Hospitals making strong progress in preventing pressure ulcers

Pressure ulcers are one of the most reported adverse health events. The injuries they cause to skin and underlying tissue are painful and can lead to infection or other complication for patients. The adverse health event reporting system has helped identify previously unknown risks for pressure ulcers, and it appears hospitals are making solid progress in preventing pressure ulcers.

In particular, in the 2012-13 reporting a long term acute care hospital and two of Minnesota’s large short term acute care hospitals made significant progress in reducing the number of reportable pressure ulcers: Bethesda Hospital, part of HealthEast Care System in St. Paul; as well as Hennepin County Medical Center and the University of Minnesota Medical Center, Fairview, both in Minneapolis.

The hospitals describe the progress made as a journey with the underlying theme of early identification and prevention of pressure ulcers. Each hospital described it as a change in how they approached pressure ulcer prevention, from something viewed as inevitable in critically ill, often immobile patients to a focus on restoring patients to health and protecting their skin at the same time. At the foundation of this culture change is strong communication and a strong commitment to patient safety and teamwork among interdisciplinary teams. The hospitals believe this culture change will allow them to sustain the gains going forward. Helping keep patients’ skin safe, no matter how critically ill, is a new standard of care. Each hospital’s effort is described below.

Bethesda Hospital, part of HealthEast Care System
Bethesda Hospital cares for highly complex, critically ill patients, many following discharge from an ICU of a typical short term acute care hospital. The average length of stay at Bethesda is 28 days. In 2012, Bethesda Hospital in St. Paul identified an upward trend in both its quarterly pressure ulcer incidence rate and reportable events. The hospital set a goal to reduce its hospital-acquired pressure ulcer incidence rates below 4.88% for 2013 and to not have any pressure ulcers progress to stage III or greater, which is the trigger for becoming a reportable event under the adverse health event law. In addition, the hospital set a goal to perform concurrent pressure ulcer tracking (reporting them as they happen) and for handovers between direct patient care providers and charge nurses to always include an update on pressure ulcers and skin integrity.

Interventions applied:
- Increased risk assessment from two times per week to every day, helping to bring pressure ulcer prevention to the forefront for nurses.
- Increased the frequency of incidence studies from quarterly to monthly.
- Created an action algorithm for staff to follow when the patient would have difficulty complying with the plan.
- Implemented “four eyes” – two nurses complete skin inspection upon admission, which ensured identification of all pressure ulcers on admission and implementation of a treatment plan in a timely fashion.
- Raised awareness that pressure ulcer prevention is everyone’s job, for example charge nurses now round to ensure patients are turned as expected.
- Engaged the interdisciplinary team with respiratory therapists, occupational therapists and physical therapists in performing pressure ulcer skin inspections; provided education and visual cues on proper documentation and identification of pressure ulcers.
- Perform skin inspection around devices at every shift.
Increased accountability and teamwork through huddle discussions. Initiated interdisciplinary huddles twice daily and used it as a mechanism to spread real-time information. Each unit also leads a day for the hospital-wide “house” huddle and reports status of pressures ulcers and which patients are high risk.

- Implemented a Value Based Improvement (VBI) Front Line Management system to generate staff ideas to improve prevention and discuss with the team these clinical quality metrics at huddles.

The foundation of Bethesda’s strategy is that every patient, every nursing staff, every shift is held accountable in pressure ulcer prevention. To sustain its gains, the hospital will continue to make pressure ulcer education and prevention visible across the hospital and throughout the HealthEast Care System. It will also continue to use the foundation of VBI and LEAN improvement system by standardizing work, as a solid routine and daily work for nurses and all caregivers that interact with the patient and family.

**Hennepin County Medical Center**

In 2006, Hennepin County Medical Center in Minneapolis (HCMC) formed a Skin Team to increase awareness of skin and wound care and to empower nurses to take action to care for patients. It is a multidisciplinary team represented by at least one nurse from every inpatient unit as well as dietary, physical therapy, occupational therapy and a physician skin champion.

Skin Team members universally attributed the gains made in 2013 to a gradual shift in culture from viewing pressure ulcers as an inevitable part of treating critically ill patients to something that can be prevented.

“HCMC has always had such a strong focus on quality and healing sick and broken patients,” said Kim Kleinschmidt, certified wound and ostomy nurse. “Initially, I don’t think we realized we could restore their health and protect their skin.”

“In the ICU (intensive care unit) we’ve always known patients were at high risk,” said Kim Schneider, senior staff nurse in the surgical ICU. “We’ve really changed the philosophy from ‘pressure ulcers are par for the course’ to ‘we can prevent it.’”

Interventions applied:

- Every nurse, every shift performs skin inspection on each of their patients.
- In the surgical ICU, a skin team member performs a head-to-toe inspection of every patient weekly. This allows for an extra set of eyes to assess patients and can serve as an education opportunity for nurses on the units. It also helps identify trends in the development of pressure ulcers, under blood pressure cuffs, for example.
- Provided education on device-related pressure ulcers and how to prevent them.
- Developed an expectation list for nurses and asked them to sign it so they clearly understood the expectations related to pressure ulcer prevention.
- Added pressure ulcers to discussion items during multidisciplinary rounds.
- Involvement of more front line nurses in the root cause analysis process for pressure ulcers.
- Demonstrations from Skin Team members to other staff on how to integrate skin assessment into other assessments performed by nurses.
The emphasis for HCMC has been on awareness of pressure ulcers and communication between team members. The Skin Team members serve as conduits to spread information and knowledge back to their units, and it opens a dialogue about what can be done to prevent pressure ulcers.

“I’ve seen an increased receptiveness on all units,” said Cindy Petrie, wound ostomy and continence nurse and nurse clinician. “There’s been an elevation of skin safety in everyone’s minds.”

The hospital plans to continue to keep skin safety at the forefront. They will continue the dialogue around skin safety and hold each other accountable. They will continue to standardize the work and make skin safety the standard of care across the hospital.

“I don’t think this will ever be something where we say, ‘OK, we’ve mastered this and can check it off the list,’” said Schneider. “It’s become standard care. It’s the care you and I would expect if in the hospital.”

University of Minnesota Medical Center, Fairview
Pressure ulcer prevention ramped up for the University of Minnesota Medical Center, Fairview (UMMC) in 2007 with the addition of unstageable pressure ulcers as reportable events. Leadership, working with the risk management team, created a common cause analysis that reviewed all pressure ulcer events in the hospital and made the Pressure Ulcer Prevention Task Force more robust. Out of this work grew a detailed action plan that covered education, physical changes, enhancements to the electronic medical record, involvement of interdisciplinary teams and more. One of the first changes made was to replace all mattresses across the entire facility.

Like the other facilities, UMMC believes that skin safety and pressure ulcer prevention has been a journey and is the responsibility of each staff member. The hospital has worked hard to make skin safety, and early identification of skin issues, a priority. There is also an emphasis on documenting all pressure ulcers present upon admission so staff can immediately begin working to reverse them or at the very least, prevent them from progressing.

Interventions applied:
- Incorporated skin documentation in electronic medical record so it could be embedded in daily work.
- Provided staff with tip sheets and articles on pressure ulcer prevention.
- Organized unit-level skin care champions who meet at least once per quarter for education and spread that learning back to other staff members on their units.
- Reviewed new equipment thoroughly to identify those that create higher risk for pressure ulcers.
- Developed individualized interventions for specific patient risk factors.
- Performed total body skin assessment at every shift – provided scripting for staff to overcome barriers from patients.
- Provided education to patients and families on the importance of turning or making small adjustments to redistribute pressure.
- Empowered all staff, including housekeeping, to make changes to improve safety. For example, if housekeeping discovers a mattress in poor condition, they have authority to replace it.
- Added discussion of pressure ulcers to hourly rounding and handoffs to keep it at the forefront.
• Limited staging of pressure ulcers to be performed by wound ostomy and continence nurses to maintain consistency and provide more reliable and actionable data.

Going forward, UMMC plans to further engage providers in the dialogue around prevention. If they give an order not to turn a patient, staff will engage them to ask about microturning and will continue to raise the issue so the patient can be turned as soon as safely possible. In addition, as a teaching facility, UMMC will be working with the medical school to provide resident training on pressure ulcers.

“This is extraordinarily important work,” said Mike Flynn, nurse manager, special programs and co-chair of the Pressure Ulcer Prevention Task Force. “No matter the size of the pressure ulcer, we take it very seriously.”