Pressure Ulcer Reduction Project

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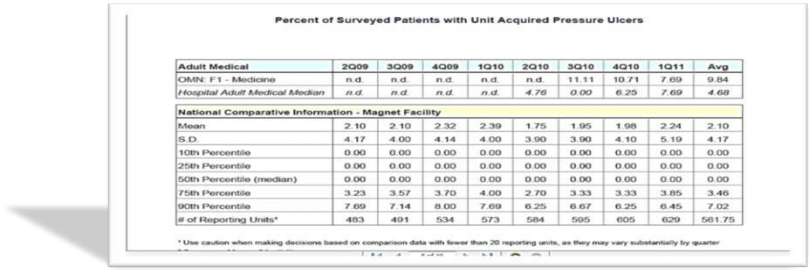
Background

- The hospital decided to go towards Magnet Recognition Program. This is when we decided to bench mark the quality indicators to compare quality of care given to our patients.
- In our Medical Unit we found UAPU was one of the areas that needed improvement. We started reporting in-patients UAPU in Q3, 2010 and noticed that there was an ongoing issue with the unit's Pressure ulcer rates. (See data below).
- Based on our data we were above 90th Percentile in unit acquired pressure ulcer compared to other magnet facilities



Percent of Surveyed Patients with Unit Acquired Pressure Ulcers

Adult Medical	2Q09	3Q09	4Q09	1Q10	2Q10	3Q10	4Q10	1Q11	Avg
OMN: F1 - Medicine	n.d.	n.d.	n.d.	n.d.	n.d.	11.11	10.71	7.69	9.84
Hospital Adult Medical Median	*n.d.*	*n.d.*	*n.d.*	*n.d.*	*4.76*	*0.00*	*6.25*	*7.69*	*4.68*
National Comparative Information - Magnet Facility									
Mean	2.10	2.10	2.32	2.39	1.75	1.95	1.98	2.24	2.10
S.D.	4.17	4.00	4.14	4.00	3.90	3.90	4.10	5.19	4.17
10th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
25th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
50th Percentile (median)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
75th Percentile	3.23	3.57	3.70	4.00	2.70	3.33	3.33	3.85	3.46
90th Percentile	7.69	7.14	8.00	7.69	6.25	6.67	6.25	6.45	7.02
# of Reporting Units*	483	491	534	573	584	595	605	629	561.75

* Use caution when making decisions based on comparison data with fewer than 20 reporting units, as they may vary substantially by quarter

Objective

- To reduce the incidence of UAPU to ZERO.
- To out perform benchmark group(below 50th Percentile).

Methodology

FOCUS-PDCA

- F- Magnet Benchmark helped to identify the gaps area in the practice by comparing our data to peer units and see how they are doing.
- O- Team was organized
- C- The current process was clarified by pretest and audits.
- U- The deficiencies were identified
- S- Our anticipated outcome is to keep pressure ulcer Zero/below 10th percentile.
- P- Education and audits
- D- Carried out education, patient assessments and documentation audit
- C- Posttest, NDNQI survey
- A- Continue the strategies to maintain the positive outcome
- We realized that there is a need to have a structure, system and process that would support reduction of UAPU.
- A Root Cause Analysis indicated that there was a high level of nursing care needed by this patient population, while there was a severe shortage of staff to provide necessary care.
- A team was formed that looked at various ideas that could improve our result. A structure approach was used to assess staff knowledge in the pressure ulcer prevention through a pre and post test. (NDNQI) pressure ulcer on line module was made a mandatory course for all RNs and with every contract.
- Additional education sessions were provided by the wound care CNC. As patients are supposed to be the center of our care, all newly admitted and transferred patients were thoroughly assessed by the primary nurse and charge nurse.
- Documentation audit was carried out to detect any discrepancies.
- Staff in services, education, feedback and involvement continued until final stages of the project

Intervention

- We increased the number of air mattress to meet the patient's need
- We ensured that all the F1 staff had taken the National Database for Nursing Quality Indicators (NDNQI) PU Online Module
- We educated our Patient/Family on pressure ulcer prevention and care to improve awareness.
- We invited the Wound Care team to provide in services to our staff.
- We improved ongoing peer review regarding patients assessment on admission and documentation
- Our staffing was re-evaluated based on international benchmark and we were successful to increase number of nursing staff.[Total Nursing Hours Per Patient Day was increased from below 10th Percentile(6.11) to above 50th Percentile (9.55)]

Key performance Indicators (KPI)

- Quality Information System (QuIS)
- We created an audit tool which we used for pre and post patient assessment and pre and post staff education assessment.
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Outcomes

Adult Medical	4Q11	1Q12	2Q12	3Q12	4Q12	1Q13	2Q13	3Q13	Avg
CVN: A4 - Medical Cardiology	0.00	0.00	0.00	0.00	4.55	4.00	4.00	0.00	1.57
CMN: E1 - Hematology	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CMN: F1 - Medicine	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CMN: F2-1 - Neurology	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CMN: F2-2 - Palliative Care	5.56	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.74
CMN: F3 - Medical Oncology	0.00	0.00	0.00	0.00	0.00	0.00	3.45	0.00	0.86
Hospital Adult Medical Median	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*

Lessons Learnt

- Anything that is not measured cannot be improved.
- Having looked at our quality of care given to our patients in terms of UAPU we were able to identify the major issues. Hence using the quality improvement tool such as FOCUS-PDCA we succeeded in achieving our ZERO UAPU rate.
- For Consecutive 3 years we manage to maintain ZERO UAPU although with the complexity of patient population in the unit.