BAYLOR Medical Center at Garland

Utilizing Lean Methodology in Reduction of Hospital Acquired Pressure Ulcers (HAPUs)

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Baylor Medical Center at Garland

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Abstract

Baylor Medical Center at Garland was above the NDNQI mean for Hospital Acquired Pressure Ulcers (HAPUs). HAPUs are an avoidable injury that CMS regards as a never event. HAPUs can increase a patient's length of stay; decrease their quality of life and decrease patient satisfaction. HAPUs also impact a hospital financially by increased cost and reduced reimbursement.

A multi-disciplinary team was formed to research and identify gaps in patient care that could result in a pressure ulcer. Each area where a gap occurred that issue was evaluated and a best practice was identified to address the issue.

Objective

A multi-disciplinary team will use Lean methodology to assess the patient care process on the nursing unit with the highest incidence of HAPUs to identify gaps , implement key changes, and monitor for improvements.

Methods/Measurement

Methods:

Lean Methodology

Process included:

Frontline approach

Collaborative problem solving

Three Phases:

Diagnosis Phase

Treat Phase

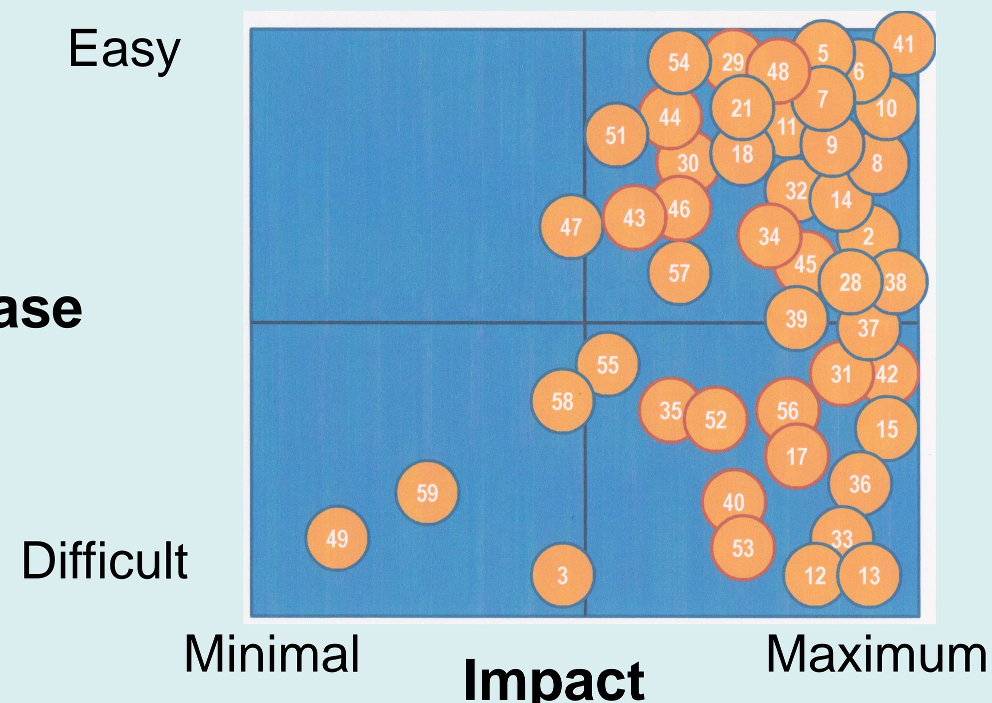
Sustain Phase

Measurement:

Data collected during the monthly NDNQI Pressure Ulcer Prevalence Study

Prioritization of solutions were made by identifying those with the highest impact and ease of implementation.

HAPU Solutions Impact 2x2



Results

Training provided to all nurses and patient care technicians. Training methods included PowerPoint presentation, video messages from nursing and medical leaders, and role playing.

Training focused on gaps identified in the Lean diagnosis phase; Patient Assessment, Knowledge Deficit, Communication, Teamwork, and Patient Safety.

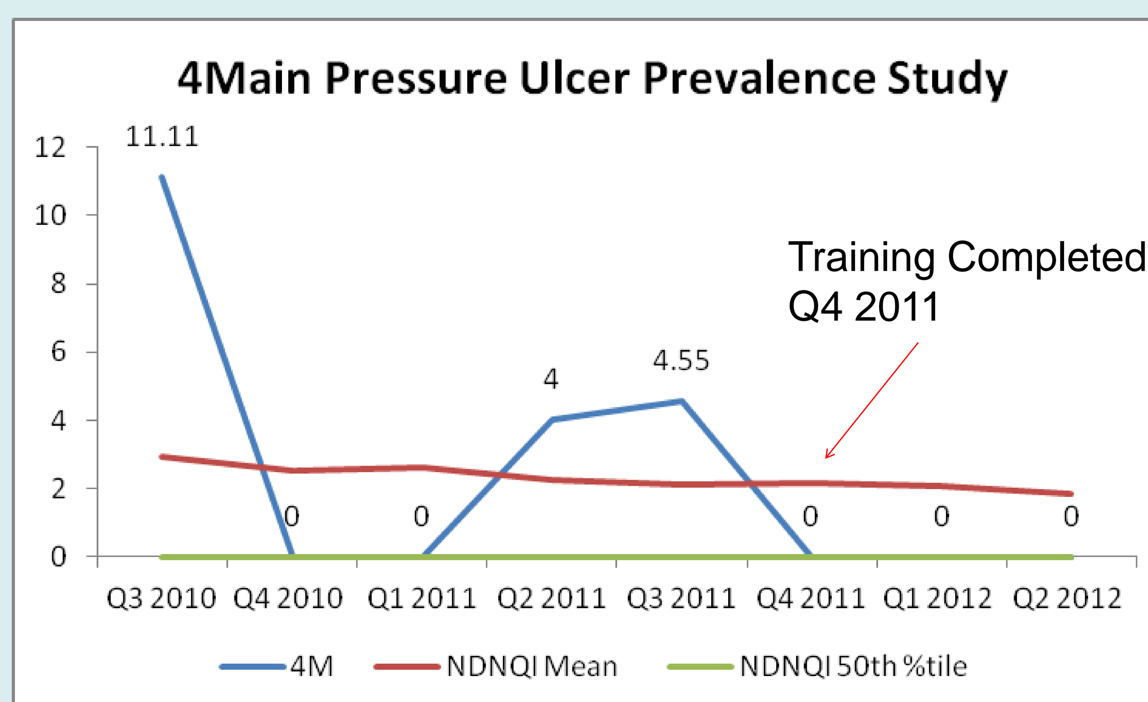
New education materials also implemented in new hire orientation.

Online NDNQI Pressure Ulcer training became an annual competency for all nursing staff

Audited patients with a Braden Score of 18 or less to ensure proper nursing interventions implemented. Audited for turning of patient, correct documentation, number of linen layers, no diapers in bed, and use of whiteboard communication.

Formed Skin Wound Assessment Team (SWAT) to create nursing champions for each floor . They serve as the resident expert, conduct monthly NDNQI Prevalence studies, and continually educate staff

Outcomes



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Conclusions/Lessons Learned

Implementing best practices and resulting culture change proved to be a challenge

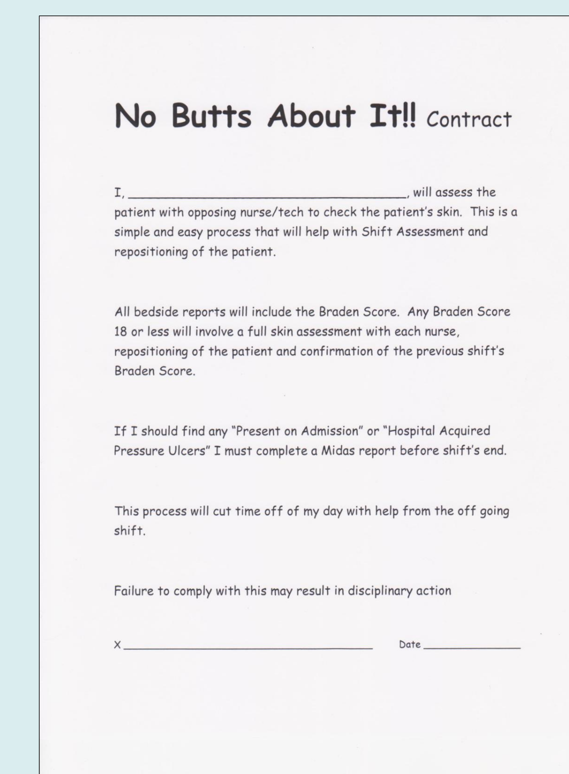
Regular audits reinforces best practice

Educate, educate, educate

Hold staff accountable

Tools

Commitment Statement Signed by Staff



No Butts About It!! Contract

I, ______________________, will assess the patient with opposing nurse/tech to check the patient's skin. This is a simple and easy process that will help with Shift Assessment and repositioning of the patient.

All bedside reports will include the Braden Score. Any Braden Score 18 or less will involve a full skin assessment with each nurse, repositioning of the patient and confirmation of the previous shift's Braden Score.

If I should find any "Present on Admission" or "Hospital Acquired Pressure Ulcers" I must complete a Midas report before shift's end.

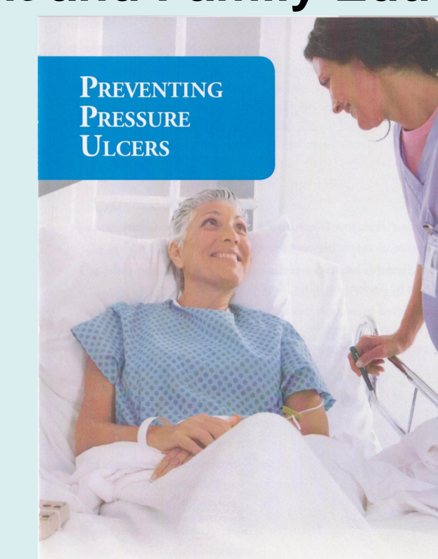
This process will cut time off of my day with help from the off going shift.

Failure to comply with this may result in disciplinary action

X ______________________ Date __________

Every nurse and patient care technician pledge to prevent pressure ulcers. The commitment statement was distributed at the end of Lean HAPU training and is now distributed in new hire orientation. The commitment statement is part of each nurse and patient care technician's employee file.

Patient and Family Education Tool



Patients and their family members need to understand the risks and complications of pressure ulcers. They also need to know that there are interventions to prevent pressure ulcers. An informational brochure is provided in admission packet.

SWAT Champions Easily Identifiable

Each Skin Wound Assessment Team (SWAT) champion wears a lapel pin to make them easily identifiable to nursing staff.

Reference

National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: clinical practice guideline. Washington DC: National Pressure Ulcer Advisory Panel; 2009.