Overcoming barriers to bedside implementation of pressure ulcer prevention programs

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Introduction

Despite the clear guidance of experts in the area of pressure ulcer prevention and the availability of research-based guidelines that describe best practice interventions that should prevent the occurrence of pressure ulcers, patients continue to suffer from these injuries. In fact, according to a December 2008 report by the Healthcare Cost and Utilization Project (HCUP) in 2006 there were 503,000 hospital stays with pressure ulcers noted as a diagnosis, representing an almost 80% increase in the incidence of pressure ulcers since 1993. Duncan reports pressure ulcer-related complications sustained in hospitals result in an estimated 60,000 deaths each year. Early in 2009, a plan was devised that would permit one nurse specialist with an interest in pressure ulcer prevention to participate in a one-year project focused on patient safety. Joint Commission Resources, Inc. and Hill-Rom partnered to sponsor this program. Pressure ulcer prevention was a natural fit for the wound, ostomy, continence (WOC) nurse who was awarded this opportunity. Four hospital systems agreed to participate in this project which included an estimated 60,000 deaths each year.

Selected Sites

Beth Israel Medical Center, New York, New York
Irene Jankowski, APRN, BC, CWOCN
Michael Wallis, APRN-BC, CWOCN, CORN, CEN
Hahnemann University Hospital-Tenet, Philadelphia, Pennsylvania
Judy D'Amato, MSN, RN, BC, WOCN, Senior Educator
Bon Secours St. Mary’s Hospital, Richmond, Virginia
Diane Whitworth, RN, CWOCN
St. Vincent’s Birmingham–Ascension Health, Birmingham, Alabama
Terri Murphy, RN, MSN, Medical Surgical Nurse Specialist

Common Barriers to PUP Implementation

Missing components of the overall program
- PUP protocols, bundles, order sets
- Expert clinical resources
- Nursing staff education
- Prevalence and incidence survey process

Limited hospital-wide awareness and education
- Inconsistent use of policies and procedures
- Missuse of the Braden Scale
- Lack of accurate and thorough documentation
- Lack of equipment training

Lack of teamwork on patient care units
- Lack of physician participation in PUP activities
- Lack of clinician participation
- Lack of inclusion of all clinical areas such as OR/PACU, ED, radiology, dialysis, diagnostic areas
- Lack of inclusion of all direct care providers such as transporters, patient care technicians, radiology staff

Communication issues
- Lack of handoff processes that include PUP information
- Inadequate Risk Management notification process
- Lack of data sharing within the organization

Expert clinical resources not available or underutilized
- Lack of WOCN
- Lack of trained support staff to follow protocols

Supply and equipment issues
- Lack of standardization of supplies
- Supplies not available when needed
- Measure of supplies, including use of the wrong products

Discussion

Although the barriers to PUP implementation varied across the organizations several barriers were common to all organizations. The Nurse Scholars partnered with the site team leaders to identify and implement strategies to overcome the identified barriers. Examples of interventions to improve compliance with the PUP include:

Physician Participation
- Physician partners were identified and recruited to communicate with physicians and residents and clarify the physician role in pressure ulcer prevention.

Communications
- All the organizations are developing methods to include the Braden score during routine hand-offs and to include the Braden score in hand-offs when the patient is traveling to another department.

Supply and Equipment Issues
- Educational programs for support personnel are being developed. Printed reference materials including pocket cards and small posters are being developed to provide simple, ready to use references for staff.
- Pair levels and standardization of products are being developed.

Nurse Safety Scholars

Irene Jankowski, APRN, BC, CWOCN is the first JCR/Hill-Rom Nurse Safety Scholar-in-Residence selected by the JCR – Hill-Rom Nurse Safety Steering Committee. Ms. Jankowski provides leadership in the area of wound and skin care at Beth Israel Medical Center New York, New York. As the first Nurse Safety Scholar Irene led the work on identifying the barriers to implementing a successful pressure ulcer program. Deborah Nadzam, PhD, FAAN, the initial project director, provided oversight of the work of Ms. Jankowski.

Diane Whitworth, RN, CWOCN is the current JCR/Hill-Rom Nurse Safety Scholar completing the second phase of the initial work in the Nurse Safety Scholar-in-Residence program. She is currently responsible for the wound care team at Bon Secours St. Mary’s Hospital in Richmond, VA. Roberta Fruth PhD, FAAN, current project director, is providing ongoing project oversight.

Project Processes

The Nurse Safety Scholar and Project Director visited each selected site for two days on two separate occasions. During these visits they reviewed the components of each program through document review, discussion with the site team leaders, discussion with key clinical leaders, unit observations, review of pressure ulcer data, and focus group meetings with the pressure ulcer team members.

Detailed notes were taken for later review and analysis. Barriers to the implementation of a pressure ulcer program were identified. The barriers varied across the organizations.

Pressure Ulcer Prevention Goals

To decrease the incidence of Pressure Ulcers by:

- Evaluating the current PUP program and protocols within the organization
- Identifying barriers that interfere with consistent application of PUP protocols
- Removing or minimizing barriers to successful implementation of the PUP program
- Increase staff compliance with pressure ulcer programs and protocols

Hill-Rom provides financial support for the Nurse Safety Scholar-in-Residence Program. Joint Commission Resource supports the project directors and oversight for this program.