Transforming Wound Care Delivery
A Multidisciplinary Approach

Presented to:
MA Pressure Ulcer Collaborative
June 16, 2011
Presenters

- Janet Madigan, MS, RN, NEA-BC
  Vice President, Patient Care Services, CNO
- Gail Slotnick, MBA, RN BC
  Director, Wound Care Program
- Mary Beth Urquhart, RN, MBA, CPHQ
  Vice President, Quality, Risk and Compliance
Key Points of Discussion

- Background
- Pressure Points
- Team-based interventions/initiatives
- Evolution with outcomes
- Short and long-term goals
Background

- NE Sinai nationally recognized center of pulmonary and rehab excellence
- Referral population diverse and predictably unpredictable
- Acuity level climbing over time
- *Skin failure rarely making it to problem list - historically below benchmark incidence and prevalence*
Distribution of Sinai Patients by Admission Type

New England Sinai Hospital *

*38% of patients have diabetes

- Complex Medical: 50%
- Pulmonary: 37%
- Ventilator-dependent: 12%
- Wound: 1%
New England Sinai Hospital
Incidence of Hospital-acquired Pressure Ulcers Jan 08 - Jan 10

Graph showing the incidence of hospital-acquired pressure ulcers from January 2008 to January 2010. The y-axis represents the incidence rate, and the x-axis represents the months from January 2008 to January 2010. The data points are marked with blue dots, and a trend line is drawn to show the overall trend during the period.
Programmatic Focus and A+ Report Card 2007-2008

- Investments in new mattresses (pressure redistribution) all beds
- Standardized skin/wound care product line
- Focused education

PUP Rate March 2007 10.2% → PUP Rate September 2008 4.8%
## Events Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 28, 2010</td>
<td>Joint Commission survey</td>
</tr>
<tr>
<td>March 11, 2010</td>
<td>CMS post-TJC validation survey</td>
</tr>
<tr>
<td>March 12, 2010</td>
<td>Reportable event to DPH: wound</td>
</tr>
<tr>
<td>March 13, 2010</td>
<td>Immediate jeopardy</td>
</tr>
<tr>
<td>March 13, 2010</td>
<td>100% daily monitoring/rounding all patients</td>
</tr>
<tr>
<td>March 15, 2010</td>
<td>Reportable event to DPH: IV-related</td>
</tr>
<tr>
<td>March 19, 2010</td>
<td>NE Sinai closed to admissions &amp; re-admissions</td>
</tr>
<tr>
<td>March 19, 2010</td>
<td>Media/healthcare consultant engagement</td>
</tr>
<tr>
<td>March 19, 2010</td>
<td>Appointment of medical director, quality &amp; safety</td>
</tr>
<tr>
<td>March 24, 2010</td>
<td>Wound team multidisciplinary rounds - all wounds</td>
</tr>
<tr>
<td>April 1, 2010</td>
<td>Admissions with cap: 4 per day to Sinai-Stoughton</td>
</tr>
<tr>
<td>April 9, 2010</td>
<td>Wing 2A (32 beds) closed - patients relocated</td>
</tr>
<tr>
<td>April 12, 2010</td>
<td>Post-survey CMS visit</td>
</tr>
<tr>
<td>April 15, 2010</td>
<td>Appointment of medical director, inpatient wound</td>
</tr>
<tr>
<td>April 29, 2010</td>
<td>Mock survey with consultants</td>
</tr>
<tr>
<td>June 8, 2010</td>
<td>Post-survey CMS visit</td>
</tr>
<tr>
<td>June 13, 2010</td>
<td>Immediate jeopardy lifted</td>
</tr>
<tr>
<td>June 22, 2010</td>
<td>Blue Cross lifts admissions ban</td>
</tr>
</tbody>
</table>
Immediate Jeopardy: Definition and Triggers*

“A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” (See 42 CFR Part 489.3.)

“Triggers” alert surveyors that some circumstances may have the potential to be identified as Immediate Jeopardy situations and therefore require further investigation before any determination is made. A detailed review of three sample cases “walk” surveyors through the steps necessary to carefully analyze and accurately determine whether or not an Immediate Jeopardy situation exists.

*Source: CMS - State Operations Manual Appendix Q - Guidelines for Determining Immediate Jeopardy - (Rev. 1, 05-21-04)
Immediate Jeopardy Principles*

- Only ONE INDIVIDUAL needs to be at risk. Identification of Immediate Jeopardy for one individual will prevent risk to other individuals in similar situations.
- Serious harm, injury, impairment, or death does NOT have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.
- Psychological harm is as serious as physical harm.
- Individuals must not be subjected to abuse by anyone including, but not limited to, entity staff, consultants or volunteers, family members or visitors.
- Serious harm can result from both abuse and neglect.
- When a surveyor has established through investigation that a cognitively impaired individual harmed an individual receiving care and services from the entity due to the entity’s failure to provide care and services to avoid physical harm, mental anguish, or mental illness, this should be considered neglect.
- Any time a team cites abuse or neglect, it should consider Immediate.

*Source: CMS - State Operations Manual Appendix Q - Guidelines for Determining Immediate Jeopardy - (Rev. 1, 05-21-04)
IJ Trigger Issue Failure to Prevent Neglect (#2 of 10)*

Triggers 1-15:

1. Lack of timely assessment of individuals after injury;
2. Lack of supervision for individual with known special needs;
3. Failure to carry out doctor’s orders;
4. Repeated occurrences such as falls which place the individual at risk of harm without intervention;
5. Access to chemical and physical hazards by individuals who are at risk;
6. Access to hot water of sufficient temperature to cause tissue injury;
7. Non-functioning call system without compensatory measures;
8. Unsupervised smoking by an individual with a known safety risk;
9. Lack of supervision of cognitively impaired individuals with known elopement risk;
10. Failure to adequately monitor individuals with known severe self-injurious behavior;
11. Failure to adequately monitor and intervene for serious medical/surgical conditions;
12. Use of chemical/physical restraints without adequate monitoring;
13. Lack of security to prevent abduction of infants;
14. Improper feeding/positioning of individual with known aspiration risk; or
15. Inadequate supervision to prevent physical altercations.

*Source: CMS - State Operations Manual Appendix Q - Guidelines for Determining Immediate Jeopardy - (Rev. 1, 05-21-04)
Reportable Event: Wound Care Issue

- On admission, the patient, age 70, was noted to have “Stage II pressure ulcers” on each buttock and the right hip by the admission nurse. However, the wound nurse admission note indicates that there were areas of darker skin tone across buttocks (patient is dark-skinned) which may have indicated deep tissue injury. Over the course of many months, these ulcers worsened and ultimately presented as “unstageable” at the buttocks region and down to exposed tendon (Stage IV by definition) in the right hip.

- Contributing Factors: Sepsis, respiratory failure, s/p CVA with hemiplegia, C. Diff + with diarrhea incontinence and incontinence related dermatitis, severe protein malnutrition, upper extremity rigidity with contractures. In addition, patient decannulated himself (tracheotomy) and needed to be restrained with mitts on for most of admission to protect his airway.

Root Cause Analysis
<table>
<thead>
<tr>
<th>Contributing Factors</th>
<th>YES</th>
<th>NO</th>
<th>If YES, what contributed to this factor being an issue?</th>
<th>Is this a root cause of the event?</th>
<th>If YES, is an action plan indicated?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues related to patient assessment?</td>
<td>X</td>
<td></td>
<td>The nurse who performed the initial assessment did not review the patient’s medical history prior to seeing patient, thus, was not aware of patient’s CVA with hemiplegia and risk thereof. No evidence of medical staff assessment of wound status.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Issues related to staff training or staff competency?</td>
<td>X</td>
<td></td>
<td>On 2/22/10, the wound was re-classified as a Stage IV. At this time, the wound nurse should have communicated the presence of a Stage IV ulcer to the attending physician, the supervisor, the Nurse Manager and Risk Management.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Equipment/device?</td>
<td>X</td>
<td></td>
<td>In retrospect, the wounds may have been better supported if the patient had been placed on a low air loss mattress.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Environment?</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of or misinterpretation of information?</td>
<td>X</td>
<td></td>
<td>See above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication?</td>
<td>X</td>
<td></td>
<td>Patient was seen by all 3 wound nurses. No formal hand-off communication process was in place. Not all wound staff aware of PMH.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Appropriate rules/policies/procedures?</td>
<td>X</td>
<td></td>
<td>Failure in internal incident reporting.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Documentation</td>
<td>X</td>
<td></td>
<td>Staff nurse documentation within Meditech was inconsistent.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Supervisory issues?</td>
<td>X</td>
<td></td>
<td>On 2/22/2010 when the right hip ulcer was excisionally debrided to the level of tendon. There is no evidence of physician supervision or competency assessment for wound staff in performing this high risk procedure.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Strategies for Improvement</td>
<td>Measure(s) of Effectiveness</td>
<td>Responsible Person(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action item #1:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assessment:</strong></td>
<td>Clinical review of pressure ulcer incidents by the Wound Clinical Specialist. Pressure Ulcer Prevalence Pressure Ulcer Incidence</td>
<td>Wound Clinical Specialist, Vice-President for Nursing, Director of Professional Development, MD supervisor-inpatient wound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The wound clinical specialist will review staging criteria with wound nurses. She will reinforce the importance of review of medical history prior to patient assessment and development of wound interventions. Nursing leadership shall revise Meditech documentation systems and will eliminate staging assessment from staff nurse responsibility. Education of medical staff on wound assessment and documentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Action item #2:**      | Daily wound monitoring Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence | Wound Clinical Specialists, Vice-President for Nursing, Director of Professional Development |
| **Staff training/competency** | daily wound monitoring Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence | Wound Clinical Specialists, Vice-President for Nursing, Director of Professional Development |
| Education of wound staff on staging, internal reporting of Stage III and IV ulcers |

| **Action Item: #3**      | Daily wound monitoring Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence | Wound Clinical Specialists, Vice-President for Nursing, Director of Professional Development |
| **Equipment Device**     | Daily wound monitoring Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence | Wound Clinical Specialists, Vice-President for Nursing, Director of Professional Development |
| The wound clinical specialist shall develop a treatment algorithm for wound care and use of specialty mattresses. |

| **Action Item: #4**      | Daily wound monitoring Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence | Wound Clinical Specialists, Vice-President for Nursing, Director of Professional Development |
| **Information**          | Daily wound monitoring Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence | Wound Clinical Specialists, Vice-President for Nursing, Director of Professional Development |
| The wound clinical specialist will reinforce the importance of review of medical history prior to patient assessment and development of wound interventions. |

<p>| <strong>Action item #5:</strong>      | Revised hand-off mechanism Augmented wound census report Weekly staff meetings Daily wound monitoring | Wound clinical specialists, Director of Professional Development |
| <strong>Communication</strong>        | Revised hand-off mechanism Augmented wound census report Weekly staff meetings Daily wound monitoring | Wound clinical specialists, Director of Professional Development |
| The wound clinical specialist shall develop a hand-off communication system to assure continuity and consistency of wound care. The wound clinical specialist shall revise and augment the weekly wound census report to facilitate communication of wound information. The wound clinical specialist shall conduct weekly staff meetings to review current case load and provide supervision of wound care |</p>
<table>
<thead>
<tr>
<th>Strategies for Improvement</th>
<th>Measure(s) of Effectiveness</th>
<th>Responsible Person(s)</th>
</tr>
</thead>
</table>
| **Action Item # 6** Policies and Procedures | Incident Reporting  
Pressure Ulcer Prevalence  
Pressure Ulcer Incidence | Wound clinical specialists  
Director of Professional Development |
| **Action item #7:** Documentation | Medical Staff meeting minutes  
Revised documentation policies  
Staff education records. | Director of Professional Development and CMO  
Surgeon Supervision |
| **Action item #8:** Supervision/Training | Revised Organizational Chart  
New Competency Assessment Tool  
Staff educational records | Director of Professional Development  
Vice-President for Nursing |
| **Action item #9:** Policies and Procedures | Revised policies and procedures | Wound clinical wound specialists  
Director of Professional Development |
Searching for Best Practice

- More diversity than commonality despite standard patient population
- Diverse care product and support surface use
- **Consensus** on:
  - raising awareness
  - increasing educational efforts
  - embedding safety tools
  - standardization of processes
  - monitoring quality
  - continuous/consistent communication
“Treatment of Pressure Ulcers – A Systematic Review,”
(Ready, et al., 2008)

“Many treatments for pressure ulcers are promoted, but their relative efficacy is unclear.”

“There is little evidence from RCTs to justify the use of 1 support surface or dressing over alternatives. Similarly, there is little evidence to justify the routine use of nutritional supplements, biological agents, and adjunctive therapies compared with standard care. Clinicians should make decisions regarding pressure ulcer therapy based on fundamental wound care principles, cost, ease of use, and patient preference.”
First Response

- Media consultant
- Safety and quality consultants/additional resources
- Project management support
- Wound care medical expert
- Immediate interventions to assure daily environmental assessment
- **Transparency**
# Daily Rounding

**NE Sinai Hospital Monitoring Tool**

**Unit (circle one):** 1AN  1AS  1BN  1BS  1C  2AN  2AS  2CN  2CS  Sinai-Tufts  Sinai-Carney

Attach Patient Addressograph Sticker Here

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound #1/PU#1</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound #2/PU#2</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound #3/PU#3</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound #4/PU#4</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Access Y/N</td>
<td>Y/O</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YO/NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restraint Y/N</td>
<td>Y/O</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YO/NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IC Precautions Y/N</td>
<td>Y/O</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YO/NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Personnel Re-alignment

Leadership
Chief Quality Officer

Wound Program
Director, Wound Care
Consultants, Provider/Nursing

Medicine
Director, Inpatient Wound Care

Nursing
Resource Nurses
Reporting Problem: Raising Awareness

From: Urquhart, Mary Beth  
Sent: Saturday, March 20, 2010 6:36 PM  
To: Physicians Assistants; Nurse Coordinators; Nurse Managers; Department Managers; Department Heads; Perrotta, Barbara; Terceira, Kathy; White, Alexander C.; Villarini, Althea; Assistant Nurse Managers  
Subject: Important Clarification about Incident Reporting

Hello everyone. This message is to clarify current expectations for staff related to internal incident reporting. I believe you are all aware that the following events must be reported to me via incident report, within 3 days:

- Pressure ulcers
- Falls
- Complaints
- Med Errors
- Treatment errors
- Eloignments
- Suicidal ideation
- Injury to patient or visitor
- Skin tears
- Unsafe conditions
- Code Yellows
- AMA discharges
- Lost items
- Equipment malfunctions

Effective immediately, and as part of our Immediate Jeopardy response plan, I am now requesting that you instruct staff to report these incidents to me within 24 hours rather than 3 days. I will make necessary changes to the Incident Report policy as soon as possible.

Also, please add the following to the list of events which must be reported to me within 24 hours:

- All IV infiltrations specifying location, appearance, type of IV
- Unstageable, Stage 3 or Stage 4 pressure ulcers that develop at Sinai
- All PICC line occlusions or complications
- Disruptive behavior
- ANY other unusual occurrence

Serious incidents should be phoned to me immediately regardless of day or time.

In summary, I am requesting that you educate all staff about the change in timeframe for reporting internal incidents (ALL reports within 24 hours). Finally, please initiate reporting of any and all of the last 4 event types.

Thank you and please do not hesitate to call with any questions.  Mary Beth Urquhart
<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>Physician</th>
<th>Admit Date</th>
<th>Wound Location</th>
<th>Stage or Description</th>
<th>Validation by</th>
<th>Origin/n Cause</th>
<th>Date Seen</th>
<th>Wound Type</th>
<th>Monitor</th>
<th>QDV</th>
<th>Wound VAC</th>
<th>Mattress</th>
<th>Comments: Discharge/ weighing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>PCI</td>
<td>M. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>PCI</td>
<td>T. W., MD</td>
<td>04/02/11</td>
<td>L.L.E</td>
<td>Venous</td>
<td>P.O.A.</td>
<td>04/03/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Staging Responsibilities Restricted

Wound Care and providers only
Documentation Aligned with Workflow - PAPER

- Clear, visual chronology of care
- Ease of access
- Plan of care and weekly status
- Wound care RN input
- Educational/Staging tools
- Protocols
- Standard across all 3 campuses
Paper Record – Skin and Wound Section

Contents

- Pressure Ulcer Staging Tool
- Standard skin & wound care protocols
- Nursing care plan
  - weekly or with changes
- Assessment/Photo-doc forms
  - on discovery
  - on admission
  - weekly or worsening wound

Advantages/Benefits

- Ease of use for all stakeholders
- Provides clear chronology of course of illness
- Supports staff in recognizing change in condition and earlier intervention
## Paper Medical Record – Skin and Wound Section

![Image of NE Sinai Hospital Wound and Pressure Ulcer (PU) Assessment Form]

### NE Sinai Hospital Wound and Pressure Ulcer (PU) Assessment Form

<table>
<thead>
<tr>
<th>Date:</th>
<th>Patient label here</th>
</tr>
</thead>
<tbody>
<tr>
<td>PU/Wound Site (body):</td>
<td></td>
</tr>
<tr>
<td>Current Braden Scale Score:</td>
<td></td>
</tr>
</tbody>
</table>

#### Note Type (circle one)
- Admission finding
- Post-admission new finding
- Change in Status

#### Wound Type
- Please circle (add detail to incision or other option)
- Pressure Ulcer (PU)
- Open/necrotic ulcer
- Other (example: burn, abrasion, etc.)

#### Description
- Please circle all that apply
- Thickness
- Partial - Full - Unable to determine
- Slough/Exudate
- No - 25% - 50% - 75% - 100% - NA
- Granulation Tissue
- No - 25% - 50% - 75% - 100% - NA
- Suspected Deep Tissue Injury
- No - Partial - Full - Unable to determine
- Structure: Liver - Muscle - Fat - Subcutaneous
- Other (describe)
- Drainage: Yes - No
- Serous - Serous/green/bloody - Serous/renal - None - Other (describe)
- Odor: Yes - No
- Describe:
- Skin around wound
- Intact - Partially Intact - Intact with infection

#### Measurement
- In centimeters
- Length
- Width
- Depth
- Undermining: Yes - Measurement
- No
- Tunneling: Yes - Measurement
- No

### PHOTO DOCUMENTATION HERE – ONE WOUND PER PHOTO
- Patient ID, date, time, nurse/photographer initials
- Photos required: discovery & weekly:
- Any open wound
- Suspected deep tissue injury (SDTI)
- Other recent surgical wounds
- Drainage or areas of redness (not pressure ulcers)
- Tumors
- Dressed/Un-dressed/Chest tubes
- Skin tears

### Additional information:

- [Blank lines]

[Signature of clinician completing wound description/photo documentation]

[Date/Time]

[Clinician Name]

[Date/Time]
### Skin and Wound Section

#### Interventions

<table>
<thead>
<tr>
<th>RN Signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicate prior to dressing change as ordered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use adhesive remover prior to dressing removal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage patient to meditate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement diversional activities (describe)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Goals

- Patient will be as comfortable as possible during wound care.

#### Nutrition/Hydration Optimization

<table>
<thead>
<tr>
<th>Nutrition/Hydration Optimization</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO/Tube Feeding Intake: Good/Optima/Poor</td>
</tr>
<tr>
<td>Feeding: Independent Assist</td>
</tr>
<tr>
<td>Pre-Albunin Level (date)</td>
</tr>
<tr>
<td>Glucose levels WNL Y N</td>
</tr>
<tr>
<td>Other labs</td>
</tr>
<tr>
<td>Maximize hydration status</td>
</tr>
<tr>
<td>Staff assist with meals/intake</td>
</tr>
<tr>
<td>Protein supplementation _______ grams per day.</td>
</tr>
</tbody>
</table>

#### Risk for Skin Breakdown

<table>
<thead>
<tr>
<th>Risk for Skin Breakdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinent of stool urine</td>
</tr>
<tr>
<td>Urinary catheter Fecal mg in system</td>
</tr>
<tr>
<td>Incontinence briefs</td>
</tr>
<tr>
<td>Loss of sensation due to</td>
</tr>
<tr>
<td>Impaired mobility</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Specialty Bed or Mattress</td>
</tr>
<tr>
<td>[AH]Soothing cushion when OOB</td>
</tr>
<tr>
<td>[AH]Turn/reposition every 2 hours</td>
</tr>
<tr>
<td>[AH]Encourage shifting every 15 min, while OOB</td>
</tr>
<tr>
<td>[KH]Offload heels while in bed</td>
</tr>
<tr>
<td>[AH]Use lifting device moving patient</td>
</tr>
<tr>
<td>[AH]Moisturize skin daily and as necessary</td>
</tr>
<tr>
<td>[AH]Discuss plan with team treating patient</td>
</tr>
</tbody>
</table>

#### Risk for Infection

<table>
<thead>
<tr>
<th>Risk for Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precautions Y N O Describe</td>
</tr>
<tr>
<td>Immuno compromised Y N O Describe</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Follow precaution policy/universal protocol</td>
</tr>
<tr>
<td>Emphasize and educate patient/visitors re: need for strict adherence precaution</td>
</tr>
</tbody>
</table>

#### Educational Needs Related to Skin and Wound Care

<table>
<thead>
<tr>
<th>Educational Needs Related to Skin and Wound Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient can participate in learning &amp; self-care around skin and wound care Y N O</td>
</tr>
<tr>
<td>Family/significant others should be involved in education &amp; care teaching YD NO</td>
</tr>
<tr>
<td>Patient Family participate in wound care</td>
</tr>
<tr>
<td>Patient Family receive information (describe)</td>
</tr>
</tbody>
</table>

#### Healing

<table>
<thead>
<tr>
<th>Healing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential to heal: Yes No Uncertain</td>
</tr>
<tr>
<td>Discussed w/patient/family</td>
</tr>
<tr>
<td>Please supplement documentation in notes.</td>
</tr>
</tbody>
</table>

#### Discharge Plan

<table>
<thead>
<tr>
<th>Discharge Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please supplement documentation in notes.</td>
</tr>
<tr>
<td>Patient and/or family will be optimally prepared to manage skin and wound care upon discharge.</td>
</tr>
</tbody>
</table>
Enhanced Electronic Documentation

**Hair - General**
- Texture/Quantity/Distribution: [ ] Thinning, [ ] Sparse, [ ] Fine, [ ] Medium, [ ] Thick
- Nails - General: [ ] Pink, [ ] Pale, [ ] Cyanotic
- Texture: [ ] Brittle, [ ] Clipping, [ ] Ridged, [ ] Smooth

**Nail Comment:**
Please document specific irregularities in nails and cuticles.

**Oral Mucous Membranes - General**
- Color: [ ] Pink, [ ] Pale, [ ] Cyanotic
- Hydration: [ ] Dry, [ ] Moist
- Membrane Comment: Please document any irregularities, lesions, or additional findings.

**Tongue Appearance**
- Color: [ ] Pale, [ ] White, [ ] Yellow, [ ] Black
- Texture: [ ] Dry, [ ] Wet, [ ] Smooth, [ ] Furry, [ ] Crenulated
- Palatal Symmetry: [ ] Symmetrical, [ ] Asymmetrical

**Tongue Comment:**
Please document any irregularities, lesions, or additional findings.

**Inspection and Palpation of Skin**
- Temperature: [ ] Warm, [ ] Hot, [ ] Cool, [ ] Cold
- Moisture: [ ] Dry, [ ] Moist, [ ] Diaphoretic
- Color: [ ] Normal, [ ] Pink, [ ] White, [ ] Yellow, [ ] Black
- Turgor: [ ] Normal, [ ] Sunken, [ ] Hypertonic, [ ] Hypotonic
- Texture: [ ] Smooth, [ ] Rough, [ ] Thick, [ ] Thin, [ ] Sticky, [ ] Dry, [ ] Oily

**Hydration - Skin**
- Immediate Recall: [ ] Tending, [ ] Retaining

**Additional Findings**
- Arteriosclerosis, [ ] Ankle, [ ] Blushing, [ ] Erythema, [ ] Edema
- Lesions/Necklace: [ ] Old Abnormal
- Tattoo: [ ] Star, [ ] Skin flap, [ ] Other

**Other Additional Finding/Comments:**

---

**Inspection of Integumentary System**

**Complete initial inspection during this shift?**
- [ ] Yes
- [ ] No

**Visual Inspection should include skin, skin contact with assistive devices, hair, nails, and mucosal membranes.**

**Document any findings in the skin findings section below.**

If no inspection done, document reason in finding comments.

**Skin Findings**
- [ ] None
- [ ] Bruising
- [ ] Erythema
- [ ] Blistering
- [ ] Redness (Non Pressure*)

*Other*

These are notable on assessment, but do not require treatment. Please communicate with the next shift.

Please create an occurrence to document wounds or ulcers.

**Findings Comments**

Document any abnormal finding or reason inspection was not done.

Please note description of location, distribution, and/or severity of identified findings.

**Skin Problem Occurrences - Occurrence #1**

**Location Modifier**
- [ ] Left
- [ ] Right
- [ ] Left Anterior
- [ ] Right Anterior
- [ ] Left Lateral
- [ ] Right Lateral
- [ ] Left Medial
- [ ] Right Medial
- [ ] Left Posterior
- [ ] Right Posterior
- [ ] Medial/Medial
- [ ] Generalized (Lt. & Rt.)

Select the option that describes the wound's body site location.

**Location (Body Site)**
- [ ] Head Occipital
- [ ] Neck
- [ ] Head Frontal
- [ ] Shoulder
- [ ] Eye
- [ ] Upper Arm
- [ ] Nose
- [ ] Forehead
- [ ] Ear
- [ ] Eyebrow
- [ ] Lips
- [ ] Wrist
- [ ] Hand
- [ ] Thumb
- [ ] Carpus
- [ ] Ankle
- [ ] Foot
- [ ] Heel
- [ ] Hind Toes
- [ ] Fourth Toes
- [ ] Third Toes
- [ ] Fourth Toes
- [ ] Little Toes

---

**Explain Other Finding**
Please note the location, distribution, and/or severity of identified additional findings.
Education: Back to Basics – Providers & Nursing

Authors:
Sandra Bergquist-Beringer, PhD, RN, CWCN
Jan Davidson, MSN, RN, ARNP

Planning Team:
Nancy Dunton, PhD
Susan Klaus, PhD, RN
Isis Montalto, MS, MBA, RN

Pressure Ulcer Training

Module One
Pressure Ulcers and Staging

Module Two
Other Wound Types and Skin Injuries

Module Three
Pressure Ulcer Survey Guide

Module Four
Community vs. Hospital/Unit Acquired Pressure Ulcers
Education: Ongoing

- Skin, Wound and Pressure Ulcer Nursing Orientation
- Incontinence Associated Dermatitis vs. Pressure Ulcer
  - Identification
  - Diagnosis
  - Treatment
- Braden Scale Scoring
  - Developing inter-rater Reliability
- NE Sinai Team Patient Care Case Review
  - Multidisciplinary Care of the Patient at High Risk for Skin Integrity Compromise
Education: Competency Assessment

- Designed with deep detail
- ↓ inter-rater reliability variation
- Didactic, problem-based
- Simulation training component
- Policy and standards review
  - Assessment
  - Description
  - Dressings/treatments
  - Products
  - Documentation
### Education: Resource Nurses

The resource nurse provides an additional layer of expertise to nursing and multidisciplinary practice development and implementation at NE Sinai Hospital. Their continuous focus on the skin and wound care needs of all patients includes their involvement in the following processes:

<table>
<thead>
<tr>
<th>Role Responsibility</th>
<th>Action Item Processes</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing process</td>
<td>Reviews and identifies skin and wound care plan, development, implementation, and follow-up for patients assigned to their unit.</td>
<td></td>
</tr>
<tr>
<td>Skin Health evaluation</td>
<td>Reviews barriers to assessment completion and success with the nurse team care for the patient. Collaborates with nurses to ensure risk interventions are in place.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conducts with the wound team with nurses assigned to patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develops expertise in safe patient handling and movement to support patient safety.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Works with nursing assistants to develop handoff process to enhance risk reduction.</td>
<td></td>
</tr>
<tr>
<td>Wound Care assessment</td>
<td>Trains nurses to develop and implement care plans for safe and compliant skin and wound care delivery.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performs daily care by wound care nurses and providers with nurses caring for patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interacts with school of nursing instructors to monitor safe practice delivery related to skin and wound care.</td>
<td></td>
</tr>
<tr>
<td>Wound Care practice</td>
<td>Assists direct care nurses with technical skill development, i.e., dressing changes, product applications, negative pressure therapy application and removal.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sees wounds care needs and equipment as needed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensures wound care standards are implemented as indicated.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interfaces with vendors to ensure proper implementation of specialty beds and chairs.</td>
<td></td>
</tr>
<tr>
<td>Quality monitoring</td>
<td>Monitors skin pressure ulcer prevalence audit.</td>
<td>QUALITY INDICATORS ASSIGNED per policy.</td>
</tr>
<tr>
<td>Professional development</td>
<td>Develops sharing expectations.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meets S skin and wound care on monthly basis.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reviews monthly, structural education - hour long programs daily wound care nursing team (products, protocols, care review, nursing research discussed).</td>
<td></td>
</tr>
<tr>
<td>Mentoring</td>
<td>Assists requested and prescribes information.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acts as liaison to nurses from wound care committee.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attends wound care committee meetings once a month.</td>
<td></td>
</tr>
<tr>
<td>Nursing research</td>
<td>Provides one educational article to unit staff meeting discussion per quarter.</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- Layer of clinical expertise for all nurse-sensitive indicators
- Eyes & ears on each care unit
- Liaison to Wound Care Team
- Support direct care nurses in their professional development

- **Rounding with the wound care team weekly on all patients followed.**
- **Review of photos documentation on all patient records with the wound care RN assigned to their unit.**
- **Practice in simulation lab setting care-based staging scenarios: memory - created and facilitated by wound care nurses as part of ongoing educational sessions.**
Policies & Procedures

- Multidisciplinary rounds weekly
  - Wound care MD
  - Wound care RN
  - Direct care nursing personnel
  - Nursing leadership
  - Medicine
  - Nutrition
  - Allied health

- Plan of care nursing, medicine
- Consult process redefined
- Wound care on-call
Embedding Safety Tools

Wound Care RNs
- Assigned “territories”
- Daily inter-team handoff (verbal handoff required)
- Handoff documentation
- On-call policy
Embedding Safety Tools

- Wound Care Registry – wound “reconciliation” tool
- Multidisciplinary Rounds – formal, weekly
- Appointment of Medical Director, Inpatient Wound Care
- Electronic and paper skin & wound documentation revisions
- Standardized wound care protocols
  
  *support for off-hours clinicians*

- Quality monitoring audits – clinical care/documentation
- Chain of Command policy
Increasing Serious Reportable Events (SREs)

5 wound SREs
March – May 2010

- 8 Stage III or IV hospital acquired pressure ulcers between February and May 2010
- Overall incidence of hospital acquired pressure ulcers was above external benchmark mean

Pressure Ulcer Prevention Team
convened and chaired by VP Quality
# Pressure Ulcer Prevention (PUP) Team

## Membership
- Wound Care
- Nutrition
- Nursing Informatics
- Information Systems
- Health Information Management
- Purchasing
- Occupational Therapy
- Nursing
- Physicians Assistants
- Radiology
- Physical Therapy
- Case Management
- Medicine
- Occupational Health
- Quality Management
- Respiratory
- Social Work

## Goals
- Identify risks for PU development
- Reduce incidence of HAPUs
- Implement risk reduction strategies

## Tools
- Control Charts
- Root Cause Analysis
- Common Cause Analysis
- Focus Groups
- Cause and Effect Diagram
- Bar Graphs
## Common Cause Analysis

<table>
<thead>
<tr>
<th>Communication</th>
<th>Knowledge Deficit</th>
<th>Equipment</th>
<th>Care Plan</th>
<th>Policy</th>
<th>Documentation</th>
<th>Envir.</th>
<th>Nutrition</th>
<th>Assessment</th>
<th>Patient Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>No hand-off between 3 WCRN's.</td>
<td>Wound staging</td>
<td>Low air loss mattress not used</td>
<td>Lack of wound protocols and wound register.</td>
<td>Inconsistent staging of wound by RN's and WCRN</td>
<td>CVA with hemiplegia - not factored into care plan/mattress selection No wound assessment by medical staff</td>
<td>CVA with hemiplegia. POA wound. C Diff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wound staging</td>
<td>Wound treatments were not ordered by MD or PA. RN acted upon recommendation from WCRN.</td>
<td>Lack of wound protocols and wound register.</td>
<td>Inconsistent staging of wound by RN's and WCRN</td>
<td>Low pre-albumin</td>
<td>Presence of scar tissue on coccyx and h/o pilonidal cyst not factored into risk assessment and care plan. 9 day gap in between WCRN visits.</td>
<td>Incontinence, agitation, pelvic fx with limited mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehab/Nsg/OT</td>
<td>RN not aware of significance of increased moisture and tone on pressure ulcer risk. Rehab nursing staff not trained on new documentati</td>
<td>Hand splints were attempted but contributed to skin breakdown.</td>
<td>Relationship of moisture, increased tone and wound care not defined. RN oversight of care plan and nursing aidaes.</td>
<td>Lack of documentation of rehab nsg interventions</td>
<td>Increased acuity on &quot;chronic&quot; unit.</td>
<td></td>
<td></td>
<td>Severe contractures. Increased moisture and tone in hands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>On 4/20/10, pt was kept in static mode on low air loss mattress rather than alternating mode</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cause and Effect Diagram

COMMUNICATION
- In-house Transfers
  - Turning/OOB
  - Nsg Rehab

DOCUMENTATION
- Wound Register
  - Meditech - complex system
  - Care plans

ASSESSMENT
- Admission
  - Weekly Rounds
  - Staging

PATIENT FACTORS
- OOB Activity
  - Up too long
  - Immobility
- Nutritional Status
- Vent/Weaning
- Scar Tissue
- Low Pre-Albumin
- Low motivation
- C-Diff
- Incontinence
- IAD

PATIENT FACTORS

EQUIPMENT
- Waffle Cushions
  - Venodyne Boots

HAPU

ASSESSMENT
Application Of Generic Error Modeling System To Common Cause Analysis

- Patient Risk Factors
  - Wound Staging

- Knowledge Based Errors = 8 or 32%

- Skills Based Errors = 9 or 36%

- Rules Based Errors = 8 or 32%

- Wound registry
  - Wound Consults

- Long Term Patients
  - In-house transfers
PUP Team Outcomes

- Decreased incidence of HAPU
- Stratified data on HAPU by stage of ulcer
- Introduced new nutrition products
- Reinforced use of Waffle cushions
- Streamlined processes for Wound Registry
- Introduced new incontinence management products
- Reduced concurrent use of sequential compression devices and systemic anticoagulants
- Increased compliance with medical assessment of wounds upon admission and weekly
Quality Monitoring

- Organizational
- Medicine
- Wound Care
- Nursing
Quality Monitoring – Nursing/Wound Care

- Electronic reports to validate assessment
  - Braden Scale Absent report
  - Skin/Wound Occurrence documentation
  - Sequential compression boot clinical need
- Mattress type and settings
- Bedside availability of cushions and incontinence care products
- Compliance with policy and use of assistive patient movement devices
Provider Audits

Documentation & Orders New Admissions

Nursing Audits

Risk Assessment, Documentation, Plan of Care

QUALITY MONITORING WEEOKET

HIGHEST PRESSURE ULCER CAKE

SAMPLE: 10 RECORDS PER UNIT PER MONTH

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>QUALITY MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Wound assessment completed?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Full pressure assessment within 24 hours of admission?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Risk assessment documented upon admission?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Wound assessment documented within 24 hours of admission?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. Wound assessment documented within 24 hours of admission?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6. Wound assessment documented within 24 hours of admission?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7. Wound assessment documented within 24 hours of admission?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8. Wound assessment documented within 24 hours of admission?</td>
</tr>
</tbody>
</table>

Comments:

Action Taken on any Identified Issues:

- [ ] Discussion at Medical Staff Meeting
- [ ] In-service education for RNs & PA
- [ ] In-service education for staff
- [ ] Additional order/certification on orders
- [ ] Additional documentation in record

Date of Review: __________ Name of Reviewer: _____________

Form version: 7/16/16
Skin and Wound Program Quality Dashboard

Inpatient Wound Care Demographic Data

Hospital-acquired Pressure Ulcer (HAPU) Prevalence by Total HAPU

- December 2019

- Percent of HAPUs

<table>
<thead>
<tr>
<th>Month</th>
<th>Total HAPU</th>
<th>HAPU Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>16</td>
<td>1</td>
</tr>
</tbody>
</table>

Present on Admission (POA) Pressure Ulcer Prevalence by Total POA

- December 2019

- Percent of POA

<table>
<thead>
<tr>
<th>Month</th>
<th>Total POA</th>
<th>POA Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>40</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>52</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>48</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>45</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>43</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>41</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>44</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>39</td>
<td>3</td>
</tr>
</tbody>
</table>

Pressure Ulcer Severity (HAPU + POA) Summary

- December 2019

- Percent of Ulcers

<table>
<thead>
<tr>
<th>Severity</th>
<th>Total Ulcers</th>
<th>Ulcer Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Stage 2</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Stage 3</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Stage 4</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>134</td>
<td>134</td>
</tr>
</tbody>
</table>

Inpatient Wound Care Outcomes Data

Hospital-acquired Pressure Ulcers (HAPUs) Status Summary

- December 2019

- Percent of HAPUs

<table>
<thead>
<tr>
<th>Status</th>
<th>Total HAPUs</th>
<th>HAPU Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healing</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>New</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>Persistent</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

ME Sinai HAPU Prevalence Audit

- December 2019

- Percent of HAPUs identified per patient reviewed

<table>
<thead>
<tr>
<th>Month</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2020</td>
<td>12.2%</td>
</tr>
<tr>
<td>Feb 2020</td>
<td>3.8%</td>
</tr>
<tr>
<td>Mar 2020</td>
<td>18.2%</td>
</tr>
<tr>
<td>Apr 2020</td>
<td>2.2%</td>
</tr>
<tr>
<td>May 2020</td>
<td>3.6%</td>
</tr>
<tr>
<td>Jun 2020</td>
<td>4.2%</td>
</tr>
<tr>
<td>Jul 2020</td>
<td>5.2%</td>
</tr>
<tr>
<td>Aug 2020</td>
<td>3.8%</td>
</tr>
<tr>
<td>Sep 2020</td>
<td>4.4%</td>
</tr>
<tr>
<td>Oct 2020</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Front Pane: Demographic Data Inpatient | 123010 | HAPU Healing Rates | PUP Audit | IAD vs S
Communication, Communication, Communication

- Reports
  - Payors
  - Regulators
  - Accreditors
- Patients/Families - letters
- Town meetings
- Board of Director communication process change
- Patient Care Assessment Committee monthly update
- Medical Performance Improvement Committee
- Quality Management reporting changes
Communication – Clinicians

Email Attestations Huddles

CLINICAL PRACTICE ALERT
(PLEASE POST IN THE COMMUNICATION BOOK)

To: Nursing Department Staff
From: Mary Beth Urquhart
Date: May 10, 2011
Topic: Safe Patient Handling

Please use hygiene foam to bathe, cleanse and safeguard the skin of our incontinent patients at risk for and/or with active incontinence associated dermatitis (IAD). This product is available in each unit supply room and is stocked by CSR.
Success Stories – Internal & External Stakeholders

A Team Approach to Wound Care Delivery

The teamwork approach to wound care delivery is alive and well at New England Sinai Hospital. Nursing, Medicine, Therapies, Nutrition and Respiratory work collaboratively to ensure that our patients with wounds receive consistent and compassionate care. This was never more evident than in our recent interaction with a complex and challenging patient admitted to ICU for wound care. Since clinical and support departments all played critical roles in supporting AE during his stay and collectively worked to get him better.

A complicated case

Like many of our patients, he had complex medical and nursing needs. He became a quadruplegic following a motor vehicle accident. He came to Sinai with multiple wounds and, in all, after a two-month acute hospital stay, the multiple wounds were a result of infections, prolonged surgical and significant pain—limiting AE’s capacity to turn and reposition. On his initial day to ICU the clinicians and support team implemented a coordinated plan of care for his wounds and to prevent further skin breakdown. The Sinhasan scale was used to measure his risk for skin damage. Goals for AE included improving pain management, optimizing nutrition, enhancing wound healing and gradually encouraging mobilization. Thanks to the dedicated teamwork on TON, many of the patient’s goals were met, a large percentage of his skin healed and he was discharged and returned to his residence in mid-February.

Open and clear lines of communication

LEWIS Nahmad, RN, recalls spending a great deal of time assisting him and gaining his confidence in order to optimize his care. “He was so grateful to me. We had to look after all the people in with him to help turn or do any dressing changes. I was always looking at him or talking through any physical activity.”

She says that the support of the wound care team was key in supporting the nursing staff as they provided direct care. “Wound care always there or responding quickly when we needed some advice or direction. She would always listen to our input,” she added.

Valued wound care expertise

Dr. Mankikian worked closely with nursing and the wound care team to make sure all aspects of the patient’s care were coordinated. “Jespas commented that working closely with Dr. Mankikian was helpful. “He has respect for the nursing staff which is something we appreciate.”

Vivian Stormer, MSN, wound care RN, assessed the patient on admission from head to toe, reviewed findings and plan of care recommendations with Dr. Mankikian and nursing to assure that the communication was remained continuous and consistent—a safety mechanism usually called a “handoff.”

A difficult case

Many of the patients we care for have been dealt a difficult hand and this patient was no exception. As a long term acute care facility, Sinai has to be prepared to manage and care for patients that are suffering great physical and spiritual loss. The carefully orchestrated teamwork in this case shows Sinai at its best. What we learn from one patient helps us care for the next patient.
Evolution with Outcomes

NE Sinai HAPU Prevalence Audit

% HAPUs identified
# patients assessed

LTACH benchmark
2007 = 7.5%

Quarterly audits - results reported to Patient's First/Patient Care Link
Wound Policy and Practice Refinements
# Strategic Quality Goals

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Goal for next 12 months</th>
<th>As of 5/31/11</th>
<th>Interventions to achieve goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce inpatient falls resulting in major injury</td>
<td>≤2</td>
<td>1</td>
<td>Fall Task Force which includes bedside Nursing, Environmental Services and Pharmacy staff</td>
</tr>
<tr>
<td>Reduce the number of Stage III and IV hospital acquired pressure ulcers</td>
<td>≤7</td>
<td>1</td>
<td>Pressure Ulcer Task Force Weekly wound rounds New Nutrition Products Ongoing monitoring by Nursing and Medicine.</td>
</tr>
<tr>
<td>Reduce Hospital Acquired infections:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vent Pneumonia</td>
<td>≤5</td>
<td>3</td>
<td>Removal of unnecessary catheters and IV lines Curos port protectors Hand Hygiene Compliance Antibiotic Stewardship C-Diff Collaborative/Team Foley Catheter Care Team with Physician Champion</td>
</tr>
<tr>
<td>• Catheter Associated UTI</td>
<td>≤43</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>• C-Difficile</td>
<td>≤40</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>• Central line infection</td>
<td>≤12</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Short and Long Term Goals

- ↓ HAPU incidence
  - ½ in 12 months
  - 0 in 3 years
- Full time MD director inpatient/outpatient wound care
- Grow outpatient wound care program
- Develop NE Sinai Hospital wound care clinicians