Pressure Ulcer Prevention: The Goal is Zero

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Reducing Pressure Ulcers

For All Patients:
- Conduct a pressure ulcer admission assessment for all patients
- Reassess risk for all patients daily

For High Risk Patients:
- Inspect skin daily
- Manage moisture – keep the patient dry and moisturize skin
- Optimize nutrition and hydration
- Minimize pressure
Conduct a Pressure Ulcer Admission Risk Assessment; Reassess Daily

- Use visual cues in admission documentation for completion of skin and risk assessment.
- Standardize risk assessment tool/checklist across the institution.
  - Incorporate action steps linked to risk.
- Use multiple methods to visually identify patients at risk.
  - Place stickers on chart, use visual cues on door and bed.
- Post compliance rates to motivate staff.
- Improve processes to ensure risk assessment is conducted within four hours of admission and reassess daily.
- Assess surgical patients.

Design for Reliability: Risk Assessment and Skin Assessment

- Independent Redundancies:
  - Admission queue on IT system if assessments not completed within 4 hours
  - Shift check for each admitted patient
  - IT system will not proceed without complete assessment
Inspect Skin Daily

- Daily skin inspection is required for high-risk patients.
- Skin integrity can deteriorate in a matter of hours.
  - Always look at sacrum, back, buttocks, heels, and elbows every time the patient is assessed.

Design for Reliability: Inspect Skin Daily

- Design Work, routine to include skin inspection
- Design documentation to include detailed skin inspection
- Make it hard NOT to complete skin inspection
- IT documentation, Cannot complete documentation without completed detailed
  - Shift checks – walking report, multi-disciplinary rounds scripts,
  - Engage Families –
Manage Moisture

- Cleanse skin at time of soiling and at routine intervals.
  - Watch for excessive moisture due to perspiration and wounds.
  - Use gentle cleansing agent.
- Use moisturizers for dry, fragile skin.
- Provide under-pads that wick moisture away from skin.
- Keep kit of needed supplies at bedside for at-risk incontinent patients.

Design for Reliability: Manage Moisture

- Design kit to be at the bedside of each at risk patient
  - To include supplies to clean patients quickly
  - Develop process for assuring kit is complete
- Develop Process for Hourly rounds
  - Utilize IT to remind staff of rounds, documentation
  - Use Audio or visual queues to remind staff of rounds.
  - Everyone who enters the room can check the patient and assist the patient
  - Engage Families
Optimize Nutrition/Hydration

- Respect patient’s dietary preferences.
- Involve dietician, use supplements as needed.
- Monitor hydration.
  - Offer water (when appropriate) whenever patient is turned.

Design for Reliability: Optimize Nutrition and Hydration

- Automatic Clinical Dietary Consult
- Strategy on care plan
- Develop Hourly Rounds
  - Offer water
- Measure I and O for each patient at risk
- Shift checks – walking report, multidisciplinary rounds scripts,
- Consider visual clue for encouraging fluids
- Engage Families –
Minimize Pressure

- Turn/reposition patient at least every two hours.
  - Use alerts and cues to remind staff to turn patient.
  - Protect skin when turning patient (use lift devices or “drawsheets,” heel and elbow protectors, sleeves and stockings; do not “drag”).
- Use pillows and cushions strategically.
- Use static and/or dynamic pressure-relieving support surfaces.
  - Static surfaces include well-designed mattresses, mattress overlays filled with water, air, gel, foam, or a combination of these.
  - Dynamic surfaces include devices that vary pressure beneath the patient, reducing duration of pressure at any given skin site.

Design for Reliability: Minimize Pressure

- Design turn schedule
  - Design turn clock to be placed on door
  - Educate, expect all who enter to turn the patient according to the turn clock or schedule
- Develop hourly rounds:
  - Check patient
  - Offer water
  - Turn patient
  - Document
  - Utilize audio queue to remind staff of rounds (beepers, IT systems, etc)
- Engage Families
Key Concepts:

Patient and Family Engagement

- Patients and Family need to know (and want to know):
  - WHY they may be vulnerable to pressure ulcers
  - WHAT areas of your skin may be vulnerable to pressure damage
  - HOW to inspect their own skin and recognize skin changes
  - HOW to relieve or reduce pressure
  - WHAT they can do to assist in the prevention of Pressure Ulcers
Measures are Powerful!

- Process Measures Matter!
  - Spot check and reward often
- Safety Cross
  - Raises awareness at the frontline & is easy to use
- Time between events-
  - Time between chart & safety cross
  - Aim to increase the number of days between events
- Pressure Ulcer count
  - More meaningful as it relates to people!
- Pressure Ulcer incidence rate (per 1000 days)
  - Enables comparison between sites

Visual Cues can be Magical

Pressure Ulcer Prevention
Visual Measurement

Safety Cross

- **Aim**: To acquire a green cross or decrease the number of red squares (time between)
- **No new case identified**

- **New case identified**

- **Admitted with or transferred from another unit with pressure ulcer**
Safety Cross

Days since last PU

Ward acquired PU

Patient admitted

Pressure ulcer prevention Results

• >50% reduction in pressure ulcers in all pilot wards
• 1 site has just gone 3 years and 5 months with only 1 grade 2 pressure ulcer
• 93 ward spread
• System wide results
Incidence 14% down to 0.6%

Many units at zero for greater than one year

Intentional Rounding – What is it?

Structured process where frontline staff regularly round on patients and reliably perform scheduled/required tasks

Can build reliability with many preventative interventions

Rounding with a purpose-linked to an aim

Start small! One Purpose! Build habits, reliability, accountability

8 key behaviors
1. Opening key words – Script
2. Perform scheduled tasks
3. Address the 3 p’s of pain, potty? (toileting), and position
4. Assess comfort needs
5. Environmental assessment
6. Closing key words- Script
7. Explain when you or others will return - script
8. Document the round on the log
Recommended Content from the Knowledge Center

**Measures**

- **Prevent Pressure Ulcers**
  - Care teams should ensure compliance with each of the key components of evidence-based pressure ulcer care recommended in the How-to Guide: Pressure Ulcers.

- **Percent of Patients Receiving Daily Pressure Ulcer Risk Assessment**
  - The percentage of patients for whom a pressure ulcer risk assessment was performed daily or with greater frequency (or for whom an appropriate contraindication was documented).

**Tools**

- **Prevent Pressure Ulcers Brochure**
  - This brochure provides information for patients and families on what a pressure ulcer is, who is at risk, how to keep skin healthy, what to do at home and in the hospital to prevent pressure ulcers, and what caregivers in the hospital will do to prevent them.

- **How-to Guide: Prevent Pressure Ulcers**
  - The How-to Guide describes key evidence-based care components for preventing pressure ulcers, including implementing skin interventions and recommends practices to improve outcomes.

- **Photographic Wound Documentation Form**
  - This tool is used to document the presence of a wound and condition of surrounding skin at admission and at regular intervals thereafter to document wound progression.

- **Preventing Pressure Ulcers Turn Clock Tool**
  - This tool is used to document the presence of a wound and condition of surrounding skin at admission and at regular intervals thereafter to document wound progression.

- **Nursing Assistant Ostomy Competency Tool**
  - A tool used to rate nursing assistants on their performance of critical elements of care for patients with ostomies.

Questions?

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