ADVANCING THE CULTURE OF SAFETY: Strategies to Prevent Pressure Injuries

Wednesday, October 18, 2023 12:00 PM | (UTC-04:00) Eastern Time (US & Canada)

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How to Use the Chat Box Feature

To send a Chat Message:

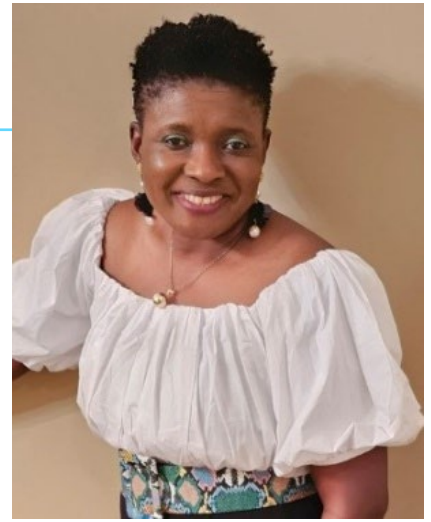
- **Open** the **Chat** Panel

- ***Scroll** All the Way **Down***
- ***Select "Everyone"***
  - ***Do not** select "All Attendees"*
- **Type message** in Chat Text Box, press **Enter** on your keyboard

Enter in Chat:

- **Name**
- **Role**
- **Organization**
- **State**

Today's Speakers



Priscilla Ebone, MSN, RN, CPPS
Patient Safety Subject Matter Expert
HQIC (Hospital Quality Improvement Contractor)

- Priscilla Ebone, MSN, RN, CPPS, provides patient safety expertise to healthcare systems and organizations to advance the culture of patient safety and innovations at the point of care.
- With 15 years of RN bedside patient care, Priscilla has practiced in the areas of home healthcare, acute care hospitals, hospice care, rehabilitation, and post-acute care settings. She recognizes that across the continuum of care, quality care is the necessary basic step to improve patient satisfaction, decrease length of stay, and better outcomes. In her patient safety role, she has conducted pressure ulcer event investigations, is very familiar with various root cause analysis outcomes, and has provided suggestions for best practices.
- Her passion to improve patient safety has motivated her to facilitate quarterly HQIC Lunch and Learns. She has chosen the topic of pressure injury prevention for this quarter.

Today's Speakers

Angela Dubuc, RN, MSN, CPHQ
System Director Quality Services
Central Maine Healthcare

- Angela Dubuc, RN, MSN, is the director of quality services at Central Maine Healthcare. She drives improvements in quality and patient safety through the utilization of evidence-based processes, continuous performance improvement, high-reliability science, and a collaborative approach to problem solving.

Today's Speakers

Gisele Castonguay, RN, MSN, APRN-CNP, CWOCN
Program Director Wound Care Services
Central Maine Healthcare

- Gisele Castonguay, RN, MSN, APRN-CNP, CWOCN, is the program director of wound care services at Central Maine Healthcare. She practices in both the outpatient and inpatient settings providing consultation and management of complex wound and ostomy continence issues including preoperative, intraoperative, and postoperative wound and ostomy consultation and care.
- Through her role, she collaborates with the multidisciplinary team, develops and implements systemwide guidelines and protocols, educates providers and nursing staff, and guides SWAT (Skin Wound Assessment Team) activities. She is also responsible for the development and implementation of Wound Treatment Associate and Ostomy Care Associate programs for the institution and the surrounding region.

Today's Speakers

Kaitlyn Smith, MBA, MSN, RN, CCRN
Director Cardiovascular and Critical Care Services
Central Maine Medical Center

- Kaitlyn Smith, MBA, MSN, RN, CCRN, is a respected Nurse Leader overseeing operations and personnel management in departments that include the Intensive Care Unit, Cardiovascular Intensive Care Unit/Intermediate Care Unit, Cardiac Cath Lab, Endovascular Lab, Electrophysiology Lab, Echo Lab, Vascular Lab, Cardiac Diagnostics, Cardiopulmonary Rehabilitation Program, and Respiratory Therapy.
- She is energetic about staff engagement using relationship-based transformational leadership techniques with a focus on goal setting and growth. She is a forward thinker who consistently looks to streamline processes in order to improve staff and patient experience. She led a pressure injury prevention PI project resulting in zero reportable hospital acquired pressure injuries January 2022-present. She had a Poster presented at Organization of Maine Nurse Leaders' Summit in March 2023.

IPRO HQIC

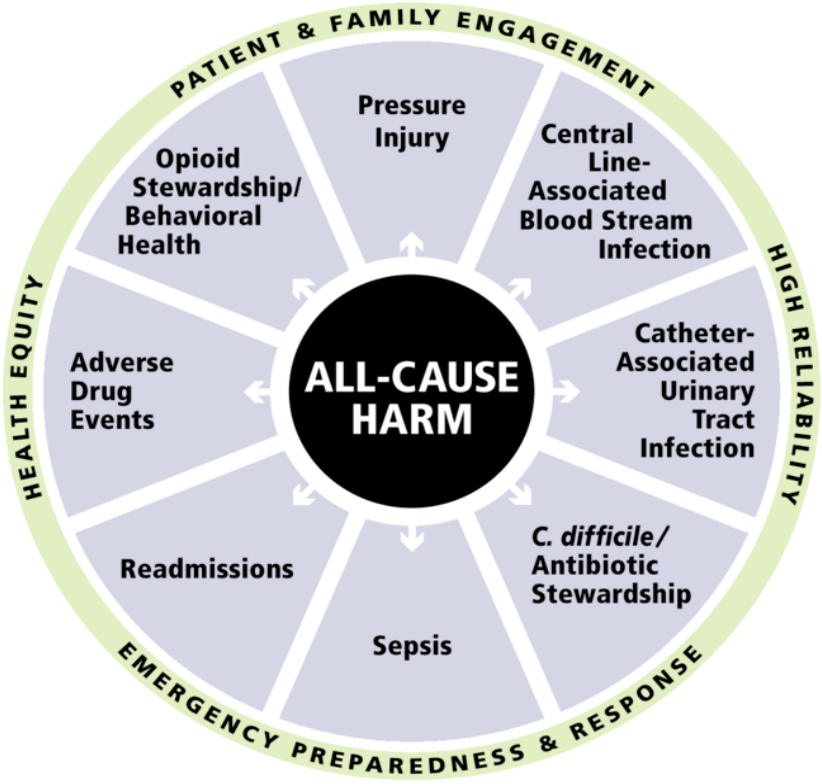
What are HQICs?

Data-driven. It's the data that help hospitals measure progress toward quality improvement (QI) gains. Hundreds of thousands of patients and families benefit from CMS-supported QI projects that make today's hospital stays safer and improve the quality of hospital care.

Dynamic and collaborative. HQICs partner with small, rural and critical access hospitals and facilities that care for vulnerable and underserved patients. Their quality improvement consulting and expertise – offered at no cost to the hospitals – help hospital leaders and clinical teams develop local QI projects designed to:

- Reduce opioid misuse and adverse drug events.
- Increase patient safety with a focus on preventing hospital-acquired infections.
- Refine care coordination processes to reduce unplanned admissions.

HQICs also share their QI resources to assist hospitals with pandemic responses and emergency preparedness.



The federally funded Medicare Hospital Quality Improvement Contractor (HQIC) in 12 states

IPRO (joined by)
- Healthcentric Advisors
- Kentucky Hospital Association
- Qlarant
- Q3 Health Innovation Partners
- Superior Health Quality Alliance
- American Institutes for Research (AIR)
- QSource

States
- MA
- ME
- NY
- OH
- KY
- NJ
- PA
- DE
- MD
- MI
- MN
- WI

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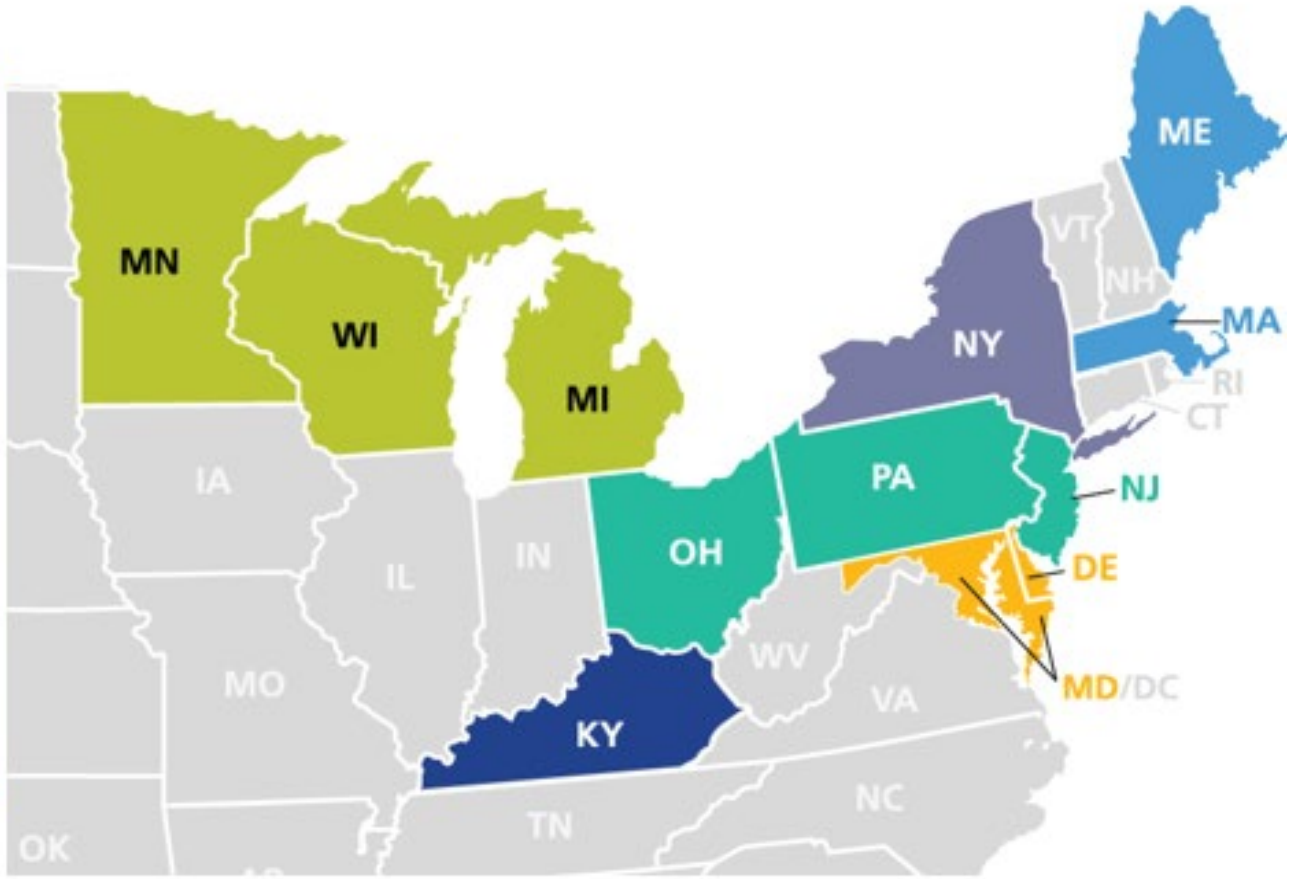
IPRO Hospital Quality Improvement Contractor (HQIC)

- IPRO supports hospitals in improving care delivery systems affecting vulnerable populations
- IPRO works with 272 hospitals across 12 states
- Focus areas include:
  - All-cause harm
  - Patient and family engagement
  - Health equity
  - Immunizations and vaccines
  - Healthcare-acquired infections



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QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
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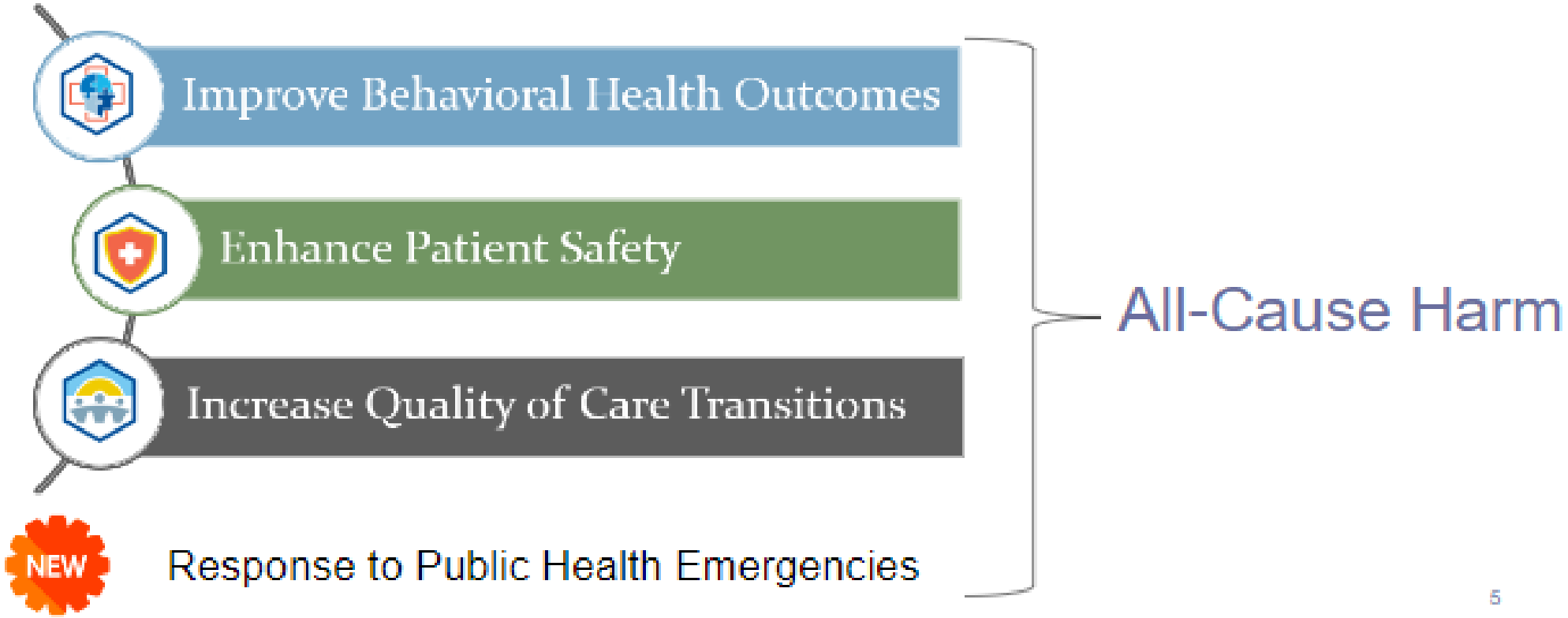
IPRO Hospital Quality Improvement Contract (HQIC)

Welcome: Program Goals



Objectives of Today's Presentation

In this Lunch and Learn Series, we will learn:

- The pathophysiology of pressure injuries and how they develop.
- How to appropriately identify patients' risks for developing pressure injuries.
- How the Central Maine Healthcare System successfully implemented evidence-based strategies that resulted in a significant decrease in HAPI rates.

Pressure Ulcer - Sentinel Event

- Each year, more than 2.5 million people in the United States develop pressure ulcers (AHRQ, 2023).

- The mortality rates from pressure ulcers are 2 to 6 times as much as from other diseases, with 60,000 deaths annually due to this complication (NIH, 2020).

What is a Pressure Ulcer/Injury?

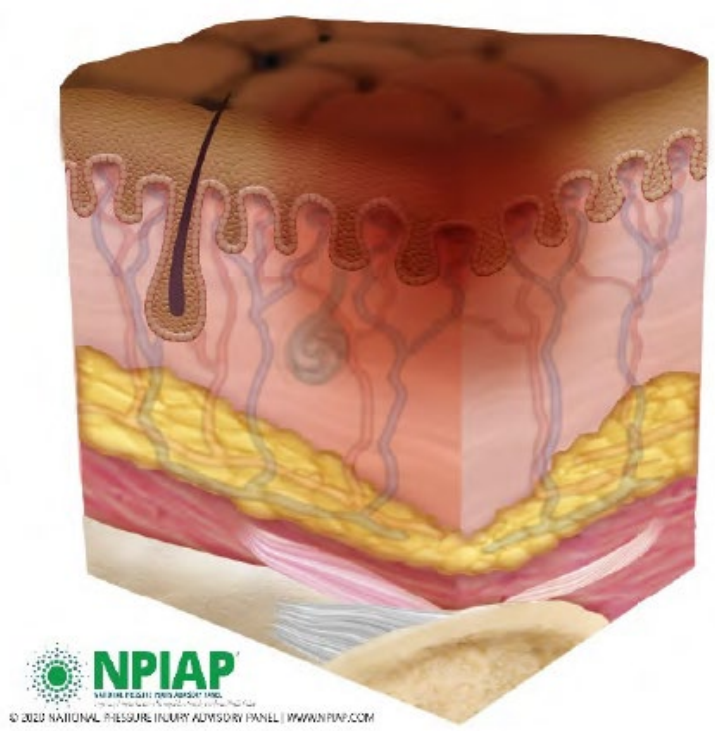
- **"Pressure Ulcer/Injury (PU/PI)"** refers to localized injury to the skin and/or underlying soft tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear.

- It may also be related to a medical or other device. A pressure injury can present as intact skin and may be painful.

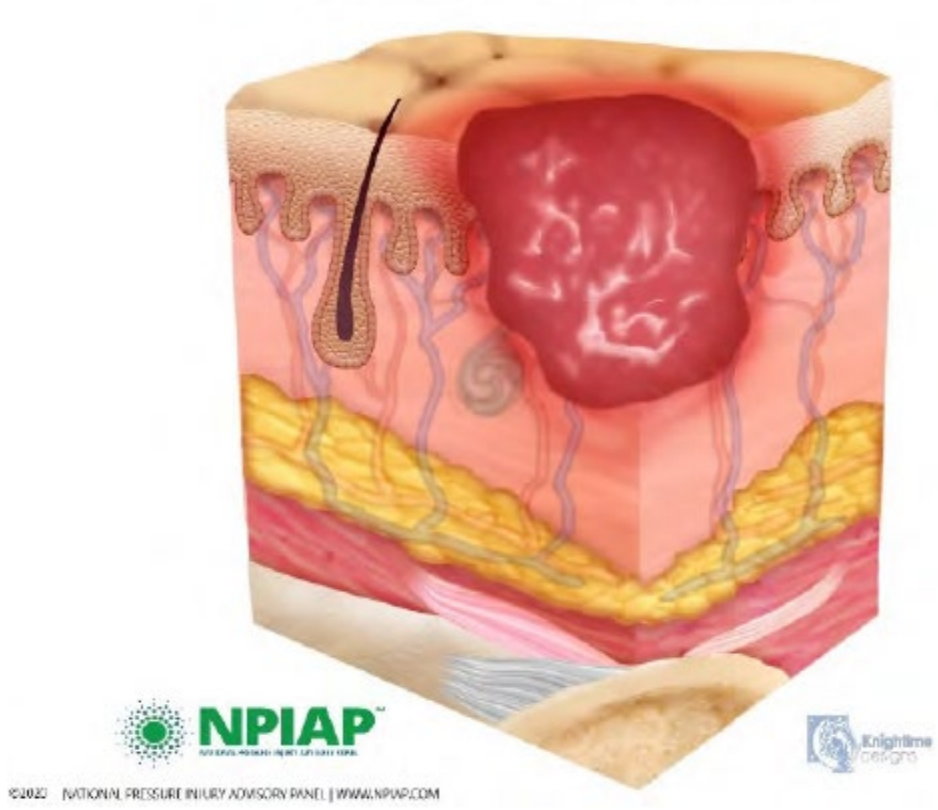
- A pressure ulcer may present as an open ulcer, the appearance of which will vary depending on the stage and may be painful.

Development of Pressure Ulcers

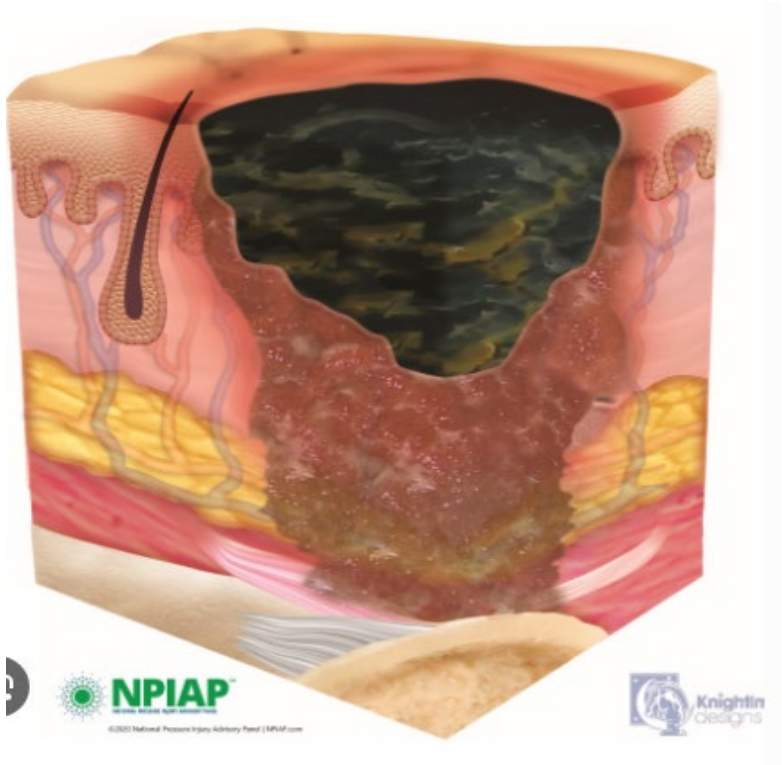
Stage 1 PI



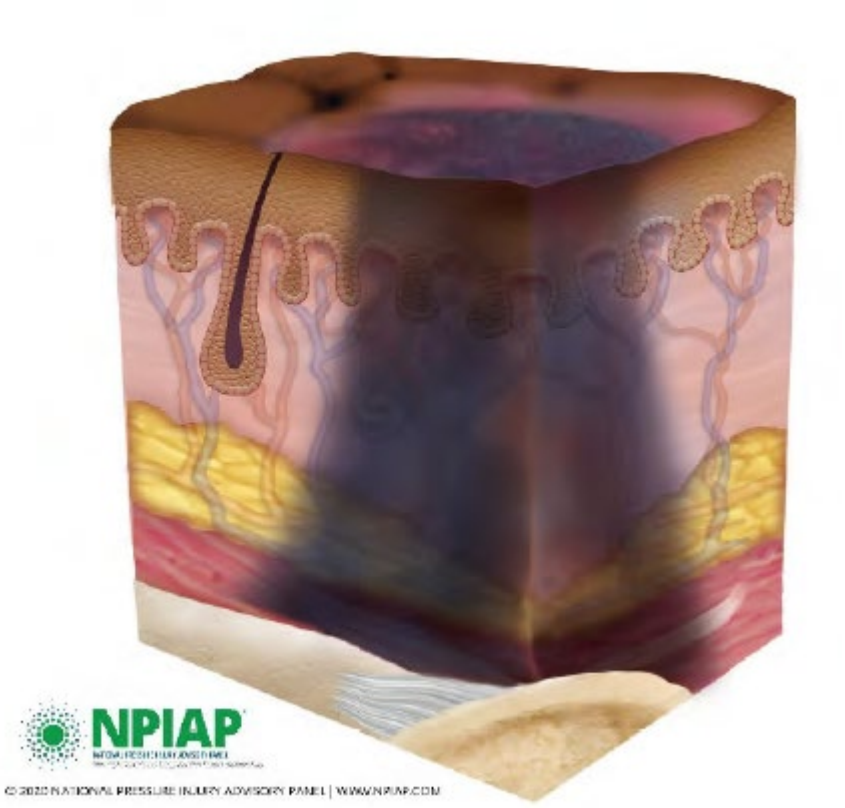
Stage 2 PI



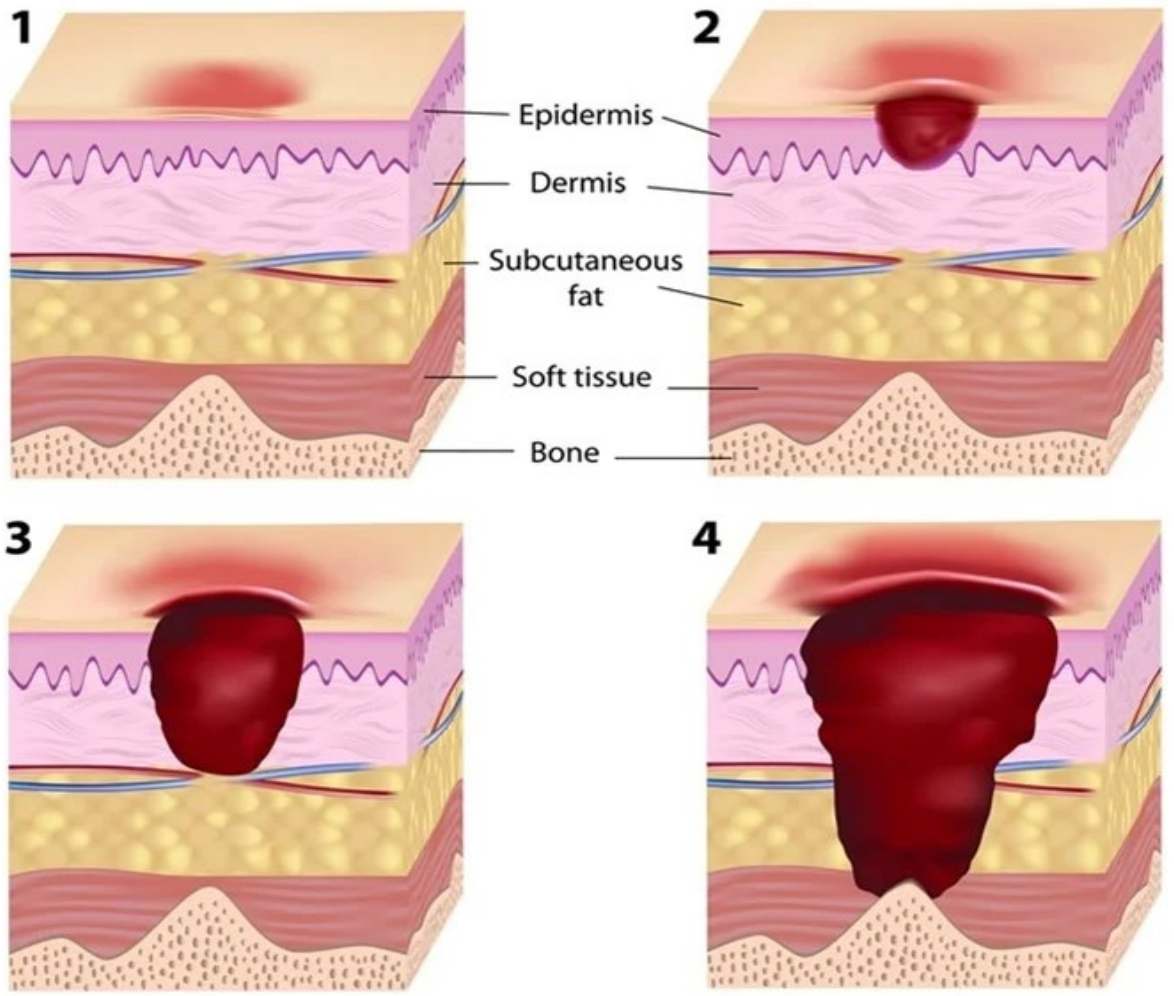
Stage 3



Deep Tissue Injury



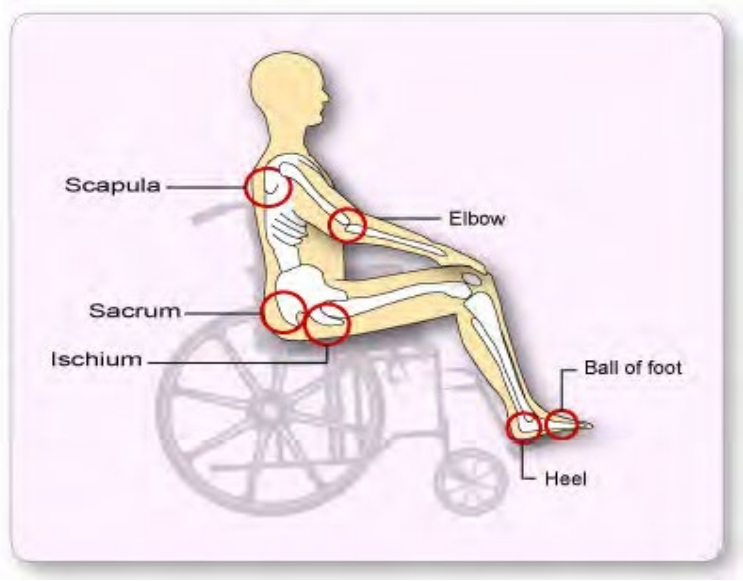
Stages of Pressure Sores

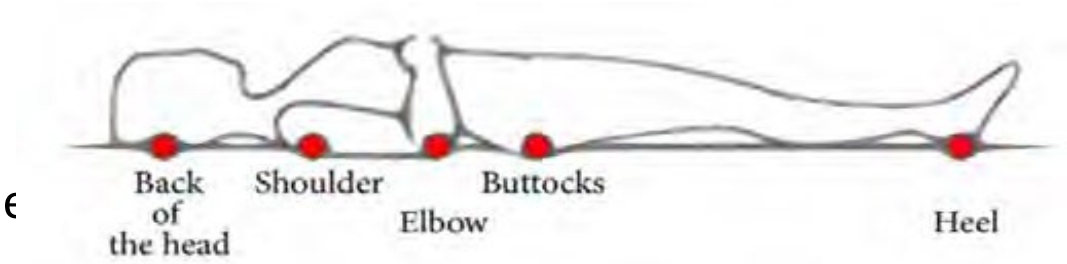


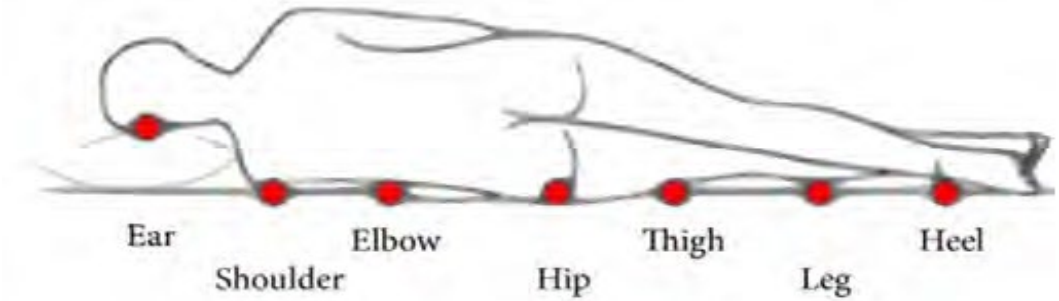
Stages of pressure sores. Image Credit: Alila Medical Media / Shutterstock

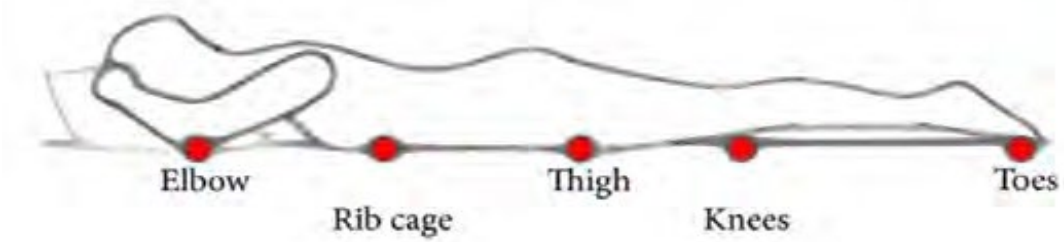
At-Risk Body Parts

- Sacrum/buttock
- Heels
- Boney points such as elbows, shoulders, back, ankle etc.









Examples of Risk Factors

- Impaired/decreased mobility and decreased functional ability
- Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus
- Drugs such as steroids that may affect healing
- Under nutrition, malnutrition, and hydration deficits
- Cognitive impairment
- Impaired blood flow, for example, vascular or arterial insufficiency
- The presence of a previously healed PU/PI
- Exposure of skin to urinary and fecal incontinence
- Patient's refusal of some aspects of care and treatment

Strategies to Prevent Pressure Injuries

- Perform a thorough skin assessment every shift.
- Manage moisture and incontinence in a timely manner.
- Redistribute pressure for bedbound patients.
- Provide appropriate caloric intake.

Interdisciplinary care teams should be involved in pressure ulcer prevention. For example, RN, CNA, Nutritionist/dietician, PT/OT, physician, etc.

Patient / Family Engagement (PFE)

CMS Recognizes that PFE is essential to the health and well-being of our communities, and is committed to supporting, implementing, and integrating PFE principles into all of our actions and programs.

- Educate patient/family on pressure ulcer risk factors.
- Involve patient/family in skin care plans.
- Education them on what they can do prevent pressure ulcers.
- Explain rationale for all care actions. For example, turning and repositioning, use of pressure relief devices, the need to be cleaned regularly, if incontinent, dietary/hydration compliance, etc.

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Factors that Can Increase the Risk of Pressure Ulcers

- Advanced age
- Impaired nutritional status (including not eating or drinking enough)
- Decreased ability or inability to move independently
- Loss of ability to change and control body position
- Moisture, including loss of bowel or bladder control
- Confusion or a change in mental status
- Certain medications and use of various medical devices
- Decreased sensation or ability to feel
- Certain illnesses such as diabetes and circulatory diseases
- A previous pressure ulcer
- Obesity

Gold STAMP Program to Reduce Pressure Ulcers

www.goldstamp.org

The Gold STAMP program to reduce pressure ulcers in New York State is a coalition of organizations convened to provide resources and education across the continuum of care to improve the assessment, management, and prevention of pressure ulcers.

SCHOOL OF PUBLIC HEALTH
UNIVERSITY AT ALBANY State University of New York

References:

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. (2009). *Prevention and treatment of pressure ulcers: quick reference guide.* Washington DC: National Pressure Ulcer Advisory Panel.

New Jersey Hospital Association. (n.d.). *Help us protect your skin.* Retrieved January 7, 2014 via http://www.njha.com/media/43477/puconsumereng.pdf

Preventing Pressure Ulcers

Information for Patients and Families

A Guide for Healthy Skin

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What is a Pressure Ulcer?

A pressure ulcer, sometimes called a "bedsore" or "decubitus ulcer," is an injury to the skin and underlying tissue caused by unrelieved pressure or pressure in combination with shearing (often from sliding down in bed). These ulcers usually occur on the buttocks, hips, heels, elbows and shoulders. These body parts are under the most pressure when you are lying in bed or sitting for long periods of time.

Can Complications Develop from Pressure Ulcers?

Yes. Pressure ulcers can cause pain, increase the risk for infection, and may slow recovery from another illness or surgical procedure.

Report any skin changes to your health care provider.

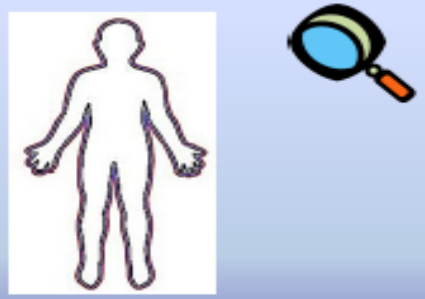
Can Pressure Ulcers be Prevented?

While not all pressure ulcers can be prevented, many can. By assessing what puts you at risk for pressure ulcers, your care team is able to determine the best possible prevention plan for you!

Skin Care is Important!

Check the skin daily.
Look for:

- Redness or any color changes
- Changes in temperature
- Broken skin
- Pain
- Drainage
- Discomfort or itching
- Swelling
- Odor



Prevention

Keep skin clean and well-lubricated; manage excessive moisture.

- Use a mild cleanser for bathing and pat skin dry.
- Bath water should be warm but not hot.
- Do not massage (rub) bony areas (such as the hips and elbows.)

Ensure adequate nutrition.

- Fluids, protein and calories are important for maintaining healthy skin.
- Ask a health care provider to help determine the right diet for you.

Change positions.

- In bed: every two hours.
- In a chair: at least every hour.

If able to move independently:

- Shift position every 15 minutes while sitting.

Ask a health care provider about devices to help increase mobility and decrease pressure. Chair cushions that are shaped like donuts should never be used.

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Are We Ready to Change?

- *Because pressure ulcer care is complex, efforts to improve pressure ulcer prevention require a systematic approach that will involve organizational change.*

- Failure to assess your organization's readiness for the change at multiple levels can lead to unanticipated difficulties in implementation, or even the complete failure of the effort.

- If a sense of urgency does not yet exist among key organizational leaders and members, your job as change agents is to increase or create it.


Thank
YOU

Central Maine Healthcare

- An integrated, non-profit, 501(c)(3) health delivery system.
- Created in 1982 serving an expansive geographic area spanning western, central and coastal Maine.
- Three hospitals
- Central Maine Medical Group

Central Maine Medical Center
Lewiston, Maine
250 licensed beds
Acute Care Hospital

Bridgton Hospital
Bridgton, Maine
24 licensed beds
Critical Access Hospital

Rumford Hospital
Rumford, Maine
24 licensed beds
Critical Access Hospital

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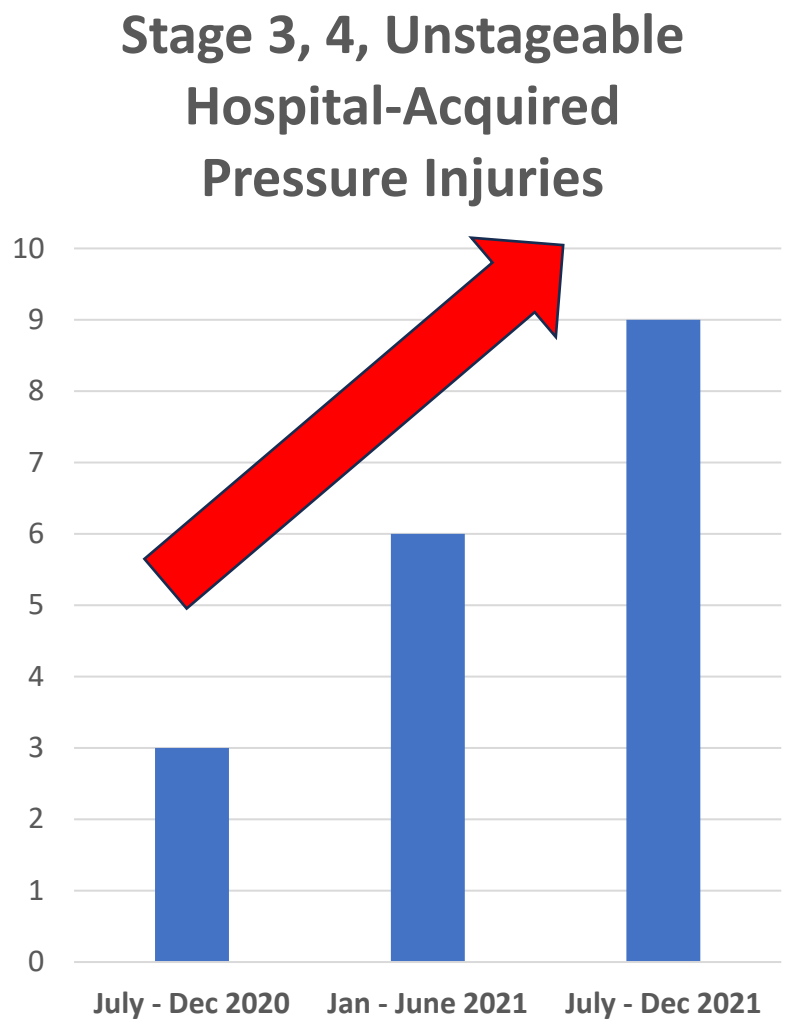
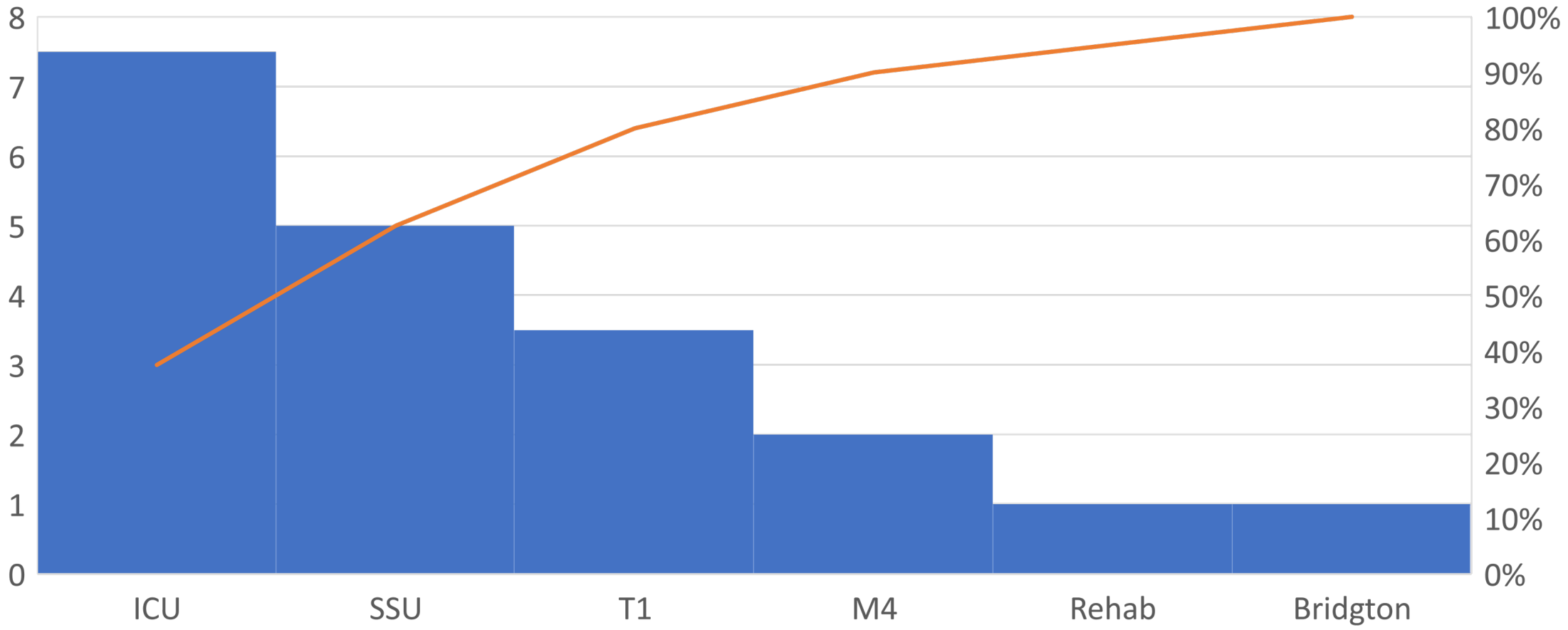
A Call to Action

- **December 2021**: Increase in reportable hospital acquired pressure injuries
- **January 2022**: Pressure Injury Task Force kick off
- Utilized traditional process improvement techniques
  - Involve key stakeholders
  - Analyze data
  - Fishbone: Brainstorm root causes
  - Driver diagram: To identify gaps in best practices
  - Tests of change: Brainstorm change ideas to address gaps/root causes



FY21 and FY22 CMH Stage 3, 4 & Unstageable Hospital-Acquired Pressure Injury Attributed Nursing Unit



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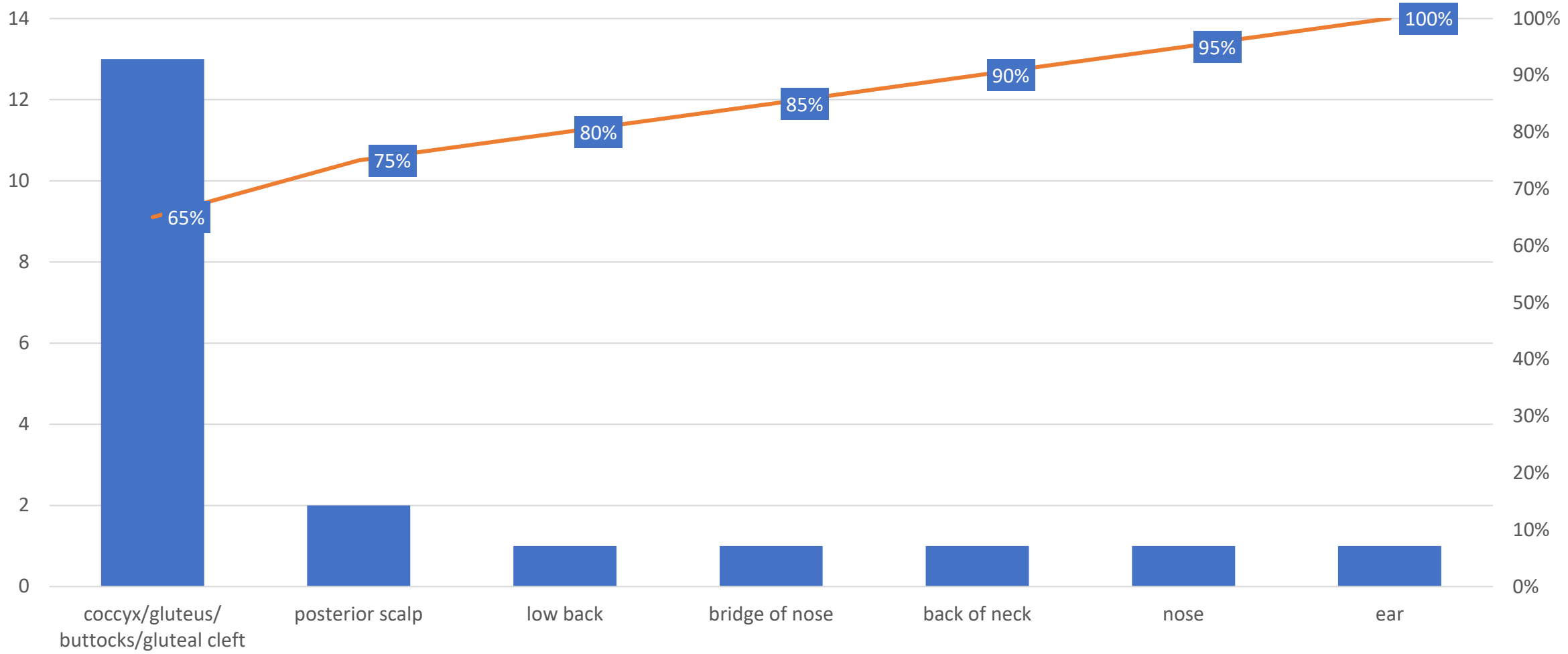
FY21 and FY22 CMH Stage 3, 4 & Unstageable Hospital-Acquired Pressure Injury Location



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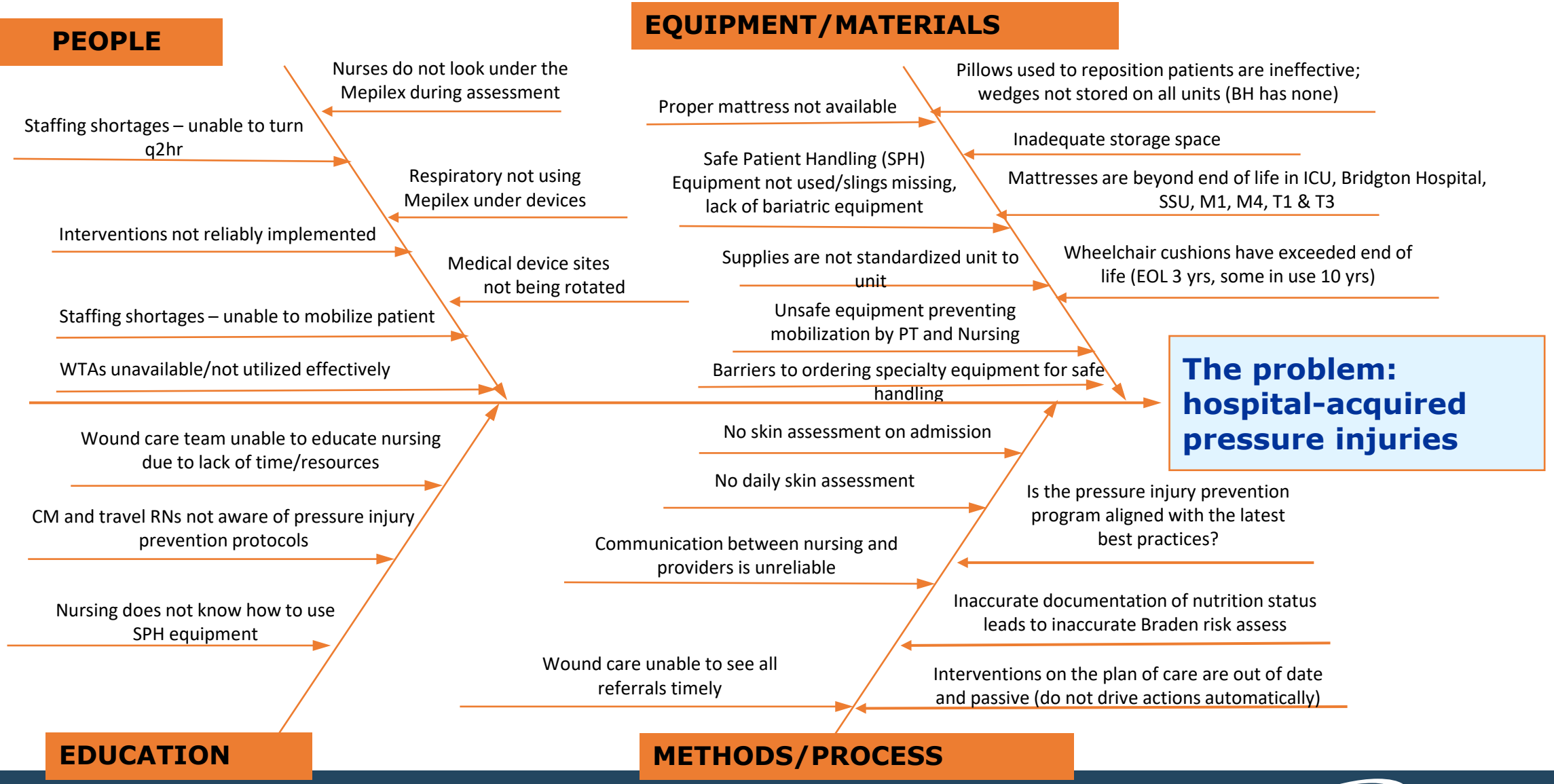
CAUSES OF CMH HOSPITAL-ACQUIRED PRESSURE INJURIES



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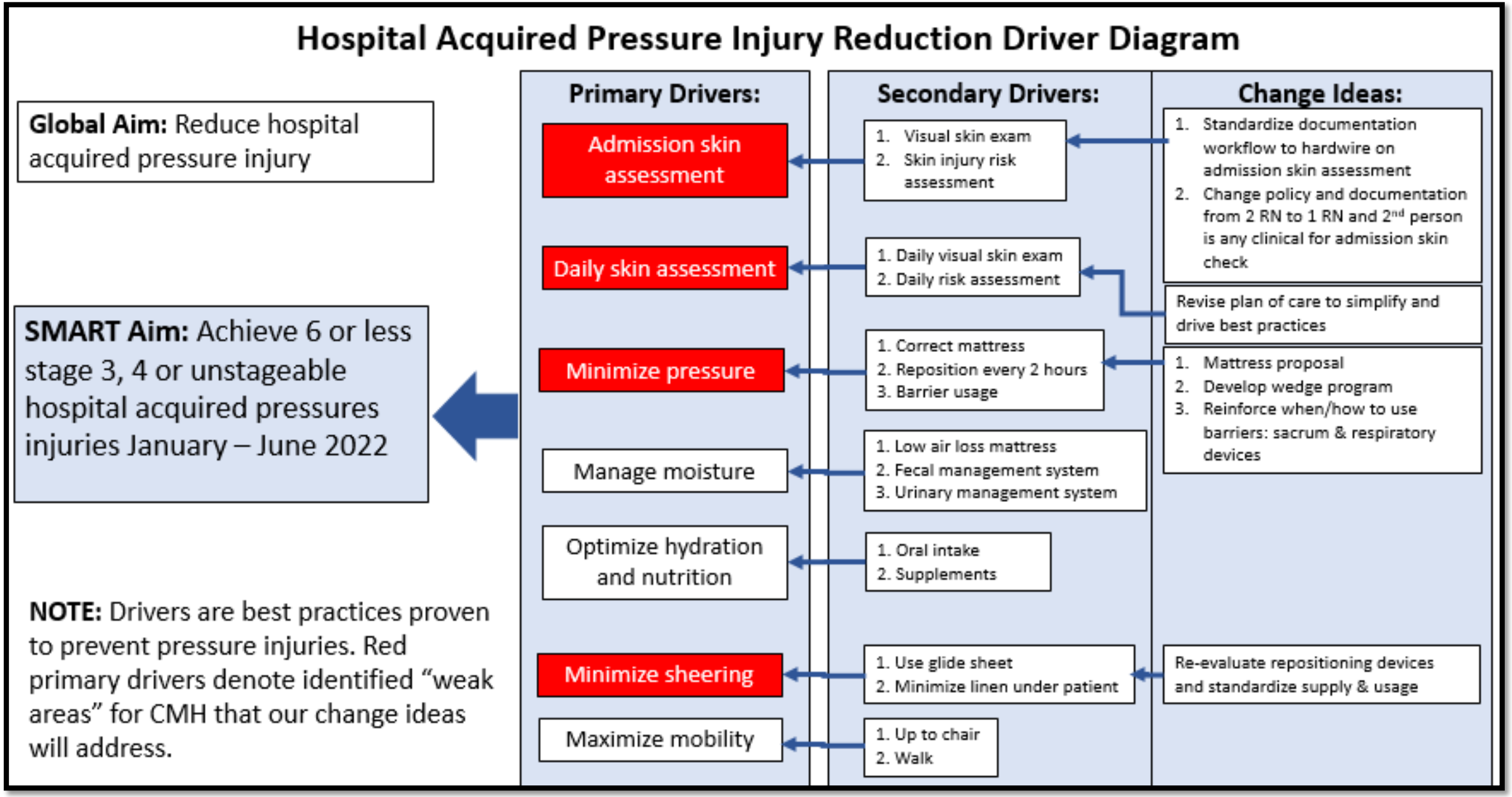
Hospital Acquired Pressure Injury Reduction Driver Diagram



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Tests of Change

National Pressure Injury Advisory Panel (NPIAP) guideline adherence gap analysis

Develop a process to utilize wedges for repositioning instead of pillows

Evaluate current state of mattresses and submit a replacement proposal to senior leadership

Re-evaluate repositioning devices

[adequate supply, update protocol, and re-educate]

Reinforce when to use barriers (sacrum and under devices)

Improve reliability of identification of pressure injuries present on admission

Request additional wound care resources (WOCN RN and Nurse Practitioner)

Allow non-RNs to be the second set of eyes for skin assessment on admission

Surfaces Beyond End of Life Replacement Proposal

- Telling the story …

1. Pictures of actual hospital- acquired pressure injuries (HAPIs)

2. SBAR proposal included data that demonstrated a connection between:
   a. Units where HAPIs occurred
   b. Anatomical area of HAPIs and
   c. Beyond end-of-life surfaces

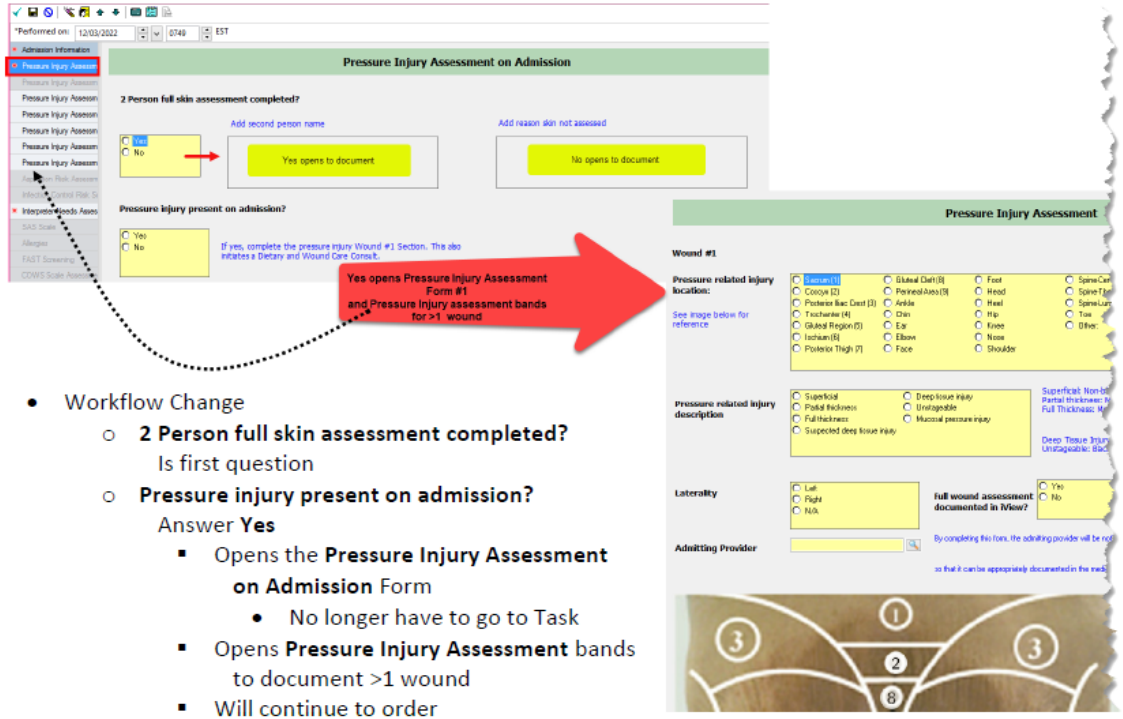
3. SBAR proposal included the risk of doing

Improve Reliability of Identification of Present on Admission Pressure Injuries

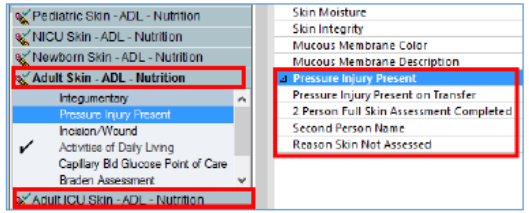
- Two problems to solve:
  1. Nursing assessment and documentation
  2. Provider documentation

- Tests of change:
  1. Changed pressure injury assessment on admission to be part of our Admission Required Form
  2. Provider quick text pulls in nursing assessment along with language that endorses wound care documentation

Added to Admission Required Information Form:



- Workflow Change
  - **2 Person full skin assessment completed?** Is first question
  - **Pressure injury present on admission?** Answer **Yes**
    - Opens the **Pressure Injury Assessment on Admission** Form
      - No longer have to go to Task
    - Opens **Pressure Injury Assessment** bands to document >1 wound
    - Will continue to order
      - Dietary Consult
      - Wound Consult
  - **Pressure Injury Assessment Form**
    - No change in workflow
  - **Pressure Injury Present on Admission** removed from iView Bands
    - **Adult Skin – ADL - Nutrition**
    - **Adult ICU Skin – ADL - Nutrition**



Skin Assessment on Admission

Hospital	Aug-22	Mar-23	March 2023 Variances
Bridgton Hospital	86%	10/11 = 91%	1 charting error
CMMC	75%	151/156 = 97%	5 Admission required form not completed
Rumford Hospital	69%	14/14 = 100%	N/A

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Financial Impact of Pressure Injury - ROI

	Stage 1 HAPU	Stage 2 HAPU	≥ Stage 3 HAPU	Total
HAPU rates 2003	4.5%	3.9%	2.0%	
Mean cost per HAPU	$5255.89	$8206.27	$13785.73	
Predicted cost/pt. 2003	$236.51	$320.04	$275.71	$832.27
HAPU rates 2010	2.5%	2.6%	1.1%	
Predicted cost/pt 2010	$131.40	$213.36	$151.64	$496.40
Predicted return/pt				$335.87
Cost for prevention				
Surveillance /pt				$11.00
Mean cost of intervention/pt				$197.36
Total cost/pt				$208.36
ROI for HAPU preventions program				
ROI				$1.61
Net savings/pt				$127.51

(Spetz, Brown and Aydin)

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Consistency in Care Audit 2022

- Rising pressure-related injuries across the hospital
  - Focused increase in units with high acuity and staffing challenges
- Are the systems and guidelines set in place working?
- Do we have all the needed equipment to prevent pressure injury?

Consistency in Care Audit 2022

- Audit location
  - ICU
  - Cardiac ICU
- Factors assessed through observation included:
- Prophylactic dressings - Sacrum:
  - Prophylactic sacral dressing on patients that met criteria, dressing placed correctly, dressing labeled correctly
- Heel offloading:
  - Heels properly offloaded, heel boots present
- Reposition and early mobilization:
  - Reminder tool in place, all pressure points offloaded, seating support surface present, turning and positioning device in use and used correctly
- Microclimate:
  - Assess for skin care tools at bedside, but observations affecting microclimate were noted
- Medical devices:
  - Medical device pressure injury prevention in place/in use
- Support surfaces:
  - Specialty bed/surface in use, number of layers/linen/pads present, PIP cushion/surface when up in chair

Initial Audit Results

- Staff compliance for prophylactic sacral dressing application for patients identified at risk was 53.8% (ICU), 33.3% (step-down).
- Of the 19 patients assessed - 53.8% (ICU), 33.3% (step-down) had the sacrum dressing applied, 71.4% (ICU), 0% (step-down) were applied correctly.
- PAR levels at zero on both units for sacrum dressings.
- Heel/boot offloading comments:
  - Boots on window not on patient.
  - Low compliance with prophylactic heel dressing in addition to poor compliance with adequate offloading of heels creates increased risk for HAPI development.
- Use of an appropriate seating support cushion when seated out of bed was observed with 15.4% (ICU), 0% (step-down) patients.
- Prophylactic dressing in place to protect tissue at risk under high-risk medical devices
  - 69.2% (ICU) 16.7% (step-down)
- Support surfaces – confusion on surface selection, aging fleet.
  - BED LINEN AND PADS BENEATH PATIENT AT A MINIMUM:
  - 2-3 layers 4 layers noted on one patient

Monthly Education Rounding

- Education and wound team
- Industry support

1. Monthly audit completed by WTAs along with the prevalence study
   a) Wedge utilization
   b) Correct surface
   c) Barrier usage
2. Products available
   a) Wedges
   b) Positioning sheets
   c) Dressings
   d) Surfaces
3. EMR education

Addressing Staffing Issues: Measuring Productivity for Inpatient WOC

OSTOMY & CONTINENT DIVERSTIONS

O-1	Pre-op preparation & Stoma Site Marking	90 minutes
O-2	Post-op assessment & Appliance fitting	45 minutes
O-3	Education – self-care, lifestyle modifications, Discharge planning, approp.referrals	60 minutes

SKIN & WOUND CARE

W-1	Initial assessment & Development of POC	60 minutes
W-2	Follow-up assessment & Modification of POC	30 minutes
W-3	Complex wound management Debridement, pouching fistulas, NPWT,	90 minutes
W-4	Re-evaluation of POC; Communication with staff	60 minutes

MANAGEMENT OF FECAL OR URINARY INCONTINENCE

C-1	Initial assessment & Development of POC	60 minutes
C-2	Follow-up assessment & Modification of treatment plan	45 minutes

OUTPATIENT OSTOMY

OP-1	Pre-op preparation & stoma marking	90 minutes
OP-3	Education & trouble shooting for pouching problems	60 minutes

MAGGOT THERAPY

M-1	Maggot application	90 minutes
M-2	Maggot takedown	60 minutes

ADMINISTRATIVE

A-1	Teaching inservice/orientation	60 minutes
A-2	Meetings	60 minutes
A-3	Attending education inservice	60 minutes
A-4	Hospital wide projects	240min/ 4hr
A-5	Interdisciplinary rounds	
A-6	Program development	
A-7	Clinical Prep time	
A-8	Managerial time	60 minutes

JOURNAL OF WOUND OSTOMY & CONTINENCE NURSING

- [View From Here: Building and Justifying a Comprehensive WOC Nurse Team]

- Saunders, Kim
- Journal of Wound Ostomy & Continence Nursing43(4):341-345, July/August 2016.
- doi: 10.1097/WON.0000000000000239

- WOC Productivity Codes.

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Using the WOCN model

	Hours	Avg /month	Avg /month		
New Assessment	1	173	173		
Follow-Up	0.5	295	147.5		
Ostomy	1	14	14		
Rounding	1	20	20		
			354.5	Total hours /month	
2 WOCN @36 /week			288	Total per month	
			-66.5	Deficit	

Financial Impact of Pressure Injury – ROI

	Stage 1 HAPU	Stage 2 HAPU	≥ Stage 3 HAPU	Total
HAPU rates 2003	4.5%	3.9%	2.0%	
Mean cost per HAPU	$5255.89	$8206.27	$13785.73	
Predicted cost/pt. 2003	$236.51	$320.04	$275.71	$832.27
HAPU rates 2010	2.5%	2.6%	1.1%	
Predicted cost/pt. 2010	$131.40	$213.36	$151.64	$496.40
Predicted return/pt.				$335.87
Cost for prevention				
Surveillance/pt.				$11.00
Mean cost of intervention/pt.				$197.36
Total cost/pt.				$208.36
ROI for HAPU preventions program				
ROI				$1.61
Net savings/pt.				$127.51

(Spetz, Brown and Aydin)

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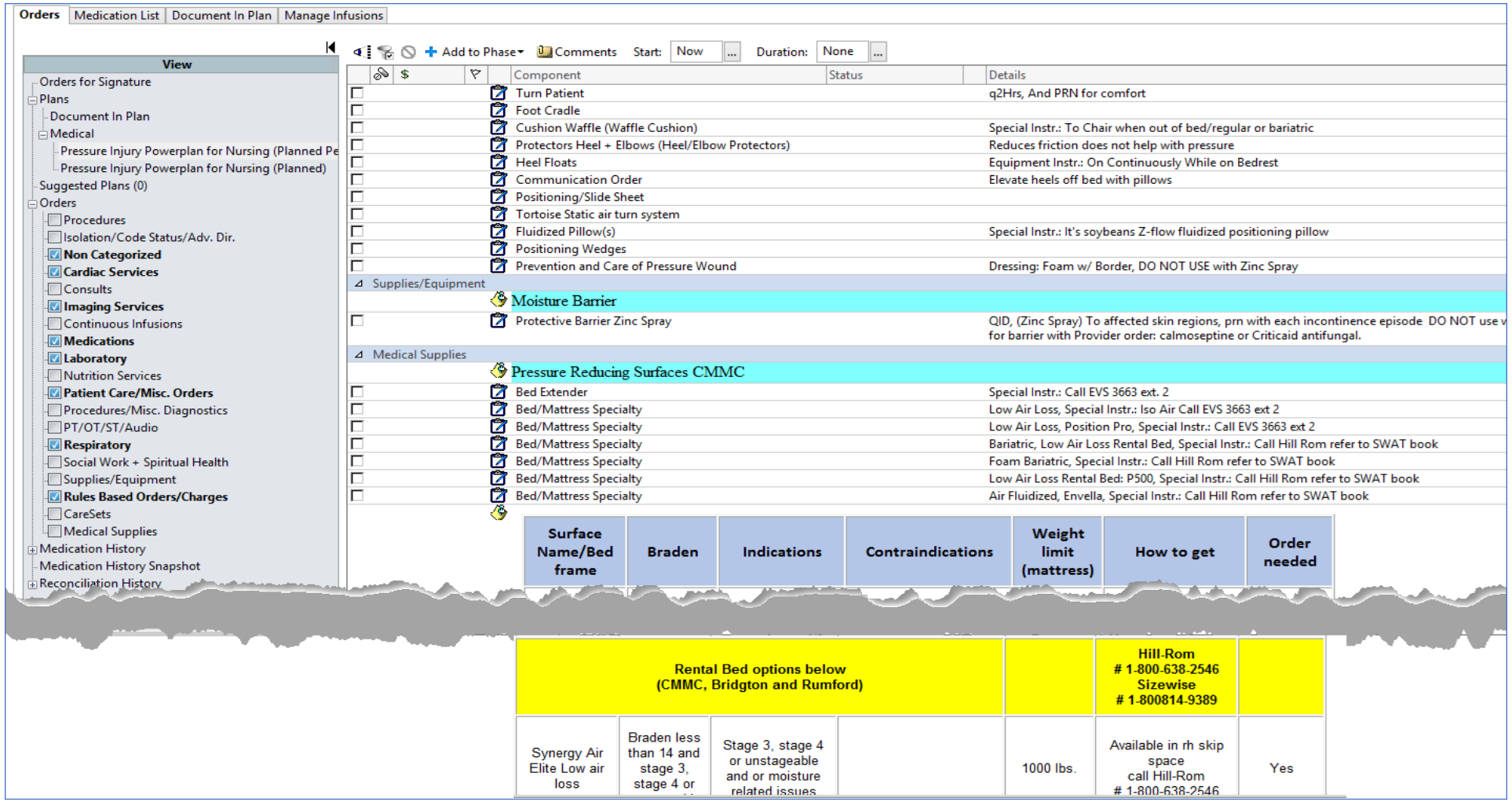
Enhancing EMR Resources



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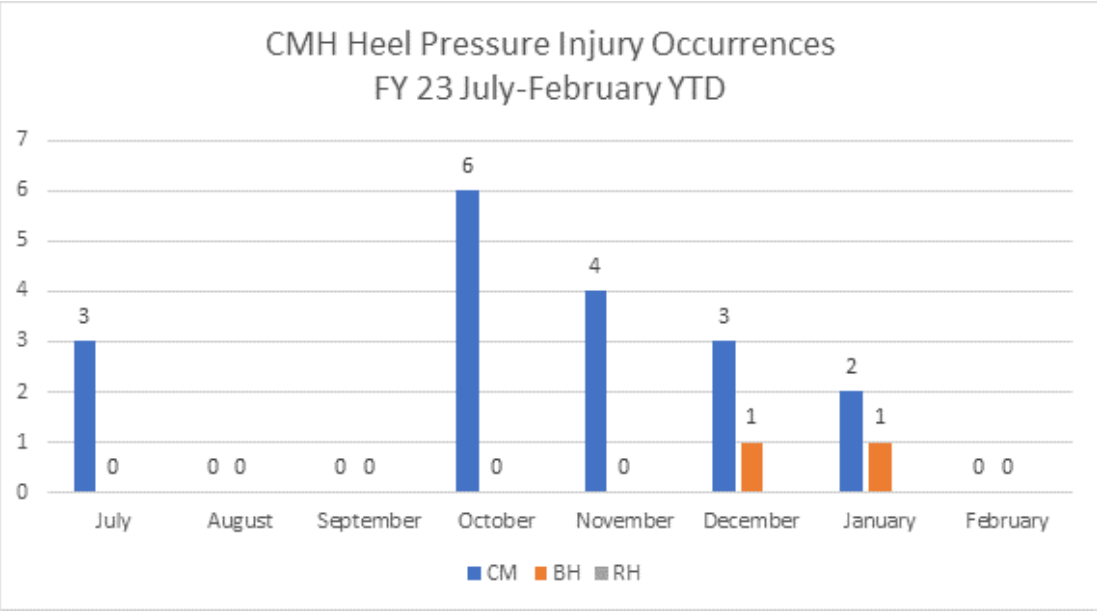
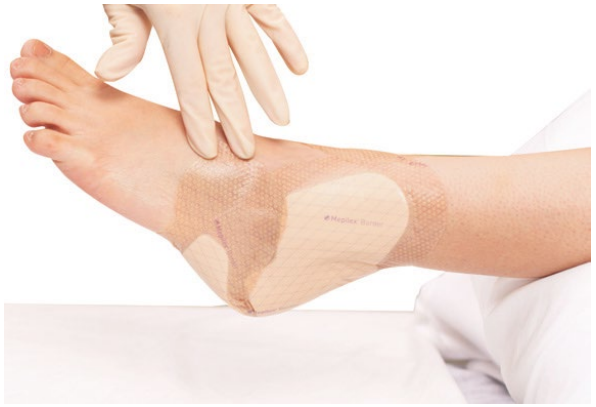
The Missing Component

- Lack of use of offloading boots
- No heel dressing available
  - Reeducation and increased par of offloading boots
  - Trial and addition of bordered foam heel dressing





Team Engagement and Focus in the ICU at Central Maine Medical Center in 2022

THE Gisele Wound Cart

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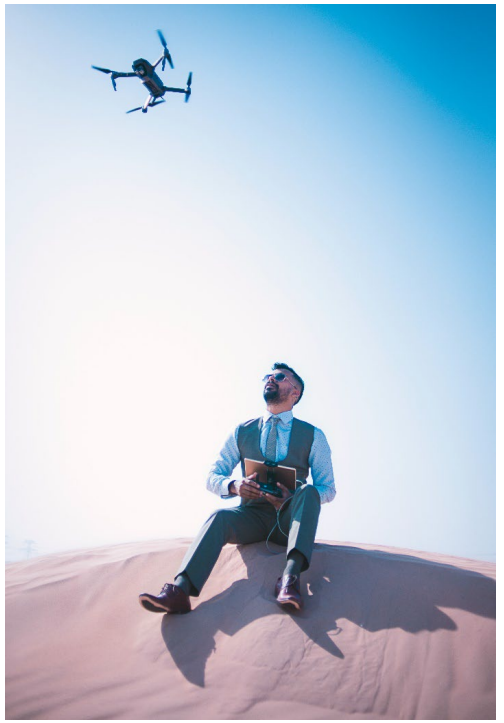
Educating the ICU Nursing Staff

- Barriers during the Covid-19 pandemic
  - Educator
  - Staff turnover
  - Travel RNs
  - Inability to gather
  - Case Mix Index
- Major knowledge deficits identified
  - Product knowledge
  - Product utilization
  - Professional accountability

Starting From the Ground Up

- Rounding twice per week starting February 1, 2022
- Led by Nurse Leader
- Just-in-time education including real time application of products
- Increased wound care presence
- February/March 1:1 focused education with NL
- Surfaces identified as an immediate opportunity



Tool

	Date:		Unit: ICU		Auditor:						
Room #	FIN#	Patient Braden score	Is the patient on the correct mattres surface? Cushion in chair? **Y/N**	Is there a mepilex in place **(Trigger is Braden of 14 or less)** **Y/N or N/A**	Is the wedge device inplace when appropriate? **Y/N or N/A**	Was the skin properly check and padded on patients who have devices (oxygen tubing, braces, collars etc.) **Y/N or N/A**	Does the patient need Reposition q2 hr **Y/N or N/A**	Does the patient have Incontinence care interventions in place? **Y/N or N/A**	Is the patients Nutrition adequate? **Y/N**	Is there an intervention for offloading heels in place? **Y/N or N/A**	Comments
411											
412											
413											
414											
415											
416											
417											
418											
419											
420											
421											
422											
423											
424											
425											
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427											
428											
429											
430											
											__0_ TOTAL INTERVENTIONS

Instructions:

1. Utilize daily Braden report to audit 100% of patients who are at High Risk with a Braden score 14 or less.
2. Note in comments section the total # of interventions that needed to be added by auditor. Mepilex added, wedges etc.
3. Turn in these audits to Jen Wells weekly.

Standardization to Proning

Proning Procedure Checklist for Intubated Patient: Date _____ Time Initiated _____

Prior to Procedure			
Establish Team Roles: · Provider · Airway Leader (RT or Provider) · Primary RN or Charge Nurse · 3+ additional staff · Available RN Runner			
Provider, charge nurse and primary RN aware		Y	N
Any foreseen events difficult to perform once patient is proned?		Y	N
Contraindications?		Y	N
Enteral nutrition stopped 1 hour prior?		Y	N
NGT/OGT/SBFT insertion length noted		Y	N
Airway and Ventilation	Pre-oxygenate with 100% o2	Y	N
	Suction airway/oropharynx	Y	N
	ETT at teeth or lip noted	Y	N
	ETT secured w/ tape or other approved non-pressure device	Y	N
	Appropriate ventilator settings	Y	N
	Tidal Volume	Y	N
	Inspiratory pressure	Y	N
	PaO2/FiO2 ratio	Y	N
	If applicable- Chest tubes secured; disconnect suction if safe	Y	N
	ABG done as indicated	Y	N
Non-essential monitoring and infusions stopped		Y	N
All lines secured and situated towards the head or towards the feet		Y	N
Adequate length on remaining lines above and below waist		Y	N
Skin integrity assessed and documented		Y	N
Anti -pressure dressings applied on bony prominences		Y	N
Remove urinary catheter securement device		Y	N
Urinary catheter position between legs		Y	N
Daily hygiene complete		Y	N
Assess need for addition medication (pain, sedation, NMB)		Y	N
Equipment Available: ___ Re-intubation equipment ___ Difficult airway box ___ Crash cart ___ Closed circuit suctioning ___ Endotracheal tube tape ___ ECG electrodes ___ Positioning sheet ___ 2+ Clean bed sheets ___ 3-6 Pillows ___ Cushioning pads ___ Absorbent pads			

Time Out		
Verbal confirmation among team members	Y	N
Minimum of 5 people at bedside	Y	N
Team member roles assigned and known	Y	N
Person at head of bed and managing airway is assigned	Y	N
Appropriate ventilator settings	Y	N
Confirm hemodynamic status w/ provider	Y	N
Adequate sedation [collaborate with provider – typically RASS -4 – -5]	Y	N

Proning Procedure Primary RN or Charge to call out steps and collaborate with assigned airway staff	
1.	Lay patient flat in neutral position
2.	Tuck arm closest to ventilator underneath buttock with palm facing anteriorly
3.	Remove anterior ECG electrode
4.	Add additional pillows if indicated
5.	Place an absorbent pad and sheet on top of patient leaving head and neck exposed
6.	Roll the edges from the top and bottom sheets tightly together to encase patient
7.	Keep sheet taut and edges rolled tight
8.	Keep patient flat and move patient to the top edge of bed opposite of ventilator
9.	On the call of Airway staff, team should maintain tight grip of rolled sheets and rotate patient to 90° to lie on side
10.	Switch hand positions with opposite side of bed team member except airway staff who should continue to maintain airway securement
11.	On the call of Airway staff, pull up the rolled sheet from beneath the patient while turning into prone position
12.	Support head and neck and turn head to face the ventilator
13.	Check ETT is not kinked and verify length at lip or teeth
14.	Check ventilator settings
15.	Remove the sheet covering the back
16.	Re-attach ECG electrodes on back and resume monitoring
17.	Place patient at center of bed
18.	Place absorbent pad under head to catch secretions
19.	Position arms in 'swimmer's position" – raise arm on opposite side head is facing, place other arm by patient's side
20.	Abduct shoulder to <90°, elbow flexed about 90° on raised arm
21.	Position pillows under chest – ensure chest and breasts is supported / free from pressure
22.	Position pillows under shins – prevent hyperextension at ankle and pressure on knees
23.	Adjust pillow height so neck and lower back are not hyper-extended / shoulder should fall slightly forward of the anterior capsule of shoulder joints
24.	Position patient in reverse Trendelenburg
Guidance for Obese Patients - Use 3 sheets for proning - Orient "burrito" sheets length-wise across upper half of patient - For lower half of patient, orient sheets in head-to-toe direction	

Prone to Supine
Follow 16 hours of pronation therapy unless otherwise indicated
Activate team
Follow pre-procedure preparation for proning
Perform patient wrapping
Move patient towards the edge of the bed closest to the ventilator, maintaining face of patient towards the ventilator unless otherwise indicate

Patient Label

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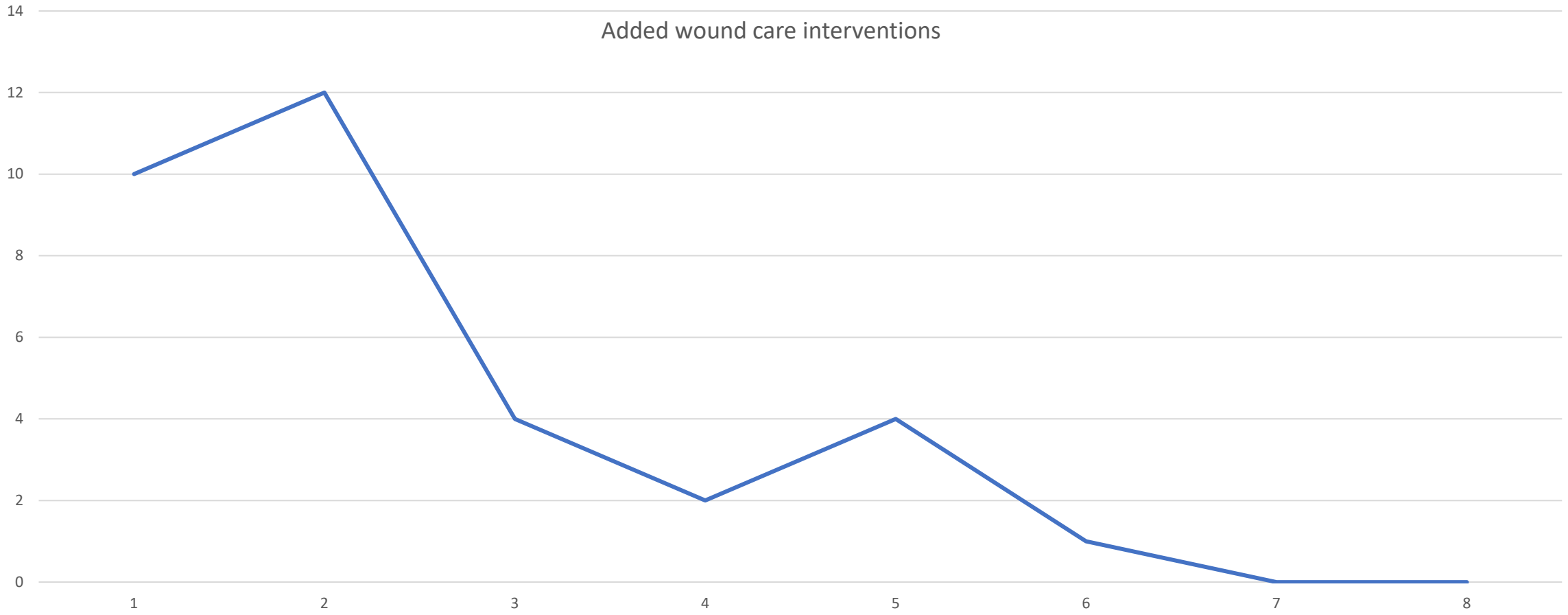
ICU Results February – March 2022



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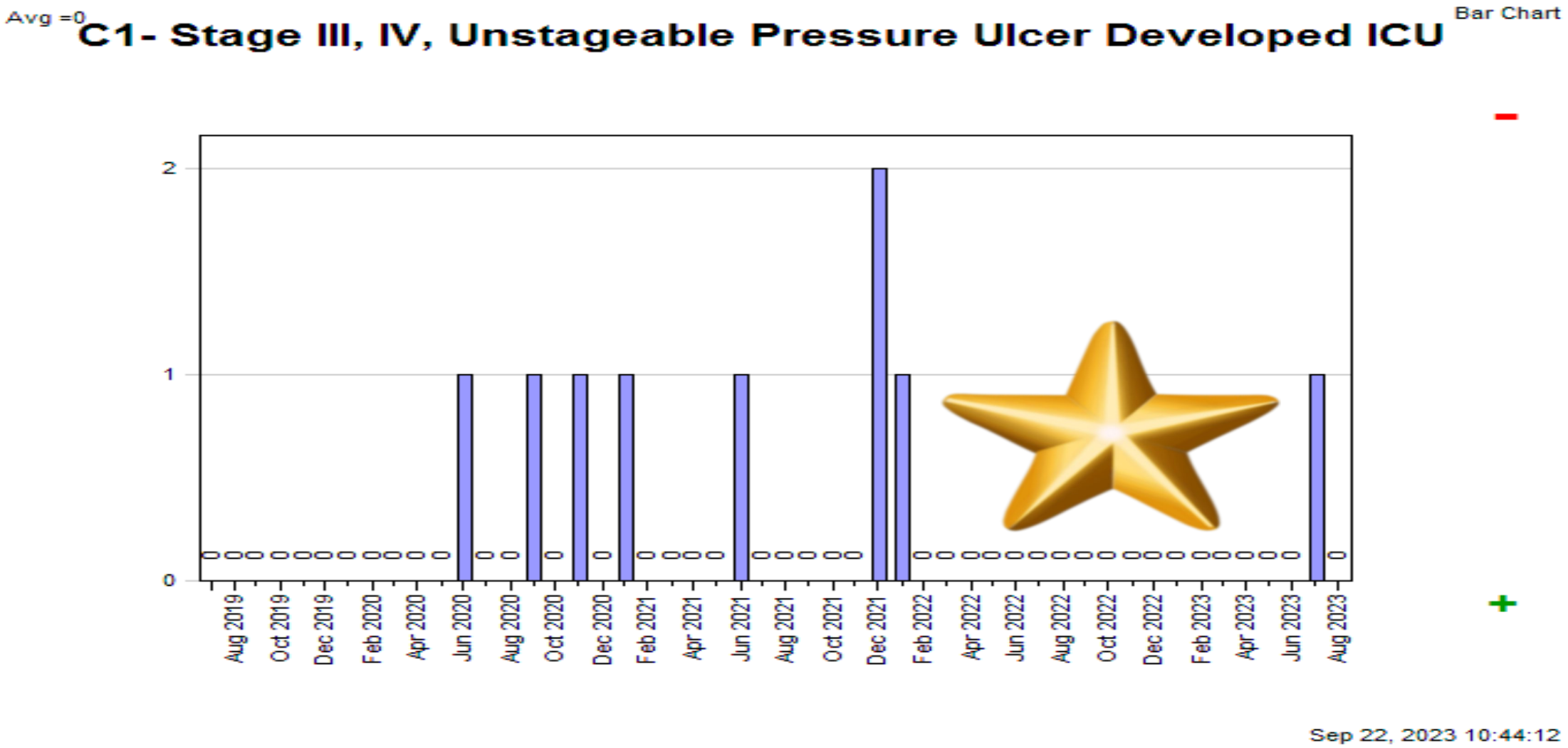
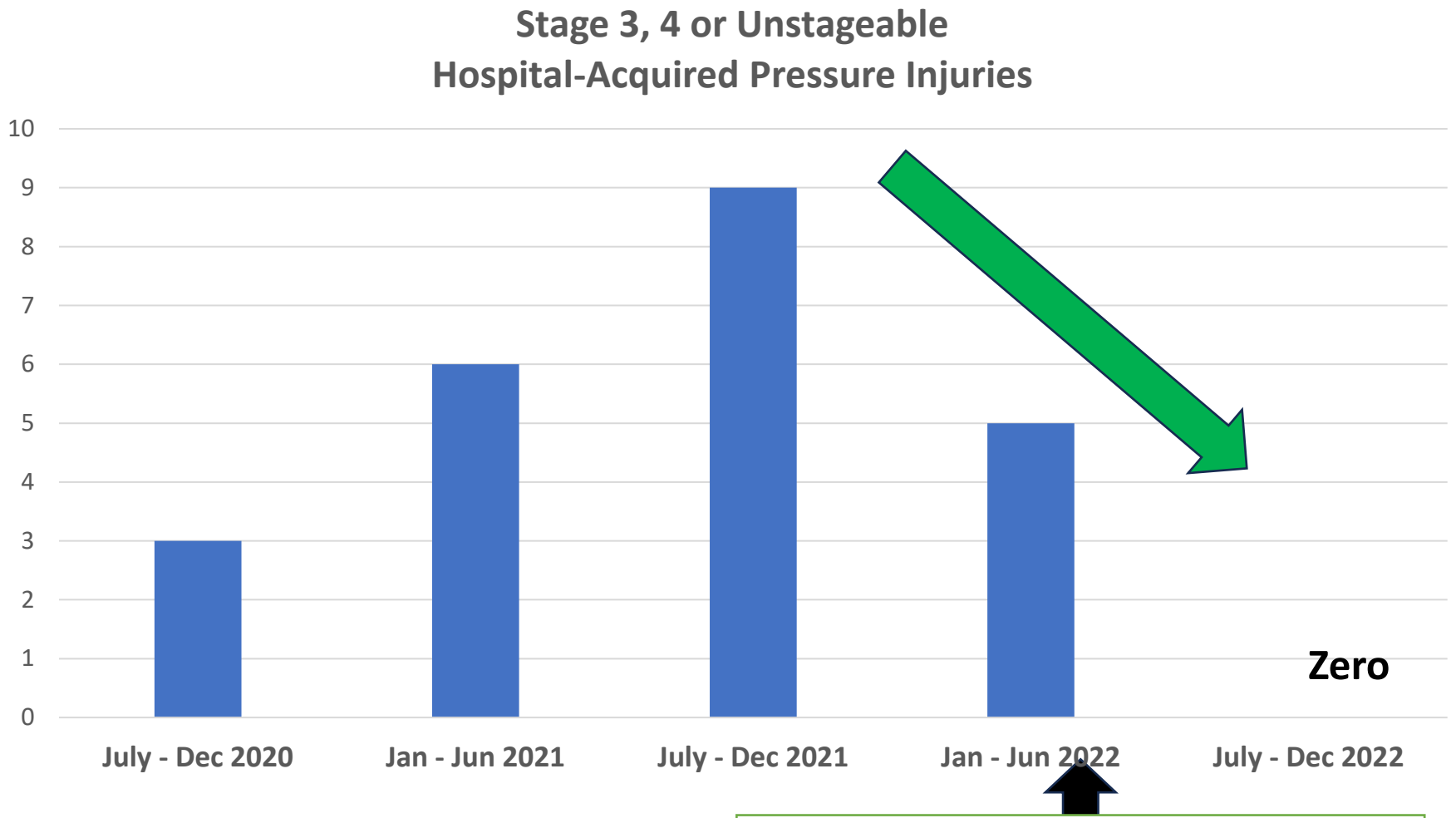
Sustainability



Wound Treatment Associate (WTA) Nurses

- Attend monthly meetings
- Complete monthly prevalence study
- Resource on the floor
- Day and night shift expertise
- Own their practice!

Have the Changes Been Effective?



Jan 2022: Pressure Injury Task Force kick off
Feb – May 2022: Interventions implemented

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Consistency in Care Comparison of Outcomes Jan – Sept 2022

Consistency in Care Audit Central Me Med Ctr	January	Sept.	January2	Sept
	ICU	ICU	CCU	CCU
Prophylactic Sacral dressing on patient that met criteria	53.80%	60.00%	33.30%	70.00%
Sacral dressing placed correctly covering tissue at risk	71.40%	60.00%	0.00%	71.40%
Sacral dressing dated and labeled with 'T' or 'P'	60.00%	100.00%	0.00%	28.60%
Prophylactic Heel dressing on patient that met criteria	N/A	N/A	N/A	N/A
Heel dressing placed correctly covering tissue at risk	N/A	N/A	N/A	N/A
Heel dressing dated and labeled with 'T' or 'P'	N/A	N/A	N/A	N/A
Heel Offloading				
Heels offloaded	84.60%	10.00%	14.20%	52.90%
Offloading boot(s) on patients that met criteria	0.00%	N/A	0.00%	N/A
Offloading boot(s) placed correctly	N/A	N/A	0.00%	N/A
Patient Repositioning and Early Mobilization				
Is there a repositioning reminder in use?	0.00%	100.00%	0.00%	90.00%
T&P Aid in Use	23.10%	N/A	33.30%	50.00%
HOB < 30° (Unless medically contraindicated)	92.30%	N/A	100.00%	N/A
Use an appropriate seating support cushion when an individual is seated out of bed.	15.40%	25.00%	0.00%	20.00%
Microclimate				
Tools for skin care regime located at the bedside	100.00%	40.00%	83.30%	44.40%
Device Related Pressure Injuries				
Prophylactic dressing in place to protect tissue at risk under high risk medical devices	69.20%	75.00%	16.70%	60.00%
Support Surfaces				

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Accomplishments

- ✓ Gap analysis completed
- ✓ Wedges have replaced pillows
- ✓ Beyond end-of-life mattresses replaced
- ✓ Two-person skin check policy revised – second person can be a non-RN
- ✓ Roaming education program “March to Zero Pressure Injuries”
  - ❖ Braden risk assessment
  - ❖ Interventions to mitigate risks
  - ❖ Two-person skin check
  - ❖ Barrier usage under devices and on the sacrum
  - ❖ Correct surface
  - ❖ Repositioning devices
- ✓ Wound care RN and Nurse Practitioner positions approved and filled
- ✓ Pink sheet process converted from paper to electronic
- ✓ Nursing plan of care for pressure injury prevention updated
- ✓ Wound care plan for provision of care updated

References

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