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Pressure Ulcer Benchmark Study

Determination, communication, and teamwork are at the heart of an initiative to reduce acquired pressure ulcers at a Pennsylvania nursing facility.

IN REDUCING ITS RATE OF ACQUIred pressure ulcers—those that appear after admission to a skilled nursing facility (SNF)—from 21 percent to 2 percent in only one year, Good Samaritan Nursing Care Center, Johnstown, Pa., did not employ methods unavailable to most other facilities. Rather, it created a comprehensive program of procedural changes, policy updates, and facilitywide education that can serve as an accessible road map for other providers seeking outcome-based improvements in quality of care.

The 73-bed SNF also improved staffing stability by instituting a team-oriented approach that required a greater sense of involvement in the facility's mission.

Senior staff at Good Samaritan began their performance-improvement initiative on skin integrity with some basic observations. For example, they recognized that all patients suffered from both physical and emotional issues that could potentially be root causes for pressure ulcers. It was, therefore, decided to focus the performance-improvement initiative on a range of specific indicators such as dehydration, weight loss, and degree of activity. This proved to be an important assumption in the overall success of the initiative, which ultimately required input from several different departments.

SKIN BREAKDOWN RISK ASSESSMENT

Item	Score	Item	Score
General physical condition		**Mental status**	
Good	0	Alert	0
Fair	1	Lethargic	1
Poor	2	Semicomatose/ confused	2
Severe	3	Comatose	3
Activity		**Mobility**	
Ambulatory	0	Full	0
Walks with help	1	Slightly limited	1
Chairfast	4	Very limited	4
Bedfast	6	Immobile	6
Elimination		**Nutrition/fluid intake**	
Normal	0	Good	0
Usually controlled	1	Fair	1
Minimally controlled	4	Poor	2
Uncontrolled	6	Severe	3
Skin appearance and sensation		**Existing skin breakdown**	
Good	0	None	0
Fair	1	Stage 1	4
Poor	2	Stage 2	4
		Stage 3	6
		Stage 4	6

SCORING
Low risk 6-11 **Moderate risk** 12-20 **High risk** 21+

Source: Conemaugh Health Systems

Baseline Studies Conducted

In November 2001, the performance-improvement committee—consisting of the facility's medical director, administrator, director of nursing (DON), assessment coordinator, case manager, social worker, activities director, and others—completed a four-week internal baseline study that included an assessment of every patient in the facility. The average daily census was 56 patients, with an average age of 80.6 years and an average per-patient length of stay of 122.9 days. This study revealed that the facility had a 21 percent rate of acquired pressure ulcers. The accuracy of the data was then tested by an outside consulting company, which performed a prevalence and incidence study on acquired pressure ulcers at the facility. That study confirmed that the internal data collected were accurate. The finding that about one in five patients who were admitted to Good Samaritan was at risk was well above the state benchmark of 8 percent.

Next, staff performed a closed medical records review. Sampling for the review was randomly based on the previous year's discharges. Results indicated a pattern of inadequate documentation on admission and throughout a patient's length of stay and revealed that skin-integrity issues were being improperly recorded. Documentation was, at best, sketchy and inconsistent, the reviewers found, making it difficult to determine which patients actually had pressure ulcers or other skin abnormalities.

Goals And Answers

The performance-improvement committee established an immediate goal of reducing pressure ulcers from 21 percent to 13 percent in three months and then to attempt to achieve an acquired rate of only 6 percent within 12 months. If such an improvement could be achieved, it would put Good Samaritan ahead of the 8 percent benchmark for acquired pressure

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ulcers established by the Centers for Medicare & Medicaid Services (CMS).

But while it was necessary to establish goals, the committee first needed to find out why Good Samaritan's performance on acquired pressure ulcers was out of kilter with CMS and state benchmarks. The committee identified a number of contributing factors, including staff competency, documentation, reassessment, prevention, supplies, hygiene protocol, supportive programs, and education.

The committee then determined that although Good Samaritan patients were being examined upon admission to the facility, they were not being reassessed on a weekly basis to ascertain their risk for developing acquired pressure ulcers.

Simultaneous Actions Taken

In April 2002, the facility implemented several changes simultaneously at the urging of the committee. Senior staff integrated a risk-assessment screening tool for pressure ulcers into the admissions process for all new patients and determined that the DON would receive notification of every patient found to be at high risk for developing a pressure ulcer. The screening tool for skin evaluation was a complete assessment that placed each individual patient into a scoring category of low, moderate, or high risk based on eight factors—general physical condition, activity-ambulatory status, continence-incontinence, skin appearance and sensation, mental status, degree of mobility, nutrition and fluid intake, and existing skin breakdown. Caregivers would monitor low-risk patients weekly to ensure they were not developing higher-risk profiles. But patients found to be at moderate or high risk of developing a pressure ulcer, in addition to being monitored, were issued pressure-reducing mattresses—a gel-foam mattress for moderate-risk patients and an airflow mattress for high-risk patients. In conjunction with the screening tool, the staff dietician began performing evaluations of patients exhibiting nutritional deficits such as low body weight that could potentially lead to skin-integrity issues.

The DON—working in close consultation with the dietician, restorative licensed practical nurse (LPN), the registered nurse (RN) assessment coordinator, and the physician—then determined the best plan of care.

An RN was chosen to do consistent weekly documentation and reassessment rounds on all patients in the building to evaluate each patient's skin integrity and risk factors. This RN also assessed any patient with a pressure ulcer to determine if treatment currently being utilized was effective or if the physician needed to change the treatment. This consistency and continuity of staff and monitoring were essential in developing accurate and

reliable data regarding a patient's skin integrity and risk. By initiating these consistent rounds and new documentation tools, Good Samaritan began to slowly decrease the potential for the root causes of acquired pressure ulcers that had been identified during the closed medical record review.

In conjunction with the weekly RN rounds, the enterostomal nurse (ET nurse), trained in wound care, began weekly pressure ulcer rounds in the facility. Using her expertise, the ET nurse worked closely with the physician, recommending appropriate plans of care.

The performance-improvement team also recognized the fact that nutrition, hydration, and mobility are integral parts of pressure ulcer prevention. As a result, the dietician began a regular regimen of nutritional screens and weight monitoring of at-risk patients and worked with the RN assessment coordinator and restorative LPN to implement multi-inclusive, restorative dining programs in which patients were divided into small dining groups based on needs and expected outcomes.

This assisted in encouraging fluids and nutrition for those patients at risk for dehydration and skin-integrity issues. While encouraged to take adequate nutrition, the patients were out of bed for all meals and taking part in a supervised social environment with their peers.

Broad-Based Communication

Finally, a communication tool was developed to identify those patients at risk for dehydration and skin-integrity issues. This allowed all members of the facility from housekeeping and laundry to clerical support to be aware of the special requirements for each individual patient.

The entire initiative involving all facility staff was achieved by having frequent staff and performance-improvement team meetings.

Communication between all departments in the facility was an essential element, with team members receiving monthly data reports on state quality indicators (QIs), skin rounds, weights, changes in activities of daily living (ADLs), and nutritional assessments of at-risk patients. The state QIs proved an especially good source of external comparison analysis because they provided a risk-adjusted, benchmark-focused quality control source to prevent biases. Weekly skin records were compiled into monthly reports and then analyzed and incorporated into an ongoing graph showing past and current acquired pressure ulcer percentages.

The dietician and restorative LPN supplied the performance-improvement team with a summary of any changes in nutrition, weight, and ADLs, while staff were encouraged to

meet as frequently as possible on an informal basis to discuss the skin-integrity program. This ultimately saved time when the group met formally to discuss the performance-improvement data, and it also served to develop ties between departments in the facility. These ties proved invaluable to the performance-improvement team, which required input and expertise from multiple points of view in order to improve both the program and patient outcomes.

Ongoing statistical analysis showed a consistent improvement in the data collected each month.

Because of ultra-busy schedules, the performance-improvement team held its formal meetings to a strict one-hour time limit, which helped improve attendance. Much of the work discussed at the meetings could then be tackled by individuals or small groups between meetings.

Staffing Stability And Education

The importance of staff stability was noted at an early stage as a key issue in improving Good Samaritan's performance. Part of the process, therefore, was an investigation to determine how the facility could retain staff members. Senior staff conducted a series of interviews, staff appreciation programs, morale building, and satisfaction surveys, and the facility developed and implemented a number of programs as a result. Eventually, staff turnover was reduced from 45 percent (prior to the initiative) to 20 percent.

In July and August 2002, the ET nurse, staff educator, RN assessment coordinator, and DON conducted educational programs at all levels throughout the facility. Topics included incontinence care, spotting the early signs of pressure ulcers, nutrition-hydration needs, weight monitoring, repositioning, and psychosocial needs.

Even before much of this process had kicked in, heightened awareness throughout the facility helped reduce Good Samaritan's rate of acquired pressure ulcers from 21 percent in November 2001 to 16 percent by April 2002.

From there, with more of the initiative taking hold, the rate dropped to 8 percent by May 2002 and eventually to 2 percent in September 2002. Since then, the facility has maintained continued success, and the acquired pressure ulcer rate had dropped to 1.8 percent as of March 2003. ■

For More Information

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