EAST TENNESSEE Children's Hospital

Our Journey To Zero Harm: Pressure Injury Prevention

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Abstract

Purpose: A 152 bed comprehensive regional pediatric center, striving to create a sustainable culture of safety, identified pressure injuries as an area of opportunity through quality data trends and national benchmarking. The goal for fiscal year 2017-2018 was to reduce pressure injuries by twenty percent.

Methods: A full time WOCN and a multidisciplinary pressure injury prevention (PIP) team developed strategies and tools to achieve this goal.

Interventions: Further development of the PIP team, along with education modules and tools were implemented to guide frontline staff. Weekly active surveillance by the WOCN on all units was also a key component of this comprehensive plan. Buy in from senior leadership was imperative to the success of this program.

Results: In FY 2017-2018 there was a 42% reduction in pressure injuries, exceeding the original goal of a 20% reduction. Over the last 4 years bundle reliability has increased from 40% to 90% and has been sustained.

Conclusion: It is important to have a comprehensive plan that includes key stakeholder buy in, staff awareness, a multidisciplinary team, education and guidance for staff, and weekly active surveillance.

Practice Implications: These steps and tools can be adapted to other care settings to improve patient safety outcomes and reduce pressure injuries.

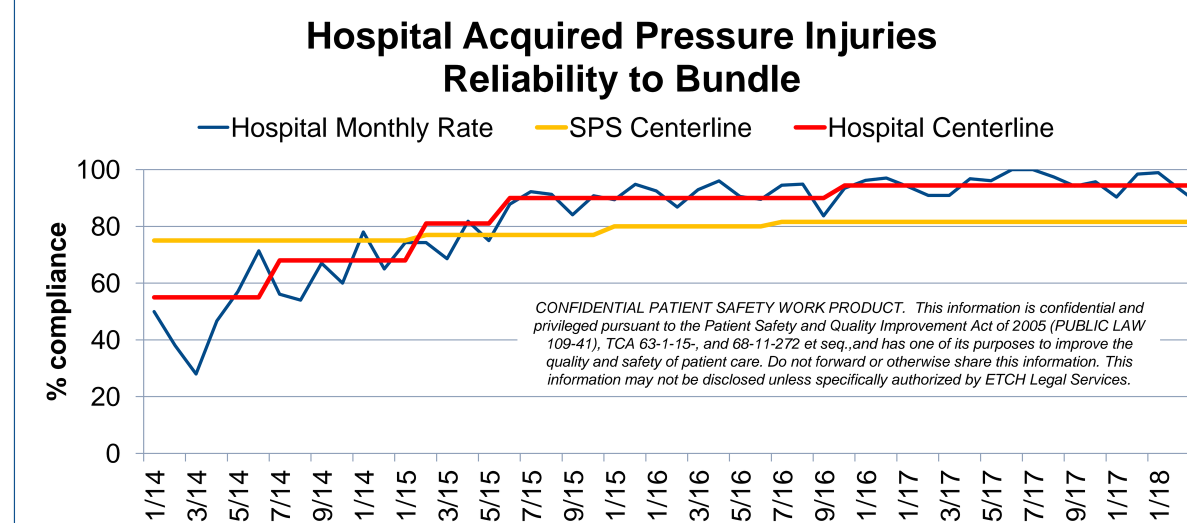
Background

- 152 bed comprehensive regional pediatric center
- Striving to create a sustainable culture of safety
- Identified pressure injuries as an area of opportunity through quality data trends and national benchmarking

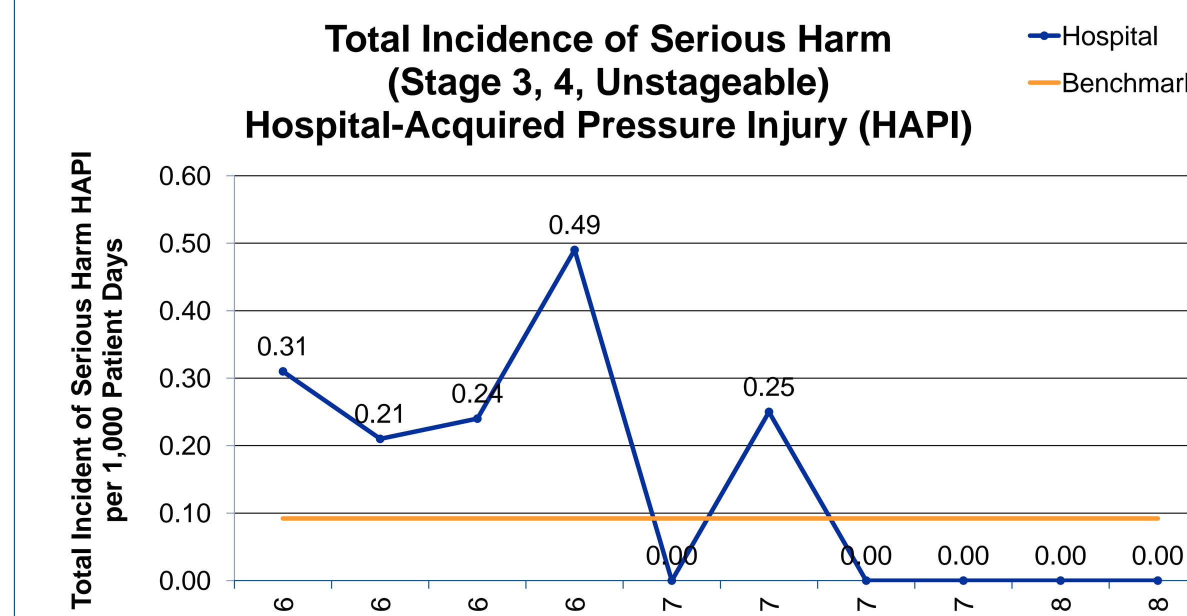
Interventions

- Education & Awareness
  - Bubble Gum Rounds
  - Quarterly ETCH days
  - Unit Specific
  - Partner with PIVIE
- Direct Observation & Skin Rounds
- Family Advisory Council
- Multi-Disciplinary Pressure Injury Prevention Committee
- ACAs on all stages of Pressure Injuries
  - Present to Pressure Injury Prevention Committee

Results



In FY 2017-2018 there was a 42% reduction in pressure injuries, exceeding the original goal of a 20% reduction. Over the last 4 years bundle reliability has increased from 40% to 90% and has been sustained. A zero serious harm rate was also achieved and sustained for a twelve month period.



Key Takeaways

Buy-In: Establish senior leadership buy-in to prioritize reduction of hospital-acquired PIs as a top patient safety initiative. Ongoing support is also fundamental to a successful program. A multidisciplinary team, including leadership and staff from nursing, medical, and ancillary departments, allows for a comprehensive approach to decreasing PIs.

Awareness: Conduct a needs assessment of existing staff awareness and cognitive bias. Reviewing data trends and benchmarking will direct the program.

Education: Leverage identified trends and gap analysis results to develop educational interventions. Start with one significant need or trend and then layer more as the program progresses.

Guidance: Provide consistent, individualized and ongoing guidance with staff. This may be provided in the form of tools, education modules, skills days or one-on-one education. Weekly active surveillance is fundamental to a successful program.

Bibliography

Clay,P.,et al. (2018). Device Related Pressure Ulcers Pre and Post Identification and Intervention. Journal of Pediatric Nursing, 41, 77-79.

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: quick reference guide. Washington DC National pressure ulcer advisory panel: 2009.

Rowe,A.D., et al. (2018). Implementation of a Nurse Driven Pathway to Reduce Incidence of Hospital Acquired Pressure Injuries in the Pediatric Intensive Care Setting. Journal of Pediatric Nursing, 41, 104-109.

Our Journey

2011

- Wound Care Training for all staff
- Formation of hospital wide PI team

2012

- Braden Q to EMR
- OR PI Bundle
- 1st Quarterly Prevalence Survey

2013

- Joined Solutions for Patient Safety (SPS, a national benchmarking collaborative)
- Collection of all Hospital-Acquired PIs regardless of staging

2014

- Reliability Audits via documentation

2015

- NICU Bundle
- Direct observation with k-cards
- Quarterly staff education days
- Addition of 2nd full-time WOCN
- Chart Triggers
- Wound Care Decision Tree
- Perform Apparent Cause Analysis on all PIs

2016

- Redistribution Mattress/Bed Replacement
- PI Reduction placed on organizational strategic plan
- Joined & Led Children's Hospital Alliance of Tennessee PI Collaborative
- NICU weekly active surveillance on Nasal CPAP
- White board & partner with families

2017

- New SPS Operational Definition for accurate reporting
- Full-time WOCN with PI focus
- Weekly Active Surveillance – All Inpatient Units

2018

- Remains a organizational strategic priority
- Ongoing collaboration to reduce all PIs
- Continue Weekly Active Surveillance
- Re-education of Skin Risk Assessment Tool
- Trial of latest Skin Risk Assessment Tool which includes devices in PICU