Decreasing Unit Acquired Pressure Ulcers and Health Care Worker Injury

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Background

- Pressure ulcers greater than Stage 1 that occur while the patient is hospitalized can be prevented by frequent turning of the patient.
- Patients who are unable to turn themselves or who need assistance with turning are at great risk for pressure ulcers during hospitalization.
- Measurement of unit-acquired pressure ulcers began in the last quarter of 2012 and the average baseline rate was 1.13%.
- In 2013, the average monthly rate began to increase to 3.99%.
- Also, B4 had 8 reported incidents of Health Care Worker Injury (HCWI) from turning and positioning patients in 2013.

Purpose

1) To decrease the occurrence of unit-acquired pressure ulcers, greater than Stage 1, by using a clinically innovative product and 2) to decrease health care worker injury by creating an environment that protects the staff from injury.

Methods

- In this quality improvement project, the pressure ulcer data was collected pre-implementation (January 2013-September 2013) and post-implementation (from October 2013-December 2015) through monthly inpatient prevalence audit reports.
- The HCWI data were collected from employee-reported incidents.
- The pre-implementation group using traditional methods of draw sheet turning was compared to the post-implementation group.
- A Turn And Position (TAP) system was introduced on patients who were either unable to turn themselves or who required assistance turning from side to side while in bed.

Results of Unit-Acquired Pressure Ulcers

- B4 Pts. w/ Unit-Acquired Ulcers > Stage 1 2013-2015

Results of Health Care Worker Injuries

- Number of Health Care Worker Injuries

Conclusions

- Prior to implementation of TAP, the average monthly unit-acquired pressure ulcer (greater than stage 1) prevalence rate was 3.99%. Post implementation, the average monthly pressure ulcer rate in 2013 was 0.47%. Average pressure ulcer rate in 2014 was reduced to 0.59% and continued to decrease in 2015 to 0.46%
- During the same pre- and post-implementation time frames, HCWI was reduced from 8 incidents of reported sprains and strains while lifting and turning patients to only 1 incident in 2014 and 0 incidents in 2015.
- Utilization of the TAP system with patients who are unable to turn themselves or need assistance turning reduces unit-acquired pressure ulcers greater than Stage 1 and also reduces reported HCWI from turning and positioning patients more than using a traditional draw sheet.

Implications

- Prevention of unit-acquired pressure ulcers greater than Stage 1 and HCWI benefit both hospitalized patients and the nursing staff taking care of them.
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility are considered as “never events”, which are defined by the Leapfrog Group as “adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.”
- Utilization of the TAP system creates an environment that is both safer for hospitalized patients who cannot turn themselves or need assistance turning and also safer for the nursing staff that are responsible for turning those patients.

What’s on T.A.P? (Turn And Position)

- Helps prevent skin pressure ulcers by off-loading the sacrum. Manages moisture due to incontinence, creating an optimal environment for wound healing.
- Helps maintain patient comfort and dignity.
- Safer for hospitalized patients who cannot turn themselves or need assistance turning.
- Helps staff move safely and easily with the TAP system.

Figure 1, TAP 2.0 System. Figure 2, Staff turning patient utilizing the TAP system.