When Pressure is your Enemy: Using Evidence to Inform Action
Building a Plan to Work for Us - Pressure Injury Prevention

Submitted by the NSHA QEII Critical Care Quality Team

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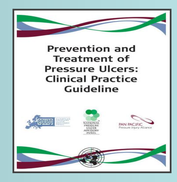
Our Goal: Minimize the risk of ICU-acquired pressure injuries with an incidence rate of less than 5%.

What Evidence?

#1 The Literature related to our Population



- Published Research Evidence
- Clinical Practice Guidelines
- Clinical Product Information

#2 Knowledge of Rates

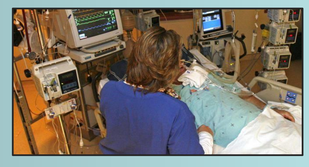
- Charge Nurses / Unit Resource Nurses monthly pressure injury surveillance
  - Prevalence of PI in our units (11 %)
  - Incidence of ICU Acquired PI (3.7-7.8 %)
  - Most common location (51% coccyx)

#3 Learnings from Documentation (Chart Audit Data)

- Monthly chart audits completed of key care components

#4 Self-Assessment of Skin & Wound Care Knowledge

- ICU pressure injury prevention strategies
- Recommendations regarding device-related PIs
- Skin Assessment including staging PIs
- Pressure injury wound care
- Current wound care products



#5 Evaluation of Wound Care Basket System

- Qualitative evaluation completed and actioned

#6 Learnings from Safety Reporting & Quality Reviews

- Pressure injuries are an opportunity to learn and improve.
- Examples include: trach care / suturing practices; decision-making about use of therapeutic bed surfaces; documentation gaps; expertise in complex PI wound care; continued use of strategies after transfer out of ICU; stool management systems.

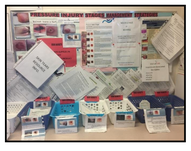
Value of Evidence: Context Appropriate Evidence-Based Actions

◦ Local incidence data reflects success with pressure injury prevention in complex critical care population.
◦ Significant incidence of device-related PIs, for example, associated with tracheostomies and stool management systems.

ACTIONS
- Inter-professional collaboration to address these issues. Includes exploring product options and resolving supply issues.
- Ongoing monitoring for product issues and knowledge gaps.

◦ High prevalence of PIs in ICU patients, indicating the importance of PI wound care expertise.
◦ Wound care products change frequently, and there is a gap in knowledge of current products.

ACTIONS
- Implemented a 'wound care basket system' as learned through Accreditation Canada Leading Practice (Timmins Hospital). Trialed in one ICU, evaluated and expanded.
- Developing ICU-specific knowledge. Unit Resource Nurses are an amazing clinical tool, strengthening bedside knowledge. Intensivist with plastic surgery expertise taking leadership role in PI prevention and wound care.
- Liaise with NSHA PI Prevention Coordinator for advice.



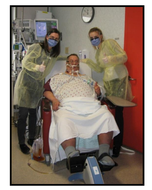
◦ Lack of consistent understanding of properties of standard ICU beds, and when a different surface is needed. Includes RNs, MDs, consulting services, company representatives.

ACTIONS
- Developing a simplified decision-making algorithm to guide when a surface other than standard ICU bed is needed. Limit options as appropriate so team is familiar with the technology and its use.

◦ There are gaps in documentation. Tools need to be useful, useable, and support transition out of ICU.

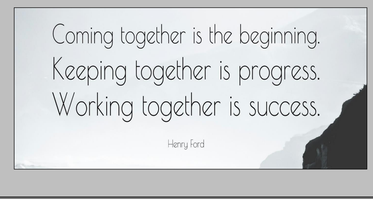
ACTIONS
- Redesigned ICU Nursing documentation
- Developed a PI Care Plan reflecting ICU specific interventions
- Ongoing auditing
- Implementing photographic documentation for wounds

◦ Ongoing Team commitment to reducing immobility through Early Mobility. Includes using the Sage Turning and Positioning system – a win for mobility, pressure injury prevention, and staff safety.
◦ Integration of Quality Work, including focuses such as delirium, mobility, pressure injury prevention.



Keys to Success

- Frontline knowledge & leadership
- Synergy with other initiatives
- Align with best practice
- Fit our local needs
- Use of simple data
- PATIENCE & PERSEVERANCE!



Thanks to the Commitment of the Nurses of 3A and 5.2 ICUs