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***Our Mission:*** Helping to prepare Iowa's health practitioners to care for our growing population of elders. *E-NEWS* is one of our methods of teaching through technology.

Each month, *E-NEWS* delivers abstracts from current multidisciplinary healthcare journal articles related to a specific geriatric topic. This month's *E-NEWS* focuses on REDUCING PRESSURE ULCERS WITH COLLABORATIVE CARE.

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## REDUCING PRESSURE ULCERS WITH COLLABORATIVE CARE

In this issue of the *E-NEWS*, you will find abstracts for:

- An article that reviews the results from a pressure ulcer prevention project implementing care system changes in collaboration with a state quality improvement organization.
  - A study that examines a pressure ulcer monitoring system used in multiple settings.
  - A study that evaluates collaborative clinical quality improvement for pressure ulcers in nursing homes.
  - A study that explores the reduction of pressure ulcer prevalence rates in the long-term acute care setting.
  - An article that discusses a Pressure Ulcer Prevention Collaborative project and its implementation within the home health program of a community medical center.
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- Abel RL, Warren K, Bean G, Gabbard B, Lyder CH, Bing M, McCauley C. Quality improvement in nursing homes in Texas: results from a pressure ulcer prevention project. *J Am Med Dir Assoc.* 2005 May-Jun;6(3):181-8.

BACKGROUND: Pressure ulcer prevalence, cost, associated mortality, and potential for litigation are major clinical problems in nursing homes despite guidelines for prevention and treatment. OBJECTIVE: To improve the use of pressure ulcer prevention procedures at nursing homes in Texas through implementation of process of care system changes in collaboration with a state quality improvement organization (QIO). DESIGN: Preintervention and postintervention measurement of performance for process of care quality indicators and of pressure ulcer incidence rates. SETTING: Twenty nursing homes in Texas. PARTICIPANTS: Quality improvement teams at participating nursing homes. MEASUREMENT: Data were abstracted from medical records on performance measures (quality indicators) and pressure ulcer incidence rates between November 2000 and August 2002. Descriptive and inferential statistics were used. INTERVENTIONS: Process of care system changes consisting of tools and education to prevent pressure ulcers were introduced to participating nursing homes. RESULTS: Participating nursing homes showed statistically significant improvement in 8 out of 12 quality indicators. Pressure ulcer incidence rates also decreased, although not quite significantly. Furthermore, facilities with the greatest improvement in quality indicator scores had significantly lower pressure ulcer incidence rates than the facilities with the least improvement in quality indicator scores (S = 131.0, P = .03). This suggests that the interventions positively affected not only the process of care but also led to a decrease in pressure ulcer incidences. CONCLUSIONS: These results show that nursing homes in a collaborative effort with a QIO were able to improve their processes of care. Although significant improvement was noted on most of the quality indicators, opportunity remains for further improvement. Furthermore, these results suggest that implementation of process of care system changes by nursing homes in a collaborative relationship with a QIO may yield improvements in measures of patient outcome (e.g., pressure ulcer incidence).



- Harrison MB, Mackey M, Friedberg E. Pressure ulcer monitoring: a process of evidence-based practice, quality, and research. *Jt Comm J Qual Patient Saf.* 2008 Jun;34(6):355-9.

BACKGROUND: A number of settings in eastern Ontario, Canada, have collaborated on establishing a common pressure ulcer monitoring system. This work was undertaken in a proactive effort to implement practice guideline recommendations related to pressure ulcer prevention. The monitoring system was developed at The Ottawa Hospital (Ottawa, Ontario, Canada), an acute care teaching hospital, and then shared with multiple settings, which adopted it. METHODS: A work group was formed with clinical, quality, and research expertise. In a prospective (rather than retrospective) chart audit, 12-hour point prevalence surveys are conducted in which risk, occurrence, and interventions are tracked. Trained surveyors conduct a standard risk appraisal, head-to-toe skin assessment, and chart scan. Reporting mechanisms were developed at the organization, program, and unit levels. RESULTS: Between 2001 and 2007, despite an inpatient population of which usually more than 25% were at "high" risk, prevalence decreased from 18% to 14%. RECOMMENDATIONS: Fifteen years' experience in pressure ulcer monitoring suggests the following recommendations: (1) create and enable skin care champions to monitor and develop unit-based solutions in response to survey findings; (2) embed monitoring in the quality and professional practice infrastructure of the organization; (3) use existing structures and processes such as unit councils or quality committees; quality processes and practice panels are ideal venues to situate pressure ulcer monitoring at both organizational and unit levels; and (4) create a data collection process that is as clinically sensible and feasible as possible. SUMMARY AND CONCLUSIONS: Monitoring is the linchpin that formed the foundation for the long-term, systemwide undertaking of the prevention of pressure ulcers and that created the climate for change and continued momentum.



- Lynn J, West J, Hausmann S, Gifford D, Nelson R, McGann P, Bergstrom N, Ryan JA. Collaborative clinical quality improvement for pressure ulcers in nursing homes. *J Am Geriatr Soc.* 2007 Oct;55(10):1663-9.

The National Nursing Home Improvement Collaborative aimed to reduce pressure ulcer (PU) incidence and prevalence. Guided by subject matter and process experts, 29 quality improvement organizations and six multistate long-term care corporations recruited 52 nursing homes in 39 states to implement recommended

practices using quality improvement methods. Facilities monitored monthly PU incidence and prevalence, healing, and adoption of key care processes. In residents at 35 regularly reporting facilities, the total number of new nosocomial Stage III to IV PUs declined 69%. The facility median incidence of Stage III to IV lesions declined from 0.3 per 100 occupied beds per month to 0.0 ( $P < .001$ ) and the incidence of Stage II to IV lesions declined from 3.2 to 2.3 per 100 occupied beds per month ( $P = .03$ ). Prevalence of Stage III to IV lesions trended down (from 1.3 to 1.1 residents affected per 100 occupied beds ( $P = .12$ )). The incidence and prevalence of Stage II lesions and the healing time of Stage II to IV lesions remained unchanged. Improvement teams reported that Stage II lesions usually healed quickly and that new PUs corresponded with hospital transfer, admission, scars, obesity, and immobility and with noncompliant, younger, or newly declining residents. The publicly reported quality measure, prevalence of Stage I to IV lesions, did not improve. Participants documented disseminating methods and tools to more than 5,359 contacts in other facilities. Results suggest that facilities can reduce incidence of Stage III to IV lesions, that the incidence of Stage II lesions may not correlate with the incidence of Stage III to IV lesions, and that the publicly reported quality measure is insensitive to substantial improvement. The project demonstrated multiple opportunities in collaborative quality improvement, including improving the measurement of quality and identifying research priorities, as well as improving care.



- Milne CT, Trigilia D, Houle TL, DeLong S, Rosenblum D. Reducing pressure ulcer prevalence rates in the long-term acute care setting. *Ostomy Wound Manage*. 2009 Apr;55(4):50-9.

Information about pressure ulcer prevalence, prevention, and optimal management strategies in the long-term acute care hospital (LTACH) setting is sparse. Although care processes in other patient care settings have been reported to affect pressure ulcer prevalence rates, the effect of such programs in the LTACH is unknown. To reduce perceived above-average pressure ulcer prevalence rates and improve care processes, a 108-bed LTACH used a failure mode and effects analysis to identify and address high-priority areas for improvement. Areas in need of improvement included a lack of 1) wound care professionals, 2) methods to consistently document prevention and wound data, and 3) an interdisciplinary wound care team approach, as well as a faulty electronic medical record. While prevalence data were collected, policies and procedures based on several published guidelines were developed and incorporated into the pressure ulcer plan of care by the newly established wound care team. Improved assessment and documentation methods, enhanced staff education, revised electronic records, wound care product reviews, and a facility-wide commitment to improved care resulted in a reduction of facility-acquired pressure ulcer prevalence from 41% at baseline to an average of 4.2% during the following 12 months as well as fewer missing electronic record data (<1% of charts had missing data). These study results suggest that staff education, better documentation, and a dedicated wound care team improve care practices and reduce pressure ulcer prevalence in the LTACH. Studies to increase knowledge about the LTACH patient population and their unique needs and risk profiles are needed.



- Werkman H, Simodejka P, DeFilippis J. Partnering for prevention: a Pressure Ulcer Prevention Collaborative project. *Home Healthc Nurse*. 2008 Jan;26(1):17-22.

In a statewide initiative, coordinated by the New Jersey Hospital Association (NJHA) Quality Institute, hospitals together with nursing home and home care agencies were asked to participate in a Pressure Ulcer Prevention Collaborative. The goal of this collaborative was to decrease the incidence and prevalence of pressure ulcers across the state by 25% within a 12-month period. This article discusses the rationale for the Collaborative as well as the requirements and implementation of the initiative within Community Medical Center's Home Health Program.



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*Next Month's Issue:*

Preview of the 2010 Geriatric Lecture Series

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