

# Pressure Ulcers

## The Problem

Pressure ulcers are viewed as a quality of care indicator. Pressure ulcers are a major cause of morbidity and mortality causing, increased pain and lengths of stay especially for patients with impaired sensation, prolonged immobility and/or advanced age.

## Aim/Goal

To increase awareness of hospital staff around assessment, prevention and treatment of pressure ulcers; to attain goal of 0% hospital acquired pressure ulcers.

## The Team

- Certified Wound Care Nurses
- Nursing Leadership
- Health Care Quality
- Pressure Ulcer Group/SWAT (Skin and Wound Assessment Team)

## The Interventions

- Quarterly Prevalence Rounds
- Initiation of the Pressure Ulcer Steering Group to coordinate and communicate our Pressure Ulcer Prevention Program
- Combine Pressure Ulcer Workgroup and SWAT (Skin and Wound Assessment Team) for a multidisciplinary approach
- Hospital-wide upgrade to pressure redistribution mattresses
- Pressure Ulcer Staging Competency developed and placed on the portal
- Development of posters for Assessment and Treatment of Common Chronic Wounds
- Clinical Symposium on Pressure Ulcer Assessment and Treatment for Unit Based Educators and Clinical Nurse Specialists
- Tracking of Pressure Ulcers stage II and above in the Patient Safety Reporting System
- Daily electronic notification to Nurse Managers, Unit Based Educators, Clinical Nurse Specialists and Certified Wound Nurses of patients with Pressure Ulcers (Stage II or greater)
- Biweekly assessment of Pressure Ulcers by Unit Based Educators, Clinical Nurse Specialists and/or Nurse Managers

- Tracking of Pressure Ulcers in Nursing Kardex with link to POE Alternate Dashboard
- Conducting timely root cause analysis and required reporting in the event of a stage III or IV hospital acquired Pressure Ulcers

## The Results/Progress to Date

Room	Name	MRN	DVT	PU	FALL	Other
0701-01	ZP:OETEST MARIA	1370240	CVL	PU	FALL	Home with services
0701-02	ZP:OETEST BARBARA	0098076				Home with services
0702-01	ZP:OETEST ROBIN	0099744				Extended Care Facility
0702-02	ZP:OETEST DANIELA	1176078			FALL	
0703-01	ZP:OETEST JOSEPH	0616960				
0703-02	ZP:OETEST MARK JR	1399902				
0704-01	ZP:OETEST DAVID	0830515	DVT		FALL	Home
0705-01	ZP:OETEST AMY	0547110	DVT		FALL	Extended Care Facility
0706-01	ZP:OETEST ROBERT	0756715			FALL	Extended Care Facility
0709-01	ZP:OETEST EDWARD	0819005	TELE FOLY DVT		FALL	ASPIRATION Extended Care Facility
0709-02						
0710-01	ZP:OETEST LYNN	0873179	TELE	DVT		Home with services
0711-01	ZP:OETEST CAROL	1346040			FALL	
0712-01	ZP:OETEST MAUREEN	0718034	TELE	DVT	FALL	
0714-01	ZP:OETEST HOWARD	2304540	TELE		FALL	ASPIRATION Home with services
0715-01	ZP:OETEST THOMAS	2212707				
0715-02	ZP:OETEST JAMES	2333540		PU	FALL	
0716-01	ZP:OETEST ISABELLA	0878307			FALL	
0716-02	ZP:OETEST ANCOLE	1016040			FALL	Extended Care Facility
0717-01	ZP:OETEST REBECCA	2332374			FALL	
0718-01	ZP:OETEST GEORGE	2332360			FALL	Extended Care Facility
0719-01						
0720-01	ZP:OETEST JUDITH	0400057			FALL	
0721-01	ZP:OETEST JULY	0423200		DVT		Home
0721-02	ZP:OETEST KAREN	0402062	TELE			Home
0722-01	ZP:OETEST JANET	0448065			FALL	Extended Care Facility
0723-01	ZP:OETEST WALTER	1114007		DVT	FALL	
0725-01						
0726-01	ZP:OETEST KEITH	2014655	FOLY DVT		FALL	ASPIRATION Home
0727-01	ZP:OETEST HELEN	0873070	FOLY DVT		FALL	
0727-02	ZP:OETEST MARY	1024066	FOLY DVT		FALL	
0728-01	ZP:OETEST SANDRA	0088071	TELE	DVT	FALL	
0728-02	ZP:OETEST SHARON	2332286	DVT		FALL	Home with services

## Lessons Learned

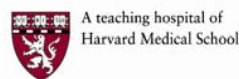
Without a strong tracking mechanism it is difficult to determine the scope of the presence of pressure ulcers both pre-existing and hospital acquired.

## Next Steps/What Should Happen Next

- Systematic collection of data will assist in identifying specific unit education needs regarding prevention, assessment and treatment of pressure ulcers
- Enhanced communication between newly formed Pressure Ulcer Work Group/SWAT Team and Steering Committee to strategize optimal pressure ulcer prevention program



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## For More Information Contact

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