



Ongoing Continuous Quality Improvement Efforts at a Veterans Health Administration Hospital Result in Decreased Incidence of Pressure Injuries

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INTRODUCTION

Veterans Health Administration (VHA) facilities are striving to adhere to evidence-based best practices for pressure injury (PI) prevention.¹ Critically ill patients are at increased risk for development of PI due to prolonged immobility and impaired physiologic status. In many cases, patients who are critically ill are exposed to increased forces of friction and shear because they are completely dependent on staff for repositioning. One study of critically ill patients reported that the development of Stage 2 PIs was nearly 6 times greater in immobile critically ill patients at high risk for friction compared to those at low risk.²

In 2015, the Veterans Administration (VA) Office of Inspector General (OIG) published recommendations for VHA facilities to help ensure adherence to best

practices in PI prevention. Recommendations were made regarding clinician training, risk assessment, documentation, and medical storage.¹ Evidence-based guidelines have also been published to help prevent the development of facility-acquired PIs.³ One of these recommendations is related to support surfaces, which should be evaluated regularly to ensure that patients with poor local or systemic oxygenation and perfusion have improved pressure redistribution, shear force reduction, and effective microclimate control.³

A quality improvement (QI) initiative was developed at the Federal Health Care Center in North Chicago to adhere to the recommendations of the OIG and prevent the development of PIs in critically ill patients.

METHODS

Clinical Setting: This QI initiative took place on a 10-bed Critical Care Unit (CCU) that treats veterans and active-duty military personnel.

Support Surface Committee: A Support Surface Committee was assembled to select new support surfaces. The committee considered the technology, evidence, and baseline pressure-mapping metrics.

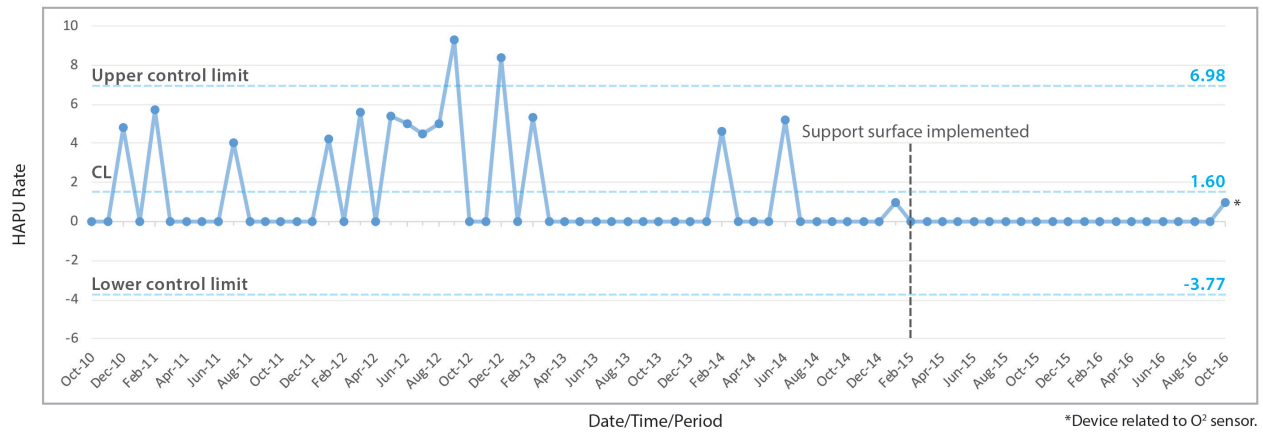
Interventions: An incontinence management protocol was developed and implemented, and the pressure ulcer and skin alteration policy was updated to include a "3-layer or less" rule. Evidence-based education was provided regarding PI prevention and treatment and incontinence-associated dermatitis prevention and treatment. New support surfaces* were purchased for all CCU beds.

- Early identification of patients at risk and risk re-assessment every 12 hours for CCU patients
- Turning and repositioning system[†] implementation
- Offloading with heel protector boots[†]
- Limited layers and use of advanced-technology, moisture-wicking, absorbent pads and briefs
- Use of sacral foam dressing to prevent friction injury in CCU patients
- Assignment of skin-care champions on each unit including long-term care facilities
- Meet all of the OIG requirements
- Conduct quarterly audits for PI monitoring and preventive measures, along with National Database of Nursing Quality Indicators

*Solibrium[®] Support Surface (Stryker Corporation, Kalamazoo, MI)

RESULTS

CCU Facility-Acquired Pressure Injury Stage II or Greater



*Device related to O₂ sensor.

DISCUSSION

The success of this QI initiative is attributed to the standardization of evidence-based interventions and technology.

REFERENCES

1. Department of Veterans Affairs Office of the Inspector General. Report No. 14-05132-90. Combined assessment program summary report: evaluation of pressure ulcer prevention and management at Veterans Health Administration facilities. February 3, 2015. Available at: <http://www.va.gov/oig/pubs.VAOIG-14-05132-90.pdf>
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3. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel, and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed). Cambridge Media: Perth, Australia; 2014.