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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

**PLAN:** July-2013

-Review of Data: July 2013.

-Plan review of Ulcer Staging and documentation: July-August 2013.

**DQ:** August-October 2013

-Implement review of ulcer staging and documentation August 2013

-Plan education of Turn And Position (TAP) System August 2013.

-Education of Turn and Position System September-October 2013

-Implement Turn and Position System on B4 as the pilot unit for the small test of change at the end of October 2013.

**CHECK:** First-Quarter 2014

**ACT:** April to Dec. 2014

-Received feedback from other units that patients had been transferred to with the TAP system during the first quarter of 2014.

-Monthly feedback of unit acquired pressure ulcers and HCWIs.

-Read and Sign education about the TAP System sent to all inpatient nursing units.

-Product Upgraded to TAP 2.0 System in May.

-TAP 2.0 Inservices for all hospital staff begin in May of 2014.

-Use up remaining stock of original TAP system. June-August 2014.

-Reinservice all hospital staff of TAP 2.0 in August 2014.

-Implement TAP 2.0. September to December 2014.

### Aims

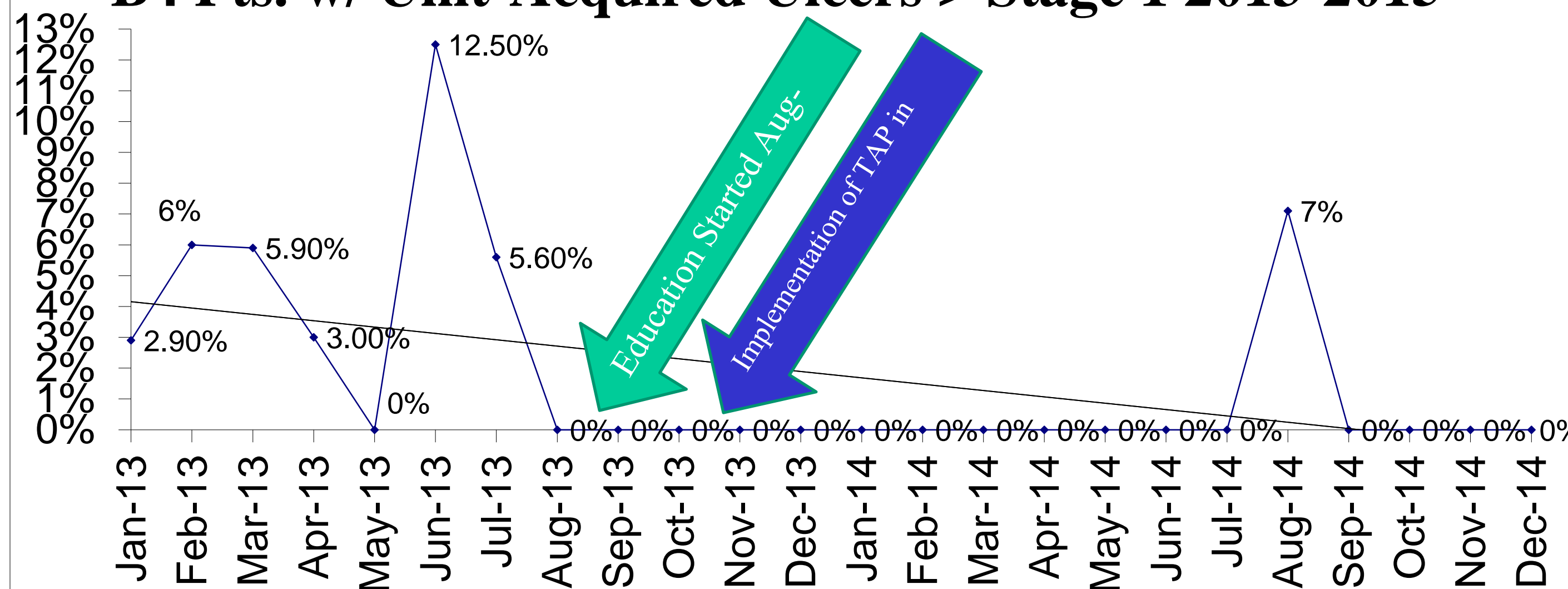
- To decrease the occurrence of unit-acquired pressure ulcers, greater than Stage 1, by using a clinically innovative product and
- to decrease health care worker injury by creating an environment that protects the staff from injury.

### Methods

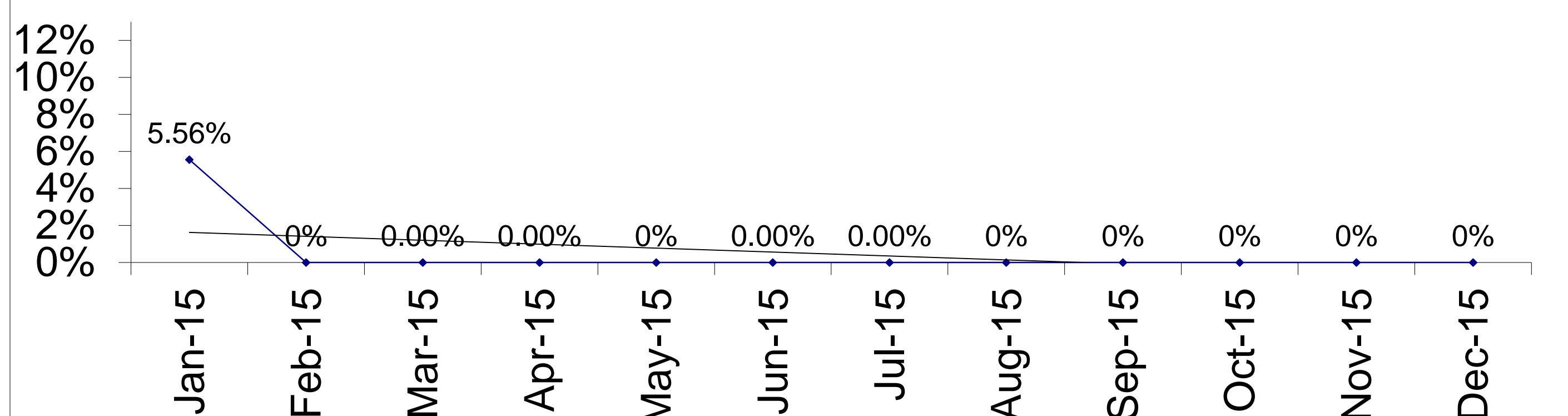
- In this quality improvement project, the pressure ulcer data was collected pre-implementation (January 2013-September 2013) and post-implementation (from October 2013-December 2015) through monthly inpatient prevalence audit reports.
- The HCWI data were collected from employee-reported incidents.
- 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**

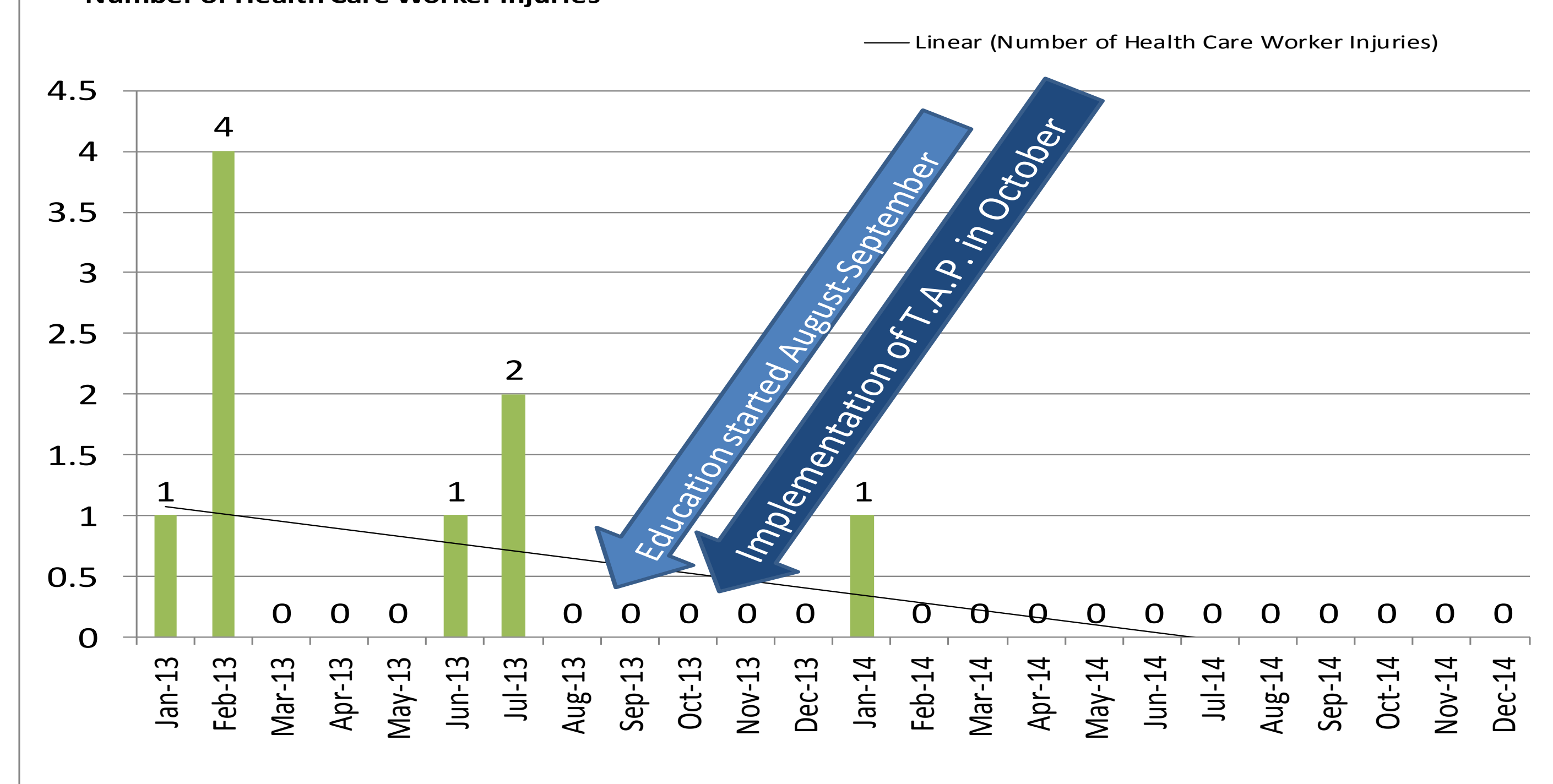


**B4 Pts. w/ Unit Acquired Ulcers > Stage 1 2015**



### 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)



•Figure 1, TAP 2.0 System. Figure 2, Staff turning patient utilizing the TAP system. Helps prevent sacral pressure ulcers by offloading the sacrum. Manages moisture due to incontinence, creating an optimal microclimate for the skin. Helps minimize friction and shear. Keeps patient positioned at the appropriate angle. Reduces exertion needed to turn and boost patients. Requires fewer staff and less time to turn. Decreases strain on staff's hands, wrists, shoulders, and backs. Helps staff more easily follow best practice prevention guidelines. All that is necessary to position the patient at the appropriate angle is a quick microturn, which requires 90% less exertion than traditional methods using draw sheets.