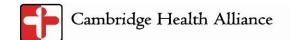


Cambridge Health Alliance: Pressure Ulcer Prevention Program

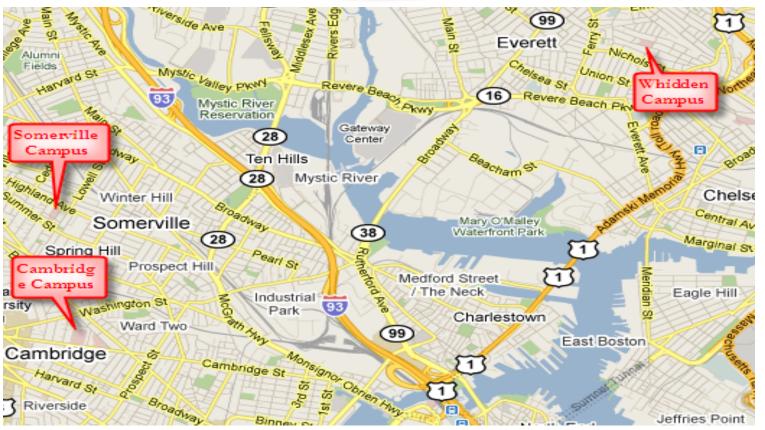
Pressure Ulcer Collaborative August 19, 2010

Janet Cline MSN, RN
Cambridge Health Alliance
Critical Care Clinical Specialist
Medical Surgical Clinical Specialist















- Three hospital campuses
 - Medical surgical: 5 inpatient units
 - Intensive care: 2 units
 - Maternity Unit with level 1B Nursery
 - Emergency Department: 3 medical and 1 psychiatric
 - Psychiatric: 2 adult units, geriatric, adolescent, & child
- Multiple Ambulatory Settings:
 - Primary care, Pediatric, Medical Specialty, Surgical Specialty & Mental Health Clinics
 - Cambridge Dept of Public Health
 - School based health centers







Academic Affiliations

Schools of Nursing

- Simmons College
- Northeastern University
- U Mass Boston
- Regis College
- MGH Institute of Health Professionals
- Salem State University
- Bunker Hill Community College

Medical Schools

- Harvard Medical School
- Tufts University School of Medicine
- Harvard School of Dental Medicine





At the Beginning.....

Nurses lacked knowledge of differentiating between chronic ulcers (arterial or venous stasis) and pressure ulcers

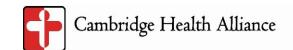
No established team identifying the problem of pressure ulcers (physician, nursing and pharmacy)

No standard of care in place

Hospital Acquired Pressure Ulcers Prevalence Study – findings 8-10 pressure ulcers

Modified Braden Score which was not evidenced based

Nurses did not complete skin assessment in the initial Nursing Assessment, therefore PU's not identified on admission







Found some surprises

Care team identified pressure ulcers as not preventable, accepted as a routine complication

Assessment tool used described pressure ulcer stage I as "reddened" area. This essentially eliminated all persons of color

"Miracle cream" widely used, many different "recipes" being mixed by nurses and pharmacists - the cream included some or all of these ingredients: Vit A&D, Zinc Oxide, Vasoline

Wet to dry dressings routinely prescribed

Use of diapers & paper chux for incontinence







Improvement Plan included:

Research!

Identify an evidence based standard of care for pressure ulcers

Established a CHA wound care resource nurse

Established a team, led by RN with advanced nursing degree, to cull the most salient information regarding pressure ulcers

Included a vascular surgeon, clinical pharmacist, nurses, and nursing assistants

Assessment of the situation

Lack of assessment on admission, lack of standard process, treatment supplies, healthcare team knowledge

Set a target date and goal to reduce HAPU as part of the organizational strategic objectives for patient safety







Improvement plan included:

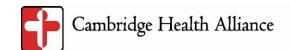
Standardizing products and standard of patient care Development of Standard of Care/Protocols

- Standard of Care: Pressure Ulcer Prevention
- Pressure Ulcer Prevention: Incontinence Dermatitis
- Pressure Ulcer Treatment: Stage 1 (SDTI) through Unable to Stage
- Wound/Pressure Ulcer Assessment & Treatment Documentation Form
- Patient/family Education

Education for the entire health care team, not just nurses!

- Importance of skin assessment on admission
- Assessment of pressure ulcers
- Treatment
- Assessment and Documentation Tool

Establishing unit based resource nurses







Second Steps

- HAPU training for new resident education program
- Education with all nursing staff on the unit
- Weekly rounds with the Care Team
- PU resources easily available to the Care Team
- Intentional rounding (pain, personal needs and positioning)
- Several education programs per year
- Every patient with a HAPU > Stage 1 is evaluated using the RCA process
- Patient Safety expectation changing the culture Zero tolerance for HAPU's!





Who were the nurses that we engaged?

Staff nurses from each campus

ICU, Medical Surgical and Geri-Psych units

How were they chosen?

- Resource nurse
- Nurse Manager
- Peer identification
- Self chosen

What extra education were they given?

- Rounds with Resource Nurse
- Review of SOC, Protocols, Assessment/Documentation
- Some attended 6 hour program multiple times and then began to teach portions







Quarterly Prevalence Studies

Patient's First (Patient CareLink)

- Conducted by trained staff resource nurses
- During prevalence study RNs examine all at risk patients
 - initial skin assessment
 - implementation of SOC if appropriate
 - plan of care/order set
 - medical and nursing continued documentation
- Detailed feedback to entire nursing staff at the unit level
- Share the outcome of the Prevalence Study:
 - Patient Safety Committee
 - Patient Care Performance Committee
 - Hospital Quality Board





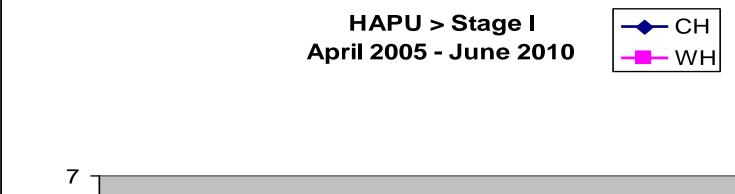
Other Improvements Regarding Skin Integrity

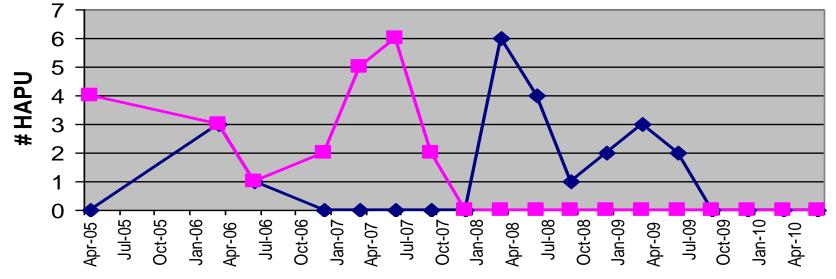
- Orthopaedic Patients
- OB-Gyn Patients
- Geriatric Psychiatric Unit
- Skin Tears
- Superficial Wounds
- Residents/Hospitalist Education
- Elder Service Program





CHA HA Pressure Ulcers April 2005 - Jan 2009









Sustainablitiy

Staff nurses supported research based change in practice Leadership support

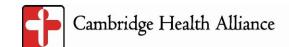
- CEO, CNO, CMO and Board Quality
- Medical Chiefs of Services
- Nurse Managers
- Nursing Supervisors

Staff nurses telling the success story and celebrating

- Nursing Grand Rounds
- Acknowledge during Nurses Week
- Academic Poster Sessions for past 2 years with Harvard Medical School
- Regional Staff Nurse Council Boston College November 2010
- Education to new residents and hospitalists

Nursing Professional Development

- Clinical Ladder Program (novice to expert)
- Northeastern University College of Professional Studies, RN-BSN pressure ulcer prevention and treatment option for clinically focused study (Care of the Vulnerable Population, Leadership and Capstone courses)







The Spread ...

Focus work with the Geriatric Psychiatry Unit population

Develop expertise in our Outpatient Clinics:

- Elder Services
- Surgical Specialty
- HIV Clinic

Reach out to our long term care partners

Continue to practice zero tolerance for all hospital acquired pressure ulcers







Questions?

