

**WE  
WILL**

**PREVENT PRESSURE ULCERS.  
KNOW THE FACTS. TAKE ACTION.**

ISDH Long Term Care  
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Registration



Indiana State  
Department of Health

Long Term Care Newsletter  
Pressure Ulcer Initiative Update Issue

## Pressure Ulcer Initiative Update

In June 2008 the Indiana State Department of Health (ISDH) and University of Indianapolis Center for Aging and Community began preparing for the Indiana Pressure Ulcer Initiative. The Initiative was planned as a fifteen-month Initiative. The interest was exceptional with more facilities wanting to participate than space allowed. Starting the Initiative in September 2008 were 105 nursing homes, 40 hospitals, and 24 home health agencies.

The Indiana Pressure Ulcer Initiative provided resources, toolkits, online education modules along with the opportunity for participants to share their experiences, challenges, and successes. Tools and resources are nothing however without the people to implement them and embrace their success. The outcomes and successes of this Initiative have relied on the work, efforts, and passion of individual facilities, agencies, residents/patients, and families.

At the beginning of the Initiative, participants were challenged to "Collaborate on Quality". The collaborative effort has been outstanding. We have now reached the conclusion of this phase the Indiana Pressure Ulcer Initiative. It is therefore time to celebrate successes. On August 26, the Indiana Pressure Ulcer Initiative will hold an Outcomes Congress to share the many successes and positive outcomes resulting from this Initiative.

To kick off this celebration, today's newsletter is dedicated to a few of the successes and experiences of participating facilities and agencies. Over the next month, we look forward to sharing with you many more positive outcomes and successes of participants.

## Success Stories

COMPREHENSIVE CARE FACILITIES (NURSING HOMES)

Franklin United Methodist Community  
Franklin, IN

The main changes that have been made at our facility are:

- discussing the residents that are in their multi-data set (MDS) window and discussing all interventions that are in place or interventions that need to be in place to prevent pressure ulcers during our weekly wound meeting
- PUP program
- providing cushions in beauty shop and transportation wheelchairs as residents may sit those chairs for an extended periods of time
- using special briefs from Medline on residents with a pressure ulcer and for those residents that have a history of skin breakdown
- using luggage tags on resident's wheelchairs to indicate what each resident needs in their wheelchair to prevent skin breakdown.

Our goal was to prevent coccyx pressure ulcer. All interventions appear to work well.

We are working with the medical surgical unit at Johnson Memorial Hospital in Franklin, Indiana. Since most of our residents use Johnson Memorial Hospital, Franklin United Methodist Community is working with the hospital on transfer information including areas of decubitus/skin breakdown, treatment orders, measurements, and interventions that are in place.

Since our facility is so large, we chose one wing of one of health centers to begin with. Our goal was to have 5% or less coccyx pressure ulcers throughout the initiative. Our program was successful as our pressure rate is 2.3%. Both of the residents involved were hospice residents and had a decline in all areas. Since our program has been so successful we have initiated our interventions throughout the facility.

Contact:

Joann Johnson, RN, ADON

Phone: (317) 736-1136

E-mail: [jjohnson@fumeth.com](mailto:jjohnson@fumeth.com)

Scenic Hills Care Center

Ferdinand, Indiana

Changes since the team came back from Learning Session #1 have been that nurses do rounds and check to make sure their residents are turned, repositioning, or toileted every two hours. The nurse aides have become more focused on toileting and repositioning. The team did a great job of coming back and informing other line staff of the things they learned.

All line staff has the skin report cards. The aides carry the report cards with them and when finding any areas they fill out the form and give the white copy to the nurse. The charge nurse assess the area found and starts a treatment if needed. The form then goes to the wound nurse who assess the treatment and area in question to make sure that the treatment is correct. The wound nurse then gives the information the Director of Health Services (nursing) or the assistant so that on the next weekly wound and skin rounds the director goes along and re-assesses and makes sure the treatment is working and appropriate.

Family members have been involved in preventing pressure areas. They have joined in on the initiative by signing the commitment board, attending teleconferences, and informing staff when other residents need to be repositioned. They watch for their loved ones along with all the other residents in the health center.

We measure our success by looking weekly at the number of skin areas that we have. We have seen the number drop drastically since the Indiana Pressure Ulcer Initiative has started. We continue to monitor and congratulate the line staff when we see the decline in areas. It is important to make sure that everyone knows that they play a part in reducing the number of skin issues a health center has.

Contact:

Lisa Stallman, RN, ADHS

Phone: (812) 367-2299

E-mail: [303-scenicills-dhs@trilogyhs.com](mailto:303-scenicills-dhs@trilogyhs.com)

Warsaw Meadows Care Center

Warsaw, IN

Warsaw Meadows Care Center has benefited from being a part of the Indiana Pressure Ulcer Initiative. Since becoming part of the program, many changes have been implemented.

- We have a complete program set up to identify, track, and treat pressure wounds that did not exist in the past. The program includes tools such as the Braden scale, push tool, individualized turning and repositioning schedules, toileting programs (as well as other preventative measures) and tracking tools that have been created after researching and attending wound care seminars.
- We have begun an auditing system of the preventative measures that have been put in place for all residents at risk for skin breakdown.
- One person had been designated to measure and care for the wounds on a weekly basis as well as educate staff on the many options that are available for wound prevention and treatment. Education of the direct care staff on a routine basis is one of the most important changes that we have made.

All of the changes that have been implemented have been working well. The combination of all of the changes working together has decreased our number of pressure ulcers as well as increased the early identification of potential pressure ulcers. Explaining our involvement with the Initiative and our continued efforts to family members and residents has also had positive effects. Families and residents have been grateful, to say the least, when they are aware of preventative measures that have been put in place for them and are informed throughout the process of managing a wound. Our marketing department used the Initiative as a marketing tool to residents that we have accepted with wounds.

Just having the above programs in place has been a measure of our buildings' success. The results of our audit tools have shown us that education has been successful. Staff has been putting preventative measures in place initially and with increased risk. They ask questions, follow preventative programs, and actually want to do wound rounds with the nurse weekly to see if wounds are healing. This Initiative has improved the quality of care that our building gives.

Contact:

Sarah Clay, RN, DON

Phone: (574)-267-8922

E-mail: [warsawdon@yahoo.com](mailto:warsawdon@yahoo.com)

Whispering Pines Health Care Center

Valparaiso, IN

Activities implemented:

- We have changed how we address Braden Scale Scores by really keying in on preventative measures to include mattresses, cushions, boots, etc.
- What is working well is a new skin care line Remedy from Medline. Olive oil based, more adherent, subtle texture, with less amount used, and residents plus staff like the fragrance.
- Families are brought in through care plan meetings and informed what is in place for prevention. The pressure ulcer consumer brochure is distributed to families.
- We track pressure ulcers monthly for QA and are able to check progress along with the rate of occurrence.

Contact:

Renel Hemmerling

Phone: (219) 462-0508

E-mail: [rhemmerling@wphcc.org](mailto:rhemmerling@wphcc.org)

HOME HEALTH AGENCIES

Saint John's Home Care Services

Anderson, IN

This collaborative has allowed Saint John's Home Care Services the opportunity to address agency processes and protocols related to pressure ulcer prevention and reduction. With our increased awareness, the following have been implemented:

- a new pressure ulcer prevention protocol has been created and added to our process for identifying patients at risk
- a new clinical plan of care has been written to provide clinical interventions for patients at risk and those with current pressure ulcers
- a revamped patient education process that includes focused visits on pressure ulcer prevention/reduction
- an on-going educational program for staff
- A booth at our annual competency fair highlighted the Indiana Pressure Ulcer Initiative and each participant was informed of the initiative and our agency's progress. A scavenger hunt was issued to address the 5 most frequently missed questions from the Facility Specific Knowledge Questionnaire. Signatures were obtained for the poster *We Will Know the Facts and Take Action* to confirm our commitment to the initiative and the storyboard was displayed.

Contact:

Sharon McKnight, RN, BSN

E-mail: [slmcknig@sjhsnet.org](mailto:slmcknig@sjhsnet.org)

## HOSPITALS

Bloomington Hospital

Bloomington, IN

Improvements and changes that we have implemented since our involvement with the program:

- Pilot study to test the effectiveness of pressure ulcer alert signage in patient rooms for Braden scores < 18.
- Pilot study to evaluate the effectiveness of nurse, patient care tech, unit coordinator, and housekeeper education and involvement in pressure ulcer reduction.
- Hospital wide availability of perineal disposable wipes.
- Continual staff education at monthly unit meetings.
- Collection pressure ulcer incidence data is being used to drive changes.

Positive Outcomes:

- Implementation of education visible when rounding (Example patient found with head of bed lowered when resting to reduce sacral pressure)
- New use for old product – skin barrier protectant wipes used on heels to prevent shearing.
- Sharing information to implement changes hospital wide.

Measuring Our Successes:

- Pre and Post education testing of employees
- Monthly incidence data reviewed

- Incorporated changes into annual competencies for all staff.

Thank you for your inspiration

Contacts:

Mary Anne Proctor-Holmes, RN, BSN, PCCN  
Phone: (812) 353-2933

Jean Young RN, BSN, OCN  
Phone: (812) 353-9022

Gibson General Hospital  
Princeton, IN

Changes we have implemented:

- \*Policies and Procedures are in place.
- \*Initiated Medline Skin Care Products.
- \*Have educated front line staff on Pressure Ulcer Prevention.
- \*Have started tracking Pressure Ulcers on our patients.

What is working well:

- \*Staff seem more knowledgeable about Pressure Ulcer Prevention.
- \*Med Line Products are working well for us.

Community based collaborations:

- \*We are planning a community based skin fair in August.

Measuring Success:

- \*We have been tracking all inpatients for 4 months and have found:
  - \*Hospital acquired Stage I – 4
  - \*Hospital acquired Stage II – 1
  - \*Hospital acquired Stage III or above – 0

Contact:

Angie Brewer, RN  
Phone: (812) 385-9358  
E-mail: [abrewer@gibsongeneral.com](mailto:abrewer@gibsongeneral.com)

Good Samaritan Hospital  
Vincennes, IN

We have seen many areas of success in regards to preventing pressure ulcers in the past six months. Changes Good Samaritan Hospital has implemented:

- Currently all patients in our facility have E-Z wraps to their O2 tubing in order to prevent pressure ulcers behind our patient's ears.
- We have Waffle Cushions for our patient's chairs available to the nursing staff on each unit. No longer does the nurse have to order the cushion from Central Service.
- We also have E-Z wraps on each unit and available to all staff.
- We have Braden score cards posted on each computer that is easily accessible for the staff. All staff members have a pocket Braden card and a pocket Charting Tool guide to assist them in

charting correctly on their patient's skin

What is working well at GSH?

- Staff's participation!
- Nurse Managers participate in our weekly Prevalence study and assess patient's skin
- Easy access to products in preventing skin breakdown
- Increased awareness of staff's role in prevention of pressure ulcers

How is GSH measuring our success?

- We conduct weekly prevalence studies on 2 different units every week. Staff is unaware of what unit we will be on until we show up.
- We have a Skin Performance and Improvement committee that is made up of staff members, managers, wound care nurses, and skin team members where we discuss our plan of action to obtain ZERO percent hospital acquired pressure ulcers

Contacts:

Colleen Clidienst, RN, BSN

Cheryl Leimbach, RN, BSN, CWCN

Wound Care Department

Phone: (812) 885-3163

Hendricks Regional Health

Danville, IN

Hendricks Regional's Medical Unit had no hospital acquired pressure ulcers for July. The pressure ulcer reduction initiative was instrumental in our success by showing us how important it is to daily track and provide one-on-one education needed to correct knowledge deficits. These were the two most instrumental interventions for us.

As a participant of the Indiana Pressure Ulcer Initiative the Medical Unit at Hendricks Regional Health has accomplished the following process changes:

- Monitoring--Skin Champions audit nursing skin care records for all patients on medical unit to ensure skin risk assessment is done and preventative interventions are initiated. When a pressure ulcer finding is present treatment interventions are assessed to ensure standards of care are met and are initiated within twenty four hours of admission.
- Focused Education--Staff receives formal and informal education addressing knowledge gaps with best practice interventions for pressure ulcer assessment, prevention and care. Various methods include slide show, posted signage and one-on-one education. Auditing done by staff provided a source for determining educational needs. Inconsistencies were noted on staging ulcers which led to informal teaching to nursing staff by the Skin Champions.
- Staff Recognition-- An award system was implemented to recognize staff for assessment, prevention and treatment of pressure ulcer.

Community Collaboration:

- Initiation of educational handouts for patient and family. The handouts include information on risk factors, preventative measures and treatment for pressure ulcer.
- Planning is under way to share data collected through the initiative with the Directors of Extended Care Facilities that send patients to Hendricks Regional Health.

What Has Worked:

- All of the above process changes have worked however the monitoring intervention has had the most impact. When you can see and track what is happening with pressure ulcers, the data provides the impetus for further interventions using the PDSA process. Monitoring has been the most significant variable for us to determine which process changes need to be made and then initiate interventions to accomplish the changes.

#### Measuring Success through Outcomes:

- We chose to measure success by looking at the number of pressure ulcers acquired by patients after admission. From information on the daily data collection sheets we are able to determine how many pressure ulcers have occurred on the medical unit during a month. We examined all months of data collection for the initiative. Data revealed a significant decrease in monthly hospital acquired pressure ulcers. At the beginning of data collection we had fourteen hospital acquired pressure ulcers and last month that number was four.
- We also look at NDNQI Prevalence and since the beginning of the initiative we have been below the mean for unit acquired hospital pressure ulcer. We just finished the second quarter NDNQI Prevalence study. For the first time since doing NDNQI data collection the findings revealed no hospital acquired pressure ulcer.

#### Contacts:

Lisa Imlay

Phone: (317) 745-3496

E-mail: [laimlay@hendricks.org](mailto:laimlay@hendricks.org)

Paula Spoonmore

Phone: (317) 718-4616

E-mail: [pispoon@hendricks.org](mailto:pispoon@hendricks.org)

Schneck Medical Center

Seymour, IN

#### Changes implemented:

- "Skin Champions" Team Initiated
- Skin Champions Used Evidence Based Practice to Make Multiple Changes in Interventions
- PreAlbumins Versus Albumins
- Nurse Generated Nutrition Consults
- Wound Care Protocols
- Standardization of Products
- Improved Documentation
- Two Nurses Assessing Skin on Admission
- Aggressive Turning Schedule
- All Nurses Completed the NDNQI Pressure Ulcer Training Module
- Increased Education

#### What is working well:

- Monthly "SKIN CHAMPION" from every unit
- Monthly "UNIT CHAMPION" traveling trophy

- Mock Trials – Educating Nurses on Pressure Ulcer Prevention Utilizing Evidence Based Practices

Community based collaborations:

- Increased Communication with Long Term Care Facilities/Home Health and Hospice
- Improved Transfer Report Form
- Providing Facilities with a Day Supply of Wound Care/Treatment Supplies

Measuring success:

- Monthly Pressure Ulcer Prevalence and Incidence Studies
- Chart Reviews
- Leadership Rounding on Patients
- Feedback from Long Term Care Facilities/Home Health/Hospice

Contact:

Sarah Herb, RN, BSN, WCC

Phone: (812) 522-0712

E-mail: [sherb@schneckmed.org](mailto:sherb@schneckmed.org)

St. Francis Hospital

Beech Grove, IN

Our goal – To support and promote best nursing practice regarding skin care, prevention and treatment by standardizing skin care practices and utilizing algorithms to guide staff nurses to reduce hospital acquired pressure ulcers. Actions Taken to Reduce Hospital Acquired Pressure Ulcers at St. Francis Hospital:

Interventions:

- Establishment of a nurse driven committee that convenes on a monthly basis Skin Action Team, (SAT) with collaboration from the organizations certified wound care nurses (CWCN's). This collaborative team utilizes current best evidence to drive nursing practice and policy in regards to pressure ulcer prevention.
- We have conducted a pilot study which prominently reflects Institute for Healthcare Improvement (IHI) and National Pressure Ulcer Advisory Panel (NPUAP) guidelines and definitions for prevention of pressure ulcers.

Outcomes:

- Heightened awareness of pressure ulcer prevention strategies and visibility of Skin Action Team members on each nursing unit driving bedside practice.
- Successful implementation of IHI and NPUAP guidelines for pressure ulcer prevention.
- This initiative is expected to be implemented throughout the hospital by the end of third quarter 2009.

Measurement strategies:

- Skin Action Team members conduct monthly data collection on their respective units and focus on risk assessment and consistent implementation and documentation of preventative interventions.
- Quarterly pressure ulcer prevalence surveys are conducted.
- Monthly data collection for the Indiana Pressure Ulcer Quality Improvement Initiative has been underway on the pilot unit since the beginning of the project.

Contacts:

Stephanie Heckman, RN, CMSRN

Phone: (317)783-8525

E-mail: [Stephanie.heckman@ssfhs.org](mailto:Stephanie.heckman@ssfhs.org)

Amira Kehoe RN, BSN, CWCN, MBA

Phone: (317)783-8732

E-mail: [amira.kehoe@ssfhs.org](mailto:amira.kehoe@ssfhs.org)

Saint John's Health System

Anderson, IN

Changes Saint John's Health System has implemented during the Indiana Pressure Ulcer Prevention Initiative are:

- Two nurse skin assessments - on admission to hospital and by receiving units on transfer with documentation of findings.
- Care Coordination Unit for inpatient medical surgical admissions.
- Increased awareness and education.
- WOCN reporting to one person for inpatient nursing.
- WOCN's have regularly scheduled hours to round and consult and treat inpatients.
- Standardized documentation sheet for present on admission.

What is working well for us at Saint John's:

- The two nurse skin assessment system is working well on each floor.
- The Care Coordination Unit has provided consistency in present on admission documentation in the ERS reporting system, on the Nursing Health Admission History and on the nursing flow sheets.
- An interdisciplinary approach to increase awareness and education of staff has been implemented by providing education during education days and in traveling posters. A Wound Reference Guide is in the process of being placed on all inpatient floors, the Care Coordination Unit and the Emergency Department for reference on staging and products.
- WOCN's are more visible and staff is engaging them more with questions and asking for their opinion and suggestions.

Community based Collaborations:

- Saint John's hosts the Long Term Care Forum which includes hospital and Long Term Care Facilities throughout the county. Pressure Ulcer awareness and increased communication between facilities is one of the focuses.

How are we measuring our success?

- We are measuring our success by the ERS reporting system, in documentation reviews and quarterly skin assessments.
- Weekly reviews at the Pressure Ulcer and Falls Meeting provide current information to staff.
- Documentation is placed on each individual unit balanced scorecard.

Contact:

Tracy McAllister, RN, BSN

Director Critical Care Area/Clinical Processes

Phone: (765) 646-8175

E-mail: [tpmcalli@sjhsnet.org](mailto:tpmcalli@sjhsnet.org)

St. Mary Medical Center

Hobart, IN

St. Mary Medical Center has always taken a proactive approach to preventing pressure ulcers, but it seemed we had reached a plateau when it came to fresh, creative ideas. We had already implemented several new products, had a variety of surfaces available, employed wound nurses and had educated staff.

Our decision to participate in the Indiana Pressure Ulcer Initiative project was just the shot in the arm we needed.

The collaborative meetings of idea sharing generated rejuvenated interest and jump started our imaginations. As a result, we implemented several successful processes:

- Our pilot unit champion (a staff nurse) assures that all staff are compliant with unit PUP indicators (they are now at 98% compliance)
- A short informative "Paw Print" newsletter gives "bone bits" of pertinent information to the staff on a quarterly basis
- Every other hour, from 6a to 10p, overhead chimes cue staff to turn high risk patients
- Our inpatient units utilize the preprinted patient -family education pamphlet distributed at the Indiana Pressure Ulcer Initiative meeting
- We have a "group" email that includes participants from a variety of health care settings. The members of the group are those that were seated at our table at the last collaborative meeting.
- Any hospital acquired pressure ulcer is reviewed and correlated to the results of the units monthly quality indicators. The unit manager develops and implements an action plan.

Results: Zero hospital acquired ulcers on our pilot unit!

Thank you for what I hope is the first of many of these types of initiatives.

Contact:

E-mail: [dkrejci@comhs.org](mailto:dkrejci@comhs.org)

## Outcomes Congress Registration

Share in the success of the Indiana Pressure Ulcer Initiative!

Outcomes Congress

August 26, 2009

Registration: 7:30 am - 8:30 am

Program: 8:30 am - 3:15 pm

Lucas Oil Stadium, Indianapolis, IN

The [Agenda for the Indiana Pressure Ulcer Initiative Outcomes Congress](#) has been finalized. Participants in the Initiative are invited to attend. The Congress will also serve as a kick-off for phase two of the Initiative. Participants from phase two are also invited to attend. As space permits, other individuals interested in the Initiative are invited.

Agenda

Included on the agenda are:

- Dr. Judy Monroe, MD, Indiana State Health Commissioner

Dr. Joyce Black, member of the Board of Directors of the National Pressure Ulcer Advisory Panel, and known to many for her expertise and research

- Kathy Duncan, point person for the Rapid Response Teams for the Institute for Healthcare Improvement [100,000 Lives Campaign]

#### Registration

Online registration is now available for the Outcomes Congress, which will take place August 26 at Lucas Oil Stadium in downtown Indianapolis. The cost to attend the Congress is \$40/participant. All registration will take place online, regardless of how you intend to pay for your attendance.

#### **Payment options**

Pay by credit card: Once you complete the registration information, you will be prompted to "Check out with PayPal." Choose this option if you are paying by credit card. You do not have to join PayPal in order to pay via credit card on the PayPal site.

Pay by check: If you would like to pay by check, click the "Other Payment Options: Show" link located at the bottom left of the registration page, under the credit card symbols. You will be shown the address to which to send your payment. Be sure to click the large gray "Pay by Check" option so you can confirm your attendance.

Deadline for registration is August 12, 2009. Ready to register? Click below:

**CLICK AND REGISTER >**

The Indiana State Department of Health is thrilled with the successes of this Initiative. We thank the participants in this Initiative for their interest and enthusiasm. While we appreciate that there is still a long way to go and a lot of work to do in preventing pressure ulcers, we look forward to sharing successes at the Pressure Ulcer Outcomes Congress on August 26.

Because of the response to the Initiative, we had more facilities and agencies wanting to participate than space allowed. The ISDH and University of Indianapolis are now preparing for a second phase of the Initiative to include at least another sixty nursing homes along with other providers. Anyone interested in participating in Phase Two of the Initiative should contact the University of Indianapolis Center for Aging and Community.

That is all for this week. See you at the Outcomes Congress.

Terry Whitson  
Assistant Commissioner  
Indiana State Department of Health

Indiana State  
**Department of Health**

Visit the ISDH Pressure Ulcer Resource Center  
at <http://www.in.gov/isdh/24558.htm/>