Purpose

In 2008, the incidence of HAPU was noted to increase in the Neuroscience Unit negatively affecting mortality, morbidity, and the patient experience. The goal of the SWAT Team is to empower the direct care staff to reduce the incidence of HAPU in the neurologically compromised inpatient population.

Significance:

The reduction of HAPUs was identified as a performance improvement priority for our institution, not only to limit patient HAPU-related morbidity and mortality, but also to mitigate or avert the average $43,000 increased cost reportedly associated with these pressure injuries.

Strategy and Implementation:

In 2008, the Neuroscience Units (NSU) developed a specialized Skin & Wound Assessment Team (SWAT) to reduce the incidence of pressure ulcers by targeting risk assessment and prevention. The team consists of both nurses and nursing assistants that serve as resources, mentors and change agents for the NSU. The team rounds weekly and collaborates with the bedside nurse to identify patients at risk and implement appropriate preventative strategies. The SWAT Team trialed skin care products and positioning devices and brought the most effective product choices forward. Beginning in 2010, newly hired staff spend one shift shadowing the SWAT Team. During this experience, they receive hands-on training and resources including the Braden Scale, Pressure Ulcer Staging Guide, and Guide to Skin Care Products and Positioning Devices. Additionally, they are required to complete the NDNQI Pressure Ulcer Training Module. In 2010, the NSU team facilitated the role out of SWAT to all inpatient units.

Results

Neuroscience Units HAPU Incidence 2008 - 2011

Evaluation

Incidence of HAPU decreased 52% the first year. The NSU was able to sustain their outcomes over the next 3 years achieving an overall reduction in incidence of 67.5%. Two units maintained a zero NDNQI prevalence rate for 5 consecutive quarters; the third achieved a zero rate for 4 of 5 quarters.

Implications for Practice

In 2010, the SWAT concept was adopted hospital wide. Other units were able to replicate these outcomes. Direct care staff experienced a culture change, recognizing the impact a nurse driven initiative has on outcomes. Best practices are shared at HAPU reduction and prevention committee meetings.

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