Pump Up Your Pressure Injury Prevention

Jackie Florez, BS, RN, CNOR, Jenell Moultrie, MSN, RN, CNOR, Joyce Hall, BS, RN, CNOR, CSSM
Department of Perioperative Services, Houston Methodist Hospital, Houston, Texas, USA 77030

BACKGROUND/INTRODUCTION

Hospital acquired pressure injuries (HAPI) are a safety concern and negatively impact the cost of healthcare (Padula and Delarmente, 2019). After completing a literature review in 2018, a multidisciplinary team of registered nurses that work within the perioperative setting (preop, intraop, and PACU), wound care specialists, and quality specialists formed the Perioperative Pressure Injury Prevention (PPIP) Committee as a subcommittee of the hospital wide HAPI Committee. The hospital wide HAPI Committee refers all pressure injuries occurring within 72 hours of the post-operative period to the PPIP Committee for a thorough review. In 2019, the PPIP committee established a sustainable process to report, track and review Periop Pressure Injury occurrences.

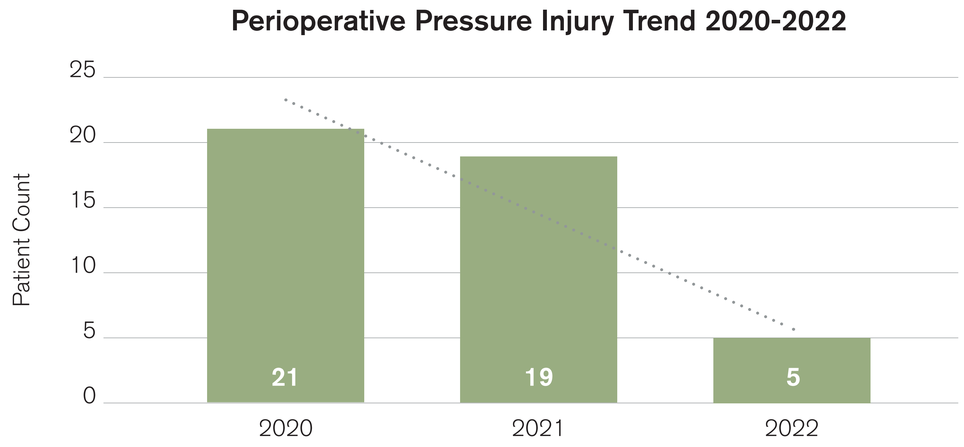
PURPOSE/OBJECTIVES/HYPOTHESIS

The hospital wide committee collects and submits data to the PPIP Committee for review to determine the number of pressure injuries occurring in the Perioperative setting. The PPIP Committee uses the data to work in tandem with the hospital wide HAPI Committee to develop interventions that reduce perioperative acquired pressure injuries.

METHODS

The perioperative pressure injury prevention Committee created a pressure injury prevention bundle and collaborated with the hospital wide HAPI Committee to develop a review process to verify pressure injuries attributed to the Perioperative setting. Association of perioperative nurses (AORN) guidelines are reviewed to impact compliance of recommended practices. All Perioperative Pressure Injuries are shared with the unit of origination. The Perioperative Pressure Injury Champion, manager, and educator of the unit prepare a unit specific review and debrief with OR staff. This process provides a focused identification of opportunities for improvement. During debrief, action plans are developed to close lapses in care. Case outcomes are then shared with all Perioperative areas to prevent similar incidences. The PPIP committee also tests new products and assessment tools to determine whether they should be added to the PPIP bundle.

RESULT



Year	Number of Procedures	Hospital Acquired Pressure Injuries	Periop Pressure Injuries
2020	33,203	166	21
2021	38,711	211	19
2022	40,463	159	5

Pressure Injury Prevention Bundle	
Skin	Head to toe assessments Pre, Intra, and Post-Op
Surfaces	Conversion of OR bed and stretcher surfaces to 3-inch memory foam and converted some positioning aids to silicone
Dressings	Standardization of prophylactic dressings placed over bony prominences
Overlay	Utilization of alternating air pressure support surfaces for high-risk patients
Education	Initial and ongoing mandatory quarterly education

RESULTS/IMPLICATIONS

All NDNQI guidelines related to hospital wide and perioperative pressure injury incidences are followed. The guidelines assist us in identifying needed changes in practice. A pressure injury bundle was implemented to standardize care. As a result, the number of perioperative acquired pressure injuries decreased from 21 in 2020 to 5 in 2022.

FUTURE ACTIONS

Next steps would include aligning pressure injury prevention practice efforts across all units and increased interdisciplinary collaboration with the hospital wide HAPI committee. Our PPIP team would also like to explore other skin injuries such as burns, blisters, tears, etc. Another goal would be to create a culture of accountability and transparency in all our cases to always ensure patient safety. Each year the committee examines the annual goals that were developed to assess whether the interventions and education have been effective. One of the goals is to consistently lower the NDNQI levels by a certain percentage or rate. Other goals are related to action items the committee wants to implement to prevent pressure injuries.

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