Organization: Good Samaritan Hospital of Maryland

Solution Title: Getting to Zero – Hospital Acquired Pressure Ulcer as a “Never Event”

Program/Project Description: What was the problem to be solved? How was it identified? What baseline data existed? What were the goals—how would you know if you were successful?
The GSH Nursing and Quality Council perform quarterly pressure ulcer prevalence studies to determine the rates of hospital and unit acquired pressure ulcers. This nursing sensitive outcome measure is monitored and compared to the results of similar organizations by our participation in the National Database of Quality Indicators®. Data gathered over the three-month period between August 2010 and November 2010, noted a spike in incidence of HAPUs.

Process: What methodology or process was used to develop the Solution? In response to the increase in HAPUs, the Nursing Quality and Safety Council, with guidance from the CNO, initiated the “Plan Do Check Act (PDCA)” performance improvement methodology. The PDCA methodology was chosen for its dynamic framework and ability to affect improvement in process and outcomes. PDCA is the approved methodology at GSH for PI projects. The framework is patient-driven, nurse sensitive, and measurable. The PDCA was first implemented in December 2010 with a successful decrease in prevalence rates over the last 3 quarters consecutively. Analysis of overall pressure ulcer rate concluded that the targeted highest risk units were the ICU and IMC (Intermediate Care Unit).

Solution: What Solution was developed? How was it implemented? An interdisciplinary, multi-faceted solution requiring revamping of existing processes was implemented. The revamped processes include electronic documentation, continuing staff education, competency testing for staff, and testing of inter-rater reliability among nurses collecting data. Individual components included:
- Continuation of quarterly or monthly unit-based skin prevalence based on results
- Computerized skin intervention task for all Braden scores <=18
- Nurses who perform the prevalence audits must complete an educational module of NDNQI tests for reliability and validity
- Upon completion of admission history and assessment the Registered Nurse prints the adult admission integumentary assessment and places it in the progress notes section for the admitting physician to review and sign
- Monthly audit for those units with a HAPU >1%
- Wound/Skin care educational module to all licensed and unlicensed nursing staff during the first quarter of 2011
- Skin assessment, wound staging and treatment were added to annual nursing competencies.
- Success of education (above mentioned module) measured by successful completion of nursing competencies
- All Stage 2 pressure ulcers or greater require consult from RN wound care specialist
- The hospital occurrence reporting system is used as an additional source for ongoing monitoring.
Measurable Outcomes: What are the results of implementing the Solution? Provide qualitative and/or quantitative results to data. (Please include graphs, charts, or tools as attachments.)

Prevalence study results show a successful decrease in HAPU prevalence rates over the last 3 consecutive quarters of calendar year 2011.

Sustainability: What measures are being taken to ensure that results can be sustained and spread?

Good Samaritan Hospital strives to provide quality patient care using a shared governance model incorporating all councils on the hospital and unit levels. The Nursing Quality and Safety Council will continue quarterly hospital-wide skin prevalence/assessment on all inpatients. RNs have the support of leadership and the resources available to promote and achieve our goal. The council will continue to improve and revise the action plan based on monthly data included in the PDCA. They will continue to monitor variables that impact or impede success. These include manpower, methods and materials.

Role of Collaboration and Leadership: What role did teamwork and collaboration play in the Solution? What partners and participants were involved? Was the organization’s leadership engaged and did they share the vision for success? How was leadership support demonstrated?

Quality outcomes and safe patient care are associated with excellent teamwork and communication. The nurses work collaboratively with the different disciplines and with the support of the CNO to achieve the stated goal. On a daily basis, as a team, we identify patients at high risk for skin breakdown and coordinate and implement care to achieve quality outcomes. Based on the expertise of the RN wound care specialist, individual plans of care are formulated. The hospital Quality and Safety Council as well as nursing leadership review pressure ulcer data quarterly.

Leadership support for this program expansion was critical. The allocation of capital resources and the participation of our nurses in product and equipment selection in this effort are well demonstrated. As a targeted unit, the ICU/CCU’s 17 beds were replaced with pressure reducing alternating air mattresses (HILL ROM total care SPO2 RT bed). An optional module can be plugged into the bed of a high risk patient which allows automatic turning to reduce pressure and ensure frequency of patient turning. A MedStar pressure ulcer prevention initiative to standardize care across all MedStar hospitals is ongoing.

Another pressure ulcer reduction strategy involved a pilot study conducted on the IMC unit trialing the Covidian* pad, a disposable under-pad that actively wicks moisture away from patients. Resulting from its success, these pads will be used hospital-wide. We have also begun a bed replacement initiative to systematically review the need for, and replace beds and mattresses, as appropriate.

Innovation: What makes this Solution innovative? What are its unique attributes?

The Good Samaritan Experience is described as “Quality Care that is Inherently Safe, wrapped in Great Service.” By setting our target at zero, we have also set the expectation. The Executive Team at Good Samaritan shares not only our pressure ulcer rates, but all “Never Event” data at quarterly employee town hall meetings. It has become a respectful way to acknowledge unplanned outcomes and recognize all patients as individuals and our duty to protect them. Individual nursing units have a mounted “Never Event” board that illustrates days since the last pressure ulcer was identified. It is a strong visual reminder. The challenge to achieve and maintain excellence in pressure ulcer prevention requires not only constant vigilance, but hardwiring into our daily operations. Our enhanced program has shown it is achievable.

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