

Falls and Pressure Injuries Collaborative Learning Session 3 26 August 2014

Title: Improving Pressure Injury Reporting

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Organisation: Waitemata DHB

FAST Improving Pressure Injury Reporting Project Team members

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Key problem

- Comparison of RiskPro (incident reporting system), Clinical Coding and Pressure Injury Prevalence audit data in 2013 showed reporting across these systems was inconsistent.

Waitemata DHB July 2013 - Dec 2013

107 pressure injuries reported

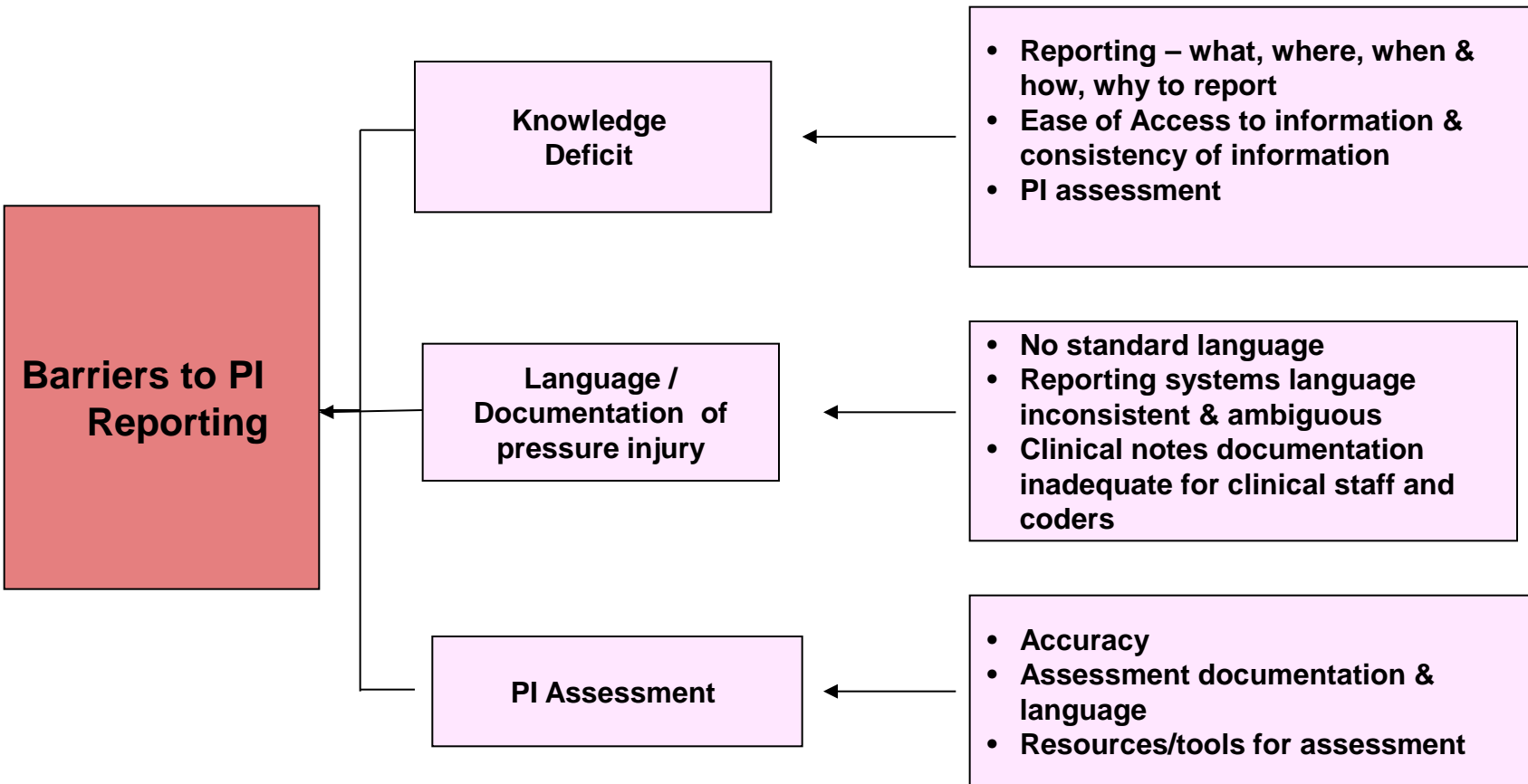
- Risk Pro reported only 67% of all PI (n=72)
- Clinical Coding reported only 30% of all PI (n=32)

PI Prevalence Audit

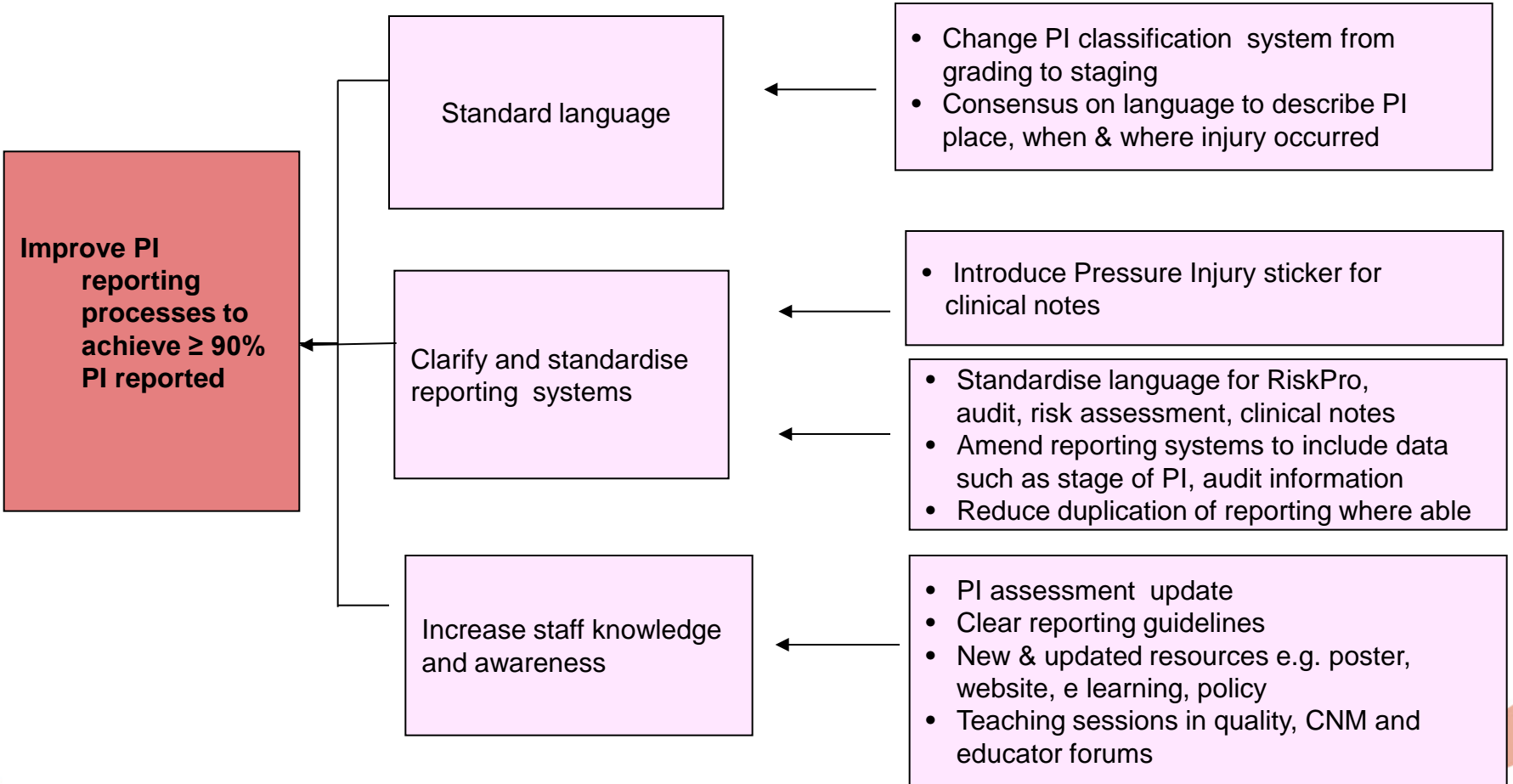
- 580 patients audited
- 15 PI reported at audit
- Only 7/15 reported in Risk Pro (46%)
- Only 1/15 reported in coding (6%)

- A Quality improvement project was commenced in March 2013 using the WDHB FAST QI methodology to improve pressure injury reporting

Barriers to accurate reporting



Driver Diagram for Improvement



Changes tested

- Introduction of pressure injury sticker to clinical notes on 30 June 2014
- Pressure Injury language standardised in RiskPro, Prevalence Audit, Waterlow assessment forms
- Teaching sessions and resources on assessment & reporting requirements e.g. posters, updated website, updated policy and e-learning (in progress)

PRESSURE INJURY (PI) IDENTIFIED			
Anatomical location of Pressure Injury Please use 1 sticker per Pressure Injury	Stage of PI	How Pressure injury developed?	Action/Treatment
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Unstageable/Suspected deep tissue Injury	<input type="checkbox"/> Present on this admission to hospital <input type="checkbox"/> Hospital acquired (This stay) Care setting where PI developed? <input type="checkbox"/> Acquired on this ward <input type="checkbox"/> Acquired on another ward (name ward) <input type="checkbox"/> Acquired at home <input type="checkbox"/> Acquired at another health setting (name setting)	<input type="checkbox"/> Risk Monitor Pro Logged Incident number <input type="checkbox"/> ACC form logged if 2 Stage 2 ACC number <input type="checkbox"/> Pressure risk assessment reviewed <input type="checkbox"/> Treatment care plan documented <input type="checkbox"/> Wound chart commenced <input type="checkbox"/> PI resolved/healed
Specify	Staging Change (Report deterioration only)		
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Unstageable/Suspected deep tissue injury		
	Name: _____	Date: _____	Date: _____
	Sign: _____	Ward: _____	Time: _____
Date Issued: Jun 2014 Classification: 0180-01-048			

Pressure Injury Reporting and Documentation

- Report ALL STAGES of pressure injury (hospital and community acquired) in incident reporting system (RiskPro)
- Complete ACC 45 & ACC 2152 for hospital acquired PI Stage 2 or >
- Complete pressure injury sticker & place in notes
- Complete wound care chart
- Complete pressure injury risk assessment (Waterlow)

PRESSURE INJURY MANAGEMENT

Stage 1 pressure injury: non-blanchable erythema

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence.
- Discoloration may be pale, red, or purple and may differ from the surrounding area.
- The area may be painful, itchy, warm or cool compared to adjacent tissue.
- May be difficult to detect in individuals with dark skin tones.
- May indicate "at risk" persons (a foreshadowing sign of risk).

Stage 2 pressure injury: partial thickness skin loss

- Partial thickness loss of dermis presenting as a shallow, open wound with a well-pink wound bed, without slough.
- May also present as an intact or ruptured serum-filled blister.
- Presents as a shiny or dry shallow ulcer with or without slough or fibrinous (fibrinous) material present near the wound.
- Stage 2 PI should not be used to describe skin tears, stage 2 burns, or other devices, restraints or excoriations.

Stage 3 pressure injury: full thickness skin loss

- Full thickness tissue loss. Subcutaneous fat may be visible or visible or visible or visible.
- Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- The depth of a stage 3 PI varies by anatomical location. This stage of the tissue loss indicates that full-thickness tissue loss has occurred. Stage 3 PI can be shallow in certain areas of significant adiposity can develop substantially deep stage 3 PI. Slough or fibrinous is not visible or directly palpable.

Stage 4 pressure injury: full thickness tissue loss

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage 4 pressure injury varies by anatomical location. The bridge of the nose, ear, orbital and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage 4 PI can extend into muscle and/or supporting structures (e.g. tendon, tendon or joint capsule) (unless contraindicated, exposed bone or tendon is visible or directly palpable).

Unstageable pressure injury: depth unknown

- Full thickness tissue loss in which the base of the PI is obscured by slough (yellow, tan, grey, green or brown) and/or eschar (black, brown or black) to the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Slough (dry, adherent, moist without erythema or fluctuance) within the wound serves as the body's natural biological cover and should not be removed.

Suspected deep tissue injury: depth unknown

- Purple or maroon localized area or discolored, intact skin or blood-filled blisters due to damage of underlying tissue. The area may be painful, itchy, warm or cool compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Eschar may include a thin layer over a dark wound bed. The PI may further evolve and become covered by this eschar. Evaluation may be made, exposing additional layers of tissue even with optimal treatment.

Incident / Event Reporting System (Test)

1 Results Listed

INCIDENT

Please take care that you are reporting the correct PI stage in your selection of incident type. We will only use the information you provide to assist you in the care of the patient.

Please click the 'PI' link to go to the report.

General Incident/Event Information

Person Affected

Event Details

Specific Incident/Event Details

Staff/Incident/Event Type:

Person/Event Stage:

Incident/Event Description:

Contributing Factors:

Immediate Action Taken:

When was skin injury noticed:

If help acquired - which ward:

Severity Score (See Appendix):

Has the incident been reported:

PRESSURE INJURY PREVENTION

CHECK All patients on admission • Full risk assessment • Assess patient within 8 hours of arrival or prior to care using Waterlow assessment to determine pressure injury risk	DETECT High Risk Level • Waterlow Score 23+ • Unstageable or suspected deep tissue injury • Major orthostatic surgery	ACT Minimum Pressure Injury (PI) prevention measures • Complete pressure injury risk assessment (Waterlow) • All four hour prevention • The bed base patient care and other on broken skin • 2 hourly repositioning (turning) • Twice daily skin inspection • Document care and treatment • Use minimum risk PI prevention plan with all staff, patient and their carer	Pressure Injury Reporting and Documentation • Report ALL STAGES of pressure injury (hospital and community acquired) in incident reporting system (RiskPro) • Complete ACC 45 & ACC 2152 for hospital acquired PI Stage 2 or > • Complete pressure injury sticker & place in notes • Complete wound care chart • Complete pressure injury risk assessment (Waterlow)
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What tests worked

- Changes to database information implemented successfully
- Good compliance completing stickers and RiskPro for pressure injuries identified on audit.
 - Monitoring of impact on improved congruence between coding and RiskPro planned for September onwards
- Educational resources in development

What tests failed

- Project progressing well.
 - Implementation is in early phase
 - Interventions continue to be progressed eg: education review

What we learnt

- Do not assume every person interprets the process or language in the same way
 - Eg: present on admission (to the ward or the hospital)
- Following up initial implementation to ensure understanding is sustained
- Investigate good performance to gain assurance that reported performance is actual performance
- Keep information for reporting simple and standardise if possible

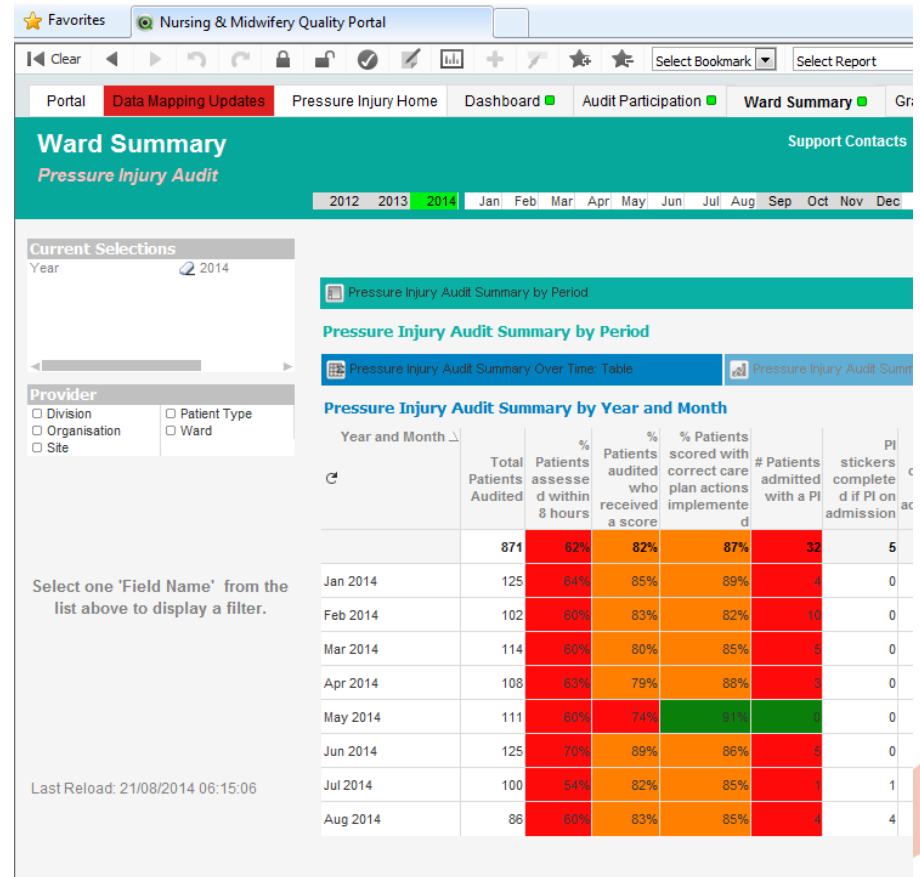
Any data demonstrating success or failure

- Data from total PI reported on RiskPro and Clinical Coding planned for September
- PI Prevalence audit data shows:
 - 54% improvement in completion of RiskPro
 - 100% compliance with sticker completion

Date	PI at prevalence audit	PI Sticker completed	Risk Pro completed
July 2014	2	100%	100%
Aug 2014	5	100%	100%

How will the changes last?

- Monitoring impact
 - FAST QI project team monthly tracking of Risk Pro, Clinical Coding and Audit reported pressure injuries
 - Incorporate into QlikView data analysis
- Results provided to Charge Nurse Managers
 - Qlikview audit database allows wards and services to monitor results monthly including compliance of sticker and Risk Pro completion
- Continue to use results for Quality improvement
 - Identify next area for improvement based on results and investigations



Suggestions

Any comments, questions, suggestions or contact information from teams who might be able to contribute to solution finding

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