THE LINK

www.caet.ca

DECEMBER 2014

VOLUME 25, ISSUE 3

The Canadian Association for Enterostomal Therapy

TARGETING PRESSURE ULCERS

© Wavebreak - istock

LE LIEN

DECEMBRE 2014

VOLUME 25, PUBLICATION 3

PM42202514

Association Canadienne des Stomothérapeutes

LET'S TAKE THE PRESSURE OFF!

STREAMLINING PRESSURE ULCER IDENTIFICATION AND PROMOTING IMPROVEMENT USING AN ELECTRONIC PATIENT SAFETY EVENT AND LEARNING SYSTEM IN BC

Authors:

Rosemary Hill RN, BSN, CWOCN, is an Enterostomal Therapist with Vancouver Coastal Health – Lions Gate Hospital

Shannon Handfield RN, BSN, CWOCN, is Clinical Lead/Implementation Lead eWMS (Pixalere) with Provincial Health Services Authority, Vancouver Coastal Health, Providence Health Care.

Annemarie Taylor RN, BSN, MA, is Executive Director, BC Patient Safety & Learning System, Provincial Health Services Authority.

Michelle Preston MA, is Communications Specialist, BC Patient Safety & Learning System, Provincial Health Services Authority.

INTRODUCTION:

The prevalence of pressure ulcers (PUs) has, in recent years, become widely recognized as a serious patient safety concern. Studies show that PUs can occur in all locations of care – in hospitals, residential settings and the community – and cause considerable distress for patients, families, caregivers and healthcare providers.[1] The resulting costs incurred by the healthcare system can be exorbitant due to lengthy or extended hospital stays and the additional nursing time required. The majority of PUs occur in patients aged 65 years and older and, given the increasing numbers of our aging population, PUs are likely to become an even greater clinical concern in the near future.[2] Early detection and early intervention are essential to both prevent pressure ulcers from occurring and to provide effective mitigating treatment before wounds become serious or life-threatening.

Early detection and early intervention are essential to both prevent pressure ulcers from occurring and to provide effective mitigating treatment before wounds become serious or life-threatening.

Wound Clinicians and Enterostomal Therapists practicing in acute, community, and residential care settings, with their focus on PU prevention, need current data about PU occurrences in order to be most effective in their work. This data includes information about the different patient populations in which PUs have occurred and the areas of the body most often affected. Knowing whether the healthcare provider used a PU risk assessment tool is also a key piece of information. Much of the current literature regarding PU prevention and management states that it is critically important for nurses to use a reliable and valid PU risk assessment tool to identify those at risk.[3] The literature also underscores the value of incorporating an interdisciplinary approach to PU prevention, which is enabled by the PU risk assessment.[4] Once patients, clients or residents are identified to be at risk of PU, nursing interventions can be employed to manage extrinsic factors such as friction,

LET'S TAKE THE PRESSURE OFF! (cont.)

The PNSWC Committee and the BC PSLS Central Office team met regularly for several months using an evolving, iterative approach to come up with a new Safety Event Report Form tailored to PU reporting.

shear and moisture. Consultation with an occupational therapist may result in a variety of off-loading devices being added to the plan of care. These are just a few examples of strategies that can be broadly incorporated throughout an institution while being individualized to specific care areas in an effort to stop a PU from developing, halt further deterioration or prevent additional occurrences of skin breakdown and, ultimately, minimize pain and suffering for the individual. The first steps, however, are to collect the necessary PU incident information and make it readily available to Wound Clinicians and Enterostomal Therapists so they can act upon it for the individual patient, client or resident and also respond to the cumulative data that would allow unit, site or regional strategies for the prevention of PUs.

BC Patient Safety & Learning System:

In British Columbia (BC), healthcare providers across the care continuum use the BC Patient Safety & Learning System (BC PSLS), a provincial online 'incident reporting system', to report and manage patient safety events, safety hazards and near misses (http://bcpslscentral.ca/). Since the system was first launched in early 2008, BC PSLS has helped to foster and promote a culture of safety that values reporting, shared learning and quality improvement in all areas of patient care in BC. Approximately 100,000 healthcare providers use BC PSLS to report safety concerns identified in their clinical areas. Over 10,000 healthcare leaders, responsible for responding to and following up on safety reports, log into the system and perform event management tasks. Summary reports of BC PSLS data are available to these leaders in order to give them a comprehensive overview of safety issues in their area(s) of responsibility. There are, on average, over 350 safety event reports submitted each day from across BC, resulting in, to date, approximately 600,000 event reports in the BC PSLS database, which offer a rich basis for learning and improvement.[5]

PUs were not initially well-reported to BC PSLS. The data classification system was originally set up so that it was hard for users to find the "right place" to report a PU and no targeted efforts had been made to encourage staff to report these specific issues in the system. Beginning in 2013, however, an increased focus on PUs as a major patient safety concern led to changes and improvements in the way information about these events was collected in BC PSLS.

Pressure Ulcer Reporting:

The British Columbia Provincial Nursing Skin & Wound Committee (PNSWC) carefully considered the kind of information that should be collected about PUs in order to prevent them and to mitigate the harm associated with them. They asked questions such as: At what points of care are PUs occurring? At what points of care are they being discovered? What type of patient is most affected? Are assessments being done consistently and what tools are being used? What is being done to prevent pressure ulcers? Are prevention efforts being applied consistently? How can BC PSLS data support learning and improvement across the care continuum?

The PNSWC Committee and the BC PSLS Central Office team met regularly for several months using an evolving, iterative approach to come up with a new Safety Event Report Form tailored to PU reporting. Enhancements included new standardized questions, more relevant data fields, images of pressure ulcer stages to guide reporters and customized "help" text. All updates were designed to enable care providers

LET'S TAKE THE PRESSURE OFF! (cont.)

Table A: Specialized questions used on BC PSLS Pressure Ulcer Safety Event Report Form

Assessment
On admission, was a head-to-toe skin inspection documented?
When was the first pressure ulcer risk assessment documented?
As a result of the assessment, was the patient documented to be at risk for a pressure ulcer?
Was the Braden Scale used?
If yes: What was the most recent Braden Scale score?
Were other risk assessment scales
If yes: What scales were used?
When was the most recent pressure ulcer risk assessment documented?
Prevention
Prior to discovery of the pressure ulcer, was any preventative intervention initiated?
If yes: Which interventions were initiated?
Description and contributing factors
Describe the circumstances resulting in the pressure ulcer
What is the stage of the most severe pressure ulcer?
For each pressure ulcer, select the stage and body part involved
Was the use or availability of a device or product a factor in the development of the pressure ulcer?
If yes: What was the device or product involved?

to report PU issues in a more comprehensive, simple and uniform way. (See Table A)

The work of the Committee was further informed by work done by the Agency for Healthcare Research and Quality (AHRQ) focused on PUs as a patient safety concern.[6] These "Common Format" questions for reporting PUs were helpful as they are intended to help users collect the information needed to understand why, where, how and to whom the problem is occurring so that targeted improvements can be made in the areas of prevention, detection and mitigation.

On February 14, 2014 the new Pressure Ulcer Safety Event Report Form was launched and made available to healthcare providers across BC. A provincial marketing campaign that included a specialized logo, buttons, bulletins and the slogan 'Let's take the pressure off!' helped raise awareness among staff regarding the importance of pressure ulcer detection, early prevention and the new report form. Wound Clinicians and Enterostomal Therapists helped to get the word out by connecting directly with staff on the front lines, offering educational sessions and in-service opportunities and providing support to staff who needed help or information. Pressure Ulcer incidents were reported to BC PSLS in the same way other types of safety events were reported with an emphasis on the same key message – that this information was being collected and shared to promote learning and drive improvement… not to assign blame.

The authors of this paper received a great deal of positive feedback on the form. Nurses at Lions Gate Hospital in North Vancouver, BC were quick to report that the completion of the electronic document was simple and intuitive and that they particularly appreciated the quick link to pictures meant to help them discern the stage of the PU that they had discovered. A surgical nurse of 11 years summed it up well when she said "That link is brilliant!". A Licensed Practical Nurse, new to practice, chose the "band-aid" icon link (see Figure 1) to the safety report form and described it as "really helpful". An emergency geriatric triage nurse from Vancouver Coastal Health, who sees many elderly patients in the course of her 10 hour work days, commented that she found it easy to access the report with just a click on the band-aid icon and was able to quickly fill in the form. She also commented that the best part of the new electronic form is the ready access to pictures of

Wound Clinicians and Enterostomal Therapists helped to get the word out by connecting directly with staff on the front lines, offering educational sessions and in-service opportunities and providing support to staff who needed help or information.

LET'S TAKE THE PRESSURE OFF! (cont.)

Figure 1: BC PSLS landing page with forms icons

pressure ulcers and their stages to help guide consistent reporting. It is worth noting that a nurse or care provider usually experiences a degree of distress upon discovering a PU so it is important that the reporting tool is simple and easy to complete, focuses on the PU, and does not look to assign blame.

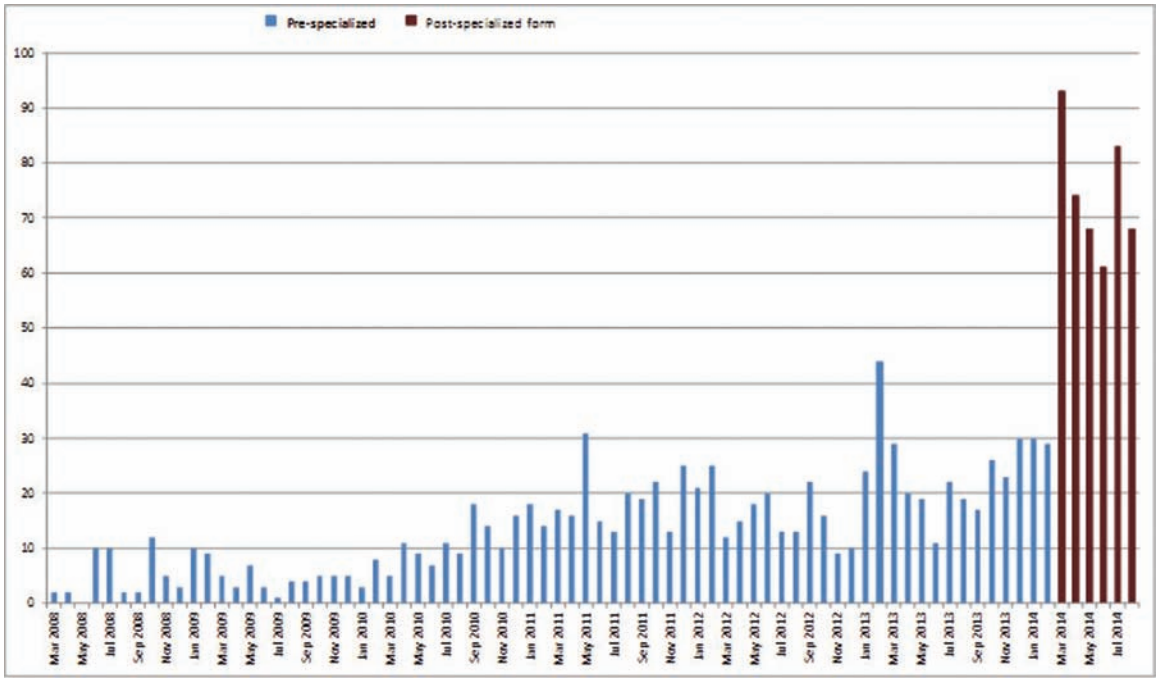
Wound Clinicians and Enterostomal Therapists consider it essential to know as much as possible about patients, clients and residents that develop a PU. Specific data related to individual intrinsic and extrinsic factors, including advanced age, poor tissue perfusion, the use of a PU risk assessment tool and any prevention interventions utilized all contribute to the understanding of how the PU occurred and help inform strategies toward the overall long term goal of PU prevention. One Enterostomal Therapist noted, to one of this paper's authors, that "Having a documentation tool that is readily accessible, used by a variety of healthcare professionals and easy to complete is invaluable. I have appreciated the opportunity to teach many staff members about BC PSLS, specifically pressure ulcer reporting, as I believe it will provide significant steps towards ongoing prevention. It's helpful for staff to realize that multiple efforts are underway to capture the information so all efforts can be focused on reduction of occurrence."

Early Findings and Future Opportunities:

The increased focus on PU reporting and learning has helped shed light on the severity of this issue across BC's healthcare system. The Pressure Ulcer Safety Event Report Form is still relatively new but the BC PSLS Central Office reports that all six BC health authorities have provided feedback and it has been positive. BC PSLS data shows a steady increase in reporting volume since the form was launched, which tells us that the new form and awareness campaign have brought greater attention to this issue across BC. (See Table B.) The increased focus on awareness, education and early intervention may also have a positive impact in the longer term by preventing the pain and suffering experienced by patients and the distress caused to their loved ones and healthcare providers.

Prior to launching the new form, in early 2014, the BC PSLS Central Office reported fewer than 300 reports of pressure ulcers being submitted annually. Almost all of these reports came from only two of the six BC Health Authorities and many were entered by wound and skin care specialists rather than the front-line care providers.

Table B: Pressure Ulcer reporting volume to BCPSLS pre- and post-implementation of new form
(based on information provided by BC PSLS Central Office)



LET'S TAKE THE PRESSURE OFF! (cont.)

In the first 6 months following the new forms implementation, using the 'Take the pressure off!' campaign to raise awareness, BC PSLS Central office received nearly 500 PU reports. All of the Health Authorities are actively reporting and reports are being submitted by front line nursing staff, physiotherapists and occupational therapists, students, allied healthcare providers and physicians, in addition to Wound Clinicians and Enterostomal Therapists.

CONCLUSION:

The collaboration between the British Columbia Provincial Nursing Skin & Wound Committee, the BC PSLS Central Office Team and other stakeholders was an effective way to advance this important work in BC. Future meetings will take place, as the database grows, to create summary reports and enable Wound Clinicians and Enterostomal Therapists with the meaningful information and data that will drive improvement and further promote PU prevention.

All images and logos used with permission of BC PSLS Central Office, Vancouver, BC

REFERENCES:

1. Keast DH, Parslow N, Houghton PE, et al. Best practice recommendations for the prevention and treatment of pressure ulcers: Update 2006. *Wound Care Canada*. 2006;4(1):R19-R30

2. Padula CA, Osborne E, Williams J. Prevention and early detection of pressure ulcers in hospitalized patients. J *Wound Ostomy Continence Nurs*. 2008;35(1): 65-75.

3. Cox J. Predictive power of the Braden Scale for pressure sore risk in *adult critical care patients. J Wound Ostomy Continence Nurs*. 2012;39(6):613-621.

4. Bry K E, Buescher D, Sandrik M. Never Say Never: A descriptive study of hospital-acquired pressure ulcers in a hospital setting. J *Wound Ostomy Continence Nurs*. 2012;39(3):274-281.

5. http://bcpslscentral.ca/ accessed October 20, 2014.

6. https://psoppc.org/web/patientsafety/commonformats Viewed September 15, 2014.