Title:
Departmental Quality Improvement Using Collaboration to Reduce Pressure Injury

PRESENTERS:

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INTRODUCTION:

Development of unit-acquired pressure injuries (UAPI) results in poor outcomes for the patient and hospital system. Pressure injuries (PI) are associated with pain, increased morbidity and mortality, longer hospital stays, and increased costs. PI prevalence can influence National Database of Nursing Quality Indicators (NDNQI) results and other quality indicators that impact hospital safety ratings and reimbursement. A collaborative approach to prevention of PI is key.

AIM:

The aim of the project was to lower the Johns Hopkins Hospital Surgical Intensive Care Units' (ICU) UAPI prevalence rates, therefore lowering the overall prevalence rate for the department of surgical nursing.

Interventions:

An ICU Pressure Injury Prevention workgroup was established in the surgical ICUs. Through this workgroup, a sharing of ideas, successes and strategies led to the following departmental initiatives. These initiatives included wound champion certification as wound treatment associates (WTA), a needs assessment which resulted in monthly education topics for champions to share with bedside staff, transparency of PI data, discussion of prevention strategies, and collaboration as a department.

Data Collection and Analysis

Data was obtained using the electronic medical record and verified by nurse champions and wound ostomy specialty nurses on a monthly basis for the three surgical ICUs and on a quarterly basis for eight acute care units. Outcome measures for these initiatives were UAPI quarterly prevalence rates obtained from Tableau. Analysis of UAPI prevalence rates revealed rates declined after the development of the collaborative work group and implementation of the initiatives.

RESULTS:

In fiscal year 2019, the department led the hospital in PI prevalence, with 4 out of 11 units having a prevalence rate at 5% or higher. By fiscal year 23, quarter 1, the majority of nursing units were at 0% prevalence, with only 2 units above 5% prevalence. This improvement within the department of surgical nursing units decreased the hospital's pressure injury prevalence rates.

DISCUSSION:

Through development of a committee structure and promotion of training and certification, the department was able to collaborate, educate, and disseminate best practices in wound prevention to 11 nursing units, lowering their pressure injury prevalence and improving patient outcomes. Collaboration among all members of the team was an essential component in facilitating initiatives during the project.

Collaboration Reduces Pressure Injuries

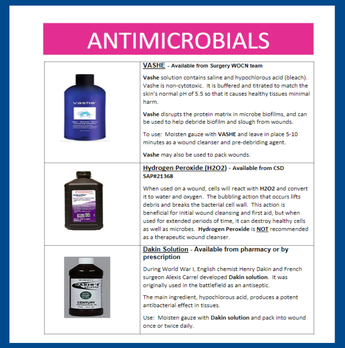
Certification: Wound Treatment Associates: 13

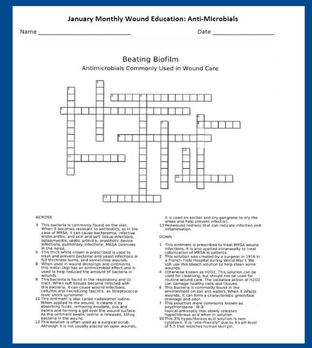
The Johns Hopkins Bayview Medical Center and Johns Hopkins Hospital
Wound Treatment Associate Course Schedule

Wound Ostomy and Continence Nurses Society™
Advancing the practice and guiding the delivery of expert health care to patients

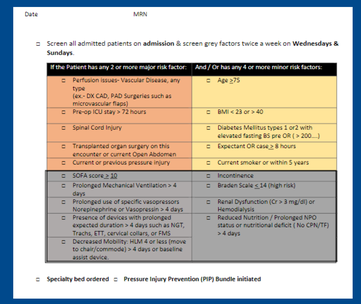
Quarterly Meetings: Wound Care Champions/ CNS/Educator/ WOCN/ Nursing administration

Monthly education projects by unit



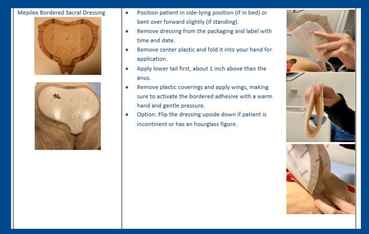


ICU screening tool development



CVSICU zero Unit Acquired Pressure Injuries with PI Prevention bundle

Decreased number of surgical units above benchmark for UAPI



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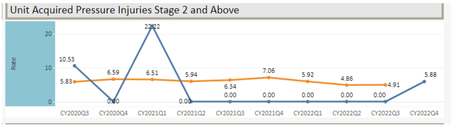
Results

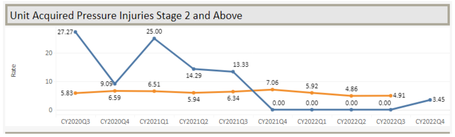
Due to COVID-19, we did not submit data for CY2020 Q3 and Q4.

Unit Name	CY2020Q4	CY2021Q1	CY2021Q2	CY2021Q3	CY2021Q4	CY2022Q1	CY2022Q2	CY2022Q3	CY2022Q4
Adult Rehab	5.56	0.00	5.56	0.00	0.00	0.00	0.00	5.56	0.00
CVICU (Zayed 4NW)	0.00	0.00	0.00	0.00	0.00	0.00	3.45	3.33	6.67
CVSICU (Zayed 5E)	9.09	29.55	17.86	13.33	0.00	7.69	0.00	0.00	6.90
Marburg 2	0.00	0.00	7.14	12.50	0.00	0.00	0.00	0.00	0.00
Marburg Pavilion	0.00	0.00	0.00	7.69	0.00	0.00	0.00	0.00	0.00
SICU (Zayed 9E)	0.00	22.22	0.00	0.00	0.00	0.00	0.00	5.88	5.88
Weinberg ACD	0.00	0.00	2.86	0.00	0.00	2.94	0.00	0.00	0.00
WICU	5.88	12.44	13.51	0.00	5.71	10.00	7.14	7.41	3.55
Zayed 9W	0.00	3.85	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Zayed 11E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Zayed 11W	4.35	3.85	0.00	3.33	0.00	0.00	0.00	0.00	0.00

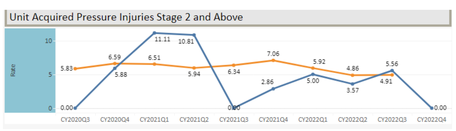
CVSICU



SICU



WICU



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1) Ballesteros, C. (2017). Teamwork for prevention: Reducing HAPUs in cardiac surgery patients. Nursing Management, 48(7), 17-20. https://doi.org/10.1097/01.NUMA.0000520731.16668.89 2) Cooper, D. N., Jones, S. L.1) Ballesteros, C. (2017). Teamwork for prevention: Reducing HAPUs in cardiac surgery patients. Nursing Management, 48(7), 17-20. https://doi.org/10.1097/01.NUMA.0000520731.16668.89 2) Cooper, D. N., Jones, S. L., & Currie, L. A. (2015). Against all odds: Preventing pressure ulcers in high-risk cardiac surgery patients. Critical Care Nurse, 35(5), 76-82. https://doi.org/10.4037/ccn2015434 3) Rao, A. D., Preston, A. M., Strauss, R., Stamm, R., & Zalman, D. C. (2016). Risk factors associated with pressure ulcer formation in critically III cardiac surgery patients. Journal of Wound, Ostomy & Continence Nursing, 43(3), 242-247. https://doi.org/10.1097/WON.0000000000000224

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