Brant Community Healthcare System
The Willett, Paris
The Brantford General

BCHS Pressure Ulcer Prevention Program

Steven Cassel BSc, DCh, MHSc, MClSc-WH

Patient Safety and Professional Practice Leader
Skin and Wound Care Consultant

Why a pressure ulcer prevention program……

- Mr. S was admitted to MIP without any skin breakdown on day 1….
- On day 4 during the incidence audit, Mr. S had a stage 2 pressure ulcer on his heel.
- An acute care hospital stay to treat the ulcer is approximately $3000/ month!!!

Where we started……

- E:\SLT presentation\Wound care poster presentation April 2014 draft 6.pptx

KATA- A3

Title:	Wound Care Inititative	Team:	Steven Cassel, Diane Wood, Peggy Baker, Monica Hewitson, Sandra Kagoma, PPLs, Wendy Benson, Vennessa Bailey	Start Date:	23-Oct-13
Area:	PEQO			Revision Date:	Jan-14
Sponsor:	Sandra Kagoma			Revision #:	
Lead:	Steven Cassel				

PLAN

What is the Target Condition?

No wounds - hospital aquired wounds - all categories
Complete and accurate documentation; consistent and accessible documentation (access to info)
Decrease time and "double" charting
Documentation standard
Standard process for wound referrals
Build capacity with frontline to buld competence
Wound resource biinder
"Excellence in Wound Management"
Evidence based practice
ROP for accreditation
Clear, consistant process to access "products" (beds, custions etc) all equipment
Interprofessional referral
Care pathway for wounds
Braden Scale O/E
Streamline hospital wound care to (free footcare) community (DEC - integration)
O/E to wound referrals - more info
No more "double" referrals - acute to CCIP/Rehab
Patient and family centred care - more involved
Seamless wound prevention from program to program
Cost effective wound care
Monday to Friday - WRT

What is the Actual Condition now?

The following results were obtained from:
Survey:
1) Staff felt that their level of wound care knowledge was less than adequate due to the complex wounds
2) Staff felt they needed more resources and education
3) Valued the current Wound Team
4) Concerned on how the PSW role fits into wound care in the new Team based model of care

"Go and See"
1) Very inefficient process to obtain and collect patient referral information (25% of shift was gathering patient information prior to care)
2) Routinely searching for stock to provide wound care (25% of shift)
3) Very complex wound and multiple site wounds

Prevalence/Incidence study:
1) 45% prevalence and 17.5% incidence(same in 2009/2011)

Costs:
1) Over$ 60000 increase on negative pressure therapy and 330% on surfaces in one year

PLAN

What Obstacles are preventing you from reaching the target condition?

See fishbone diagram for obstacles

DO

What is your Next Step?

Action	Who	When	Status
Environmental scan of BCHS wound care processes	Steve/WRT	Dec-13	
Environmetal scan of costs associated with rentals and dressings	Steve/Finance	Jan-14	
Go and See with WRT	Steve	Oct -Dec 2013	
Develop Wound Care Rollout and Plan	Steve/WRT	Mar-May2014	

STUDY

When can we go and see what we Have Learned from this step?

ACT/ADJUST

Follow Up / Unresolved Issues/Parking Lot

$ lost with pts moving from unit to unit - cost centre increases
engage the DEC post d/c
prducts - how to acces
process to obtain VAC, surfaces (reassessment of suface)
patient reassess when come off

Stakeholder Signatures	Project / Change Initiative Lead	Project / Change Initiative Sponsor	Department / Unit Lead

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Mapping out process…Takt Time

Decision to Admit																		
Admit in ER	1st 24 hrs patient to "unit"	>24 – 48 hours									>48 hours Stage 2 and multisite							
	Physician order for PT/OT (nursing initiates)	OT	PT	Dietician	SLP	Nursing	TL	WRT	Physician	Pharmacy	OT	PT	Dietician	SLP	Nursing	TL	WRT	Physician
- Assessed (physician) Lab work for chief complaint - Normal stretcher or chair waiting room -SLP; Dietician referrals and assess - *No process to capture high or patients at risk -PT/OT assessment for surface -No PCS/ EMR in ER	-Admission documentation all assessments head to toe q 12 hr -HOBIC - Action rounds CCIP 2 x week Rehab 2x week ISU – daily Med – daily Surgery – daily -Not all disciplines at DAR q day -*Braden Scale completed - Delay in getting PMH d/c delirium, cognitive issues - Delay in getting BPMH; not started in ER - Q 2 h turning "I did it" - May have dietician referral - Criteria Braden admission q Monday increase in condition - Positioning - Where do we get supplies for pressure relief? - Lack of clarity around process for the surfaces - Turning sheets, lifters - Aware of diet elimination, dementia, CAM scale - Dietician report to flag high risk pts - Physician order for PT/OT (nursing initiates)	-Chart review; physical assessment; communicate with nursing - Mobility in med; mobility - Use hospital air bed; call ESA; say request - Explore other options i.e ROHO; gel pad - Not consistent due to HR, education - Communicate POC in text bubble (not consistently done)	-Same as OT + mobility -*Critical care have 2 air beds; bad beds in CCU - CCU does not have dedicated OT/ PT - Accessible disability options - Not consistent due to HR, education - Communicate POC in text bubble (not consistently done)	-Review reports involve tech to see; prn chart review; chart with nursing - Attend rounds as able; recommend diet changes - Not automatically involved with increase risk Braden Scale	-Swall-owing assessments -Risk NPO	-Work with physio to mobilize; communicate - PSW bathing document meals - Head to toe assessment - interventions; wounds; meds; dressing; document (double document) - Restraints safety assessments - Collaborate with OT/ PT/ pharmacy - Q ½ hour rounds -*GAP high risk patient communicate to PSW interventions	Consult for potential wound	Rarely consulted at risk pts!	Practice orders	Review needs post op delirium meds side effects	-Review of surface and seating – collaborate with nursing – additional devices -*flow of data regarding wound (BI tool?)	Mobile as possible "time" seat - repositioning	-Review intake supplements (vits/mineral) - GAP * how o engage and inform dietitian	- Swallowing assessments - GAP P&I not consistently done	-*Risk pro not used consist-ently - Wound interventions; dressings; PoC - IPC (not consistent) - DAR - collaborate	New dressing products; difficult dressings; VAC; get physician	-*Referral from MD - *Assessment; document in text bubble - Call WRT; no referral needed - Wound assessment documentation - Paper documentation in chart; paper for WRT - Infection control; doctor orders; resource OT/PT/ Dieticians etc - Go get products when they are available -Education	Rounds
Delay Times																		
		OT	PT	Dietician	SLP	Nursing	TL	WRT	Physician	Pharmacy	OT	PT	Dietician	SLP	Nursing	TL	WRT	Physician
PT	1 hour 60 mins	2 hours	Surface 30 mins	30 mins		1 hour	5 mins	1 hour			30 mins	30 mins			1 hour	1 hour	4 hours	
DT	1 hour 1 - 24 hours	4 hours	1 week	48 hrs		1 day	1 hour	72 hours			1 week equip	1 week			4 hours	4 hours	72 hour to 96 hours	
	CCU * treat everyone at risk																	

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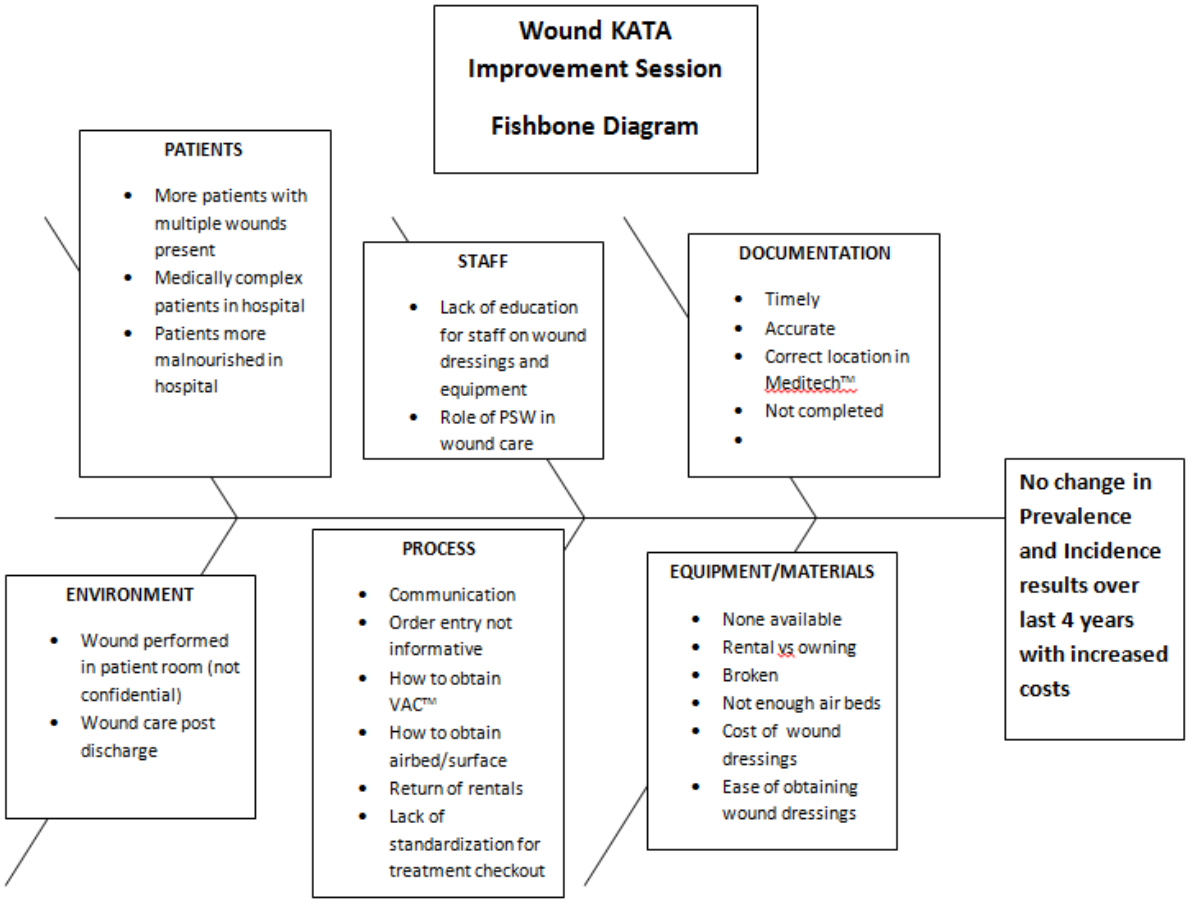
Fishbone



Target Condition:

"Patient centred cost effective wound care"

- Decrease hospital acquired wounds
- Complete and accurate documentation which meet "best practice"
- Standard process for wound referrals- more info
- Build capacity with frontline to build competence
- "Excellence in Wound Management" meeting evidence based practice
- ROP for accreditation
- Clear, consistent process to access "products" (beds, cushions) and equipment
- Interprofessional care plans and referrals
- Care pathway for wounds
- Streamline hospital wound care to community

Current Condition- Year 1

Accomplishments	ROI
▪ **Environmental Scan, Audits and Survey Staff** ▪ Nursing research students ▪ Wound Resource Team	 Survey Audits
▪ **Implement "Best Practice" and standard work** ▪ Accreditation Canada ▪ RNAO – BPG for pressure ulcers	 ROP ☑ 2016
▪ **Education** ▪ VAC Academy ▪ Therapeutic surfaces ▪ Advanced dressing ▪ Ostomy Preceptors (level 1 and 2)	 30 85 350 18
▪ **Med Pass Program** ▪ CCIP pilot ▪ All in- patient units	Target patients ↓ $$

Current Condition- Year 1

Accomplishments	ROI
▪ **Equipment** ▪ 3 new non-powered therapeutic surfaces ▪ 3 new CCU beds ▪ EHOB organizational rollout ▪ Implement a new hospital owned air bed process ▪ Implement “Project Pillow” ▪ Doppler for ABIs (B5)	► ↓incidence and costs Patient safety
▪ **Accurate Data** ▪ 10 monthly Prevalence and Incidence (2 units at 0%) ▪ Documentation audits (wound assessment and Braden score) ▪ Costs for VAC and therapeutic surface rentals	15% !! ↓ 40% !!

Obstacles preventing us from reaching our target condition

Initial Barriers	After PDSA
Resources to provide wound care support	WRT – Train the Trainer program Wound Care Champions
Lack of care pathways	Educate, Implement, Audit
Flawed and inconsistent process	In House air beds VAC returns Therapeutic surface returns
Engaging the interprofessional team	Physician support, allied health
Advanced dressings (non-stock items)	Refresh of current stock

Our Next Steps- Year 2

- Evidenced based “Best Practice” wound assessments
- Care pathways for wound care
- Streamline VAC and therapeutic surfaces process
- Documentation audits and improvements (PPNA, PPLs)
- Interprofessional Rounds
- Creating Team site on VS Net- Wound Resource Team
- Continue with Wound Care Champions
- Continue education campaign focusing on MIP
- Continue monthly P and I and respond to need

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QUESTIONS

COMMENTS