Innovation Profile: Reducing Hospital-acquired Pressure Ulcers - The Power of Persistence

### Snapshot

**Summary**
Providence Medford Medical Center (PMMC) successfully reduced pressure ulcer prevalence after several years struggling to get attention from leadership for prevalence surveys and for nurse staff training. Taking advantage of helpful consultation from a sister Providence hospital, PMMC was able to train an RN team to assist wound-ostomy care nurses in conducting the surveys. With more adequate staffing, the surveyors were able to spend time during the survey debriefing and training staff nurses on wound care.

With persistence, nurse attendance at training for pressure ulcer prevention increased and the prevention effort spread throughout the hospital. The pressure ulcer champion created training notebooks for every unit, personally conducted teaching/rounding in the ICU, and promoted the use of specialized sacral dressings. Over time, pressure ulcer prevalence has declined.

**Hospital Background**
Not-For-Profit Mixed Payer Hospital

**Date First Implemented**
2008

### What They Did

**Early Concerns**
In 2008 hospital leadership at Providence Medford Medical Center (PMMC) became concerned about pressure ulcers, not only overall prevalence but also the ability to accurately measure hospital acquired ulcers. New reimbursement policies from CMS focused attention on the issue.

**Wound Care Leadership**
Jeanette Henault, a former rehab nurse with training in wound care (and experience working with patients on longer stays) became the unofficial champion for reducing pressure ulcers in the hospital.
She began her campaign to get assistance doing quarterly NDNQI prevalence surveys and to train nurses in the essentials of pressure ulcer prevention.

**Conducting the Prevalence Survey**

Initially the NDNQI prevalence survey had to be conducted by the wound care nurse alone. To conduct the survey on the hospital’s 70-80 patients consumed 40 of the 56 hours allocated biweekly for wound care, leaving little time for teaching and training. Moreover, with this time pressure there was no time to debrief or train.

As high pressure ulcer rates continued into 2009-10 the wound care nurse brought in a nurse manager from a large tertiary hospital in the Providence System, who had been overseeing pressure ulcer prevention and achieved success in reducing pressure ulcer prevalence.

- The manager showed her how to add staff RNs to the prevalence survey team and maintain high inter-rater reliability.
- The wound care nurse then took the NDNQI online 2-hour training, which enabled her to train other staff nurses to augment her prevalence survey team.

With her persistence and the help of her sister hospital, administrators finally became convinced that the survey could not be supported only by the budget of the wound/ostomy department and that wider RN support was needed.

The wound care nurse now conducts the quarterly prevalence survey with her team, and she has someone from every unit participate. The hospital is in the middle of a major remodel but they still do their best to see every patient. With refusals their rate is around 85% of patients participating.

Now when the team sees a pressure ulcer during the survey, the reviewer gives the nurse a note with tips on how this patient’s care might be improved (e.g., creams, heels floated, bed surface). The team also talks to staff about the importance of documentation.

In the months with no prevalence survey, the wound care nurse rounds in the ICU. She goes over the Braden risk scores as well as other risk factors. She asks, “What are you doing for prevention?” She sometimes finds that nurses are not checking the skin, or not re-checking back on the same patient. She coaches, “I would consider doing ____.” Nurses are receptive to this approach and now some stop to ask her for advice. Her message: “Pressure ulcer prevention has to be part of your thinking.”

**In-Service Training**

The initial plan was to train 3-4 nurses each unit in 4 hour class. However there were many no-shows, mostly for scheduling reasons. The scheduling was done by nurses themselves without involving their managers. If nurses didn’t mark the time off their schedule their manager would schedule them for work. Others deemed it optional so they just didn’t show.
The wound care nurse persisted with nursing leadership that the training was NOT voluntary but required. She threatened to “write nurses up” as no-shows if they didn’t attend the training. And she refused to accept nurses who were sleep-deprived after 12 hour shift. This process took 2 years to get through.

Because of attrition, the wound care nurse needs to periodically train 4-5 new people each year when people leave or change units. She provides email reminders to nurses and managers to attend in-services. She encourages them – “You are making a difference!” She also stresses the importance of knowing your patient and recommends to nurses that they try to get assigned to the same patient every day. She believes this continuity promotes better skin care.

**Specific Interventions**
The wound care nurse took the time to track pressure ulcer stage and body location. She found a number of ulcers related to tubing around the ear, due in part to the position of the oxygen supply in the room. She took this information to respiratory therapy, and they came up with an algorithm for when to use ear protectors. Now during the prevalence surveys team member carry these ear protectors in their pocket and hand them out wherever they are appropriate.

An in-service for sacral dressings was also helpful. She started using the sacral dressings for HAPU prevention in the ICU and they are still in use. They can be moved to check the skin, and some patients go to the nursing floor with them. The in-service on these dressings also covered many of the comorbidities associated with skin breakdown - vasopressors, cardiac arrest, shock, poor capillary refill - that Jeanette can emphasize in her teaching.

The wound care nurse has scheduled useful vendor presentations for dressings, mattresses and beds. She made wound/ostomy training resources available in notebooks for each floor. At first they weren’t used but now nurses bring them to training, maintaining and adding to them. On bigger units she has 2 nurses, on smaller she has 1.

The Medical Center had one significant pressure ulcer sentinel event that raised awareness for all staff. The patient had a bad outcome for multiple reasons, but it was also clear that pressure ulcer care could have been better. This gave added impetus to the prevention effort.

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**Did it Work?**

**Results:** The prevalence of hospital-acquired pressure ulcers have declined over the past 2 years, as shown in the accompanying chart. There have been no Stage 2 or greater pressure ulcers in 2012.
Factors Important to Success

- Patience and persistence in getting hospital administration to support the quarterly prevalence surveys
- Making training on pressure ulcer prevention mandatory for all nurses
- Teaching and coaching during the prevalence survey
- Specific equipment for pressure ulcer prevention: ear protectors, sacral dressings, mattresses

If you would like additional information about this success story please contact: admin@HENlearner.org