

SAVE OUR SKIN: PREVENTING PRESSURE ULCERS

OSF ST. FRANCIS MEDICAL CENTER (SFMC)

- ◆ Peoria, IL
- ◆ 616 beds
- ◆ www.osfsaintfrancis.org

OSF St. Francis Medical Center serves a 37-county area. Owned by the Sisters of the Third Order of St. Francis, SFMC is a teaching hospital and has a Level I trauma center. It is part of OSF Healthcare System.

STEEEP

Safe

Substantially lowered pressure ulcer incidence rate.

Timely

Every two hours each adult patient is repositioned to prevent pressure ulcers from developing.

Effective

1,700 fewer SFMC patients a year develop pressure ulcers.

THE PROBLEM

Nearly one million people develop pressure ulcers each year, and 60,000 U.S. hospital patients die annually from complications related to pressure ulcers. The treatment costs can be significant; treating a pressure ulcer can run \$2,000 to \$70,000 per wound. The national incidence of hospital-acquired pressure ulcers averages from seven to 10 percent. At 9.4 percent, SFMC found its rate unacceptable.

THE SOLUTION

SFMC developed a comprehensive program, called Save Our Skin (SOS), to reduce the incidence of pressure ulcers among patients. The key elements of the program incorporates evidence-based practices and includes upgrading mattresses, clarifying staff roles and protocols and improving measurement and communication of pressure ulcer performance data.

RESULTS

- » SOS reduced the incidence of pressure ulcers from 9.4 percent in 2001 to 1.5 percent in 2006, the end of the official study period.
- » Progress continues, as the rate dropped to 0.6 percent as of September 2008.

BACKGROUND

When SFMC officials committed to pressure ulcer prevention in 2001, the institution was becoming a Six Sigma organization and its corporate office was looking at nursing quality across the system. “Pressure ulcers are a key indicator of nursing care,” says Bevette Griffin, RN, a certified wound ostomy nurse. Yet pressure ulcers were far too common at the hospital.

Why was the rate so high? As with many hospitals, pressure ulcers weren’t prominent on the radar at SFMC, even though guidelines for their prevention exist. Pressure ulcer prevention protocols often aren’t followed because the problem falls down the pecking order of duties of nurses, who typically need to deal with more acute patient problems.

“We put the evidence-based practice in place, but we did not have a process to support our efforts” says Hoa Cooper, then a Six Sigma black belt. To develop such processes, SOS champions were assigned on each patient care unit to provide education and support; a measurement tool was put in place so each unit could assess progress; a policy of turning patients every two hours was enacted with follow-up medical record documentation; pressure-redistribution mattresses were purchased; and the SOS effort was made public as each unit’s quarterly results are published.

“We put accountability back into the system,” Cooper says. A “quick win” was crucial for staff to see progress. Pressure ulcer prevalence was cut by half within five months; this initial success provided momentum, but sustaining the effort required other changes. These include playing part of the Olympic theme song over the hospital speaker system every two hours as a reminder to nurses, sending nurses a page message every two hours to prompt them to reposition their patients, conducting regular chart audits, and placing SOS signage on at-risk patients’ doors.

TEAM MEMBERS

- » **Susan Campbell, RN**
Chief Nursing Officer
- » **Hoa Cooper**
Operations Director
for the Hospitalist Services
- » **Mike Cruz, MD**
Vice President
for Quality and Safety
- » **Lynn Folkerts, RN**
SOS Champion
- » **Bevette Griffin, RN**
Certified Wound Ostomy Nurse
(CWON)
- » **Cassy Horack, RN**
Director of Quality and Safety
- » **Melissa Klyber, RN**
CWOCN
- » **Deborah Schimmelpfenning, RN**
CWON
- » **Keith E. Steffen**
CEO

The effort wasn't flawless, and some nurses resisted. "They thought it was too basic," recalls Susan Campbell, RN, chief nursing officer. The perception among nurses was that they were already doing the things to prevent pressure ulcers. But that wasn't the reality. "Nurses will respond to science and evidence-based care," notes Griffin. After showing them the facts, the message was while you may be doing it, doing it consistently is what matters.

PRINCIPLES OF PERFORMANCE EXCELLENCE

Eliminating Defects

SOS gave the initiative leaders a reason to step back and examine why pressure ulcers were frequent events. "We realized some started in surgery," says Campbell. The reason: patients were in the same position for up to several hours. "Trauma patients also were discovered to be at risk, because many lie prone on a backboard for extended periods. Other units, from cardiac care to orthopedics, were examined in order to get a better sense of the root causes of pressure ulcers.

Patients themselves were more thoroughly assessed. The hospital was admitting older and sicker patients. Poor nutrition is also another contributor to pressure ulcers. Traditional hospital mattresses contributed to pressure ulcers. Identifying root causes of pressure ulcers allowed SFMC to address the problem more effectively.

Creation of High Reliability Culture

Commitment starts with leadership. The decision to purchase pressure redistribution mattresses sent the message to staff that administration at SFMC was committed to improving patient care and serious about the effort. "This showed that SFMC leadership was committed to high quality care that is safe for their patients," says Cassy Horack, director of quality and safety.

Giving frontline workers ownership of SOS was essential. Confronting some initial hesitation, managers and SOS champions worked with nurses to identify and address perceived barriers. Once the tools and basic processes were in place to guide nurses, a good thing happened—SOS became a priority among staff. Suddenly, lift teams sprouted to turn certain patients, for example. Keeping patients pressure ulcer free has become a badge of honor. When the orthopedic unit suffered its first patient pressure ulcer in three years, Lynn Folkerts, RN, an SOS champion, called it "devastating."

While nurses were given more ownership, accountability was also built into the initiative. Monthly chart audits were done until a 90 percent compliance rate was reached; now audits are done quarterly. Four indicators are measured: initiation of prevention protocol; providing patient/family education; documenting patient repositioning every two hours; and putting SOS signs on patient

doors. Units that didn't meet the targets have to develop action plans and return to monthly audits.

CONTINUAL IMPROVEMENT

"It's been a journey," says Campbell. "We keep fine-tuning and fine-tuning." When lift teams were instituted, the incident rate fell lower. Every bit helps, not only in terms of preventable patient harm, but it helps SFMC financially. Compared to its baseline pressure ulcer incidence rate, the hospital now saves about \$4 million annually. Those savings became important in October 2008, when Medicare stopped paying hospitals for hospital-acquired pressure ulcers. Meanwhile, SFMC continues to seek to prevent pressure ulcers, even scrutinizing units not traditionally thought of as sources for the condition, such as the pediatric intensive care unit.