“I Can Help Prevent Pressure Injuries!” Implementation of Zero Harm Meetings

Angela Joyner BSN, RN, CWOCN; Bryan Duttman BSN, RN, CWOCN;
Maggie Elliott BSN, RN, CWOCN, CFCN; Rachel Beth Breazeale BSN, RN, CWOCN, CFCN
Rosalind Arango BSN, RN, CWON

Introduction

Increased Hospital Acquired Pressure Injuries (HAPIs) from 2016 to 2017 in a 439 bed acute care adult
hospital in North Carolina led to a change in approach to HAPIs.
2016 HAPI rate per 1000 patients days=**0.62**.
2017 HAPI rate per 1000 patient days=**1.29**.

Purpose/Significance

An interdisciplinary review of HAPIs raises awareness and shifts the approach that all disciplines are involved with pressure injury prevention. As a result, the rate of HAPIs decreased.

Methodology

What is a Zero Harm Meeting? A confidential and privileged product of a peer review committee including discussions of Hospital Acquired Injuries (HAIs): Falls with Injury, HAPI, CAUTI, CLABSI
A leadership team implemented a 30 minute weekly meeting to review HAIs that occurred the previous month. The meeting objective is to highlight the event and identify system and practice opportunities for improvement. Using Just Culture, the meetings are led by the two Nursing Directors and attended by the Chief Nursing Officer, Unit Manager and Director, WOC Nurses and Clinical Nurses. Meetings include brief demographic description of patient, injury that occurred, recall of all actions taken by co-workers to prevent, and system/practice issues to resolve. Environmental and technical needs could also be identified to support patient care. Takeaways from meetings include lessons learned, follow up action plans, and recommendations.

Little Changes Make a Big Difference: Results of Zero Harm Meetings

System/Practice

•Respiratory Therapy standardized ETT rotation to offload 8:00 (right) 12:00 (center) 4:00 (left)

•Supplement audit tool created by Quality Improvement Council- started to collect data in March 2018 to monitor documentation.

•Practice council task force regarding nutritional supplements

•Specialty offloading surface trialed for use in OR

•Surgical or specialty procedure >4 hour – apply PIP dressing prior to procedure

•Identified some HAPI’s were likely present on admission but not documented -Changed policy - 2 person (four eyes) skin assessment on every patient (New Admin and transfer) and standardized documentation.

•Braden report available to managers and during interdisciplinary rounds.

Products

•Switch in product to softer oxygen tubing to reduce device related HAPIs to ears

•Switch from zinc paste to zinc spray which allows for easier assessment of skin where product is applied.

•New product for under Trach for prevention of pressure injury

•Added skin protection for facial protection under BiPAP

Environment

•Contract with bed manufacture for routine bed assessment –replacement of mattress covers, hoses, and motors as needed.

•Exploring different fabrics for recliners.

Education

•2018 Bedside education on each unit for all co-workers related to skin care, bed functionality, charting expectation, and documentation of care.

•MASD vs pressure injury

•Specific education related to all new products, practice and technical changes implemented.

•Increase in education related to documentation of patient refusing to turn

Technical

•Implementation of body image tool for 2 person skin check on every patient (new admin and transfer)

•Monitoring real time documentation of turns – under quick links in EMR

•Utilizing “turns q 2 hours” on electronic medical record worklist for reminder/prompting for Primary RN/NA.

Manager/Director/ Other departments

•More interest in Skin and Wound Resource Team

•Unit involvement with HAPI lookup/Ownership

•More “real time” reaction to HAPI’s

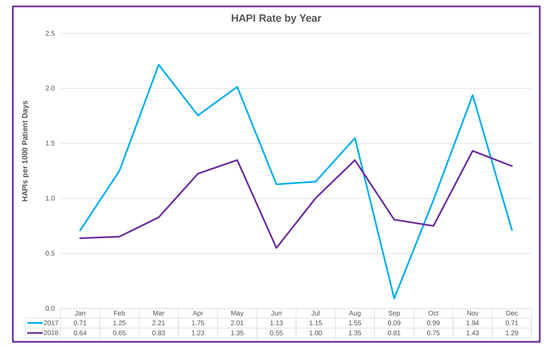
•A unit identified a need to reorganizing (facial) pressure prevention supplies by moving location of supplies (in supply room) from the skin and wound care area to respiratory section. Moving the supplies made it easier for the team to get the pressure prevention supplies when they were gathering supplies for BiPAP, patients that are on ventilators, oxygen and trach patients.

Outcomes and Conclusion

Additional units/leadership became involved for further specialty and interprofessional collaboration insights (e.g. Nutrition, Anesthesia, OR, PACU, Cath prep/recovery unit, ED, Respiratory Therapy, and Critical Care Transport). Gaps in practice, education and policy are identified and actions taken. Products and equipment are reviewed and reevaluated for effectiveness.

~ From 2017 to 2018 the hospital had an overall decrease in HAPIs of **21%**.
~ While the total HAPI events decreased 21%, the hospital rate per 1,000 patient days decreased **24%**.
(1.35 in 2017 and 1.03 in 2018.)

WOC nurse engagement, weekly discussions and hospital wide collaboration has impacted our approach and tremendously improved the safety of patients in our quest to get to zero HAPIs.



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