Plan for Sustainability

Pressure Injury Prevention

It is important that hard-won quality improvements are not lost as attention shifts to other priorities and team/staff revert to the "old ways' of doing things.

Sustainability is locking in the progress that has been made already and continually building upon it. [i]

Recommendations
• Ensure that all nursing staff are well educated on the Prevention of Pressure Injuries policy and procedure. Provide training to designated nurses on Pressure Injury Staging and obtain competencies for their Personnel/Educational file.
• All in-house developed pressure injury require investigation. Include training on the Investigation process for all nurses. Ensure that they know how to complete a thorough investigation and complete the incident report to determine Root Cause.
• Review the pressure injury incident report within 24 hours with the Interdisciplinary team. Determine root cause of the incident and brainstorm as a team to initiate the appropriate intervention. Go to the room and physically look at the environment. Pay special attention to the bed, wheelchair and positioning of the resident. Note any positioning issues and involve therapy if needed.
• Communicate this new intervention to staff and update the care plan to ensure that written instructions are available to the staff.
• Update care plan/ Kardex with targeted behaviors and individualized interventions.
• Document a thorough IDT note of your meeting including root cause, new intervention, MD/family notification and what you will do to monitor this resident.
• Provide additional training to the nursing staff on proper positioning of the residents while in bed and when up in their wheelchair to prevent skin breakdown.
• Provide training to the CNAs and Nurses on how to access the individual resident's plan of care.
• Complete an inventory of all positioning devices to ensure that adequate supplies are available. Use specialty mattresses for residents that are HIGH RISK or currently have pressure injuries and make sure that the nursing staff know how to operate and monitor the specialty mattress pumps.
• Complete rounds daily to ensure that all new wound interventions are in place. Note if the resident is positioned properly in bed or in the wheelchair. Also review resident shower sheets to identify any new skin issues. Report any issues immediately to the supervisor such as any new skin issues, missing shower sheets/ positioning supplies, improper positioning of the resident, lack of specialty mattress or malfunction, etc. Remember that the CNA is usually the 1st person to identify a skin issue when bathing or showering the resident. EARLY identification is key!
• Conduct a weekly At Risk meeting and review each resident with compromised skin to ensure that appropriate treatment is in place, healing of the wound is evident, notification of wound status to the MD and Responsible party is documented, Orders are in place and the care plan and kardex are updated. Track and trend that development of facility acquired pressure injuries to identify any specific issue such as lack of staff knowledge, improper positioning, infection control, accountability, etc.
• The use of audit tools is encouraged to ensure documentation is timely and thorough. These audit tools can be used for the QAPI meeting.

Recommendations
• Remember to discuss all wounds at your QAPI meeting. Be sure to include any trends that were identified and action plans that were taken. If there was a deficiency noted in, make sure that you have a PIP in place to address what actions the facility took and how you will monitor this system.
• Be sure to include all the above training with the new employee/agency orientation.
• Maintaining sustainability is not an easy task. It takes everyone in the facility to achieve compliance. Be sure to include and educate all staff about this process and keep them well informed of any changes.

[1]Scoville R, Little K, Rakover J, Luther K, Mate K. *Sustaining Improvement*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016