



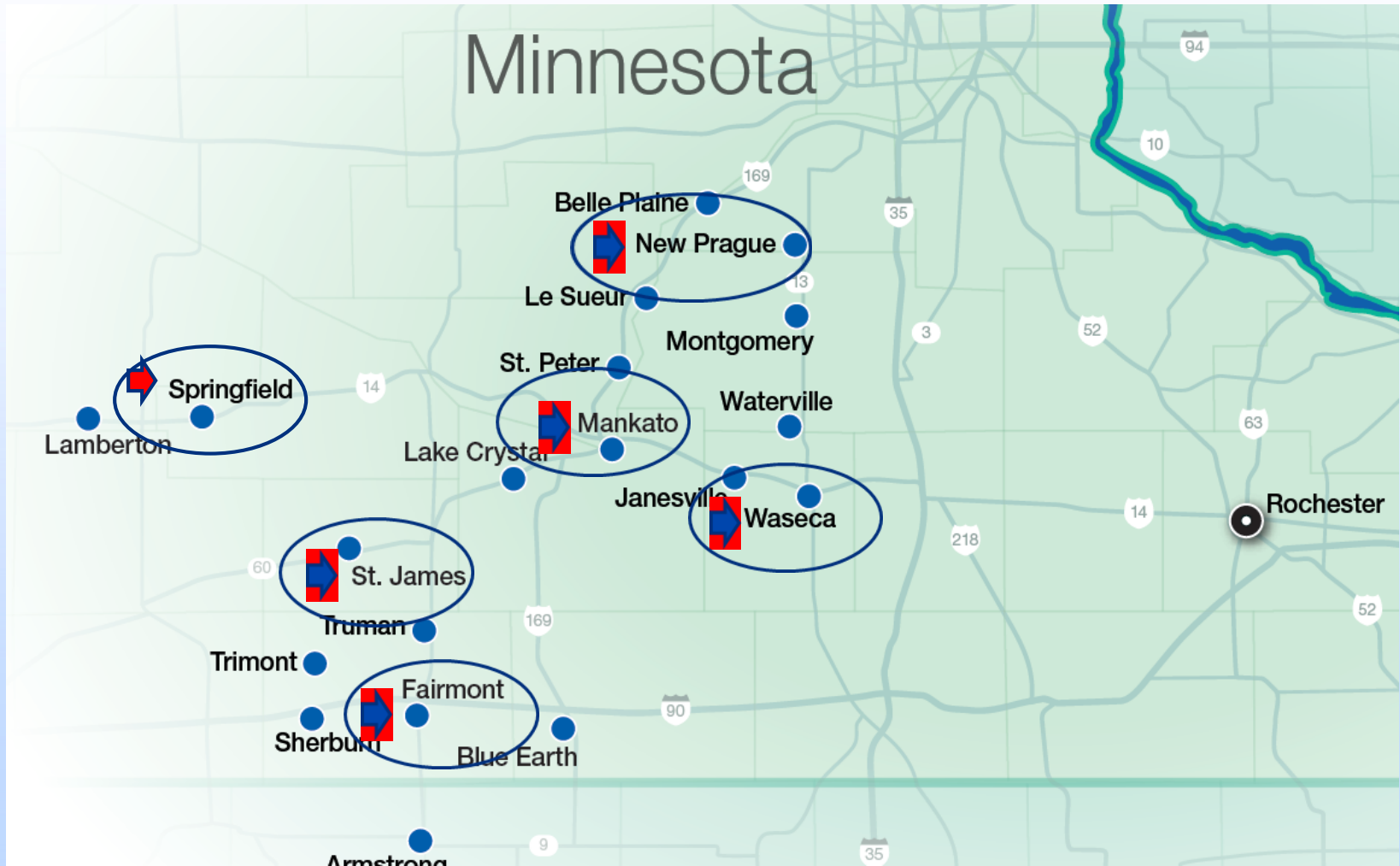
SWMN Gemba: Pressure Injuries

Go to the source to find the facts to make better decisions, build consensus and achieve goals.

Objective

- Share experience from the SWMN region in response to an increase in mandatory reported Pressure Injuries in the first quarter of the reporting period.
- Reportable: Minnesota Adverse Healthcare Event

Mayo Clinic SWMN Region



SWMN Reportable Event Data

Reporting period: October, 2016- March, 2017

Reporting Period	Sept 2016	Dec 2016	March 2017	March 2017	March 2017	March 2017	March 2017	March 2017	March 2017
	NOT in this reporting period								NOT reportable LTC
Stage 3 or 4								1	
Unstageable	1	1	1	1	1	1	1		1
Source	Medical Device (Vent/O2)	Medical Device (NG)	Pressure	Pressure /Device/ Dressing	Pressure	Medical Device O2	Medical Device BP cuff	Pressure	Pressure
Detail	R Nare and Chin Proning	L Lower Lip R nostril	Right Heel	Coccyx /Bil Knees	Coccyx	Bil Ears	LLLeg	R buttock	L Buttock

Transparent
Data/Experience Sharing

Root Cause Analysis

RCAs were completed for each individual reportable pressure injury

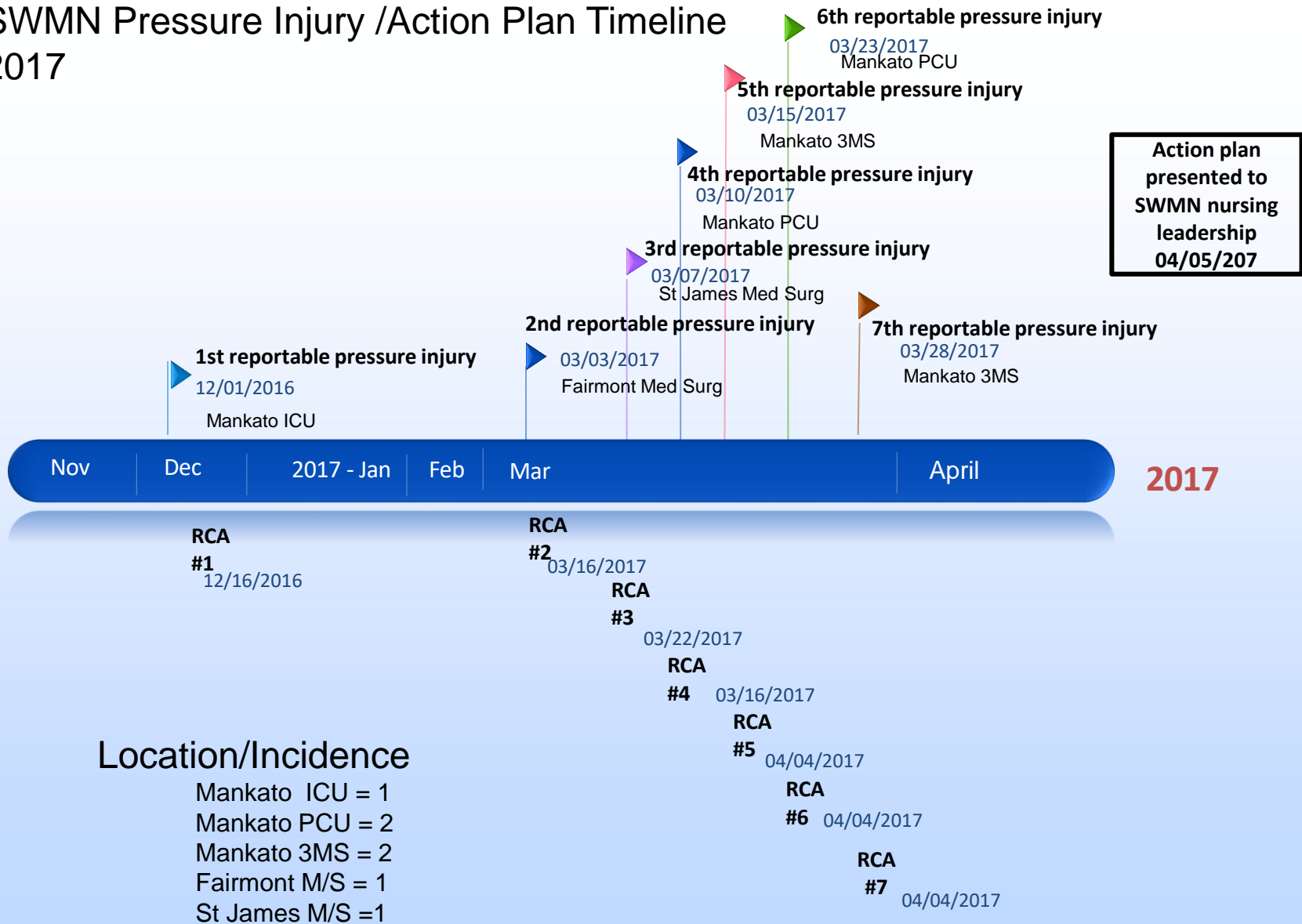
Action plans have been implemented, results tracked and prepared for reporting.

Special thanks to Ann West and Phyllis Hartwig and Jessica Holtz, leaders of care areas and staff for all their hard work.

INTERVENTIONS:

- New tape/taping method for NG Tube securement
- Nasal Cannula product change – softer/more pliable material
- Increased unit stock for Mepilex and chair cushions
- Adoption of Mayo Clinic Refusal of Care policy

SWMN Pressure Injury /Action Plan Timeline 2017



SWMN: Learning and Concern

- Remarkable increase in short period of time
- Situational analysis revealed a lack of common location/contributing factor
- Community consensus:
 - Identification of need for improved overall awareness, attention and action related to pressure injury prevention - including medical device awareness

Action plan for SWMN region

- Jodi Ndemo, RN, WOCN and Janet Ahlstrom APRN, Supervisor CNS
- Reviewed reportable incidents, RCA action plans (as they were developing)
- Best practice evidence review (IHI, AACN, NIH, National Guideline Clearinghouse)
- Consultation with staff nurses/managers
- Benchmarked with Mayo Enterprise partners
- Created Action Plan for SWMN region
- Presented to SWMN Nursing Leadership

Key elements of regional action plan

➤ **Structure:**

- Manager/Charge Nurse Rounding
- Bedside Handoff/Shift to Shift Report
- Skin Assessment Schedule – including admission assessment
- Required Education in My Learning for both licensed and unlicensed staff
- Monthly Wound/skin audits in patient care units

➤ **Process:**

- Evidence review and incorporation of best practices
- Resource access – contact for WOCN
- Communication – monthly WOCN update
- Creation of Pressure Injury Prevention team using “superuser” model

Results:

- 94% mandatory my learning training complete
- Audit process initiated in May – Sharepoint site established for data input and tracking
- 0 mandatory reported events in SWMN since March, 2017
- Draft for PIP team complete – expected launch in July/August

Exemplars:

❖ *“Hi team-Just wanted to share this great catch by ICU nurse Nicole Dunn! She documented an unstageable pressure ulcer on a patient’s toes upon admission! Nicole also submitted a safety event into midas. Great job!!”*

❖ *Dr. Becker,*

I just wanted to recognize you for doing your part in skin assessment and documentation. In May, we had a patient come through the ED department in New Prague that was directly admitted to the hospital in New Prague, and because of your excellent documentation regarding her Stage 3 Pressure ulcer on her buttock in the ED we did not have to report the pressure ulcer to the state as hospital acquired. If you had not documented the presence of the pressure ulcer we would have reported this incident to the state as I could find no other provider or nurse documentation regarding this skin alteration until a couple days into the patients admission. Thank you!

Thanks to all involved in Pressure Injury Prevention Efforts in our Real Place!

The collaboration of RCA processes with the regional action plan resulted in both unit level and overall positive impact toward reduction/elimination of pressure injury for patients receiving care in SWMN facilities.

We will continue to monitor using PDSA approach to continue the journey to excellence for pressure injury prevention.