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

- 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

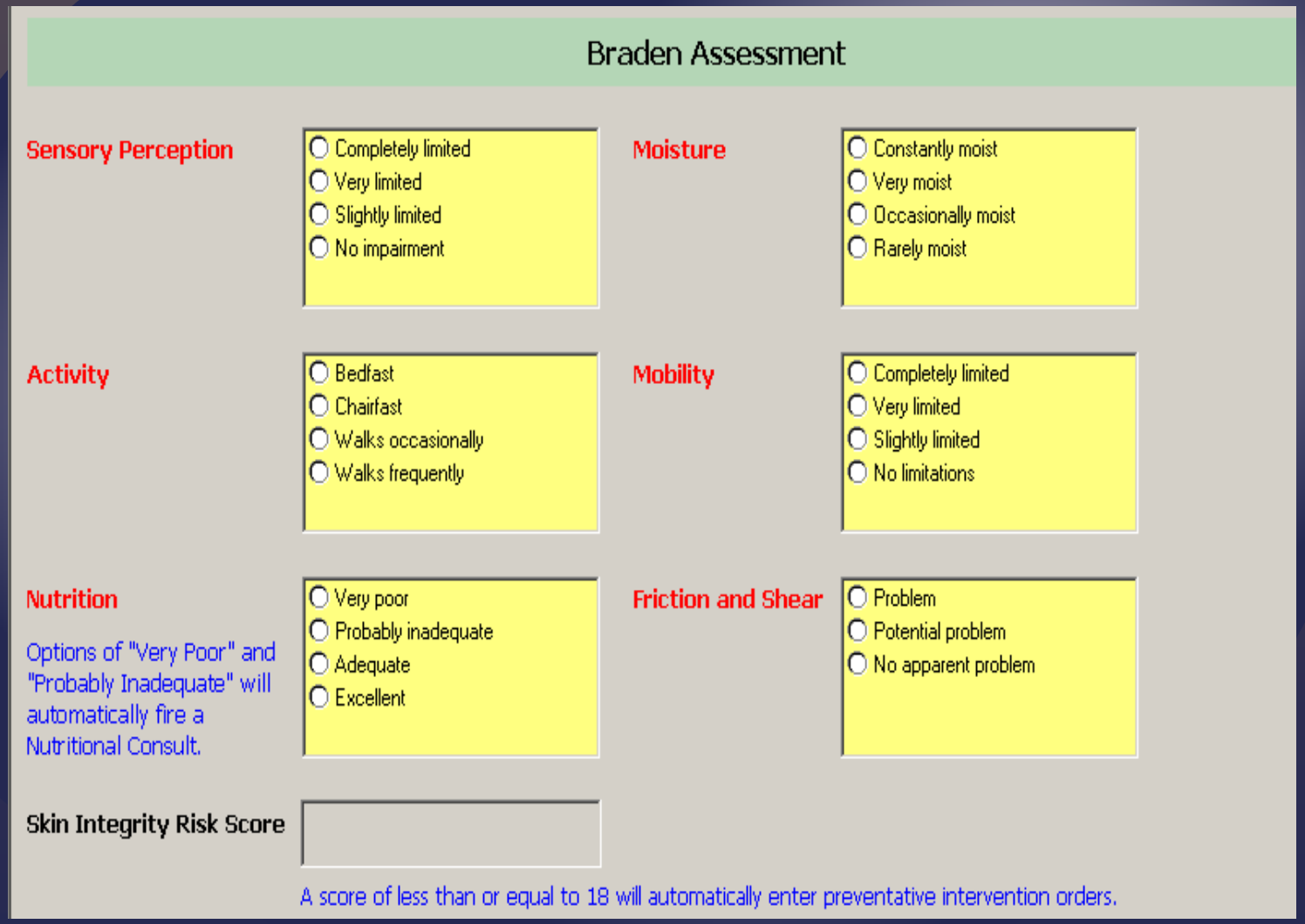
Step 3: Standardization of treatments and products

- 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 Score Tasks

Pending	11/22/2011	16:00 EST	Pressure Redistrubition 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			
☑	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 ...
☑	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

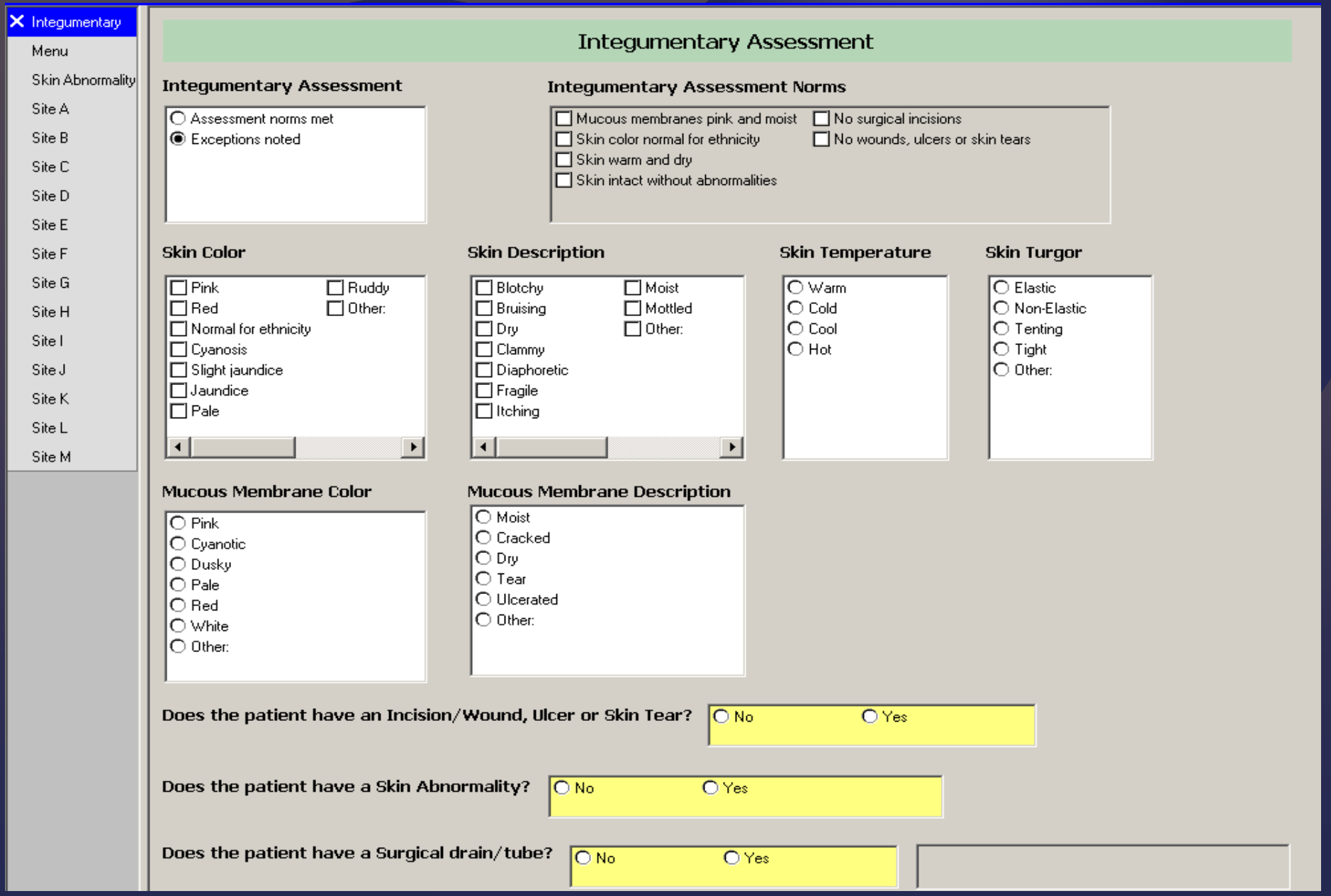
Wound/SkinCare Orders (Initiated)
Last updated on: 11/22/2011 13:28 EST by: Nichols RN, Brenda A

Activity				
☑	Activity (OOB)	Ordered	Activity: to Chair, Minimum of: BID, PRN order, with chair cushion, 11/22/11 13:28:00 EST	with chair cushion
Nursing				
☑	Bed: Specialty	Ordered	q8hrATC, 11/22/11 13:28:00 EST	
☑	Static Air Boots	Ordered	q8hrATC, 11/22/11 13:28:00 EST	

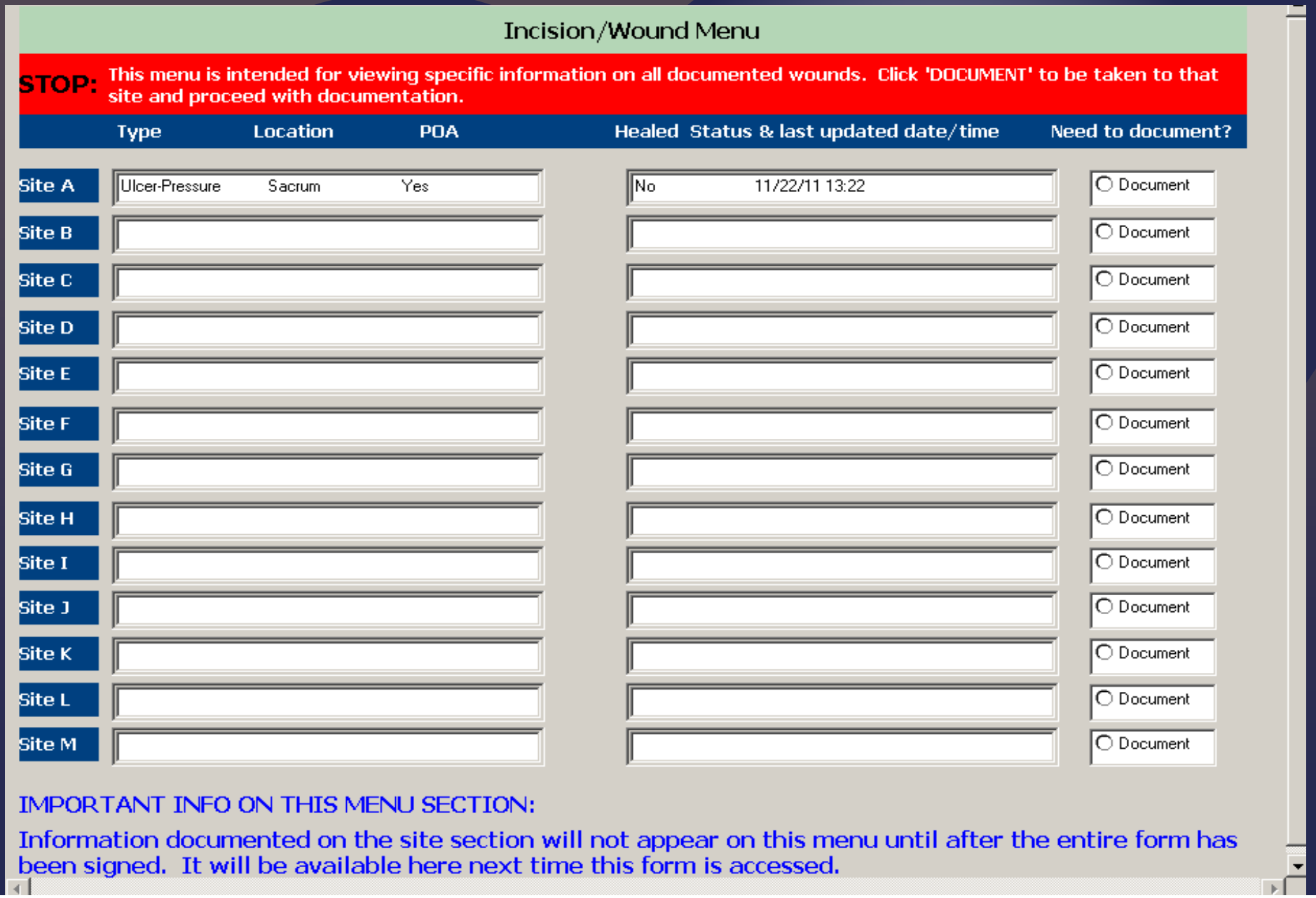
Step 4: Get our documentation to work for us

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

Integumentary Assessment



Incision/Wound Menu



Incision/Wound Care- Site

Incision/Wound Care-Site A

Type

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

Location

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

Description

- Closed
- Epithelization
- Granulation tissue
- Necrotic tissue
- Slough

- Bone
- Tendon
- Tunneling
- Undermining
- Dehisced
- Edges approximated
- Edges separated
- Stapled
- Sutured
- Other:

Pressure Ulcer Staging

Surrounding Tissue

Past charted stages/classification:

No qualifying data available

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

Treatments, Dressings & Interventions

Dressing

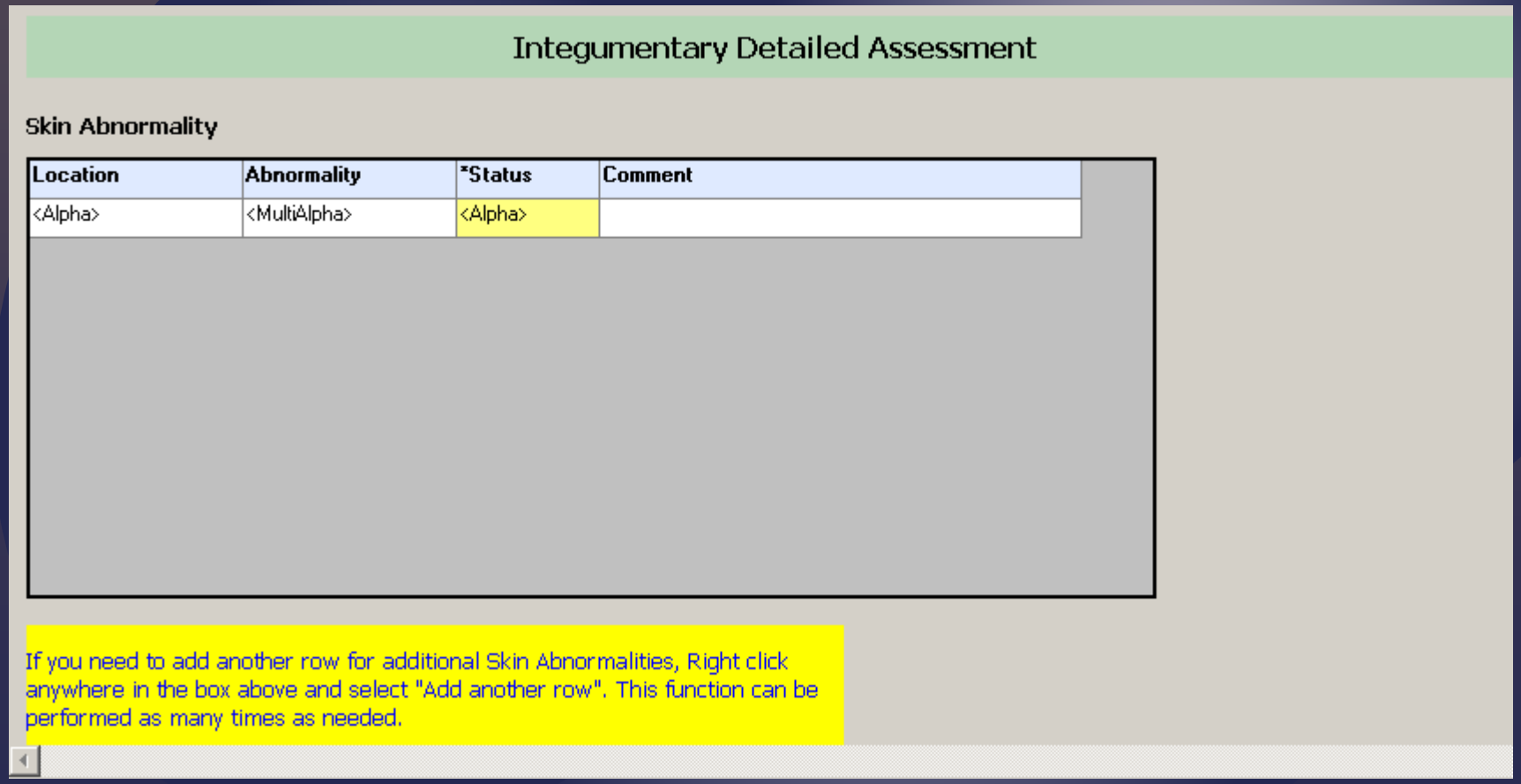
- Intact
- Reinforced
- Apply
- Changed
- Dressing discontinued
- Open to air
- Dressing changed by other discipline
- Wound Vac
- Other:

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



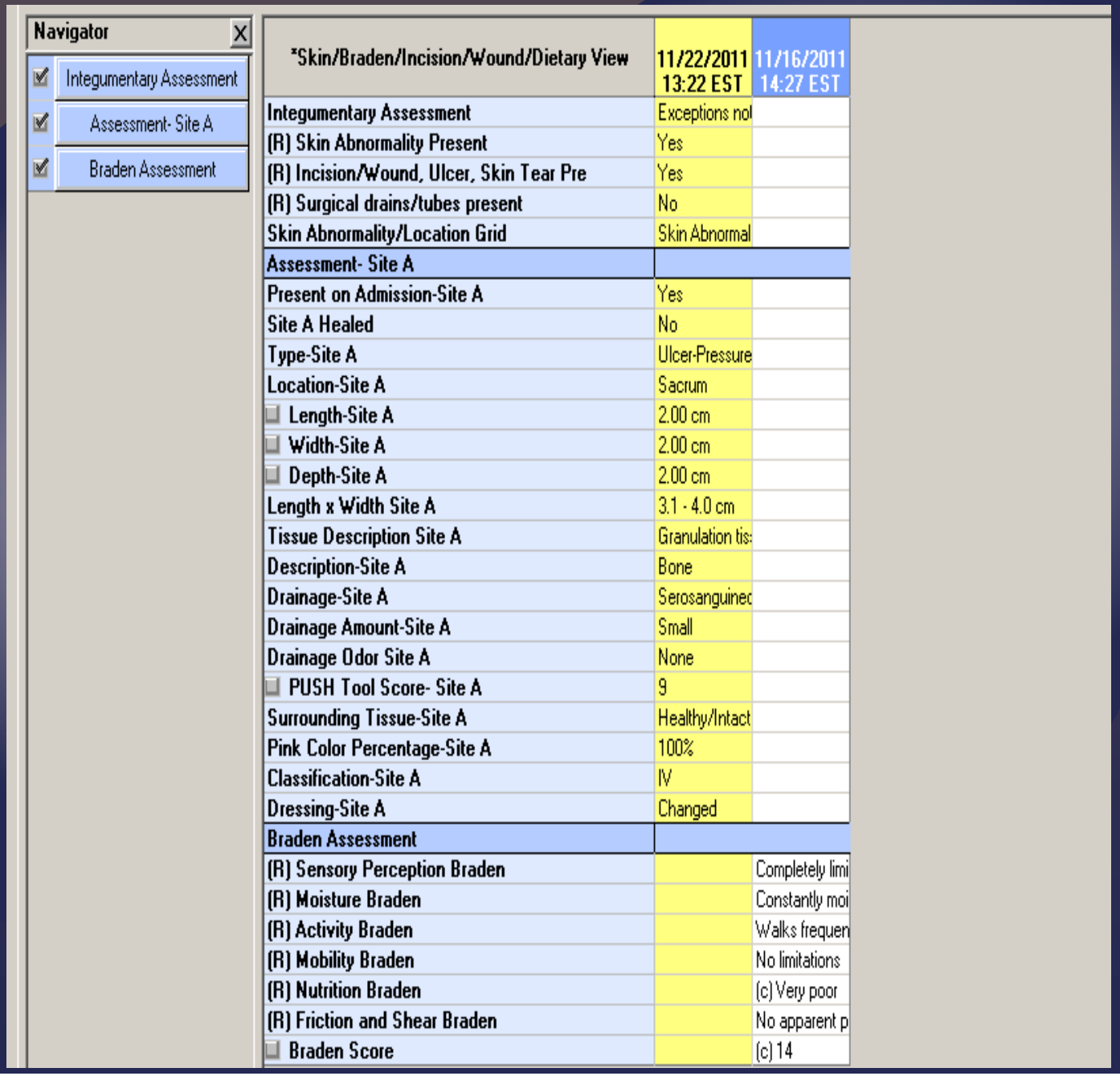
Integumentary Detailed Assessment

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

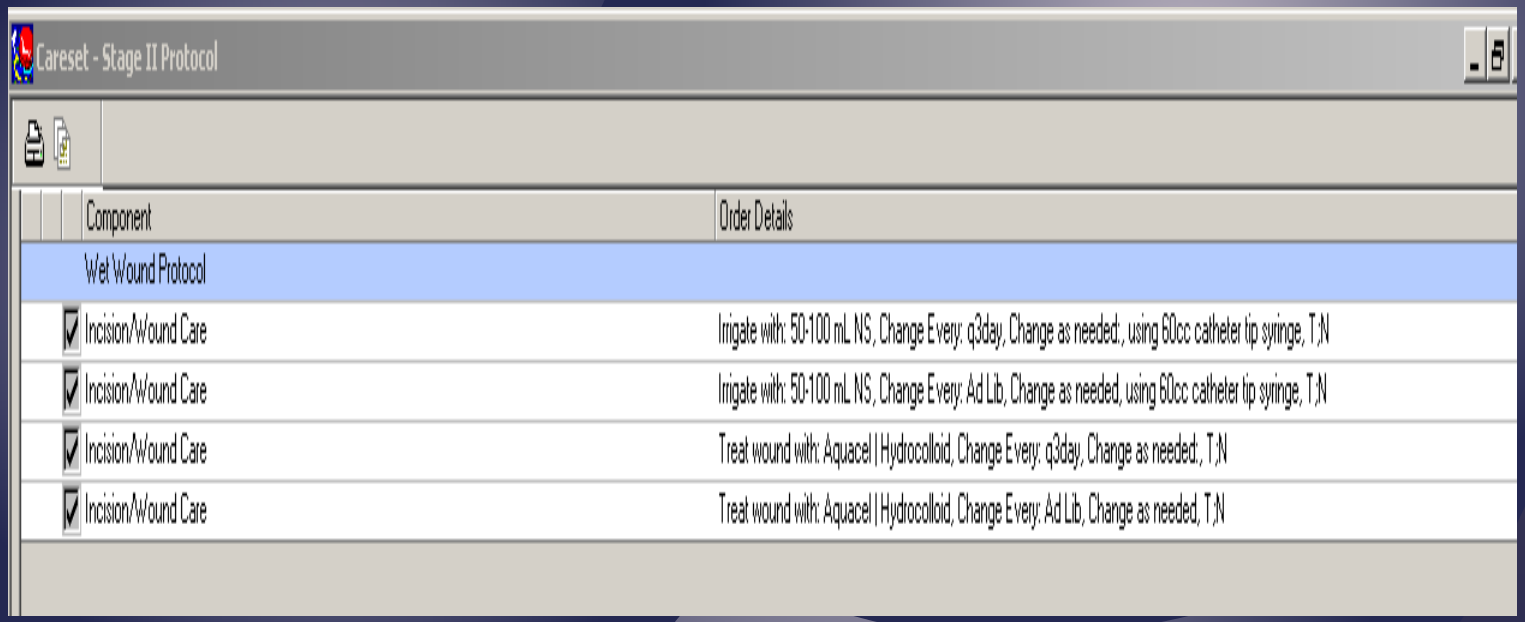


Navigator

- Integumentary Assessment
- Assessment- Site A
- Braden Assessment

*Skin/Braden/Incision/Wound/Dietary View	11/22/2011 13:22 EST	11/16/2011 14:27 EST
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	
Length-Site A	2.00 cm	
Width-Site A	2.00 cm	
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	
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
Braden Score		(c) 14

Protocol Order Set



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

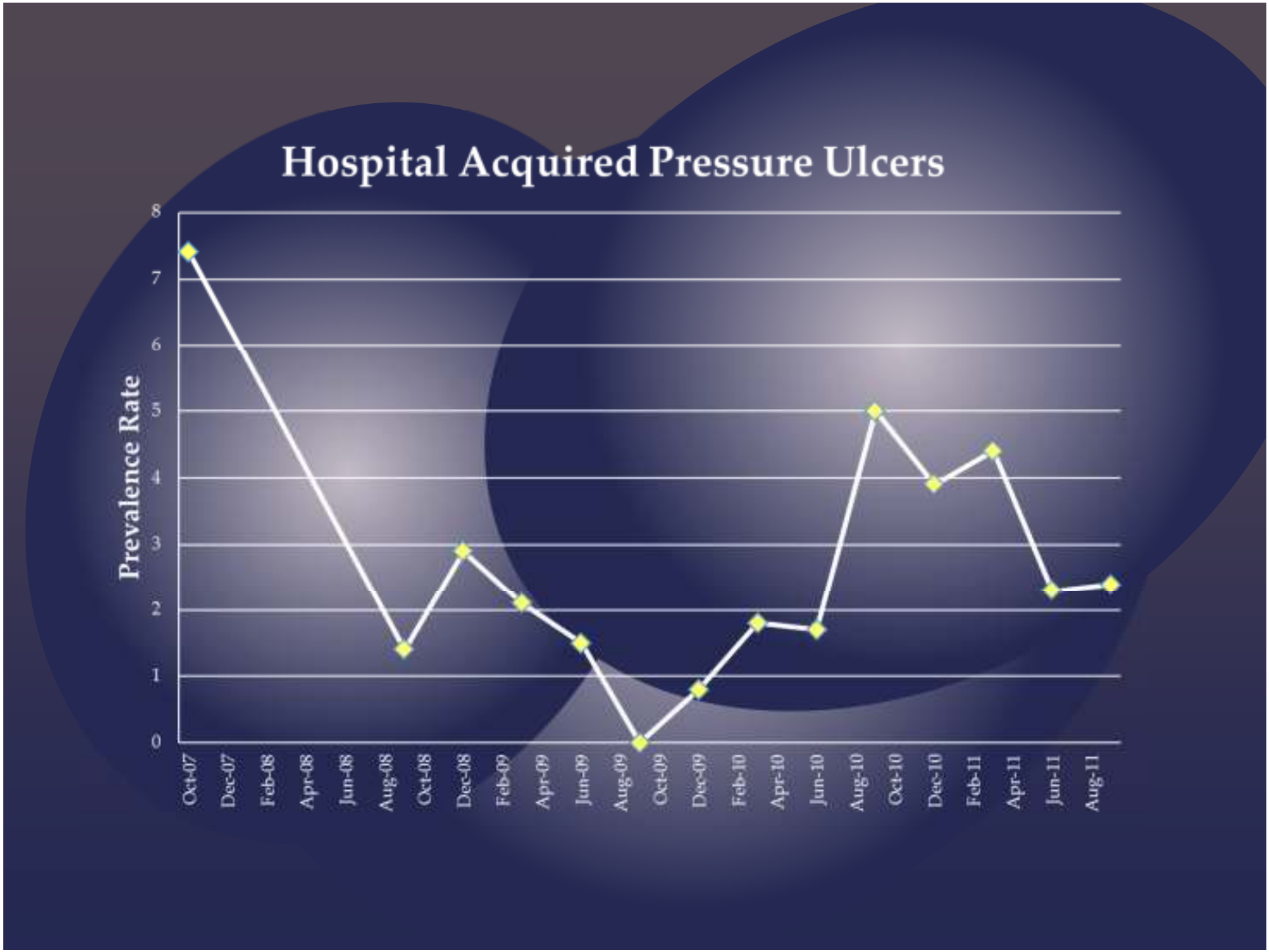
Incision/Wound Information: Below will list all Incision/Wounds NOT HEALED at time of discharge. Refer to the Discharge Incision/Wound Care order(s) above for treatment plan. If below area is blank, there are no Incision/Wounds identified as NOT HEALED at time of discharge. (POA=present on admission)

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
Prevalence Rate
0
1
2
3
4
5
6
7
8
Oct-07
Dec-07
Feb-08
Apr-08
Jun-08
Aug-08
Oct-08
Dec-08
Feb-09
Apr-09
Jun-09
Aug-09
Oct-09
Dec-09
Feb-10
Apr-10
Jun-10
Aug-10
Oct-10
Dec-10
Feb-11
Apr-11
Jun-11
Aug-11

Questions?