Skin Sense

DOM Wound Care

Volume 1, Issue 1

Special points of interest:

- MICU has new beds.
- EPIC brings new challenges and opportunities to wound documentation.
- More rental bed information to keep you updated on changes
- Pressure Ulcer Prevention at the unit level

Inside this issue:

Four ICUs Get New Beds

The ICU fleet of beds, including our MICU, was over 15 years old and had outlasted its useful lifespan. After a lengthy process to choose a high quality replacement bed from a reputable company for the ICUs, and then negotiate a volume discount with the company, the beds have been delivered. The group decided on the *Hill-Rom Progressa ICU bed* with moisture management therapy surface. This bed is equivalent (or better) than most of our rental beds, and is actually a bed that Hill-Rom would rent out as a therapy surface. Therefore, there will be no delay in care for our MICU patients to receive higher level pressure reduction therapy if they are too sick to be moved. This may decrease the incidence of skin breakdown in our sickest patients.

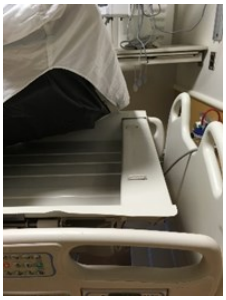
Another benefit is that our department's highest utilization of rental beds will now have minimal need for them (only very wide bariatric patients or those over 500 lbs). Also, the confusing process of figuring out if a patient should be changed to a standard bed on downgrade, will be made simpler. The units will be able to make their own assessment based on the patients improved status about the proper surface. This will assure that we are not renting products unnecessarily, but also that the product that is SAFEST for your unit's frame-can be initiated from the onset.

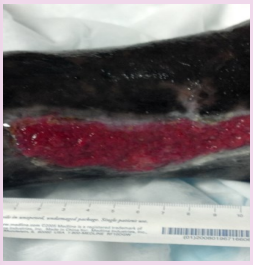
The next step is to remove all the obsolete beds from the hospital. All units that do not have Versacare frames now will be getting them. Units with newly purchased Versacares will also get a therapy mattress, while others will get Versacares that are "new to them."

Hill Rom Progressa ICU bed with P500 therapy surface.

Versacare Restraint Attachment Points

.After a recent HERO event related to the restraint attachment points on the Versacare beds, here is a review. There are two restraint attachment points on each side of the bed. One hook is near the CPR release handle, and the other is at the foot end of the lower siderail. There are no specific restraint hooks of that size above the head region for obvious reasons. However, there are times when a patient needs the Posey vest restraint that needs the shoulder straps to be secured. In this case, the hooks that keep the mattress in place may be used to secure the restraint. The patient's body will be holding the mattress down, at this point, so the hooks can be used for the restraints instead. Please take a moment to find these locations on the beds.





Hypergranulation tissue. One of the terms in the Terminology Review attachment.

EPIC Wound Documentation

There are some new challenges that come with documenting wound and skin care abnormalities with EPIC, but here are some tips to make things a little easier.

First of all, please feel free to delete any ROW that does not apply. If the wound is not surgical, then delete the rows for margin and closure. If the wound is superficial, delete the rows for tunneling and undermining. If the wound is not a pressure ulcer, delete the row pertaining to pressure ulcer staging.

Second, if the wound has healed, enter a "Date Resolved" in the header and complete it. Lets try to document only on skin abnormalities that require intervention or extra vigilance.

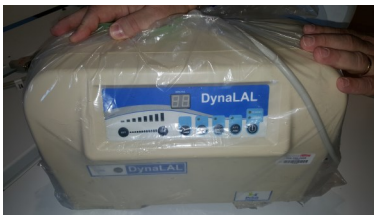
Third, I know the terminology can be tricky. Please see the attached powerpoint for visuals about the following terms and how they relate to wound care: denuded, ecchymotic, maceration, erythema, indurated, epithelialized, eschar, fibrin/ slough, hypergranulation tissue, erosion, and ulceration

Rental beds only work if they are plugged in. Please make it a habit to assure the blower box is turned ON.

Joerns Update

The RA 2000 overlay and the RA 3000 replacement mattress that utilize the same blower motor are obsolete and have to be replaced. Joerns was able to find a replacement vendor for these items in order to maintain the standard of quality that we expect. We will start seeing them soon. The blower box is pictured here and is as simple as the prior box. The replacement mattress is called the RA 3000 Elite Transport because it has more foam under the air to maintain comfort and some level of pressure relief when the bed deflates on transport.

Joerns has been training up new staff to JHH in order to provide us with optimal customer service. There have been some bumps in the road, but please continue to notify the Wound RNs of any issues with service or products. Don't forget that the number to reach our onsite Service Tech is 410-443-1324.



Rental Beds and Fall Alarms

Most of you had the opportunity to be fully inserviced on the use of the fall alarms on the rental beds, particularly the RC 850 Hi-Lo Bed. These beds come with cords that tie in to our call bell system in order to alert the staff of the fall alarm. As with all cords, they should stay with the bed when it gets moved. Please get into the habit of using these fall alarms. The instructions are printed below the scale. We have many falls from specialty beds, and most could be prevented by utilizing the fall alarms.

Pressure Ulcer Prevention is a Strategic Priority

The JHH Department of Nursing has declared pressure ulcer prevention to be one of our strategic priorities since this has a significant effect on patient safety, patient satisfaction, and of course—***reimbursement***. This puts the level of investment the same as for CLABSI, CAUTI, and Falls. JHH is charged with decreasing our rate of hospital acquired pressure ulcers by nearly 1/3 based on our NDNQI pressure ulcer survey results Our goal is to have a rate less than 2.1% of any type of hospital acquired pressure ulcer (HAPU) by the end of the 2017-2018 fiscal year.

The focus at the hospital level will be with the ICUs because approximately 60% of our HAPUs come from the ICUs. However, there is plenty of opportunity for improvement on the floors. We need to commit to a culture of pressure ulcer prevention and a high level of vigilance to patients' risk level and skin integrity. This translates into ownership and accountability.

We had a brainstorming session in our Wound Committee Meeting and will be exploring ways to operationalize this.

Step one belongs to you. Continue DAILY full skin assessments. Continue WEEKLY full wound assessment documentation, WITH measurements. Utilize the RN Managed Skin and Wound Care Protocol to assist with product choices.

With skin, early intervention is key. Critically think about the Braden score when completing it, and make sure you have interventions that match the patient's risk area.

Also, be sure to capture using the Wound Header information if a pressure ulcer is ***present on admission.***

World Wide Pressure Injury Prevention Day—

Use this day to to re-commit to preventing pressure ulcers on your unit.

Do you have a safety huddle? Which patients are most likely to get a pressure ulcer? Consider adding this topic into your huddle and assure all applicable interventions are in place.

Do you have an active wound champion to help you with your

"Wound Care Wednesday" assessment and documentation? Use them as a resource, not a substitute, for your vigilant care. Nothing makes a champion more excited than to have unit staff engaged in this subject.

Consider celebrating all the good things you do for your patients on this day and recommit as a unit to vigilance and accountability to your

"Avoidable pressure ulcers are a key indicator of the quality of nursing care"

Wound Care Committee — October 21, 2016 Participants

Lindsay Ricketts	PCCU
Jennifer Scott	CCU
Megan Prosise	Nelson 6
Jess Groom	Nelson 8
Sibyl Vinas-Kerner	Halsted 4
Kelly Conner	Med Nursing
Irina Baum	H202

Dates to Remember

Pressure Ulcer Survey :

Dec. 14, 2016

Mar. 8, 2017

Jun. 15, 2017

Sep. 13, 2017

Dec. 13, 2017

Wound Committee Meetings (Harvey 412 noon-1pm):

*Monthly

Nov. 18, 2016 - 12:30***

Dec. 16, 2016

Jan. 20, 2017

Feb. 17, 2017

Wound Consult Orders

"Adult Wound Eval and Treat" for the Wound RN

CRITERIA FOR THIS CONSULT:

- Stage 3 – 4 Pressure Ulcers or hospital acquired pressure ulcer
- Necrotic wounds
- Large or extensive wounds
- Current therapy failing after 7 days
- Floor RNs are trained in basic wound care.
- Wound care not covered by PT Wound care criteria (i.e. Dermatology cases)
- *Do NOT consult for: stage 1 or 2 pressure ulcers, skin rashes, boo boos, skin tears, pt that already has multiple consult services involved for skin, or wounds that no one has assessed yet.*

"PT Wound Care Eval and Treat" for the Physical Therapists

CRITERIA FOR THIS CONSULT – Must meet 1 criteria:

- Pulsed lavage (No whirlpool)
- Selective debridement
- Negative pressure wound therapy (VAC) - ****VAC dressing changes only provided by PT wound care therapists for patients who also require pulsed lavage or selective debridement.**
- Ultrasound – used for treatment of deep tissue injury wounds or chronic ulcers
- Compression therapy (paste layer compression "unna boots" and four layer compression "Profore")
- *Do NOT consult for skin hygiene, dermatological conditions, incontinence dermatitis, etc.*

Educational Opportunities

The NDNQI has a fantastic pressure ulcer training module that is free. Module one is pressure ulcer staging and module two is wounds other than pressure ulcers that are often mistaken for pressure ulcers. Please go to https://members.nursingquality.org/NDNQIPressureUlcerTraining/ and let your Nurse Manager and Wound Champion know that you did this.

We also showed a video about Pressure Ulcer Prevention from YouTube from the patient perspective. The link for this video is https://www.youtube.com/watch?v=Syc-hByVGF0.