Prevention of Perioperative Pressure Injury Tool Kit

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INTRODUCTION

- The incidence of perioperative pressure injuries over the past 5 years has NOT decreased but increased (Chen, 2012).
- According to a 2014 publication from the National Pressure Ulcer Advisory Panel the incident rate for pressure injury attributed to the operating room range from 5% to 53.4%.
- As a result substantial patient harm has been reported leading to complications, disfigurement, disability, and death.
- Despite published guidelines specific to the operating room (OR) significant gaps in knowledge, practice, and research exist.
- The Association of Perioperative Registered nurses (AORN) chartered a task force including AORN subject matter expert members and representation from the Wound, Ostomy and Continence Nurses Society.
- The task force has created a Perioperative Pressure Injury Prevention (PPIP) online toolkit for both association and society members.
- The roadmap describes how to utilize the quality model (DMAIC) Define-Measure-Analyze-Improve Control with the toolkit resources to create a strategic plan for prevention.

AORN POSITION STATEMENT

- Perioperative Pressure Injury Prevention in the Care of the Surgical Patient

AORN believes that:

- The entire health care team must collaborate to prevent pressure injury formation in the perioperative patient,
- Pressure injury prevention should begin before the patient enters the surgical suite,
- Every patient experiencing a surgical procedure should be assessed for risk factors that may lead to the development of a pressure injury,
- The pressure injury risk assessment and skin assessment should be communicated during all patient hand overs,
- Education related to pressure injury in the OR should be performed yearly, and
- Communication of pressure injury development back to the surgical team is imperative.

QUALITY IMPROVEMENT (QI) ROADMAP

Define

Measure

Analyze

Improve

Control

Goal: Zero Preventable Harm

DEFINE: Assess Current State

Use: Scott Triggers® Gap Analysis template

Create the Team

Use: AORN Position Statement

Interprofessional Team: Administration, OR leadership/ Clinical RNs/Educator/CNS, WOC Nurse, Anesthesia, Surgeon, Post Anesthesia Care, QI, Risk Management, Logistics

MEASURE: What is our Hospital Acquired Pressure Injury (HAPI) rate in surgical patients.

- Use PI Data Collection Tools • Incidence/prevalence reports
- Pressure Injury Worksheet • OR Chart Summary for Pressure Injury Data Collection

ANALYZE: Determine Priorities Use

- Scott Triggers® Gap Analysis
- SWOT Analysis
- Scott Triggers® PPIPP
- PPIPP Bundle/Program

IMPROVE: Make Action Plan

Decide on what tools fit your setting:

- Munro Scale • Scott Triggers® Tool
- OR Skin Bundle • Equipment and device acquisition
- Scott Triggers® PPIPP • PPIPP Bundle/Program

Education

- Webinars & Educational Slide Decks
- Positioning OR Patients to Prevent the Development of PI
- The Basics of Patient Positioning
- Pressure Injury Project Implementation of the Munro Scale
- Risk Assessment using the Munro Scale for Perioperative Patients
- Perioperative Pressure Injury Risk and Prevention: Scott Triggers®
- Best Practices to Improve Communication among Caregivers
- Posters
- Case studies

Revise Practice and Policy

- Facility Guidelines
- Skin assessment (Top to bottom, front and back)
- Standardized handoff communication
- Use research articles and guidelines from the Association of periOperative Registered Nurses (AORN), the National Pressure Ulcer Advisory Panel (NPUAP) and the Wound, Ostomy and Continence Nurses Society (WOCN)

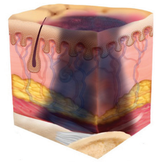
Evaluate Outcomes

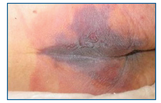
- Compare Pre and Post PI outcomes
- Refine and Improve

CONTROL: Sustain the Gain!

- Monitor data
- Perform patient safety investigation or Root Cause Analysis (RCA) for OR PI
- Use: Pressure Injury Worksheet
- OR Pressure Injury Chart Summary
- Checklist Prevent PPI

Continue Education to ALL staff: Orientation and pre-operative, intra-operative and post-operative interprofessional team members





A perioperative pressure injury is any pressure-related tissue injury that presents (i.e. non-blanchable erythema, purple discoloration or blistering) within 48-72 hours postoperatively and is associated with the surgical position. Scott, 2015

ACCESS THE PREVENTION OF PERIOPERATIVE PRESSURE INJURY TOOL KIT

Why: To supplement and strengthen current presssure injury prevention efforts. Improve communication.

What: Provides posters and evidence-based tools for performing patient risk assessments, educating team members, and implementing quality improvement projects.

Who: Anyone who wants to improve outcomes related to pressure injury can use this tool kit.

Where: Please visit the AORN website

CONCLUSIONS

- The new Prevention of Perioperative Pressure Injury Tool Kit was developed to address the needs and competency of the clinical staff around a vision of eliminating patient harm from pressure injuries in the high-risk surgical population.
- The toolkit is meant to strengthen prevention efforts by creating strategies to raise awareness, improve communication and teamwork therefore supplementing or adding to an institution-wide comprehensive pressure injury prevention program

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