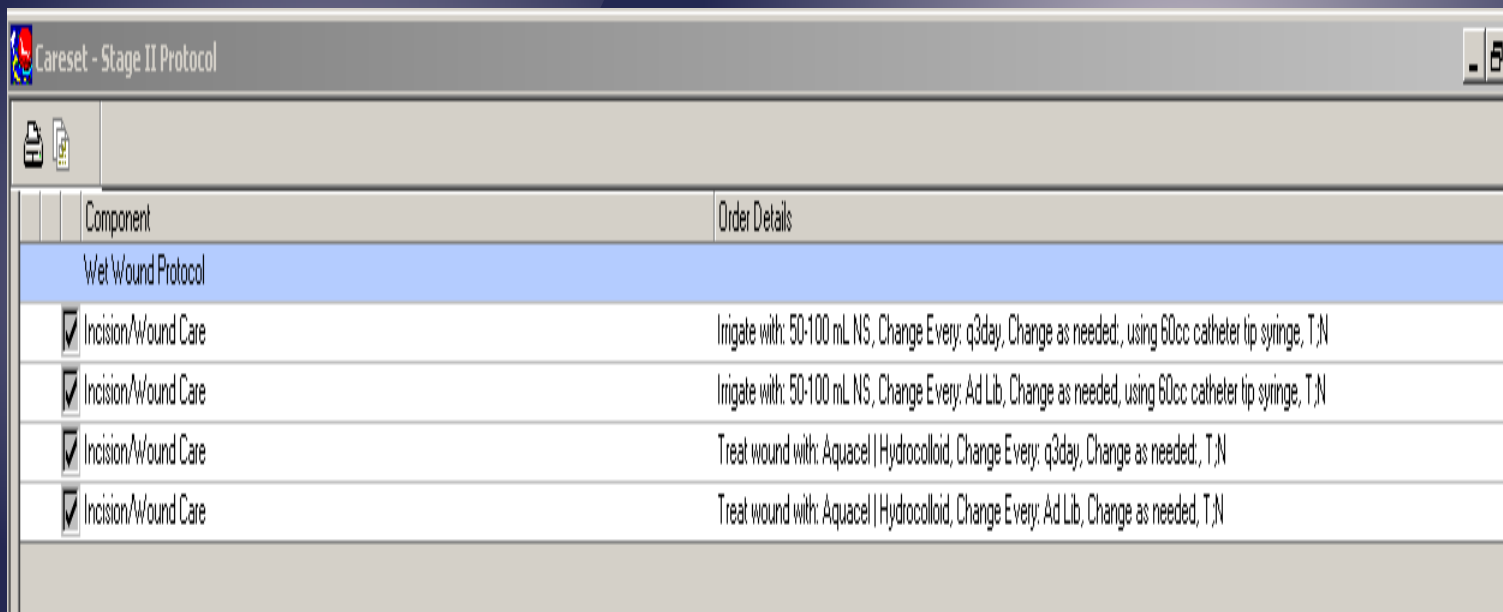
If you need to add another row for additional Skin Abnormalities, Right click anywhere in the box above and select "Add another row". This function can be performed as many times as needed.



Documentation View

Navigator		*Skin/Braden/Incision/Wound/Dietary View	
<input checked="" type="checkbox"/> Integumentary Assessment		11/22/2011 13:22 EST	11/16/2011 14:27 EST
<input checked="" type="checkbox"/> Assessment- Site A			
<input checked="" type="checkbox"/> Braden Assessment			
Integumentary Assessment		Exceptions not	
(R) Skin Abnormality Present		Yes	
(R) Incision/Wound, Ulcer, Skin Tear Pre		Yes	
(R) Surgical drains/tubes present		No	
Skin Abnormality/Location Grid		Skin Abnormal	
Assessment- Site A			
Present on Admission-Site A		Yes	
Site A Healed		No	
Type-Site A		Ulcer-Pressure	
Location-Site A		Sacrum	
<input type="checkbox"/> Length-Site A		2.00 cm	
<input type="checkbox"/> Width-Site A		2.00 cm	
<input type="checkbox"/> Depth-Site A		2.00 cm	
Length x Width Site A		3.1 - 4.0 cm	
Tissue Description Site A		Granulation tis:	
Description-Site A		Bone	
Drainage-Site A		Serosanguinec	
Drainage Amount-Site A		Small	
Drainage Odor Site A		None	
<input type="checkbox"/> PUSH Tool Score- Site A		9	
Surrounding Tissue-Site A		Healthy/Intact	
Pink Color Percentage-Site A		100%	
Classification-Site A		IV	
Dressing-Site A		Changed	
Braden Assessment			
(R) Sensory Perception Braden			Completely limi
(R) Moisture Braden			Constantly moi
(R) Activity Braden			Walks frequen
(R) Mobility Braden			No limitations
(R) Nutrition Braden			(c) Very poor
(R) Friction and Shear Braden			No apparent p
<input type="checkbox"/> Braden Score			(c) 14

Protocol Order Set



The screenshot shows a software window titled "Careset - Stage II Protocol". The window contains a table with two columns: "Component" and "Order Details". The table lists four components under the "Wet Wound Protocol" category, each with a checked checkbox in the "Component" column. The "Order Details" column provides specific instructions for each component.

Component	Order Details
Wet Wound Protocol	
<input checked="" type="checkbox"/> Incision/Wound Care	Irigate with: 50-100 mL NS, Change Every: q3day, Change as needed, using 60cc catheter tip syringe, T:N
<input checked="" type="checkbox"/> Incision/Wound Care	Irigate with: 50-100 mL NS, Change Every: Ad Lib, Change as needed, using 60cc catheter tip syringe, T:N
<input checked="" type="checkbox"/> Incision/Wound Care	Treat wound with: Aquacel Hydrocolloid, Change Every: q3day, Change as needed, T:N
<input checked="" type="checkbox"/> Incision/Wound Care	Treat wound with: Aquacel Hydrocolloid, Change Every: Ad Lib, Change as needed, T:N

Step 4: Get our documentation to work for us

- Wound assessment documentation automatically populates onto the W10

Discharge Documentation

Porrello MD, Peter T	Discharge Incision/Wound Care Instructions	Sacrum , Irrigate with: 50-100 mL NS, Treat with: Aquacel, Secure: Hydrocolloid, Change: q3day, Change as needed
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Incision/Wound Information: Below will list all Incision/Wounds NOT HEALED at time of discharge. Refer to the Discharge Incision/Wound Care order(s) above for treatment plan. If below area is blank, there are no Incision/Wounds identified as NOT HEALED at time of discharge. (POA=present on admission)

Site	Type	Location	POA	Update Date/Time
Site A	Ulcer-Pressure	Sacrum	Yes	11/22/2011 13:22
Measured - 11/22/2011 13:22 LN - 2.00 cm W - 2.00 cm D - 2.00 cm				

How we sustain our changes



Waterbury Hospital's Wound Care Program

- Focuses on empowering the nurse
- Multidisciplinary skin care team
- Weekly skin care rounds
- Ongoing review of new products, updating policies and improving our care
- Quarterly prevalence studies

Hospital Acquired Pressure Ulcers



Questions?

