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KK Women's and Children's Hospital
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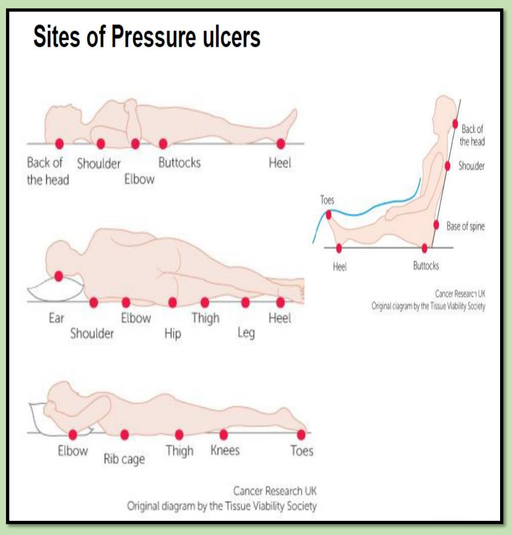
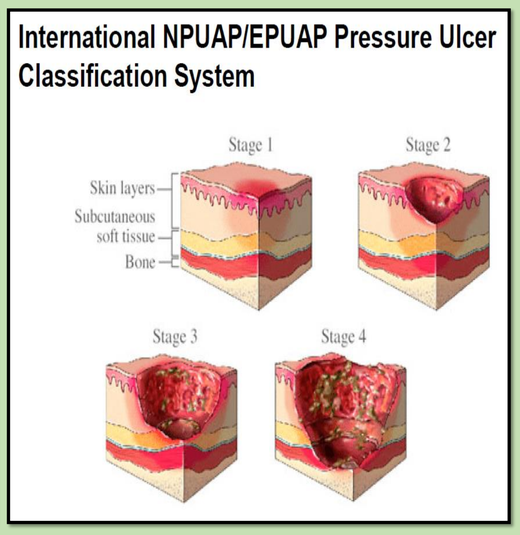
Zeroing the prevalence of Hospital Acquired Pressure Injury in a Women's Hospital

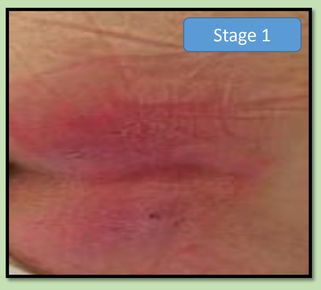
Low KK; Hoon SJ; Ngoh GL; Andaya JDL; Tan ML; Cheng SJ; Adlawan MJ; Augustion RD; Thomas J; Said NA; Alfaro PD; Simon S; Wong XY
KK Women's and Children's Hospital

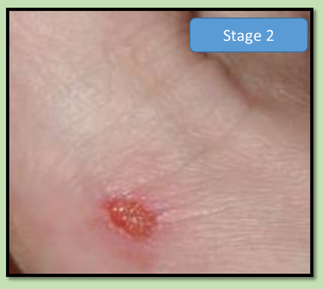
Background

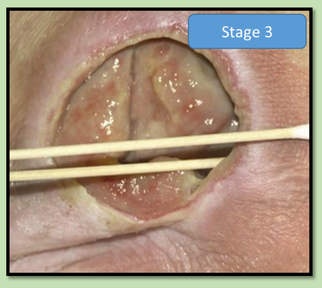
Most of the Hospital Acquired Pressure Injury (HAPI) is preventable however, some healthcare professionals are not aware that unrelieved pressure over a certain time frame can affect the integrity of the skin causing it to break. There has been an increased in observation of patients with Hospital Acquired Pressure Injury incidences arising from the time patients were in Operating Theatre to the inpatient wards. Currently there is no standard workflow on applying prophylactic pressure preventive dressing for these patients who are highly susceptible to develop pressure injury from prolong hours of surgery.

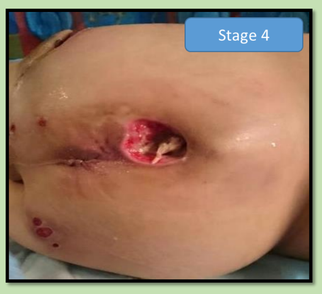


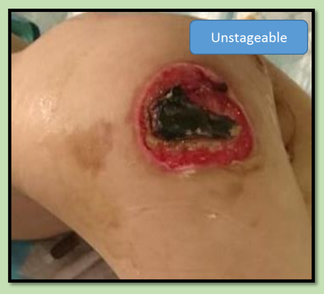


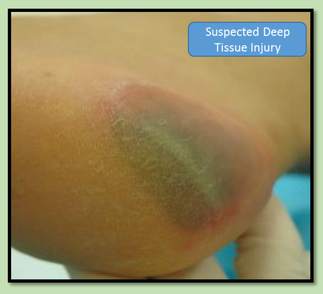






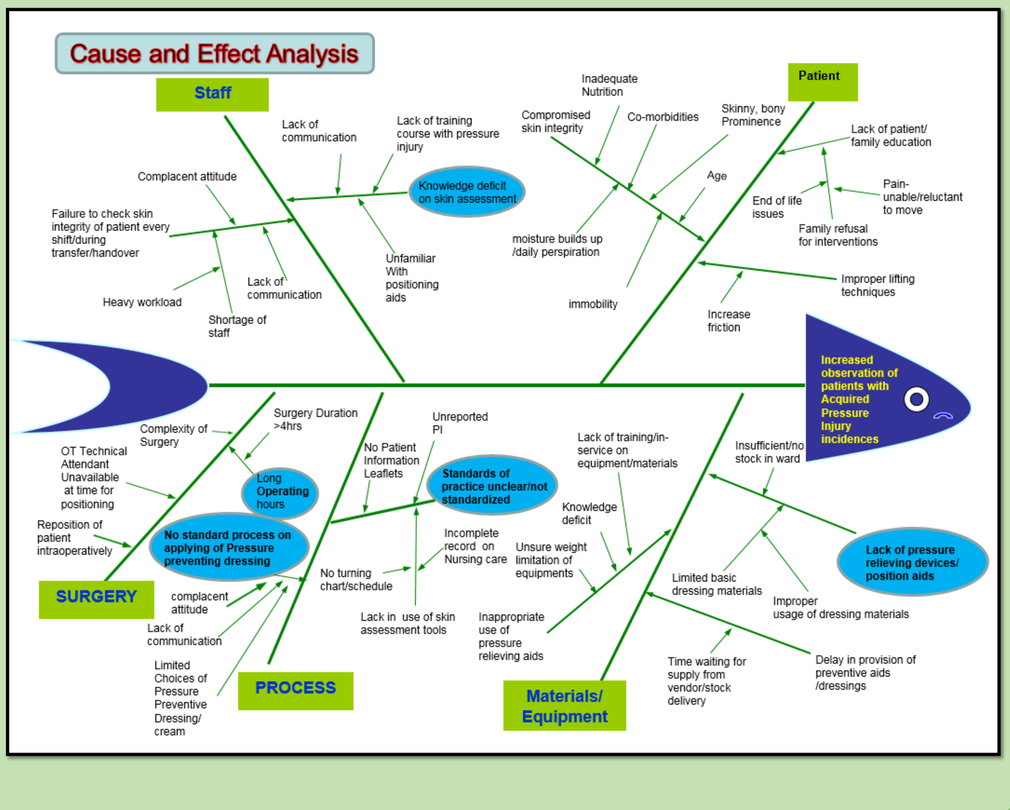






Methodology

This project was conducted using the process Improvement Project (PIP) methodology. A team was formed with representation from different departments like Plastic, Reconstructive and Aesthetic Surgery, Operating Theatre (OT), Inpatient Wards, Women Intensive Care Unit and Resources Nurses. The team were able to identify 7 main root causes using the Cause and Effect Analysis.



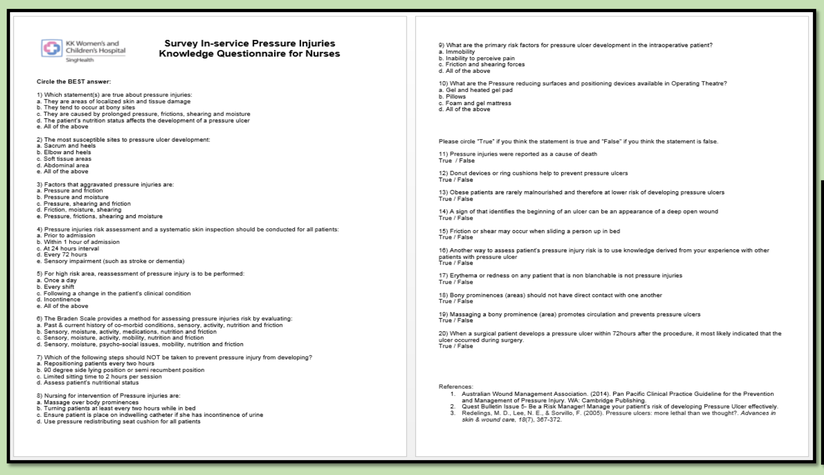
Aim(s)

To create acute awareness among nurses in
a) identifying patients who may have a certain degree of immobility
b) proactively target best prevention efforts to minimize risk of pressure injuries

Interventions

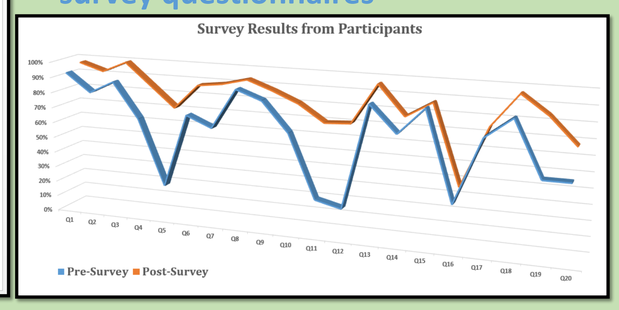
Phase 1

The team brainstorms on all the activities that occur within the scope of the inpatient stay process through **case discussion**



Phase 2

Staff knowledge were assessed using pre and post **survey questionnaires**



Phase 3

Identify gaps between **current and recommended practices and proposed a solution**

Proposed Solution

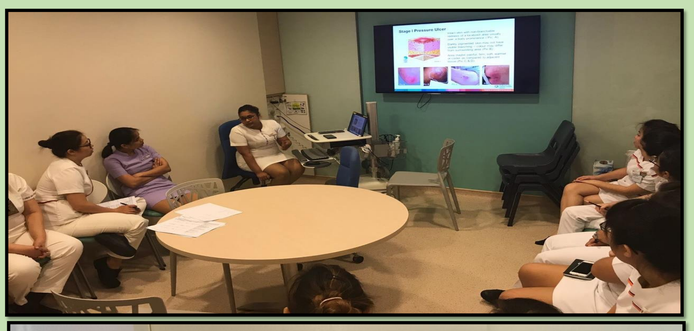
Increased observation of patients with Acquired Pressure Injury incidences

5 main root causes were identified
Focus group deliberates and decides to work to tackle on standard of practice which will cover some of the other root causes identified below

- **Knowledge Deficit on Skin Assessment**
  Action - conduct staff and patient / caregiver education
- **Standards of practice unclear/not standardized**
  Action - focus group intend to work on getting the standard of practice across the towers collaborating with Focus Group Representatives/Wound Nurses/Operating Theatre Nurse Managers/National Quality Improvement Team
- **Lack of appropriate pressure relieving devices and position aids**
  Action - team will work with Material Management Department and wound nurses/ Operating Theatre Nurse Managers/National Quality Improvement Team of devices required
- **No standard process on applying of Pressure preventing dressing materials**
  Action - team will focus on course of action in applying preventive pressure relieving aids that appear unclear to nurses. Organize in-service talks, workshop and product demonstrations
  Action- collaborate with Material Management Department /Pharmacy/Wound Nurses
- **Long Operating hours**
  Action - team acknowledged time is beyond focus group's control however the processes on relieving and preventing Pressure Injury from occurring will be initiated from Operating Theatre

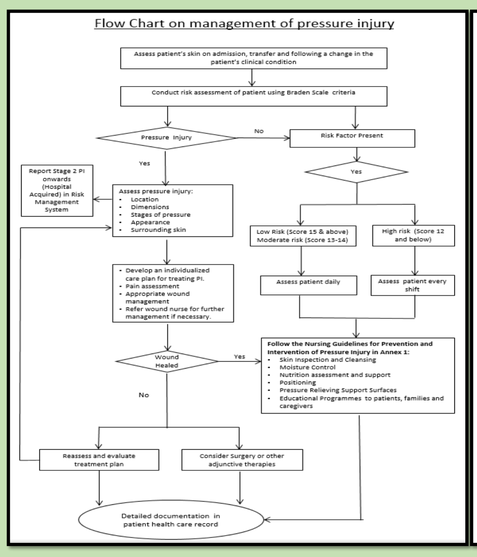
Phase 4

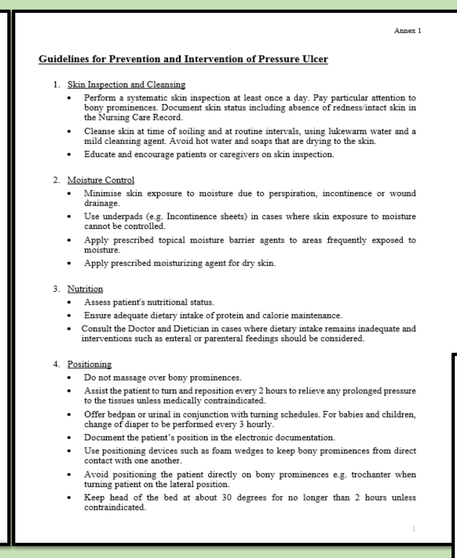
Staff Education

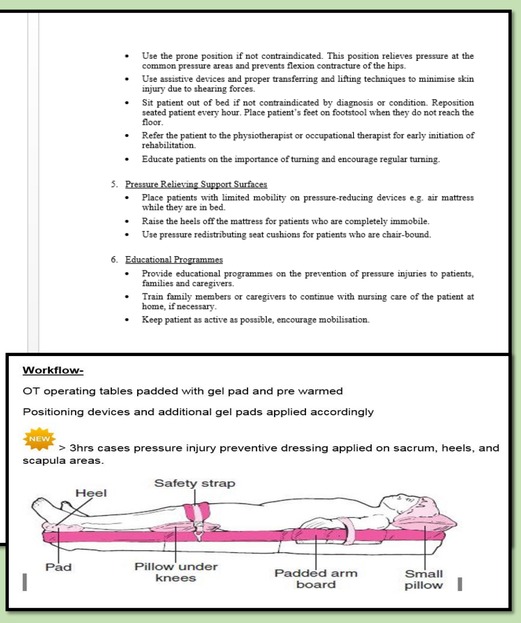


Phase 5

Initiatives were refined and implemented using **Plan Do Study and Act (PDSA) cycle**







Result

With the development of the new clinical workflow, nurses are able to engage and integrate their hands-on knowledge and expertise on the management of patients identified as at risk (based on the Braden Scale). This applies seamlessly across multiple departments in the hospital which reduces the risk of HAPI and improve better patient outcomes

Conclusion

Standardising the workflows ensures the efforts of pressure injury prevention practices continues and be seamless across the multiple departments. This helps staff to take responsibility in achieving the set objectives as well as heeding the hospital's attempt to achieve "ZERO HARM".

PATIENTS AT THE HEART OF ALL WE DO