

Process Improvement in Critical Care

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Why We Care: The Compelling News About Pressure Ulcers

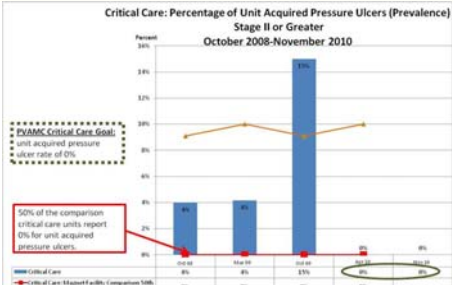
- Considered a never event (almost)
- PU rates Nursing Quality Indicator
- Prolong hospital length of stay
- Painful
- Debilitating
- Mortality 60,000 lives lost every year from pressure related injury
- Resources
- Expensive \$70,000 to treat full thickness injury
- Changes in re-imbursement

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(IHI, Dec 2011)

Our Experience: We had this bump in rates

Critical Care: Percentage of Unit Acquired Pressure Ulcers (Prevalence) Stage II or Greater October 2008-November 2010



50% of the comparison critical care units report 0% for unit acquired pressure ulcers.

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Prevalence vs Incidence (explain the difference)

Prevalence

- Ulcers present on admission
- A snapshot or sample at one point in time
- Not a clear indication of the quality of a particular unit or organization

Incidence


- Ulcers that develop in house while a patient is being cared for by nursing
- Injury occurs while under direct nursing care
- Rates are linked to quality of care on that unit

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Our Plan

- Spike in Pressure Ulcer Rates
- Action Plan
- Benchmarks
- Formed Skin Care workgroup
- Consulted Organizational Experts on wound and skin management
- Focused on capturing admission skin and risk assessment
- Educational needs assessment
- Night USL assessment and collection of incidence for data base
- Participation in PUP studies

PRESSURE ULCER STAGING
 Staging is for pressure ulcers (NPI). They are diagnosed based on their appearance.



Stage 1
 Non-palpable redness, localized to one or more areas of the body. The redness may be darker in individuals with darker skin tones.

Stage 2
 Partial thickness loss of dermis, shallow open ulcer with a red, moist wound bed. May also present as a fluid-filled blister.

Stage 3
 Full thickness loss, extending into the subcutaneous tissue. May contain slough, eschar, or necrotic tissue. May be covered by a transparent adhesive dressing.

Stage 4
 Full thickness loss with exposed muscle, tendon, or bone. May contain slough, eschar, or necrotic tissue. May be covered by a transparent adhesive dressing.

Unstageable
 Deep ulcer with a covering of slough or eschar that prevents staging. A full or partial debridement is required to determine the true depth of the ulcer.

Deep Tissue Injury (DTI)
 Deep red or purple mottled discoloration of the skin. The area may be painful, firm, spongy, or leathery. The area may be warm or cool to the touch.

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Educational needs/Action plans

- What were our learning needs?
 - Skin and risk assessment
 - Charting inconsistencies
 - Documentation within 24 hours
- Where did we need to focus our energy?
- Look to the literature for guidance

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Future Actions:

- Individualized plan of care for identified at risk patients
- Tracking the number of days since last unit acquired pressure ulcer
- Assessment of new devices and dressings on the market
- Frequent unit based PUP studies
- Nurse lead wound/mobility rounds

References

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