Today’s Host

Sarah Konstantino. Project Assistant, Institute for Healthcare Improvement (IHI), assists in programming activities for expeditions, as well as maintaining Passport memberships, mentor hospital relations and collaboratives. Sarah is currently in the Co-Operative Education Program at Northeastern University in Boston, MA, where she majors in Business Administration with a concentration in Management and Health Science. She enjoys cooking, traveling, and fitness.
Audio Broadcast

You will see a box in the top left hand corner labeled "Audio broadcast." If you are able to listen to the program using the speakers on your computer, you have connected successfully.

Phone Connection (Preferred)

To join by phone:

1) Click the button on the right hand side of the screen.
2) A pop-up box will appear with call in information.
3) Please dial the phone number, the event number and your attendee ID to connect correctly.
Audio Broadcast vs. Phone Connection

- If you are using the audio broadcast (through your computer) you will not be able to speak during the WebEx to ask questions. All questions will need to come through the chat.

- If you are using the phone connection (through your telephone) you will be able to raise your hand, be unmuted, and ask questions during the session.

- Phone connection is preferred if you have access to a phone.

WebEx Quick Reference

- Welcome to today's session!
- Please use chat to “All Participants” for questions
- For technology issues only, please chat to “Host”
- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)
When Chatting…

Please send your message to
All Participants

Chat Time!

What is your goal for participating in this Expedition?
Join Passport to:

- **Get unlimited access to Expeditions**, two- to four-month, interactive, web-based programs designed **to help front-line teams make rapid improvements**.
- **Train your middle managers** to effectively lead quality improvement initiatives.

... and much, much more for $5,000 per year!

Visit [www.IHI.org/passport](http://www.IHI.org/passport) for details.
To enroll, call 617-301-4800 or email improvementmap@ihi.org.

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**IHI Open School Courses**

- More than 20 online courses developed by world-renowned experts in the following topics
  - Improvement Capability
  - Patient Safety
  - Person- and Family-Centered Care
  - Triple Aim for Populations
  - Quality, Cost, and Value
  - Leadership
- More than 26 continuing education contact hours for nurses, physicians, and pharmacists. NAHQ has also approved the courses for CPHQ CE credit.
- Basic Certificate of Completion available upon completion of 16 foundational course.
- Mobile App for iPhone and iPad
- 20% Discount on organizational subscription for Passport Members
- [www.ihi.org/qualityskills](http://www.ihi.org/qualityskills)
What is an Expedition?

ex•pe•di•tion (noun)
1. an excursion, journey, or voyage made for some specific purpose
2. the group of persons engaged in such an activity
3. promptness or speed in accomplishing something

Expedition Support

- All sessions are recorded
- Materials are sent one day in advance
- Listserv address: PressureUlcersExpedition@ls.ihi.org
  - Sends an email to all participants and faculty
  - Use only for questions relevant to all participants
  - To add yourself or colleagues, email us at info@ihi.org
Expedition Director

Kathy D. Duncan, RN, Faculty, Institute for Healthcare Improvement (IHI), oversees multiple areas of content and is the clinical lead for IHI’s National Learning Network. Ms. Duncan also directs content development and provides spread expertise for IHI’s Project JOINTS as well as additional content direction for the Hospital Portfolio, directs a number of virtual learning webinar series, and manages IHI’s work in rural settings. Previously, she co-led the 5 Million Lives Campaign National Field Team and was faculty for the Improving Outcomes for High Risk and Critically Ill Patients Innovation Community. In addition to her leadership on the field team during the Campaign, Ms. Duncan was the content lead for several interventions in IHI’s 100,000 Lives and 5 Million Lives Campaigns. She also serves as a member of the Scientific Advisory Board for the American Heart Association’s Get with the Guidelines Resuscitation, NQF’s Coordination of Care Advisory Panel, and NDNQI’s Pressure Ulcer Advisory Committee. Prior to joining IHI, Ms. Duncan led initiatives to decrease ICU mortality and morbidity as the Director of Critical Care for a large community hospital.
Today’s Agenda

- Introduction to WebEx
- Introduction to the Expedition
- Background and context
- Pre-work: Incident Review
- Model for Improvement
- Action Period Assignment

Ground Rules

- We learn from one another – “All teach, all learn”
- Why reinvent the wheel? – Steal shamelessly
- This is a transparent learning environment
- All ideas/feedback are welcome and encouraged!
Overall Program Aim

The aim of the Expedition is to provide participants with strategies for preventing pressure ulcers that have been tried and tested in a variety of different contexts with great success.

Expedition Objectives

At the end of this Expedition, participants will be able to:

- Identify a range of simple tools and methods which will help you to prevent pressure ulcers
- Test strategies for identification of patients at risk for pressure ulcers
- Implement reliable processes for pressure ulcer risk assessment and pressure ulcer prevention
- Implement reliable processes for pressure ulcer prevention strategies
Schedule of Calls

Session 1: Getting to Zero – Strategies for Success  
Date: Tuesday, April 22, 12:00 – 1:30 pm ET

Session 2: Identification and Assessment of Patients at Risk  
Date: Tuesday, May 6, 12:00 – 1:00 pm ET

Session 3: Developing Reliable Care Processes  
Date: Tuesday, May 27, 12:00 – 1:00 pm ET

Session 4: Measurement for Improvement  
Date: Tuesday, June 10, 12:00 – 1:00 pm ET

Session 5: Engaging Patients, Families, and the Community in Pressure Ulcer Prevention  
Date: Tuesday, June 24, 12:00 – 1:00 pm ET

Session 6: Generating Ideas from Frontline Staff  
Date: Tuesday, July 8, 12:00 – 1:00 pm ET

Faculty

Annette Bartley is a registered nurse with over 30 years of experience in healthcare. She has held leadership roles in frontline clinical care, management and at director level. In 2006 she was awarded a Health Foundation Quality Improvement Fellowship spent at the US Institute for Healthcare Improvement (IHI), during which time she also completed a Masters in Public Health at Harvard University. Annette is now an Independent Quality Improvement Consultant responsible for developing, supporting and leading a number of highly successful quality improvement and patient safety initiatives across the UK at regional, and national level. Her work extends internationally and she is viewed as an authority on the prevention of avoidable pressure ulcers using quality improvement methodology. Annette’s passion is inspiring and supporting frontline care teams to reliably deliver high quality, safe, person centered care.
Expedition: Fundamental Principles

- Less about theoretical content
- Focus on aims, measures, execution and results
- More about learning from each other and from best practice
- Reliant on participant’s interaction
- Action periods between calls are designed to enable participants to apply some of the learning in practice

Bob Wachter on Patient Safety 2013

“I’ve never been more worried about the safety movement than I am today. My fear is that we will look back on the years between 2000 and 2012 as the Golden Era of Patient Safety, which would be okay if we’d fixed all the problems. But we have not.”

1. **Clinical Burnout**: “the blizzard of new initiatives – all well meaning but cumulatively overwhelming – thrust at busy clinicians has created overload”
2. **Strategic repositioning of priorities**
The Reality in Practice

Successful organizations define culture and act out their culture.

Organizations are made up of a collection of subcultures.

Paul O’Neill

- Non-Negotiable Mutual Respect
- The tools to do the job
- Acknowledgement of a job well done.

The Culture of Patient Safety is:

- An accountable culture
- A culture of learning
- A culture of partnership
- A Just culture
Focus on the Why

The Swiss Cheese Model
James Reason

Simon Sinek
http://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action.html

The Swiss Cheese Model of Accident Causation

Some holes due to active failures
Hazards
Successive layers of defenses, barriers, & safeguards
Other holes due to latent conditions
Preventing avoidable pressure ulcers across healthcare settings

Why this work is so important?

Pressure Ulcers are for the most part avoidable
Facts

- Pressure ulcers are a common problem for patients who have limited mobility, or who sit or lie in one position for long periods of time.
- Pressure ulcers are painful, and can be devastating for patients leading to surgery and longer stays in hospital.
- They can be potentially life-threatening.
- In 2006* Adult hospital stays noting a diagnosis of pressure ulcers amounted to $11.0 billion.
- In the UK the cost is £1.4–£2.1 billion annually (4% of total NHS expenditure) that’s 4p in every pound of the NHS budget! (Bennett et al 2003)

* AHRQ. Hospitalizations Related to Pressure Ulcers among Adults 18 Years and Older, 2006 C. Allison Russo, M.P.H., Claudia Steiner, M.D., M.P.H., and William Spector, Ph.D.

What Does the Evidence Tell Us?

- **Risk is predictable**
  - age immobility, incontinence, poor nutrition, sensory problems, circulation problems, dehydration and poor nutrition
- **Skin Integrity can deteriorate in hours**
  - Frequent assessment prevents minor problems from becoming major ulcers
- **Wet skin is more vulnerable to skin disruption and ulceration**
  - But dry skin is a factor as well
- **Continual pressure, especially over bony prominences, increases risk**
  - Pressure relieving surfaces work

Reddy et al JAMA 2006;296:974-84
Avoidable versus Unavoidable

**Avoidable Pressure Ulcer:** “Avoidable” means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person’s clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

**Unavoidable Pressure Ulcer:** “Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person’s clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence

*The UK Department of Health (DH)*

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**Key Factors in Improvement**

- Leadership & Culture*
- Teamwork
- Human factors
- Inter-professional communication
- Improvement capacity and capability
- Local ownership
- Reliable care processes
- Partnership with patients and families

* [http://www.ted.com/talks/drew_dudley_everyday_leadership.html](http://www.ted.com/talks/drew_dudley_everyday_leadership.html)
Fundamental Safety Principles

- Prevention
- Detection
- Mitigation

Partnership with patients

Jocelyn Cornwell
Kings Fund Point of Care

Warm but chaotic

Unpleasant and inefficient

Efficient but impersonal

Everything works
8 years of learning

Using quality improvement methods to prevent ‘avoidable’ pressure ulcers

- Leadership support is imperative
- Social and media marketing
- Setting a drumbeat and pace
- Empowering frontline ‘teams’
- Local ownership of data
- Real time root cause analysis
- Building reliable care processes

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Drivers</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Identification</td>
<td>Understand the risk factors for acquiring pressure ulcers</td>
<td>Assess pressure ulcer risk on admission/first visit for ALL patients</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>Understand the local context &amp; analyse local data to assess patients on ward/unit most at risk</td>
<td>Re-assess every 8 hours or when conditions changes where necessary Initiate and maintain correct and suitable preventative measures</td>
</tr>
<tr>
<td>Reliable Implementation of the CSSKIN ‘bundle’ or other preventative intervention</td>
<td>Utilise patient ‘At risk’ cards/visual cues to quickly identify those at increased risk</td>
<td>Effectively communicate the patient’s risk status</td>
</tr>
<tr>
<td>Identification, grading of pressure ulcers existing on admission/transfer &amp; appropriate intervention</td>
<td>Address these areas: Skin Inspection, Surface, Keep Moving, Incontinence/ Increased moisture, Nutrition</td>
<td>Initiate and maintain correct and appropriate treatment measures as per local protocol</td>
</tr>
<tr>
<td>Education and involvement</td>
<td>Educate staff regarding the assessment process, identification and classification of, and treatment of pressure ulcers</td>
<td>Access and use the expertise of local Wound Nurse</td>
</tr>
<tr>
<td></td>
<td>Educate and Involve Patients &amp; family and others</td>
<td>Develop patient information pack</td>
</tr>
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Developing a system’s based approach

Risk Identification
Communication of Risk status
Risk Assessment
Appropriate preventative strategy implemented
Partnership with patient
Evaluation of outcome

Safety Calendar

<table>
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<tr>
<th>Colour</th>
<th>Code</th>
<th>Details</th>
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<tbody>
<tr>
<td>Green</td>
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<td>No new PU cases</td>
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<tr>
<td>Yellow</td>
<td></td>
<td>Patient transferred with PU from other care setting</td>
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<tr>
<td>Red</td>
<td></td>
<td>New PU case identified</td>
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Connecting process with the outcome

SKIN Bundle Communication tool for Pressure Ulcer Prevention

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<th>Colour</th>
<th>Code</th>
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<td>19/04/2008</td>
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<td>Patient transferred with PU from other care setting</td>
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Risk Assessment and SSNP Care Bundle Compliance

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<tr>
<th>Risk Assessment</th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Patient 5</th>
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<tbody>
<tr>
<td>Surface</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<td>Risk Indicators</td>
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<td>100%</td>
</tr>
<tr>
<td>Keep Moving</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>100%</td>
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<td>Incontinence</td>
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<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>100%</td>
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<tr>
<td>Nutrition</td>
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<td>✔</td>
<td>100%</td>
</tr>
<tr>
<td>Compliance</td>
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<td>✔</td>
<td>✔</td>
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<td>✔</td>
<td>100%</td>
</tr>
<tr>
<td>Non-compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0%</td>
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Stop the Pressure Collaborative

- 44 Organisations involved across settings
- High profile regional social media campaign and resources to support the work
- 50% reduction in prevalence data in the region as measured by the Safety Thermometer
- 45% reduction in incidence in Leics Community Partnership Trust across community setting

Celebrating Success

the work has resulted in an organisational cultural shift from a belief that a pressure ulcer was an inevitable outcome for some hospitalised patients to a belief that in the main pressure ulcers are preventable.

Many wards/units across Abertawe Bro Morgannwg Health Board have gone > 500 days without an incident of a pressure ulcer and some have gone > 600 days. These include community hospitals, surgical, and medical wards. Initial pilots units have reached 4-6 years pressure ulcer free and the organisational incidence rate has gone from 14% to 0.6%
Shifting the culture

Winners of “Improving Quality through better use of resources” NHS awards 2009

The SKIN care bundle, which won an NHS Wales award in 2009, won the Patient Safety in Clinical Practice section of the Health Service Journal/Nursing Times Patient Safety Awards 2010.

NHS Borders Scotland
Risk Assessment Compliance
April 2010 – March 2011

Change 1: Real Time Education
Change 2: PURA & SSKIN in Admission Forms
SSKIN Bundle Compliance
April 2010 – March 2011

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<td>5/26/10</td>
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<td>6/29/10</td>
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<tr>
<td>7/7/10</td>
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Date

Change 1: Real Time Education
Change 2: PURA & SSKIN in Admission Forms
Change 3: Visual Cues
Change 4: Real Time Education
Change 5: Real Time Education
Change 6: Visual Cues

Quality Improvement Scotland
NHS Borders
Preventable Pressure Ulcer Count
April 2010 – March 2011

- Recorded on Safety Cross – no evidence in notes
- Recorded on safety Cross – no evidence in notes
- Patient on Care Pathway for the Dying (PC) G2
- Patient refusing to turn – (PC) G1
- Patient not receiving optimal nutritional support (S) G2
- Reviewed Operational Definition
New challenges beyond the hospital doors
Who can help keep patients safe at home?

12 months data showing 45% reduction in pressure ulcer incidence over time across Leicestershire Community Partnership Trust

Engaging Heart & Minds

‘If you want to build a ship do not gather men together and assign tasks. Instead teach them the longing for the wide endless sea’
(Saint Exupery, Little Prince)

abartleyconsulting@gmail.com

Twitter @annettebartley1
Pre-work

- We would welcome a couple of volunteers to share their learning from their pre-work
- Please raise your hands
- We asked you to review the last 5 adverse events/pressure ulcer incidents on your unit/ward/department
  - What did you learn that was new?
  - What surprised you?
  - What will you do differently as a result?
What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Model for Improvement

Aim of Improvement

Measurement of Improvement

Developing a Change

Act

Plan

Study

Do

Act

• Decide changes to make
• Arrange next cycle

Plan

• Compose aim
• Pose questions/predictions
• Create action plan to carry out cycle (who, what, when, where)
• Plan for data collection

Study

• Complete data analysis
• Compare to predictions
• Summarize learning

Do

• Carry out the test and collect data
• Document what occurred
• Begin analysis of data

Principles & Guidelines for Testing

- A test of change should answer a specific question
- A test of change requires a theory and prediction
- Test on a small scale
- Collect data over time
- Build knowledge sequentially with multiple PDSA cycles for each change idea
- Include a wide range of conditions in the sequence of tests

Repeated Use of the PDSA Cycle

Sequential building of knowledge under a wide range of conditions

Changes That Result in Improvement
Spread
Implementation of Change
Wide-Scale Tests of Change
Follow-up Tests
Very Small Scale Test
Hunches Theories Ideas

Data
Aim: Implement Rapid Response Team on non-ICU unit

Cycle 1: ICU nurse responds to rapid response team calls on one unit, one shift for one day

Cycle 2: Repeat cycle 1 for three days

Cycle 3: Have Respiratory Therapist attend rapid response calls with ICU Nurse

Cycle 4: Expand coverage of RRT on unit to one unit for one shift for five days

Cycle 5: Have Nurse Practitioner respond to calls in addition to RT and RN

Cycle 6: Expand rounds to one unit for one shift seven days a week

Questions?

Raise your hand

Use the Chat
Action Period Assignment

- Test the use of the Safety Calendar.
- Review your pilot unit’s current performance. Ask five members of staff what the unit’s process for preventing pressure ulcer is and check whether their responses match. In addition, check if they are consistent with your local policy/protocol.
- Check the charts of five patients and review the percentage compliance with risk assessment.
- Come prepared to share your learning

Expedition Communications

- Listserv for session communications: PressureUlcersExpedition@ls.ihi.org
- To add colleagues, email us at info@ihi.org
- Pose questions, share resources, discuss barriers or successes
Next Session

Identification and Assessment of Patients at Risk
Tuesday, May 6, 12:00 – 1:00 pm ET