NEW ENGLAND Sinai HOSPITAL

Transforming Wound Care Delivery

A Multidisciplinary Approach

Presented to:
MA Pressure Ulcer Collaborative
June 16, 2011

Presenters

- Janet Madigan, MS, RN, NEA-BC
  Vice President, Patient Care Services, CNO
- Gail Slotnick, MBA, RN BC
  Director, Wound Care Program
- Mary Beth Urquhart, RN, MBA, CPHQ
  Vice President, Quality, Risk and Compliance

Key Points of Discussion

- Background
- Pressure Points
- Team-based interventions/initiatives
- Evolution with outcomes
- Short and long-term goals

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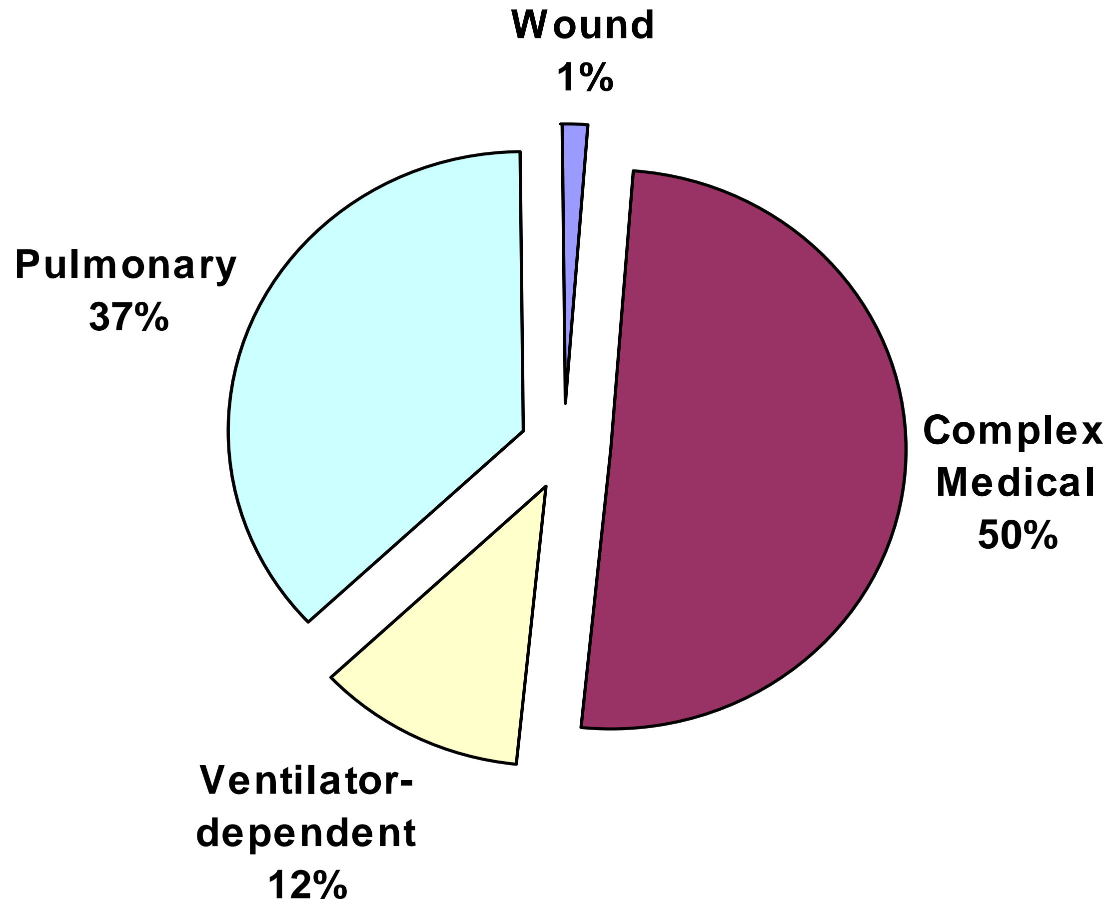
Background

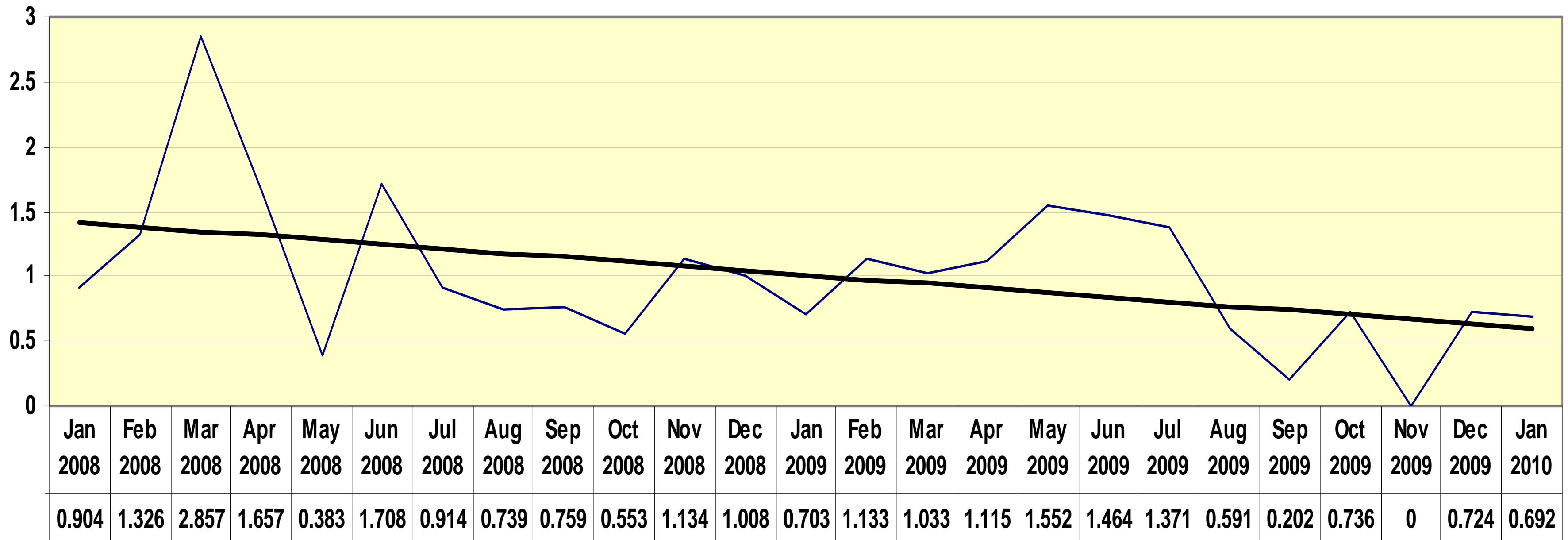
- NE Sinai nationally recognized center of pulmonary and rehab excellence
- Referral population diverse and predictably unpredictable
- Acuity level climbing over time
- *Skin failure rarely making it to problem list - historically below benchmark incidence and prevalence*

Distribution of Sinai Patients by Admission Type
New England Sinai Hospital *



**38% of patients have diabetes*

New England Sinai Hospital
Incidence of Hospital-acquired Pressure Ulcers Jan 08 - Jan 10



Jan 2008	Feb 2008	Mar 2008	Apr 2008	May 2008	Jun 2008	Jul 2008	Aug 2008	Sep 2008	Oct 2008	Nov 2008	Dec 2008	Jan 2009	Feb 2009	Mar 2009	Apr 2009	May 2009	Jun 2009	Jul 2009	Aug 2009	Sep 2009	Oct 2009	Nov 2009	Dec 2009	Jan 2010
0.904	1.326	2.857	1.657	0.383	1.708	0.914	0.739	0.759	0.553	1.134	1.008	0.703	1.133	1.033	1.115	1.552	1.464	1.371	0.591	0.202	0.736	0	0.724	0.692

Programmatic Focus and A+ Report Card 2007-2008

- Investments in new mattresses (pressure redistribution) all beds
- Standardized skin/wound care product line
- Focused education

PUP Rate March 2007 10.2% ⟶ PUP Rate September 2008 **4.8%**

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Events Timeline

January 28, 2010	Joint Commission survey
March 11, 2010	CMS post-TJC validation survey
March 12, 2010	Reportable event to DPH: wound
March 13, 2010	Immediate jeopardy
March 13, 2010	100% daily monitoring/rounding all patients
March 15, 2010	Reportable event to DPH: IV-related
March 19, 2010	NE Sinai closed to admissions & re-admissions
March 19, 2010	Media/healthcare consultant engagement
March 19, 2010	Appointment of medical director, quality & safety
March 24, 2010	Wound team multidisciplinary rounds - all wounds
April 1, 2010	Admissions with cap: 4 per day to Sinai-Stoughton
April 9, 2010	Wing 2A (32 beds) closed - patients relocated
April 12, 2010	Post-survey CMS visit
April 15, 2010	Appointment of medical director, inpatient wound
April 29, 2010	Mock survey with consultants
June 8, 2010	Post-survey CMS visit
June 13, 2010	Immediate jeopardy lifted
June 22, 2010	Blue Cross lifts admissions ban

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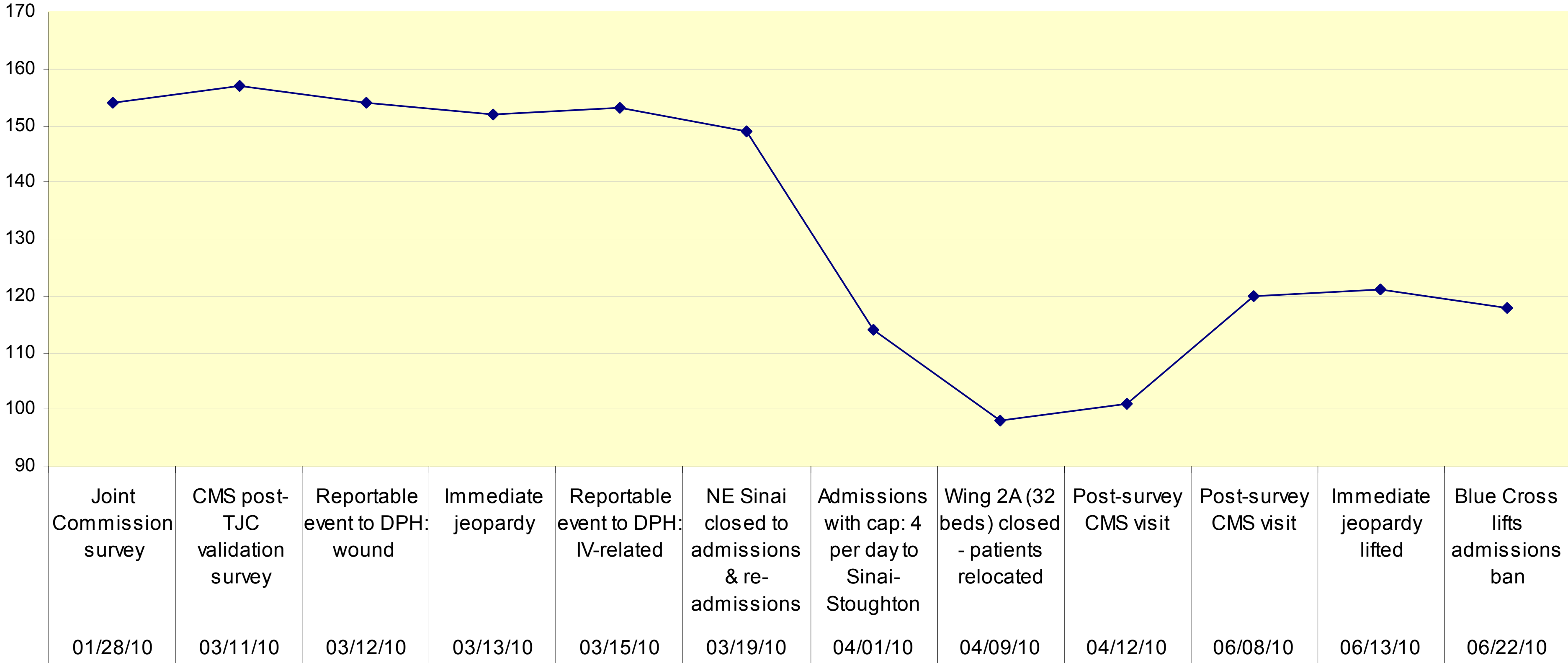
Events vs. Census



Immediate Jeopardy: Definition and Triggers*

"A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (See 42 CFR Part 489.3.)

"Triggers" alert surveyors that some circumstances may have the potential to be identified as Immediate Jeopardy situations and therefore require further investigation before any determination is made. A detailed review of three sample cases "walk" surveyors through the steps necessary to carefully analyze and accurately determine whether or not an Immediate Jeopardy situation exists.

*Source: CMS - State Operations Manual Appendix Q - Guidelines for Determining Immediate Jeopardy - (Rev. 1, 05-21-04)

Immediate Jeopardy Principles*

- Only ONE INDIVIDUAL needs to be at risk. Identification of Immediate Jeopardy for one individual will prevent risk to other individuals in similar situations.
- Serious harm, injury, impairment, or death does NOT have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.
- Psychological harm is as serious as physical harm.
- Individuals must not be subjected to abuse by anyone including, but not limited to, entity staff, consultants or volunteers, family members or visitors.
- Serious harm can result from both abuse and neglect.
- When a surveyor has established through investigation that a cognitively impaired individual harmed an individual receiving care and services from the entity due to the entity's failure to provide care and services to avoid physical harm, mental anguish, or mental illness, this should be considered neglect.
- Any time a team cites abuse or neglect, it should consider Immediate.

*Source: CMS - State Operations Manual Appendix Q - Guidelines for Determining Immediate Jeopardy - (Rev. 1, 05-21-04)

IJ Trigger Issue Failure to Prevent Neglect (#2 of 10)*

Triggers 1-15:

1. Lack of timely assessment of individuals after injury;
2. Lack of supervision for individual with known special needs;
3. Failure to carry out doctor's orders;
4. Repeated occurrences such as falls which place the individual at risk of harm without intervention;
5. Access to chemical and physical hazards by individuals who are at risk;
6. Access to hot water of sufficient temperature to cause tissue injury;
7. Non-functioning call system without compensatory measures;
8. Unsupervised smoking by an individual with a known safety risk;
9. Lack of supervision of cognitively impaired individuals with known elopement risk;
10. Failure to adequately monitor individuals with known severe selfinjurious behavior;
11. Failure to adequately monitor and intervene for serious medical/surgical conditions;
12. Use of chemical/physical restraints without adequate monitoring;
13. Lack of security to prevent abduction of infants;
14. Improper feeding/positioning of individual with known aspiration risk; or
15. Inadequate supervision to prevent physical altercations.

*Source: CMS - State Operations Manual Appendix Q - Guidelines for Determining Immediate Jeopardy - (Rev. 1, 05-21-04)

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Reportable Event: Wound Care Issue

- On admission, the patient, age 70, was noted to have “Stage II pressure ulcers” on each buttock and the right hip by the admission nurse. However, the wound nurse admission note indicates that there were areas of darker skin tone across buttocks (patient is dark-skinned) which may have indicated deep tissue injury. Over the course of many months, these ulcers worsened and ultimately presented as “unstageable” at the buttocks region and down to exposed tendon (Stage IV by definition) in the right hip.

- Contributing Factors: Sepsis, respiratory failure, s/p CVA with hemiplegia, C. Diff + with diarrhea incontinence and incontinence related dermatitis, severe protein malnutrition, upper extremity rigidity with contractures. In addition, patient decannulated himself (tracheotomy) and needed to be restrained with mitts on for most of admission to protect his airway.

Root Cause Analysis: Reportable Wound

Contributing Factors	YES	NO	If YES, what contributed to this factor being an issue?	Is this a root cause of the event? YES	NO	If YES, is an action plan indicated? YES	NO
Issues related to patient assessment?	X		The nurse who performed the initial assessment did not review the patient's medical history prior to seeing patient, thus, was not aware of patient's CVA with hemiplegia and risk thereof. No evidence of medical staff assessment of wound status.	X		X	
Issues related to staff training or staff competency?	X		On 2/22/10, the wound was re-classified as a Stage IV. At this time, the wound nurse should have communicated the presence of a Stage IV ulcer to the attending physician, the supervisor, the Nurse Manager and Risk Management.		X	X	
Equipment/device?	X		In retrospect, the wounds may have been better supported if the patient had been placed on a low air loss mattress.	X		X	
Environment?		X					
Lack of or misinterpretation of information?	X		See above	X		X	
Communication?	X		Patient was seen by all 3 wound nurses. No formal hand-off communication process was in place. Not all wound staff aware of PMH.	X		X	
Appropriate rules/policies/ procedures?	X		Failure in internal incident reporting.		X	X	
Documentation	X		Staff nurse documentation within Meditech was inconsistent.		X		
Supervisory issues?	X		On 2/22/2010 when the right hip ulcer was excisionally debrided to the level of tendon. There is no evidence of physician supervision or competency assessment for wound staff in performing this high risk procedure.	X		X	

Strategies for Improvement	Measure(s) of Effectiveness	Responsible Person(s)
Action item #1: **Assessment:** The wound clinical specialist will review staging criteria with wound nurses. She will reinforce the importance of review of medical history prior to patient assessment and development of wound interventions. Nursing leadership shall revise Meditech documentation systems and will eliminate staging assessment from staff nurse responsibility. Education of medical staff on wound assessment and documentation	Clinical review of pressure ulcer incidents by the Wound Clinical Specialist. Pressure Ulcer Prevalence Pressure Ulcer Incidence	•Wound Clinical Specialist •Vice-President for Nursing •Director of Professional Developmnt •MD supervisor-inpatient wound
Action item # 2: Staff training/competency Education of wound staff on staging, internal reporting of Stage III and IV ulcers	Daily wound monitoring Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence	Wound Clinical Specialists Vice-President for Nursing Director of Professional Development
Action Item: # 3 Equipment Device The wound clinical specialist shall develop a treatment algorithm for wound care and use of specialty mattresses.	Daily wound monitoring Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence	Wound Clinical Specialists Vice-President for Nursing Director of Professional Development
Action Item: #4 Information The wound clinical specialist will reinforce the importance of review of medical history prior to patient assessment and development of wound interventions.	Daily wound monitoring Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence	Wound Clinical Specialists Vice-President for Nursing Director of Professional Development
Action item #5: Communication The wound clinical specialist shall develop a hand-off communication system to assure continuity and consistency of wound care. The wound clinical specialist shall revise and augment the weekly wound census report to facilitate communication of wound information. The wound clinical specialist shall conduct weekly staff meetings to review current case load and provide supervision of wound care.	Revised hand-off mechanism Augmented wound census report Weekly staff meetings Daily wound monitoring	Wound clinical specialists Director of Professional Development

Strategies for Improvement	Measure(s) of Effectiveness	Responsible Person(s)
Action Item # 6 Policies and Procedures All wound care staff will be educated on requirements for internal and external incident reporting	Incident Reporting Pressure Ulcer Prevalence Pressure Ulcer Incidence	Wound clinical specialists Director of Professional Development
Action item #7: Documentation Professional development shall revise Meditech documentation processes and shall educate all nursing staff on the revisions. The medical staff shall be re-educated on documentation requirements for pressure ulcers.	Medical Staff meeting minutes Revised documentation policies. Staff education records.	Director of Professional Development and CMO Surgeon Supervision
Action item #8: Supervision/Training Effective 3/15/2010, the Director of Professional Development assumed responsibility for management oversight of the wound care program. The clinical wound specialist shall educate all wound staff about staging criteria and reporting requirements. The Director of Professional Development and the wound clinical specialist shall develop competency assessment tools for all wound staff. Nursing leadership shall review the current practice for obtaining informed consent e.g. must only be obtained by an MD,PA, NP or clinical specialist (for serial excisional debridements only).	Revised Organizational Chart New Competency Assessment Tool Staff educational records	Director of Professional Development Vice-President for Nursing
Action item #9: Policies and Procedures The clinical wound specialist shall develop a treatment algorithm for wound care and use of specialty mattresses.	Revised policies and procedures	Wound clinical wound specialists Director of Professional Development

Searching for Best Practice

- More diversity than commonality despite standard patient population
- Diverse care product and support surface use
- *Consensus* on:
  - raising awareness
  - increasing educational efforts
  - embedding safety tools
  - standardization of processes
  - monitoring quality
  - continuous/consistent communication

Searching for Best Practice

CLINICAL REVIEW

CLINICIAN'S CORNER

Treatment of Pressure Ulcers

A Systematic Review

Madhuri Reddy, MD, MSc
Sudeep S. Gill, MD, MSc
Sunila R. Kalkar, MBBS, MD
Wei Wu, MSc
Peter J. Anderson, BA
Paula A. Rochon, MD, MPH

"Treatment of Pressure Ulcers – A Systematic Review," (Ready, et al., 2008) *JAMA* reprint December 10, 2008, Vol 300(22), pp.2647-2642.

"Many treatments for pressure ulcers are promoted, but their relative efficacy is unclear."

"There is little evidence from RCTs to justify the use of 1 support surface or dressing over alternatives. Similarly, there is little evidence to justify the routine use of nutritional supplements, biological agents, and adjunctive therapies compared with standard care. Clinicians should make decisions regarding pressure ulcer therapy based on fundamental wound care principles, cost, ease of use, and patient preference."

First Response

- Media consultant
- Safety and quality consultants/additional resources
- Project management support
- Wound care medical expert
- Immediate interventions to assure daily environmental assessment
- *Transparency*

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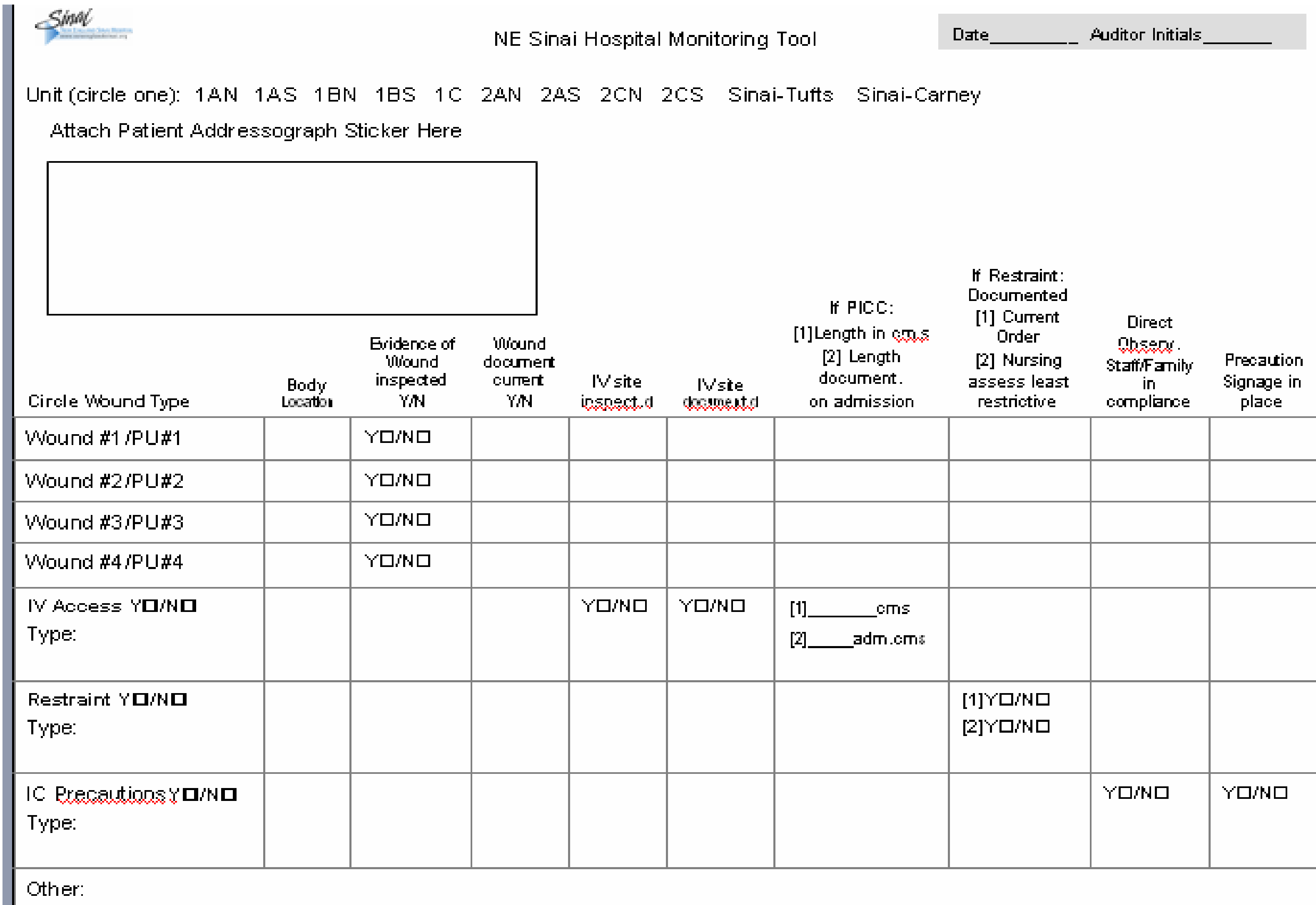
Daily Rounding



NE Sinai Hospital Monitoring Tool

Date________ Auditor Initials_______

Unit (circle one): 1AN 1AS 1BN 1BS 1C 2AN 2AS 2CN 2CS Sinai-Tufts Sinai-Carney

Attach Patient Addressograph Sticker Here

Circle Wound Type	Body Location	Evidence of Wound inspected Y/N	Wound document current Y/N	IV site inspected	IV site documented	If PICC: [1]Length in cms [2] Length document. on admission	If Restraint: Documented [1] Current Order [2] Nursing assess least restrictive	Direct Observ. Staff/Family in compliance	Precaution Signage in place
Wound #1 /PU#1		Y☐/N☐							
Wound #2 /PU#2		Y☐/N☐							
Wound #3 /PU#3		Y☐/N☐							
Wound #4 /PU#4		Y☐/N☐							
IV Access Y☐/N☐ Type:				Y☐/N☐	Y☐/N☐	[1]_______cms [2]_____adm.cms			
Restraint Y☐/N☐ Type:							[1]Y☐/N☐ [2]Y☐/N☐		
IC Precautions Y☐/N☐ Type:								Y☐/N☐	Y☐/N☐

Other:

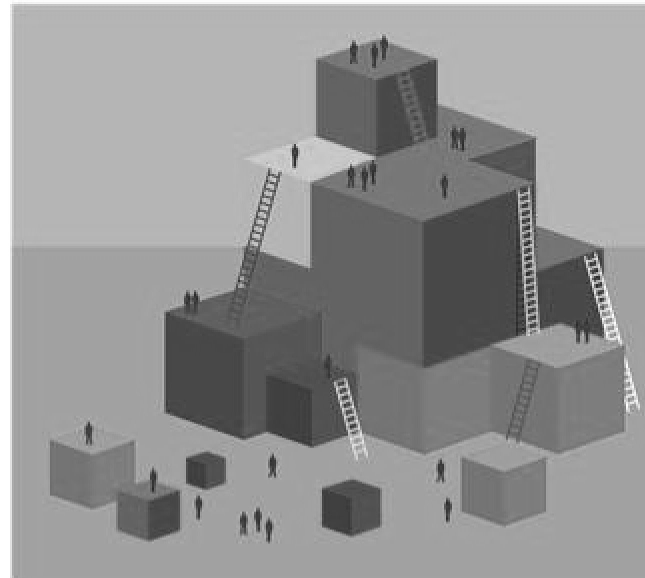
Personnel Re-alignment

Leadership

Chief Quality Officer

Wound Program

Director, Wound Care Consultants, Provider/Nursing



Medicine

Director, Inpatient Wound Care

Nursing

Resource Nurses

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Reporting Problem: Raising Awareness

From: Urquhart, Mary Beth
Sent: Saturday, March 20, 2010 6:56 PM
To: Physicians Assistants; Nurse Coordinators; Nurse Managers; Department Managers; Department Heads; Perrotta, Barbara; Terceira, Kathy; White, Alexander C.; Villarini, Althea; Assistant Nurse Managers
Subject: Important Clarification about Incident Reporting

Hello everyone. This message is to clarify current expectations for staff related to internal incident reporting. I believe you are all aware that the following events must be reported to me, via incident report, within 3 days:

- Pressure ulcers
- Falls
- Complaints
- Med Errors
- Treatment errors
- Elopements
- Suicidal ideation
- Injury to patient or visitor
- Skin tears
- Unsafe conditions
- Code Yellows
- AMA discharges
- Lost items
- Equipment malfunctions

Effective immediately, and as part of our Immediate Jeopardy response plan, I am now requesting that you instruct staff to report these incidents to me within 24 hours rather than 3 days. I will make necessary changes to the Incident Report policy as soon as possible.

Also, please add the following to the list of events which must be reported to me within 24 hours:

- All IV infiltrations specifying location, appearance, type of IV
- Unstageable, Stage 3 or Stage 4 pressure ulcers that develop at Sinai
- All PICC line occlusions or complications
- Disruptive behavior
- ANY other unusual occurrence

Serious incidents should be phoned to me immediately regardless of day or time.

In summary, I am requesting that you educate all staff about the change in timeframe for reporting internal incidents (ALL reports within 24 hours). Finally, please initiate reporting of any and all of the last 4 event types.

Thank you and please do not hesitate to call with any questions. Mary Beth Urquhart

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Wound Registry: Census and Demographic Data

New England Sinai Hospital (M-F) Wound Registry as of 05/09/11

POA = present on admit
HA = hospital acquired
No staging = not requiring staging
UTD = Unable to determine
SDTI = Suspected Deep Tissue Injury
IAD = Incontinence Associated Dermatitis
Items in Red - Discharged/Out

Room	Name		Physician	Billing #	Admit Date	1st Wound RN Consulted	Wound Location	Stage or Descriptor	Validation by WCRN	Validation Comment	Origin POA/HA	Date Seen	Wound Team Rounds Monitor=QOW	Wound VAC	Mattress: LAL=LowAirLoss AF=Clinitron	Comments: Dispo/Healing
1BN Donna Metcalf, x1343, pager 8303																
132	[illegible]	N	Weinreb		4/8/2011	4/8/2011	Abdomen	dehisced			POA	5/3/2011				
126	[illegible]	T	Weinreb		4/22/2011	4/22/2011	L foot	surgical			POA	5/5/2011				D/C
	as above						L heel	unstageable			POA	5/5/2011				
	as above						R heel	stage 3			POA	5/5/2011				
	as above						r foot	DFU			POA	5/5/2011				
	as above						L flank	abrasion			POA	5/5/2011				
	as above						R hand	skin tear			H/A					
134	[illegible]	R	Weinreb		4/27/2011	4/27/2011	L LE	incision	intact		POA	5/3/2011				
	as above						L5th toe	necrotic			POA	5/3/2011				
127	[illegible]	A		[illegible]	4/20/2011	4/20/2011	L gt toe	DFU			POA	5/2/2011		VAC		
1BS Donna Metcalf, x1343, pager 8303																
142	R[illegible]hague		Berhanie		04/04/11	04/04/11	L LE	venous			POA	4/26/2011				resolved
	as above						R LE	venous			POA	5/3/2011				
144	[illegible]	M	Berhane		04/15/11	04/15/11	Nasal	cavity			POA	5/3/2011				
141	[illegible]	M			04/12/11	04/12/11	R GROIN	incsion			POA	4/27/2011				
	as above						R HEEL	DFU			POA	4/27/2011				
145	[illegible]g	E	Weinreb				R shin	skin tears								
		C	Berhane				R hand	skin tears			H/A					D/C
	as above						L UE	skin tears								
	[illegible]on						L calf	skin tears			H/A					

1AN and 1AS / 1BN and 1BS / 1CN and 1CS / 2AN and 2AS / 2CN and 2CS / Sinai - Tufts / Sinai - Carney /

Staging Responsibilities Restricted

Wound Care and providers only

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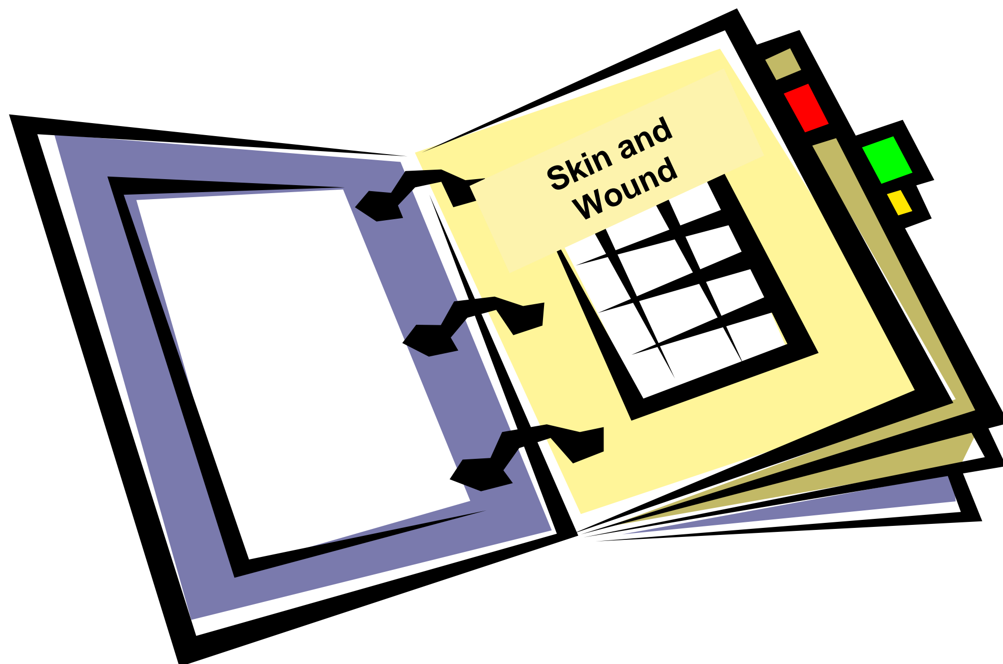
Documentation Aligned with Workflow - PAPER



- Clear, visual chronology of care
- ↑ ease of access
- Plan of care and weekly status
- Wound care RN input
- Educational/Staging tools
- Protocols
- Standard across all 3 campuses

Paper Record – Skin and Wound Section

Contents

- Pressure Ulcer Staging Tool
- Standard skin & wound care protocols
- Nursing care plan
  - weekly or with changes
- Assessment/Photo-doc forms
  - on discovery
  - on admission
  - weekly or worsening wound

Advantages/Benefits

- Ease of use for all stakeholders
- Provides clear chronology of course of illness
- Supports staff in recognizing change in condition and earlier intervention

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Paper Medical Record – Skin and Wound Section

Pressure Ulcer Staging

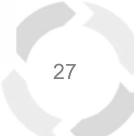
Pressure Ulcer (definition)	A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.	
Suspected Deep Tissue Injury (STDI)	Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.	Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue event with optimal treatment.
Stage I	Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from surrounding area.	This area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).
Stage II	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	Presents as a shiny or dry shallow ulcer without slough or bruising. *This stage should not be use to describe skin tear, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury.
Stage III	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.	The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.
Stage IV	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.
Unstageable	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, green or brown) and/or eschar (tan, brown or black) in the wound bed.	Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed.

Reference: NPUAP 2007

Non-Surgical Skin, Wound and Pressure Ulcer Care Protocol – *All orders must be written on medication order sheet*

RASH		
Minor rash -Intact skin	Excessive moisture and/or incontinence associated dermatitis	1. Cleanse with hygiene foam and water 2. Apply moisture barrier **cream** each shift and PRN✓ 3. Consult wound care nurse if rash is generalized or if no improvement in 3 days
Major rash -Denuded skin	As above	1. Cleanse with hygiene foam and water 2. Apply moisture barrier **paste** each shift and PRN✓ 3. Consult wound care nurse if rash is generalized or if no improvement in 3 days
Fungal Rash		1. Apply **provider ordered** antifungal agent(s) as an incontinence barrier: Powdered or dry to moist areas and moist antifungal agent to dry areas.
SKIN TEAR -Traumatic partial thickness injury with edges that may be approximated or non-approximated (base dressing on drainage)		
Extremities	Drainage Dry → minimal	1. Cleanse with dermal wound cleanser or normal saline 2. Apply in this order: xeroform (cut to fit), rolled gauze, tape 3. Change daily and PRN✓
	Drainage Moderate → heavy	1. Cleanse with dermal wound cleanser or normal saline 2. Apply in this order: xeroform (cut to fit), ABD pad(s), rolled gauze, tape 3. Change daily and PRN✓
	Drainage Moderate → heavy And/or with bleeding	1. Cleanse with dermal wound cleanser or normal saline 2. Apply in this order: xeroform (cut to fit), alginate or hydrofiber, ABD pad (as needed), rolled gauze, tape 3. Change daily and PRN✓
Head and Trunk	Drainage Dry → minimal	1. Cleanse with dermal wound cleanser or normal saline, apply skin preparation wipe to skin around the wound 2. Apply thin polyurethane foam or hydrocolloid 3. Change weekly and PRN✓
	Drainage Moderate → heavy And/or with bleeding	1. Cleanse with normal saline and skin preparation wipe to skin around the wound 2. Apply one layer of alginate or hydrofiber, cover with adhesive polyurethane foam dressing or non-adherent foam dressing, secure with transparent film 3. Change twice a week and PRN✓
PRESSURE ULCERS (PU)		
Stage II PU (partial thickness) Sacral/Coccyx/Buttocks/Hip		1. Clean with hygiene foam, blot dry and apply protective barrier cream each shift, PRN✓ 2. Turn/tilt patient off affected area at least every two hours
Stage II PU (partial thickness) Heel		1. Clean with normal saline or dermal wound cleanser and blot dry 2. Apply xeroform, dry heel cup and secure with rolled gauze and secure with tape 3. Change daily and PRN✓ 4. Float heels off bed
Stage II PU (partial thickness) Other (ears, knees, etc.)		1. Clean with dermal wound cleanser 2. Apply xeroform cut to fit 1- 2 cms larger than ulcer 3. Change daily and PRN✓
Stage III + IV PU(full thickness) **Sacral/Coccyx/Hip/Other/ *Excludes heel***	Drainage Small/Mod/Heavy	1. Cleanse with normal saline, apply skin preparation wipe to skin around wound 2. Apply/fill with alginate or hydrofiber dressing (cut to fit 1-2cms larger than ulcer) 3. Cover with ABD pad and secure with tape 4. Change dressing daily and PRN✓ 5. Turn/tilt patient off affected area at least every two hours 6. Assess patient with each turn and increase turning/tilting frequency as needed 7. Patient may lay supine only for meals
Stage III and IV (full thickness) Heel	Drainage Small/Mod/Heavy	1. Cleanse normal saline and apply skin preparation wipe to skin around wound 2. Apply/fill with alginate or hydrofiber dressing (cut to fit 1-2cms larger than ulcer) 3. Apply dry heel cup and secure with rolled gauze and secure with tape 4. Change daily and PRN✓ 5. Float heels off bed
Unstageable PU Heel	Dry	1. Swab with povidine iodine daily – if no documented allergy 2. Apply dry heel cup and secure with rolled gauze and secure with tape 3. Float heels off bed
Unstageable PU Sacral/General/Heel	Open And/or with drainage	1. Cleanse with normal saline, apply skin preparation wipe to skin around wound 2. Pack loosely with normal saline moist gauze impregnated with hydrogel 3. Cover with dry, clean dressing, secure with tape (for heels - wrap with rolled gauze and tape and apply heel cup) 4. Change twice a day and PRN✓ 5. Turn/tilt patient off affected area at least every two hours 6. Float heels off bed
Unstageable PU **Sacral/General *Excluding Heel***	Closed and/or dry	1. Cleanse with dermal wound cleanser, apply skin preparation wipe to wound edges, cover with adhesive polyurethane foam or hydrocolloid 2. Change every third day and PRN✓ 3. Turning schedule (patient supine position for meals only) 4. Float heels of the bed
Suspected Deep Tissue Injury		1. Relieve pressure (off load heels, turn off affected area) 2. Notify medical provider

✓ Change dressing PRN if excessive moisture, incontinence, soiled, saturated, dressing dislodged.



NEW ENGLAND Sinai HOSPITAL

Paper Medical Record – Skin and Wound Section

NE Sinai Hospital Wound and Pressure Ulcer (PU) Assessment Form

Date: ____________

PU/Wound Site (body): ____________

Current Braden Scale Score: ____________

Patient label here

Note Type (circle one) **Admission finding - Post-admission new finding - Change in Status**

Wound Type Please circle
(add detail to incision or other option)

Pressure Ulcer (PU)

Open/non-intact Incision ____________

Other
[example: arterial/venous stasis/diabetic ulcer] ____________

Description – Please circle all that apply

Thickness	Partial - Full - Unable to determine
Slough/Eschar/Necrosis	0% 25% 50% 75% 100% NA
Granulation Tissue	0% 25% 50% 75% 100% NA
%Suspected Deep Tissue Injury	0% 25% 50% 75% 100% NA Coloration/other____________
Structures Visible Yes or No	Bone - Tendon - Mesh - Hardware - Fistula Other (describe) ____________
Drainage Yes or No	Serous - Serosanguinous - Sanguenous Other____________
Odor Yes or No	Describe____________
Skin around wound	Intact Other (describe)

PHOTO-DOCUMENTATION HERE – ONE WOUND PER PHOTO
(patient ID, date, time, nurse/photographer initials)

Photos required (discovery & weekly):
- Any open wound
- Pressure ulcers
- Suspected deep tissue injury [SDTI]
- Dehisced surgical wounds
- Arterial ulcers
- Diabetic neuropathic ulcers
- Venous stasis ulcers

Photos not required :
- Intact Stapled/sutured incisions
- Bruises
- Rashes or areas of redness (not pressure ulcers)
- Stomas
- Fistulas
- G-tubes/J-tubes/Chest tubes
- **Skin tears**

Measurement – In centimeters

Length ______Width______Depth______

Undermining Yes: Measurement__________ No

Tunneling Yes: Measurement__________ No

Signature of clinician completing wound description/photo-documentation ____________ Date/Time ______

Additional information: ____________

*Clinician's Signature*____________ *Date*______ *Time*______

NE Sinai , Wound and PU Assessment Form 5-2011

NEW ENGLAND Sinai HOSPITAL

Paper Medical Record – Skin and Wound Section

NE Sinai Hospital Skin and Wound Care Plan Page 1 of ____ RN Signature______________________ Date______ Time_____

Date Identified	Date Resolved	Problem/Issue Statement	Assessment Subjective/Objective Data	Interventions	Goals S=short term L=long term
		Pain/Comfort Management	Pain level related to wounds/care ________________ (scale 1 to 10 rating or PAINAD)	Medicate prior to dressing change as ordered ☐ Use adhesive remover prior to dressing removal ☐ Encourage patient to meditate ☐ Implement diversional activities ☐ (describe)	S Patient will be as comfortable as possible during wound care. ☐
		Nutrition/Hydration Optimization	PO/Tube Feeding Intake: Good☐Fair☐Poor☐NA☐TPN/PPN ☐ Feeding: Independent ☐ Assist ☐ Pre-Albumin Level _____(date)_____ Glucose levels WNL Y ☐ N ☐ Other labs ________________	Maximize hydration status ☐ Staff assist with meals/intake ☐ Protein supplementation ________ grams per day.	S Patient will receive nutrition and fluid supplementation appropriate to clinical condition to optimize healing. ☐
		Risk for Skin Breakdown Based on Braden Scale [H] = high risk 14 or less [A] = at risk 15-18 Interventions [H] and/or [A]	Incontinent of stool ☐ urine ☐ Urinary catheter ☐ Fecal mgt system ☐ Incontinence briefs ☐ Loss of sensation due to _________ Impaired mobility ___________ Medications ↑ risk ___________ Other ________________	[H]Specialty Bed or Mattress_____________ [A/H]Seating cushion when OOB ___________ [A/H]Turn/reposition every 2 hours ☐ [A/H]Encourage shifting every15 min. while OOB ☐ [A/H]Off-load heels while in bed ☐ [A/H]Use lifting device moving patient ☐ [A/H]Moisturize skin daily and as necessary ☐ [A/H]Discuss plan with team treating patient ☐	S Patient's risk for skin breakdown will be minimized. ☐
		Risk for Infection	Precautions Y ☐ N ☐ Describe _________ Immunocompromised Y ☐ N ☐ Describe Other________________	Follow precaution policy/universal protocol ☐ Emphasize and educate patient/visitors re: need for strict adherence precaution ☐	S Risk or spread of infection will be minimized during hospital stay. ☐
		Educational Needs Related to Skin and Wound Care	Patient can participate in learning & self-care around skin and wound Y ☐ N ☐ Family/significant others should be involved in education & care teaching Y☐ N☐	Patient☐ Family☐ participate in wound care ☐ Patient☐ Family☐ receive information (describe)☐ *Please supplement documentation in notes.*	S Patient and/or family will be prepared to manage skin and wound care upon discharge. ☐
		Healing	Potential to heal: Yes ☐ No ☐ Uncertain ☐ Discussed w/ patient☐family☐ Date:	*Please supplement documentation in notes.*	S The patient and/or family will receive information about the probability of dealing with a healing wound or a wound that will require ongoing management. ☐
		Discharge Plan		*Please supplement documentation in notes.*	L Patient and/or family will be optimally prepared to manage skin and wound care upon discharge. ☐

NEW ENGLAND Sinai HOSPITAL

Enhanced Electronic Documentation

Hair - General	
Texture/Quantity/Distribution	☐ Brittle ☐ Coarse ☐ Fine ☐ Balding ☐ Thick ☐ Thinning ☐ Sparse
Nails - General	
Nailbed Color	○ Pink ○ Pale ○ Cyanotic
Texture	○ Brittle ○ Clubbing ○ Ridging ○ Smooth
Nail Comment	Please document specific irregularities in finger and toenails
Oral Mucous Membranes - General	
Color	○ Pink ○ Pale ○ Cyanotic
Hydration	○ Dry ○ Moist
Mucous Membrane Comment	Please document any irregularities/lesions or additional findings
Tongue Appearance	☐ Dry ☐ Smooth ☐ Furry ☐ Beefy ☐ Furrowed ☐ Ridged ☐ Pierced ☐ Symmetrical ☐ Assymetrical
Tongue Comment	Please document any irregularities/lesions or additional findings.
Inspection and Palpatation of Skin	
Temperature	○ Warm ○ Hot ○ Cool ○ Cold
Moisture	○ Dry ○ Moist ○ Diaphoretic
Color	○ Normal ○ Pink ○ Pale ○ Flushed ○ Erythema ○ Ruddy ○ Dusky ○ Mottled ○ Ashen ○ Cyanotic ○ Tan ○ Jaundiced
Hydration - Skin Turgor	☐ Elastic ☐ Loose ☐ Tight ☐ Edematous ☐ Immediate Recoil ☐ Tenting
Texture	☐ Smooth ☐ Rough ☐ Thick ☐ Thin ☐ Scaly ☐ Oily
Additional Findings	☐ Not Applicable ☐ Amputation ☐ Bruising ☐ Ecchymosis ☐ Itching ☐ Lesions/Moles ☐ Petichiae ☐ Scar ☐ Skin Flap ☐ Other These are notable on assessment, but do not require treatment. Please create an occurrence to document wounds or ulcers.
Other Additional Finding/Comments	Explain 'Other' Finding. Please note/describe location, distribution, and/or severity of identified additional findings.

Inspection of Integumentary System	
Complete visual inspection done this shift?	○ Yes ○ No Visual inspection should include skin, skin contact with assistive devices, hair, nails and mucosal membranes. Document any findings in the skin findings section below. If no inspection done, document reason in findings comment.
Skin Findings	
Finding	○ None Found ○ Bruising ○ Ecchymosis ○ Itching ○ Redness (Non Pressure* ○ Other * Ulcer or Rash). These are notable on assessment, but do not require treatment. Please communicate this finding to the next shift. Please create an occurrence to document wounds or ulcers.
Findings Comments	Document any abnormal finding or reason inspection was not done. Please note/describe location, distribution, and/or severity of identified findings.
Skin Problem Occurrences - Occurrence #1	
➔ Location Modifier	○ Left ○ Left Anterior ○ Left Lateral ○ Left Medial ○ Left Posterior ○ Right ○ Right Anterior ○ Right Lateral ○ Right Medial ○ Right Posterior ○ Medial/Middle ○ Generalized (Lt & Rt) Select the option that best describes the wound's body site location.
➔ Location (Body Site)	○ Head Occipital ○ Head Parietal ○ Head Temporal ○ Head Frontal ○ Eye ○ Nose ○ Cheek ○ Ear ○ Earlobe ○ Lips ○ Jaw ○ Chin ○ Neck ○ Shoulder ○ Upper Arm ○ Elbow ○ Antecubital Fossa ○ Forearm ○ Wrist ○ Hand ○ Thumb ○ Index Finger ○ Middle Finger ○ Ring Finger ○ Little Finger ○ Chest ○ Abdomen ○ Groin ○ Back ○ Spine ○ Sacrum ○ Coccyx ○ Genitalia ○ Hip ○ Trochanter ○ Buttock ○ Ischium ○ Thigh ○ Knee ○ Calf ○ Shin ○ Ankle ○ Foot ○ Heel ○ Great Toe ○ Index Toe ○ Middle Toe ○ Fourth Toe ○ Little Toe

Education: Back to Basics – Providers & Nursing

Authors:

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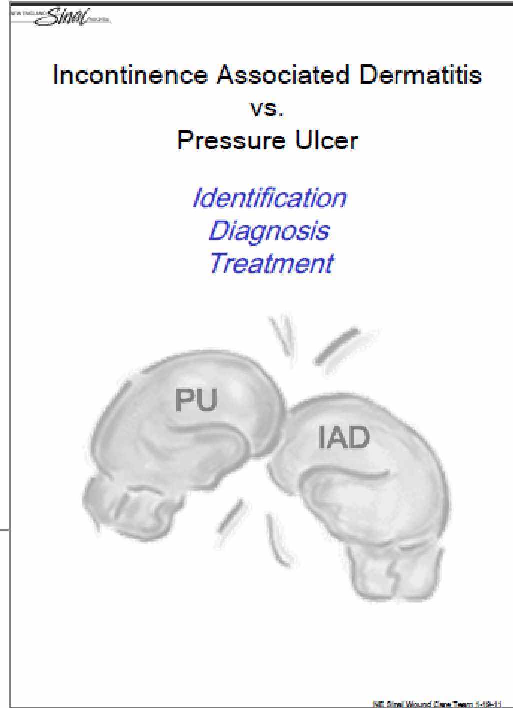
Pressure Ulcer Training

Module One
Pressure Ulcers and Staging
Module Two
Other Wound Types and Skin Injuries
Module Three
Pressure Ulcer Survey Guide
Module Four
Community vs. Hospital/Unit Acquired Pressure Ulcers

NEW ENGLAND Sinai HOSPITAL

Education: Ongoing



Pressure Ulcer Training

Module One
Pressure Ulcers and Staging
Module Two
Other Wound Types and Skin Injuries
Module Three
Pressure Ulcer Survey Guide
Module Four
Community vs. Hospital/Unit Acquired Pressure Ulcers

Begin

Braden Scale Scoring

Developing Inter-rater Reliability

Presented by: Michele Anderson, RN, CWC
July 27-29, 2010

NE Sinai Team Patient Care Case Review

Multidisciplinary Care of the Patient at High Risk for Skin Integrity Compromise

Education: Competency Assessment

Skin and Wound Competency Assessment and Validation Tool

Date:
Care Unit:

Competency Evaluator:
Name, Title

Staff Evaluated:
*Name, Title**
(all clinical staff, unit support staff, direct care providers, MS/PA, RT, PT, OT, ST, housekeeping, facilities management and dietary)

Performance Criteria	Educational Material Provided Y/N/NA	Verbalization/ Demonstration/ Observation/ Test V/D/O/T	Supplemental Education/Competency Validation required (verbalization, demonstration, observation, test) V/D/O/T (describe)*
Massachusetts Nurse Practice Act			
Define the role of the RN in assessment and care planning			
Define the role of the LPN as participating in data collection and assessment of basic health care data			
Summarize the role of RN, LPN in delegation			
Skin Risk Assessment			
Defines the need for skin risk assessment			
States the frequency of completing per hospital policy			
Summarizes the difference(s) between high risk and at risk for skin breakdown			
Can demonstrate where Braden Scale documentation is placed in the patient's record (Meditech and paper care plan)			
Skin Assessment			
Demonstrates knowledge of how to enter an admission assessment into electronic documentation			
Can articulate how to navigate EMR to review skin and wound documentation			
Summarizes how and where to initiate skin and wound plan of care			
Describes pressure ulcer stages			
Can review a case scenario and properly stage a pressure ulcer			
General Wound Assessment			
Can articulate the three aspects of a wound assessment; ▪ Type ▪ Description ▪ Measurement			
Describes how to properly measure a wound/pressure ulcer: ▪ At baseline ▪ Using a standardized, consistent process for length, width, depth, and tunneling/undermining: **Length:** length of the wound from head to toe in cms. **Width:** The aspect perpendicular to the length in cms. **Depth:** the depth of a cotton tipped applicator from the wound base to skin level in cms. *Partial thickness wounds of indeterminate depth are characterized as > 0.1 cm.* **Undermining/tunneling:** Point of cotton tipped applicator contact on the tunnel wall to the surface of the skin in cms.			
Summarizes the situations and kinds of wounds and pressure ulcers requiring photo-documentation			

Sinai Hospital Dept. of Professional Development Competency Assessment Tool [6-7-10]

Page 1 of 7

- Designed with deep detail
- ↓ inter-rater reliability variation
- Didactic, problem-based
- Simulation training component
- Policy and standards review
  - ❖ Assessment
  - ❖ Description
  - ❖ Dressings/treatments
  - ❖ Products
  - ❖ Documentation

Education: Resource Nurses

NE Sinai Hospital Resource Nurse - Role in Skin and Wound Care Management

The resource nurse provides an additional layer of expertise to nursing and multidisciplinary practice development and implementation at NE Sinai Hospital. Their continuous focus on the skin and wound care needs of all patients includes their involvement in the following processes:

Role Responsibility	Action Item/Processes	Comment
Nursing process	Reviews and facilitates skin and wound care plan development, implementation and follow up for patients assigned to their unit	
Skin risk evaluation	▪ Reviews Braden scale assessment completion and scores with the nurse/team caring for the patient ▪ Collaborates with nurses/team to ensure risk interventions are in place ▪ Rounds with the wound team with nurse(s) assigned to patients ▪ Develops expertise in safe patient handling and movement to support patient safety ▪ Works with nursing assistants, orientees to develop handoff process to enhance risk reduction	
Wound care education	▪ Reinforces infection control practices for safe and compliant skin and wound care delivery ▪ Reviews staging done by wound care nurses and providers with nurses caring for patients ▪ Interfaces with school of nursing instructors, students to monitor for safe practice delivery related to skin and wound care	
Wound care practice	▪ Assists direct care nurses with technical skill development, i.e., dressing changes, product applications, negative pressure therapy application and removal ▪ In-services new products and equipment as needed ▪ Ensures wound team consults are implemented as ordered ▪ Interfaces with bed vendors to ensure proper implementation of specialty beds and orders	
Quality monitoring	▪ Team leads all pressure ulcer prevalence audit participation on respective unit monitor quality indicator (oversight of one indicator by each wound care nurse) ▪ Monitors all wound and skin documentation	Quality indicators assigned per policy
Professional development	▪ Develops staging expertise*** ▪ Obtains 5 skin and wound care-specific contact hours annually ▪ Attends monthly, structured education - hour long programs led by wound care nursing team (products, protocols, case review, nursing research discussion)	
Mentoring	▪ Advises staff on care and preventative measures ▪ Acts as liaison to nurses from wound and skin committee ▪ Attends wound care debriefing session once a month	
Nursing research	▪ Provides one educational article to unit staff meeting discussion per quarter	

**** Staging competency/expertise is developed over time as a result of experiential learning and didactic, problem-based learning. This will be accomplished by the completion of the following steps:

- Rounding with the wound care team weekly on all patients followed
- Review of photo-documentation in all patient records with the wound care RN assigned to their unit
- Practice in simulation lab using case-based staging scenarios monthly – created and facilitated by wound care nurses as part of ongoing educational sessions

- Layer of clinical expertise for all nurse-sensitive indicators
- Eyes & ears on each care unit
- Liaison to Wound Care Team
- Support direct care nurses in their professional development

Policies & Procedures

- Multidisciplinary rounds weekly
  - *Wound care MD*
  - *Wound care RN*
  - *Direct care nursing personnel*
  - *Nursing leadership*
  - *Medicine*
  - *Nutrition*
  - *Allied health*
- Plan of care nursing, medicine
- Consult process redefined
- Wound care on-call

Embedding Safety Tools

Wound Care RNs

- Assigned “territories”
- Daily inter-team handoff (verbal handoff required)
- Handoff documentation
- On-call policy

Embedding Safety Tools

- Wound Care Registry – wound “reconciliation” tool
- Multidisciplinary Rounds – formal, weekly
- Appointment of Medical Director, Inpatient Wound Care
- Electronic and paper skin & wound documentation revisions
- Standardized wound care protocols

    support for off-hours clinicians
- Quality monitoring audits – clinical care/documentation
- Chain of Command policy

Increasing Serious Reportable Events (SREs)

5 wound SREs

March – May 2010

- 8 Stage III or IV hospital acquired pressure ulcers between February and May 2010
- Overall incidence of hospital acquired pressure ulcers was above external benchmark mean

Pressure Ulcer Prevention Team

convened and chaired by VP Quality

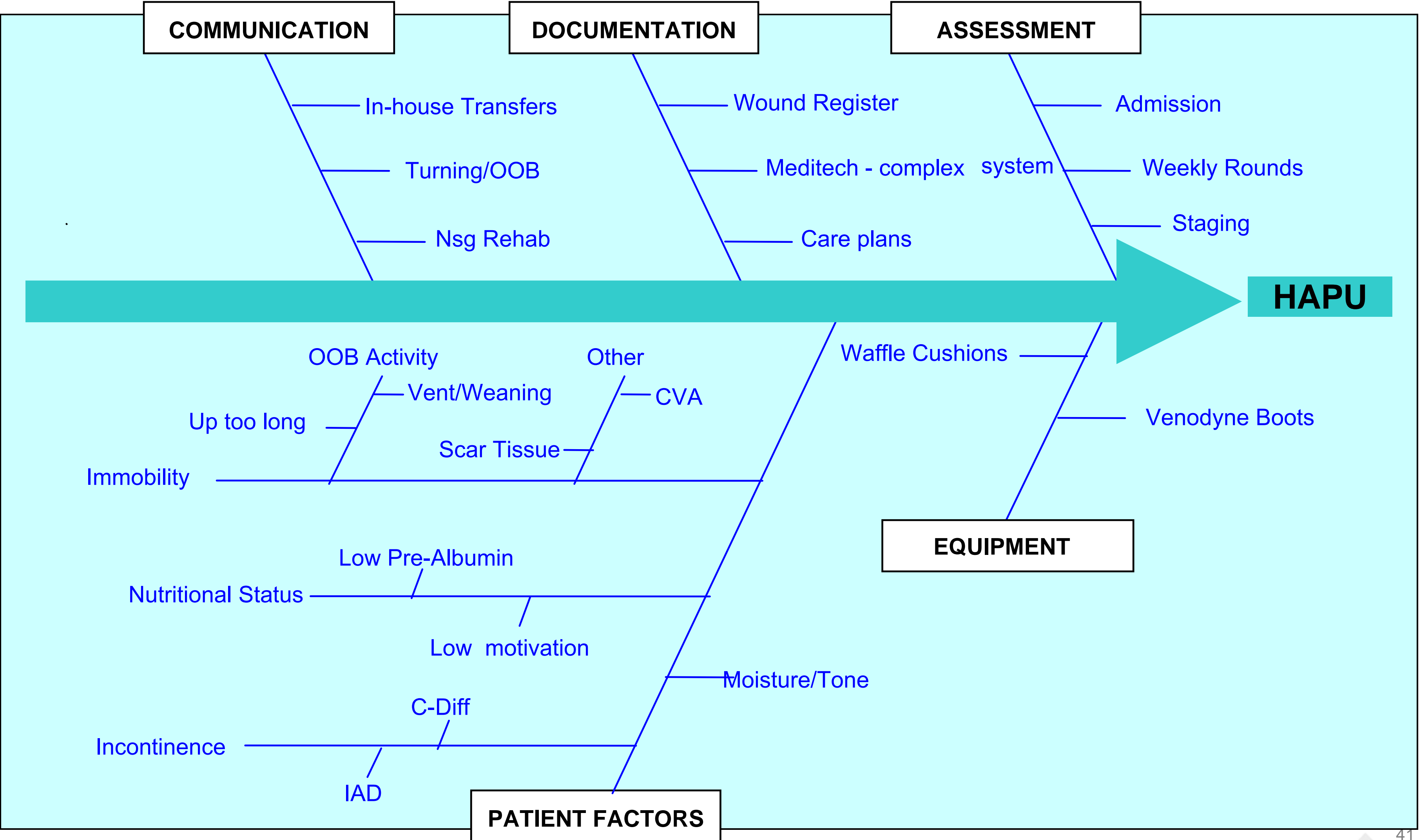
Pressure Ulcer Prevention (PUP) Team

MEMBERSHIP	GOALS	TOOLS
Wound Care	Identify risks for PU development	Control Charts
Nutrition	Reduce incidence of HAPUs	Root Cause Analysis
Nursing Informatics	Implement risk reduction strategies	Common Cause Analysis
Information Systems		Focus Groups
Health Information Management		Cause and Effect Diagram
Purchasing		Bar Graphs
Occupational Therapy		
Nursing		
Physicians Assistants		
Radiology		
Physical Therapy		
Case Management		
Medicine		
Occupational Health		
Quality Management		
Respiratory		
Social Work		

Common Cause Analysis

Communication	Knowledge Deficit	Equipment	Care Plan	Policy	Documentation	Envir.	Nutrition	Assessment	Patient Factors
No hand-off between 3 WCRN's.	Wound staging	Low air loss mattress not used	Lack of medical staff oversight. Debridement by WCRN.	Lack of wound protocols and wound register.	Inconsistent staging of wound by RN's and WCRN			CVA with hemiplegia - not factored into care plan/mattress selection No wound assessment by medical staff	CVA with hemiplegia. POA wound. C-Diff
	Wound staging	Wound treatments were not ordered by MD or PA. RN acted upon recommendation from WCRN.	Lack of medical staff oversight. Wound prevention strategies not articulated in Nsg care plan.	Lack of wound protocols and wound register. Admitting PA did not order wound consult.	Inconsistent staging. Photodoc not done in a timely manner therefore, not avail to clinical nutrition staff.		Low pre-albumin	Presence of scar tissue on coccyx and h/o pilonidal cyst not factored into risk assessment and care plan. 9 day gap in between WCRN visits.	Incontinence, agitation, pelvic fx with limited mobility
Rehab/Nsg/OT	RN not aware of significance of increased moisture and tone on pressure ulcer risk. Rehab nursing staff not trained on new documentati	Hand splints were attempted but contributed to skin breakdown.	Relationship of moisture, increased tone and wound care not defined. RN oversight of care plan and nursing aides.	Lack of formal process for rehab nursing and documentation	Lack of documentation of rehab nsg interventions	Increased acuity on "chronic" unit.			Severe contractures. Increased moisture and tone in hands
		On 4/20/10, pt was kept in static mode on low air loss mattress rather than alternating mode				4 in-house transfers	Chronic low pre-albumin		Refractory C-Diff. IAD. Miliary TB

Cause and Effect Diagram



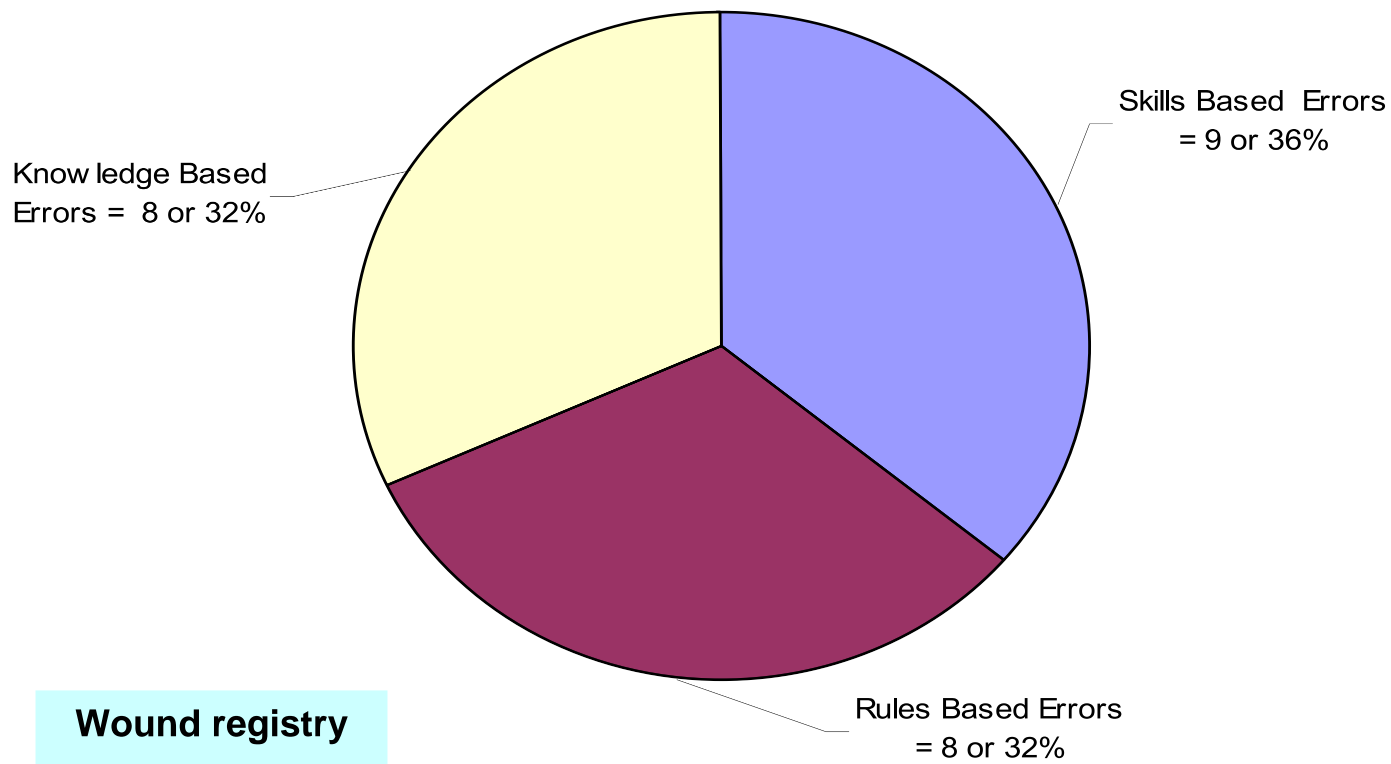
Application Of Generic Error Modeling System To Common Cause Analysis

Patient Risk Factors

Wound Staging

Long Term Patients

In-house transfers



Wound registry

Wound Consults

PUP Team Outcomes

- Decreased incidence of HAPU
- Stratified data on HAPU by stage of ulcer
- Introduced new nutrition products
- Reinforced use of Waffle cushions
- Streamlined processes for Wound Registry
- Introduced new incontinence management products
- Reduced concurrent use of sequential compression devices and systemic anticoagulants
- Increased compliance with medical assessment of wounds upon admission and weekly

Quality Monitoring

- Organizational
- Medicine
- Wound Care
- Nursing

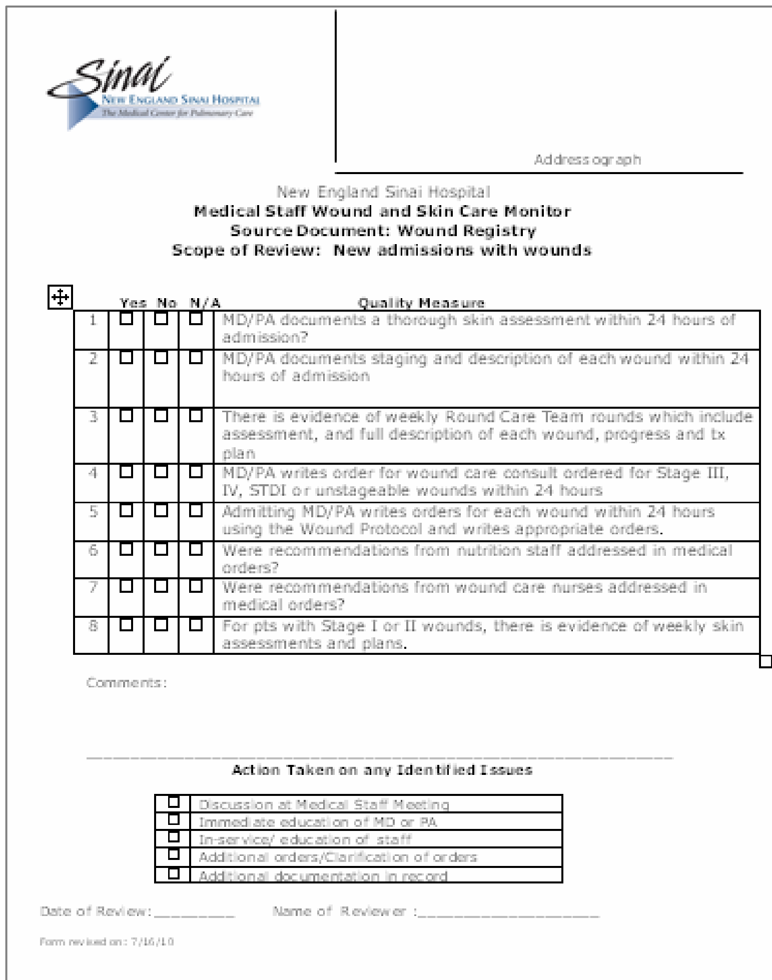
Quality Monitoring – Nursing/Wound Care

- Electronic reports to validate assessment
  - ❖Braden Scale Absent report
  - ❖Skin/Wound Occurrence documentation
  - ❖Sequential compression boot clinical need
- Mattress type and settings
- Bedside availability of cushions and incontinence care products
- Compliance with policy and use of assistive patient movement devices

NEW ENGLAND Sinai HOSPITAL

Provider Audits

Documentation & Orders New Admissions



Sinai New England Sinai Hospital The Medical Center for Pulmonary Care

Addressograph

New England Sinai Hospital
Medical Staff Wound and Skin Care Monitor
Source Document: Wound Registry
Scope of Review: New admissions with wounds

	Yes	No	N/A	Quality Measure
1	☐	☐	☐	MD/PA documents a thorough skin assessment within 24 hours of admission?
2	☐	☐	☐	MD/PA documents staging and description of each wound within 24 hours of admission
3	☐	☐	☐	There is evidence of weekly Round Care Team rounds which include assessment, and full description of each wound, progress and tx plan
4	☐	☐	☐	MD/PA writes order for wound care consult ordered for Stage III, IV, STDI or unstageable wounds within 24 hours
5	☐	☐	☐	Admitting MD/PA writes orders for each wound within 24 hours using the Wound Protocol and writes appropriate orders.
6	☐	☐	☐	Were recommendations from nutrition staff addressed in medical orders?
7	☐	☐	☐	Were recommendations from wound care nurses addressed in medical orders?
8	☐	☐	☐	For pts with Stage I or II wounds, there is evidence of weekly skin assessments and plans.

Comments:

Action Taken on any Identified Issues

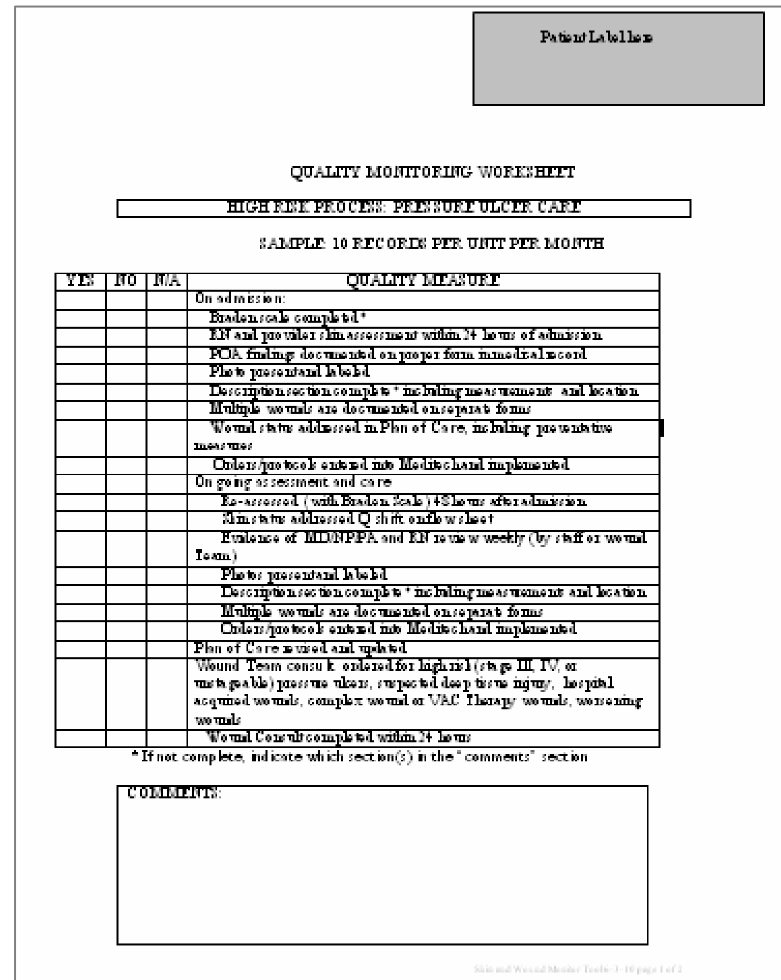
☐	Discussion at Medical Staff Meeting
☐	Immediate education of MD or PA
☐	In-service/ education of staff
☐	Additional orders/Clarification of orders
☐	Additional documentation in record

Date of Review:________ Name of Reviewer :__________________

Form revised on: 7/16/10

Nursing Audits

Risk Assessment, Documentation, Plan of Care



Patient Label here

QUALITY MONITORING WORKSHEET

HIGH RISK PROCESS: PRESSURE ULCER CARE

SAMPLE: 10 RECORDS PER UNIT PER MONTH

YES	NO	N/A	QUALITY MEASURE
			On admission:
			Braden scale completed*
			RN and provider skin assessment within 24 hours of admission
			POA findings documented on proper form in medical record
			Photo present and labeled
			Description section complete* including measurements and location
			Multiple wounds are documented on separate forms
			Wound status addressed in Plan of Care, including preventative measures
			Orders/protocols entered into Meditech and implemented
			On going assessment and care
			Re-assessed (with Braden Scale) 48 hours after admission
			Skin status addressed Q shift on flowsheet
			Evidence of MD/NP/PA and RN review weekly (by staff or wound Team)
			Photos present and labeled
			Description section complete* including measurements and location
			Multiple wounds are documented on separate forms
			Orders/protocols entered into Meditech and implemented
			Plan of Care revised and updated
			Wound Team consult ordered for high risk (stage III, IV, or unstageable) pressure ulcers, suspected deep tissue injury, hospital acquired wounds, complex wound or VAC Therapy wounds, worsening wounds
			Wound Consult completed within 24 hours

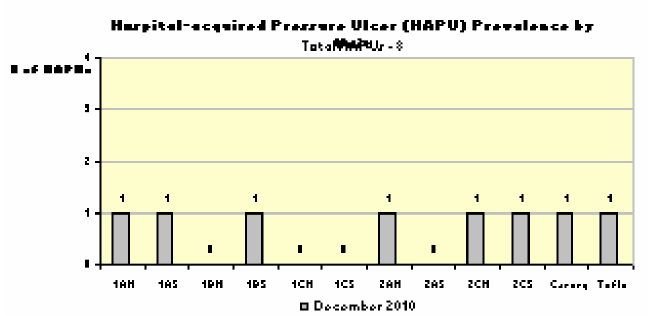
* If not complete, indicate which section(s) in the "comments" section

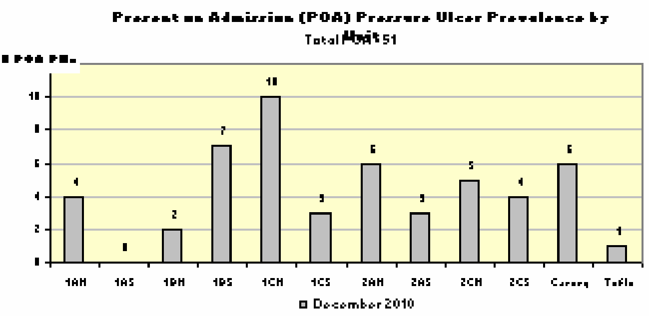
COMMENTS:

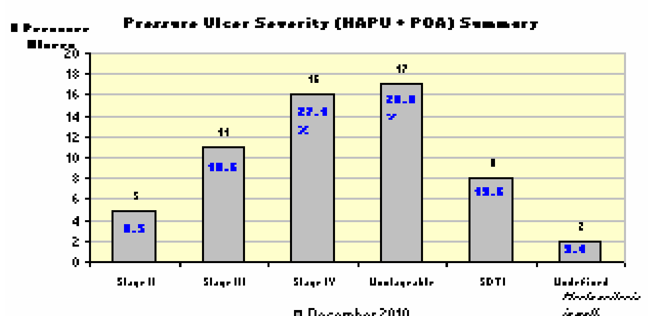
NEW ENGLAND Sinai HOSPITAL

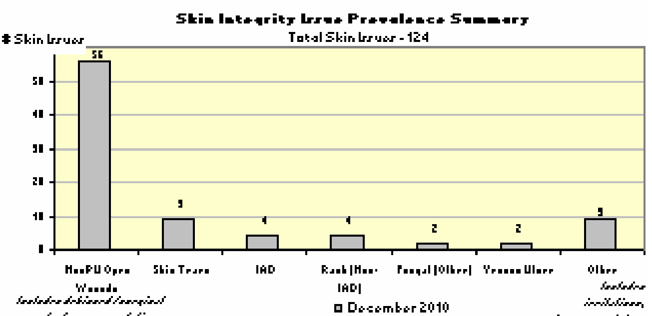
Skin and Wound Program Quality Dashboard

Inpatient Wound Care Demographic Data

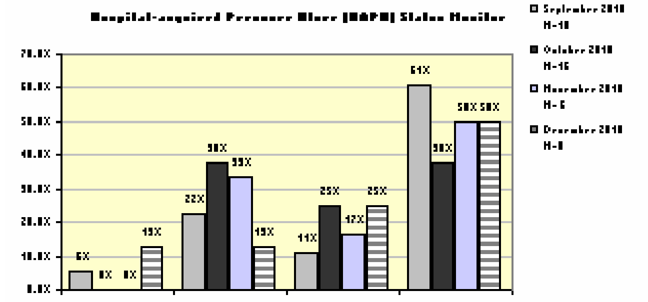


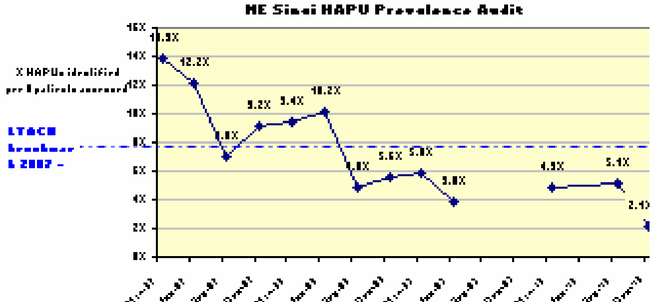






Inpatient Wound Care Outcomes Data

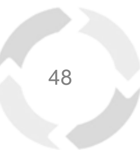




Front Page / Demographic Data Inpatient / 123010 / HAPU Healing Rates / PUP Audit / IAD vs S

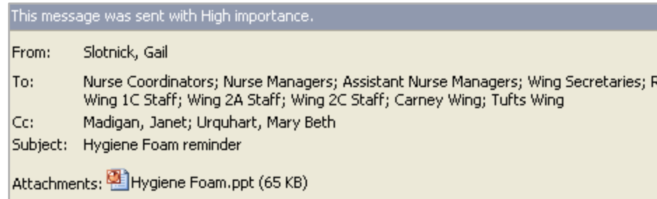
Communication, Communication, Communication

- Reports
    - Payors
    - Regulators
    - Accreditors
- Patients/Families - letters
- Town meetings
- Board of Director communication process change
- Patient Care Assessment Committee monthly update
- Medical Performance Improvement Committee
- Quality Management reporting changes



Communication – Clinicians

This message was sent with High importance.



From: Slotnick, Gail
To: Nurse Coordinators; Nurse Managers; Assistant Nurse Managers; Wing Secretaries; R Wing 1C Staff; Wing 2A Staff; Wing 2C Staff; Carney Wing; Tufts Wing
Cc: Madigan, Janet; Urquhart, Mary Beth
Subject: Hygiene Foam reminder
Attachments: Hygiene Foam.ppt (65 KB)

Please use hygiene foam to bathe, cleanse and safeguard the skin of our ***incontinent patients*** *at risk for and/or with active* ***incontinence associated dermatitis (IAD)****. This product is available in each unit supply room and is stocked by CSR.*

Thanks for your support with this.

Email
Attestations
Huddles

CLINICAL PRACTICE ALERT

(PLEASE POST IN THE COMMUNICATION BOOK)

To: Nursing Department Staff
From: Mary Beth Urquhart
Date: May 10, 2011
Topic: Safe Patient Handling

Success Stories – Internal & External Stakeholders

A Team Approach to Wound Care Delivery

The teamwork approach to wound care delivery is alive and well at New England Sinai Hospital. Nursing, Medicine, Therapies, Nutrition and Respiratory work collaboratively to ensure that our patients with wounds receive consistent and compassionate care. This was never more evident than in our recent interaction with a complex and challenging patient admitted to 1C for wound care. Sinai clinical and support departments all played critical roles in supporting AB during his stay and collectively worked to get him better.

A complicated course

Like many of our patients, he had complex medical and nursing needs. He became a quadriplegic following a motor vehicle accident. He came to Sinai with multiple wounds (ten in all) after a two-month acute hospital stay. The multiple wounds were a result of infections, prolonged bedrest and significant pain – limiting AB's capacity to turn and reposition. On his arrival to 1CN the clinicians and support team implemented a coordinated plan of care for his wounds and to prevent further skin breakdown. The Braden scale was used to measure his risk for skin damage. Goals for AB included improving pain management, optimizing nutrition, enhancing wound healing and gradually encouraging mobilization.

Thanks to the dedicated teamwork on 1CN, many of the patient's goals were met, a large percentage of his skin healed and he was discharged and returned to his residence in mid-February.

Open and clear lines of communication

LizAnn Rhodes, RN, recalls spending a great deal of time reassuring him and gaining his confidence in order to optimize his care. "He was so afraid to move. We had to have two or three people in with him to help turn or do any dressing changes. I was always looking at him or talking him through any physical activity."

She says that the support of the wound care team was key in supporting the nursing staff as they provided direct care. "Vivian was always there or responded quickly when we needed some advice or direction. She would always listen to our input," she added.

Valued wound care expertise

Dr. Weinreb worked closely with nursing and the wound care team to make sure all aspects of the patient's care was coordinated. LizAnn commented that working closely with Dr. Weinreb was helpful. "He has respect for the nursing staff which is something we appreciate."

Vivian Sternweiler, MSN, wound care RN, assessed the patient on admission from head to toe, reviewed findings and plan of care recommendations with Dr. Weinreb and nursing to assure that the communication loop remained continuous and consistent – a safety mechanism usually called a "handoff."

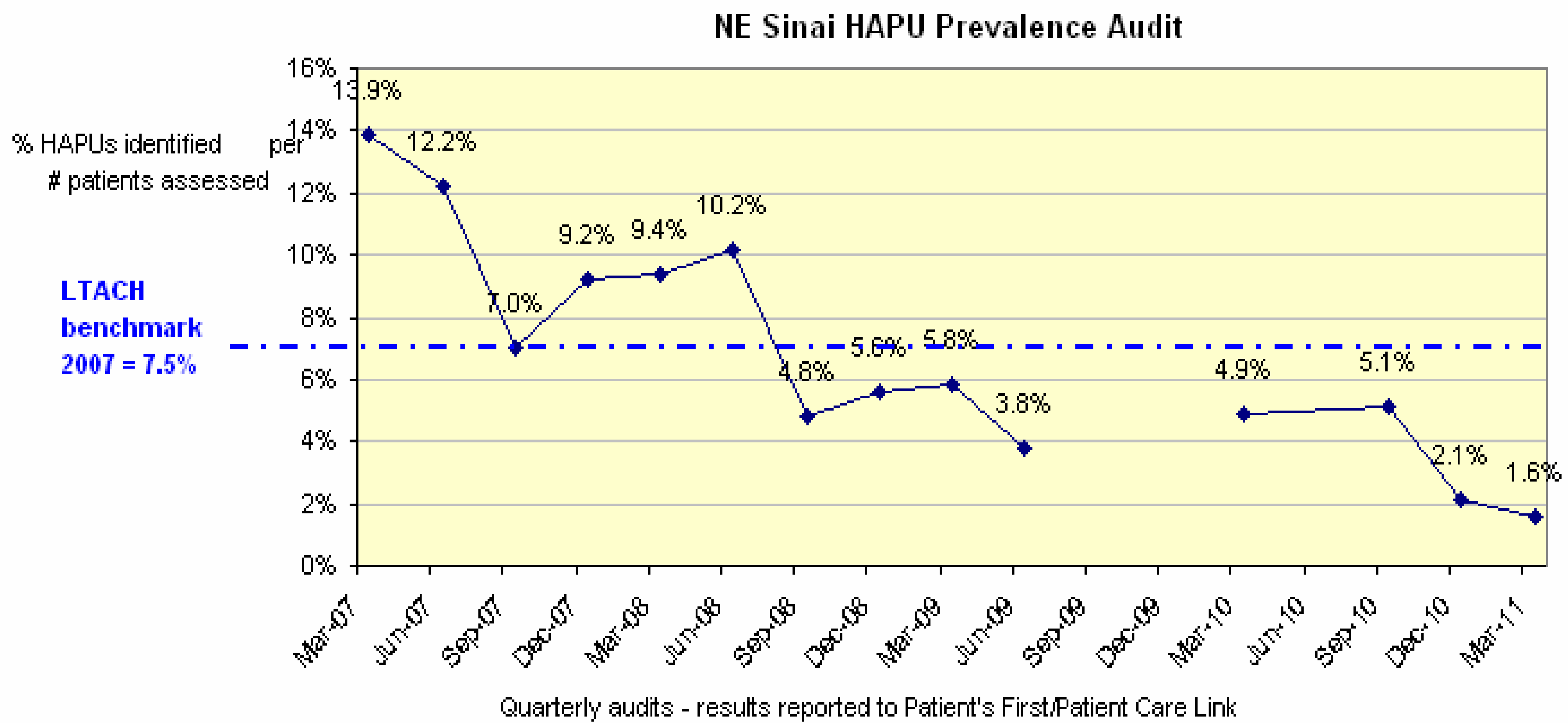
A difficult hand

Many of the patients we care for have been dealt a difficult hand and this patient was no exception. As a long-term, acute care facility, Sinai has to be prepared to manage and care for patients that are suffering great physical and spiritual loss. The carefully orchestrated teamwork in this case shows Sinai at its best. What we learn from one patient helps us care for the next patient.

Team from left to right: Heather Revaleon, Wound Care RN, Noah Rosen, MD, Director, Inpatient Wound Care, Stella Floru PA-C, Kathy Jones, RN 1C, Diane Sonia, RN, Resource Nurse 1C, Connie Barksdale, PA-C, Donna Metcalf, Wound Care RN, Michele Anderson, Wound Care RN and Yaakov Weinreb, MD, attending physician.

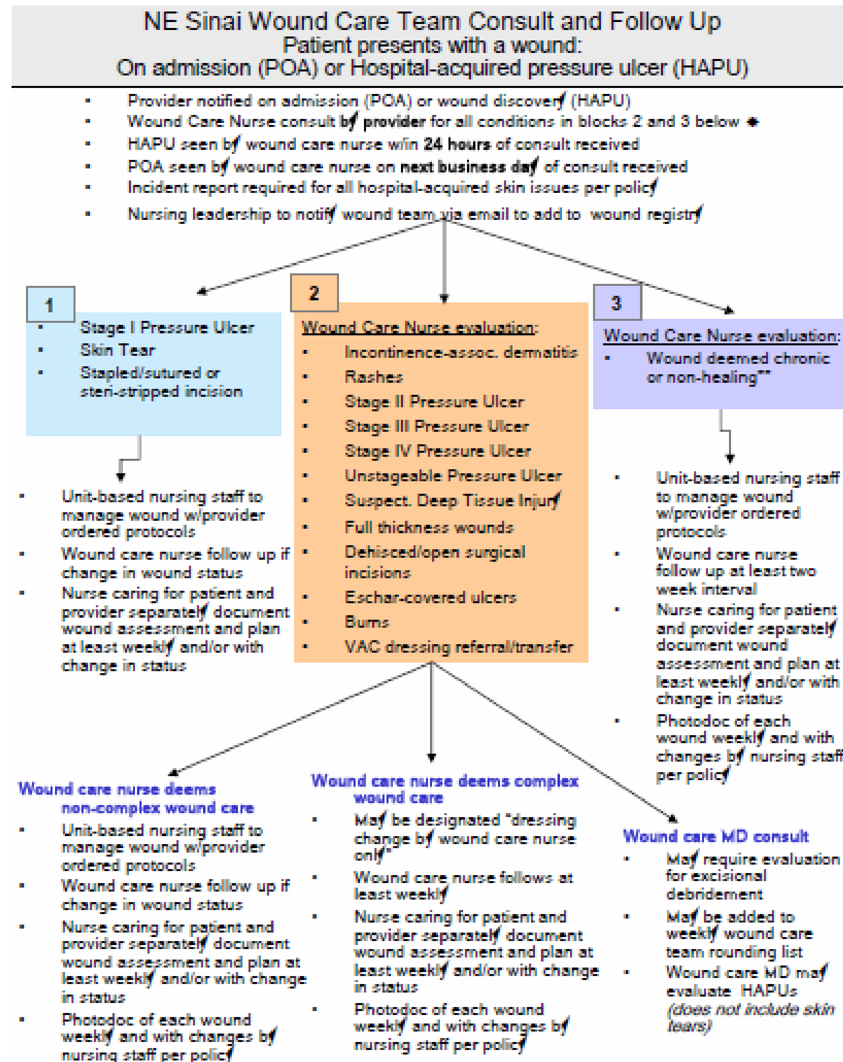
NEW ENGLAND Sinai HOSPITAL

Evolution with Outcomes



NEW ENGLAND Sinai HOSPITAL

Wound Policy and Practice Refinements



Strategic Quality Goals

Strategic Goal	Goal for next 12 months Oct 2010 – Sep 2011	As of 5/31/11	Interventions to achieve goals
Reduce inpatient falls resulting in major injury	≤2	1	Fall Task Force which includes bedside Nursing, Environmental Services and Pharmacy staff
Reduce the number of Stage III and IV hospital acquired pressure ulcers	≤7	1	Pressure Ulcer Task Force Weekly wound rounds New Nutrition Products Ongoing monitoring by Nursing and Medicine.
Reduce Hospital Acquired infections: •Vent Pneumonia •Catheter Associated UTI •C-Difficile •Central line infection	≤5 ≤43 ≤40 ≤12	3 30 49 2	Removal of unnecessary catheters and IV lines Curos port protectors Hand Hygiene Compliance Antibiotic Stewardship C-Diff Collaborative/Team Foley Catheter Care Team with Physician Champion

Short and Long Term Goals

- ↓ HAPU incidence
  - ½ in 12 months
  - 0 in 3 years
- Full time MD director inpatient/outpatient wound care
- Grow outpatient wound care program
- Develop NE Sinai Hospital wound care clinicians