# Impact of a Standardizing Approach to Turning and Repositioning Patients at Risk for Pressure Injury Development

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## Background

A work group was formed to review a system wide increase in Hospital Acquired Pressure Injuries and make recommendations for practice changes to decrease these injuries. One finding was inconsistent documentation of every two hour turning on at-risk patients. In March of 2017, a UM SJMC focused audit of at-risk patients revealed a hospital wide average of 30% compliance with turning documentation. There were also 14 hospital acquired pressure injuries that month. This Quality Improvement Project was intended to improve documentation of that repositioning for at-risk patients, by implementing a customized turn clock and a standard process.

The Agency for Healthcare Research and Quality, National Pressure Ulcer Advisory Panel and Health Research & Educational Trust all recommend turning clocks to serve as tools to improve awareness of when the patient should be in which position for all staff, patients and family members.

## Purpose and Goals

- Decrease hospital acquired pressure injuries.
- Enhance documentation of prevention measures for at- risk patients, specifically q2 hour turn/reposition.
- Simplify tasks associated with pressure injury prevention.
- Enhance awareness of prevention measures.
- Identify barriers/provide support.

## How are Goals Measured?

Our goal of zero is measured by the number of hospital acquired pressure injuries during the month.

At-risk patients will have spot-check audits. A percentage will be calculated from the number of turns that should have been performed and the number of turns that were actually performed.

## Key Points

- Staff engagement
- Promotion of program
- Organized implementation
- Clearly defined goals/expectations
- Continuous feedback
- Increased awareness of actual HAPI occurrences
- Orientation lecture to explain expectations

## The Pilot

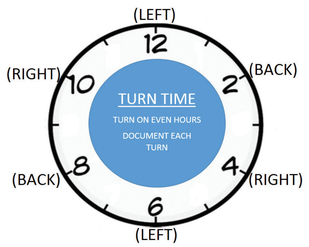
1. Survey staff to understand their perspective of HAPI prevention measures and documentation, and thoughts on ways to improve compliance.
2. Develop the tool based on staff input.
3. Submit tool to staff for approval/ recommendations.
4. Modify tool and resubmit for final approval.
5. Plan pilot with identified unit's manager, determine location and plan for installation.
6. Promote program through staff meetings, huddles, email and posters in a common staff area.
7. Perform audits throughout pilot, with continual feedback to the unit manager to deliver to staff.
8. Provide a final feedback report with recommendations.
9. Survey staff for their perspective on the pilot turn clock program.

## Pilot Results

OVERALL COMPLIANCE RATE AT END OF PILOT: 71.6%
NUMBER OF HAPI OCCURENCES DURING PILOT: 1 (Nasal Bridge from BiPap)

## How the Program Works for Staff

Signs will be placed in each patient's room at a standardized location. The default side of the sign will be the Braden score "reminder" side. A Braden score is to be done every 12 hours to determine continued needs of patient. If the Braden score is 18 or less, the sign will be flipped over to the "turn clock" side and prevention measures will be implemented and will be turned at every even hour, and each turn will be documented by the RN or tech.

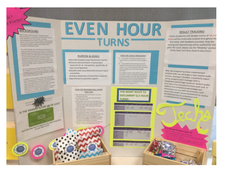



- Maintain the even hour schedule at all times. For example, If PT/OT comes and repositions the patient at 1:00, continue with EVEN hour turning- the next turn will still be at 2:00. This maintains consistency and simplifies the schedule.

The RN or tech is to document each assisted turn, refusal, or instance of independent turning.

## Taking the Program Hospital Wide


- First, we met with each Inpatient unit manager and scheduled a two week roll-out period, determined the signage location and developed a plan for installation.
- The week before each scheduled roll-out period, the new program was presented in meetings, huddles, emails and poster presentations.
- Following the one week introduction, each unit had a two week period wherein each at-risk patient's chart was audited.
- Each week, a report was issued providing a compliance rate percentage, trends and a synopsis of HAPIs that occurred during that time.

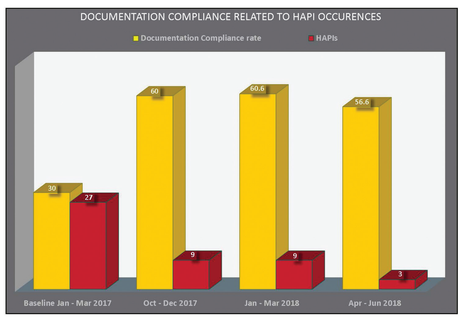




## Maintenence

Starting in October of 2017, a routine audit process began and a quarterly report was issued to staff on inpatient units. The report includes a compliance percentage based on random audits of at least 15 at risk patients from each unit. Each report will also contain recommendations to resolve identified barriers to compliance and considerations for remediation.

## Results

Documentation compliance increased to 50% at the completion of the 10 week roll-out and has since increased to 61%. HAPIs have decreased to an average of 3.2/month since implementation.




## Conclusions

Previously published Quality Improvement projects have found that improved documentation results in decreased HAPIs. That, along with our results, suggests that this model has the potential to enhance the effectiveness of standard HAPI prevention measures.

## References

1. Jacobson, T., Thompson, S., Halvorson, A., Zeitler, K. (2016). Enhancing Documentation of Pressure Ulcer Prevention Interventions. Journal of Nursing Care Quality.

2. 2016. Pressure Injury Prevention Points. Retrieved from: http://www.npuap.org