

Decreasing Hospital Acquired Pressure Injuries in Non-Critical Care Units through Education & Awareness



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Introduction

In February of 2017 Sentara Norfolk General Hospital (SNGH) was experiencing an increased rate of Hospital Acquired Pressure Injuries (HAPIs) in non-critical care units.

SNGH had employed measures such as:

- hourly rounding,
- pressure relief surfaces
- risk assessment using the Braden Scale
- use of a nursing protocol that could be employed based on the Braden.

Additionally, SNGH had a dedicated team of Wound Ostomy Continence Nurses (WOCNs) assisting to determine best nursing practice.

Background

In March of 2017, the HAPI rate in non- critical care areas was **0.268** (SNGH number of non-critical care HAPI stage 2 or greater /Patient Days x1000). The HAPI Committee set a goal to decrease hospital acquired pressure injuries across Sentara Healthcare. A professional development activity for the clinical nursing staff was created as a "call to action" to focus on general information, review and breakout sessions related to current state and opportunities related to nursing practice for HAPI prevention across the system. The Clinical Nurse Specialist for the WOC Nursing Services Team at SNGH was an active participant in the planning of the HAPI Summit and coleader of the onsite production.

Description

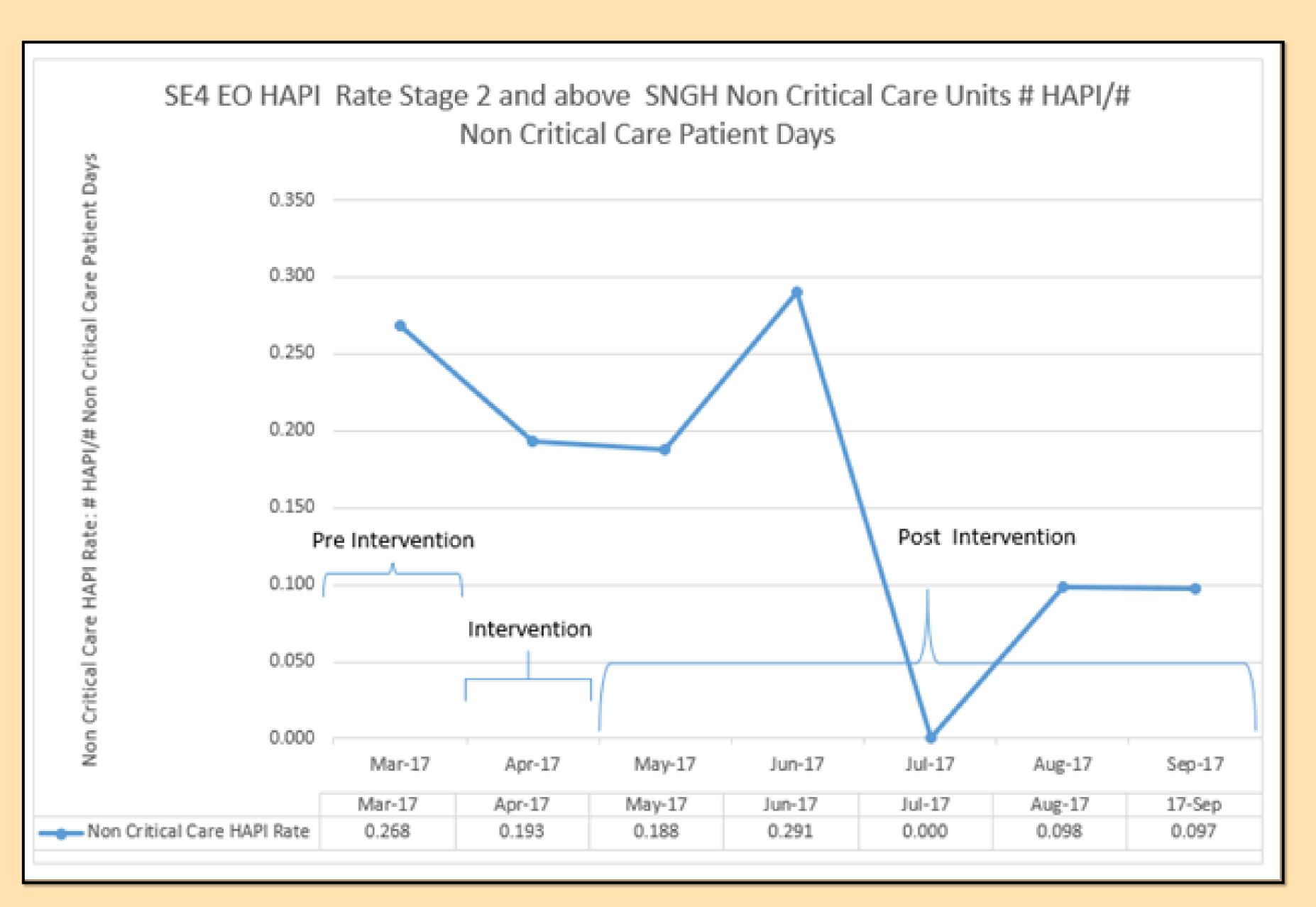
On April 20, 2017, 65 members of the SNGH nursing team participated in the system-wide HAPI Summit.



Findings

At SNGH, nurses and nursing care partners participated in live breakout sessions hosted by members of the WOC Nursing Services and Clinical Nutrition Teams. These breakout sessions specifically focused on prevention interventions including the importance of mobility, moisture management, nutrition risk, the importance of turning, heel boots, and new prevention interventions such as the waffle overlay. At the end of the professional development activity, there was the opportunity to

At the end of the professional development activity, there was the opportunity to place new ideas in a HAPI suggestion box for communication to the Clinical Nurse Specialist for the WOC Nursing Services Team.



Conclusions and Implications:

Due to the nurses' participation in the HAPI Summit, improvement in the nursing practices in the non-critical care areas needed to prevent HAPIs was made in the following areas of:

- mobility interventions,
- moisture management strategies,
- nutrition risk
- turning
- use of prevention measures such as heel boots and the waffle overlay

The adoption of these strategies resulted in improving this nurse sensitive patient outcome to 0.097.

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