ENGAGING CLINICIANS IN AUDITING FOR A POSITIVE OUTCOME

Andrea Floyd, Manager Quality & Risk

HEALTHY COMMUNITIES AND
WORLD CLASS HEALTHCARE

CARING | PASSIONATE | TRUSTWORTHY

Documentation Audit
(current admission)

1		BENDIGO HEALTH — Documentation Audit (current admission)
2		**Unit:** **No of beds in unit:** **No of records audited:** **Date:** **Auditor/s:** Is there a current copy of *The Australian dictionary of clinical abbreviations, acronyms and symbols* available for staff to refer to in this department? **State publication date**
3	A	ED RECORD MR2/MR93
4		**Documentation Standards**
5		Entries are legible and written in English
6		Patient ID sticker on each face or where indicat

141		progress notes?
142		**Patient questions**
143		Do you know what the plan is for your care today/yesterday?
144		Are you aware of the goals you need to reach today/yesterday?
145		Did medical staff discuss your care today/yesterday?
146		Did nursing staff discuss your care today/yesterday?
147		**Observations chart (MR 123)**
148		Documented on admission:

		Where entries have not been made at the time of
16		as well as the date and time of the entry
17		The record is free of derogatory, racist, sexist or othe
18		Unused areas have a line drawn across to prevent additi
19		Errors in documentation (if they exist) have been correcte
20		**ED Record MR2/MR93**
21		Pain score documented on admission to ED

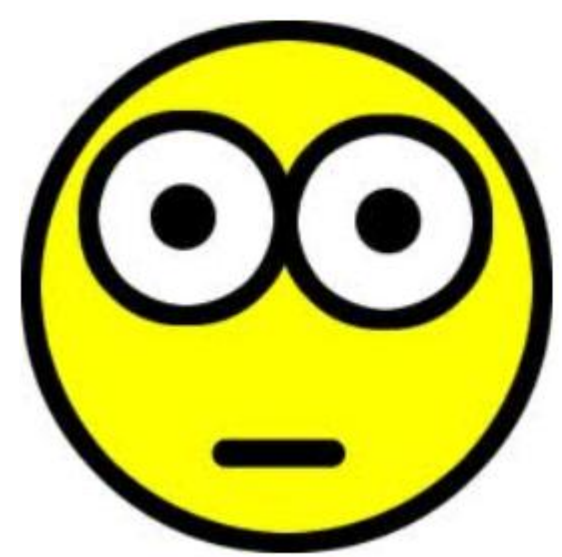
204		**Bedside check**
205		There is an orange sticker above the patient's bed
206		There is an "F" within the square?
207		The patient's gait aid is within reach? (where applicable)
208		The patient's mobility status is indicated on their gait aid? (e.g. coloured tags in Rehab)
209		Ticked (✓) interventions are in place
210		**Patient questions**
211		Have staff discussed falls risks and prevention with you?
212		Have you been involved in plans to reduce your risk of falling?
213		Have you been given the booklet about falls prevention?

38		The type of each alert has been entered
39		Reactions/recommendations have been entered for each alert (where applicable)

Over 270 questions

BENDIGO
HEALTH

The response…



HEALTHY COMMUNITIES AND
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Our revised System & Process

Focuses on one standard per month

NSQHS Standards Monthly focus

Month	Accreditation Standard Focus	
February		Governance
March		Partnering with Consumers
April		Preventing and Controlling Healthcare Associated Infections
May		Medication Safety
June		Patient Identification & Procedure Matching
July		Clinical Handover
August		Blood & Blood Products
September		Preventing & Managing Pressure Injuries
October		Recognising & Responding to Clinical Deterioration in Acute Health Care
November		Preventing Falls & Harm from Falls

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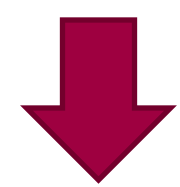
Our revised System & Process

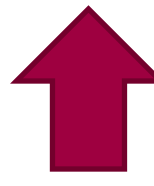
Multiple resources to support staff

- Bendigo Health Guides
- Checklists
- Visual Display Boards &
- Automated Audit Tools

Bendigo Health Guides



Standard 8 – Preventing and Managing Pressure Injuries			
Criterion	**Action**	**BH Organisation Wide Examples**	**Department Responsibility**
8.1 Developing and implementing policies, procedures and/or protocols that are based on current best practice guidelines	8.1.1 Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools	PROMPT: Electronic document repository and management system, stores all policies, protocols and guidelines with key word search capability including Pressure Injury Assessment and Management Each NSQHS clinical governing committee review audit results and relevant clinical incidents (including trending) and develop recommendations for organisational process improvement and changes. Including the Skin Integrity Committee Divisional/stream Quality and Risk meetings review audit results and relevant clinical incidents (including trending) to determine divisional/stream and or departmental actions to be undertaken Screening tools – Braden Scale, Skin inspection and Wound Chart Clinical auditing tools are developed by Quality @ BH that reflect policy, protocol and guidelines therefore allowing for monitoring of compliance to policy	Ensure all staff have access to Prompt & are aware of relevant policies: Ensure **incidents** (and near misses) relating to Pressure Injuries are reported on VHIMS- including all pressure injuries present on admission. Ensure your Preventing & Managing Pressure Injuries Visual Display board is displayed in your area and audit results are added as they become available.
	8.1.2 The use of policies, procedures and/or protocols is regularly monitored	Clinical auditing tools are developed by Quality @ BH that reflect policy, protocol and guidelines therefore allowing for monitoring of compliance to policy Each NSQHS clinical governing committee review audit results and relevant clinical incidents (including trending) and develop recommendations for organisational process improvement and changes. Including the Skin Integrity Committee	Ensure **incidents** (and near misses) relating to Pressure Injuries are reported on VHIMS- including all pressure injuries present on admission Ensure incident data, investigation outcomes and audit results are reported to staff at ward meeting and actions are developed to address noncompliance or areas of concern Undertake Audits as per schedule: - Braden Scale - Skin Inspection - Wound Charts
8.2 Using a risk assessment framework and reporting systems to identify, investigate and take action to reduce the frequency and severity of pressure injuries	8.2.1 An organisation-wide system for reporting pressure injuries is in use	Electronic incident systems VHIMS & Maxed – used to report all clinical and non-clinical incidents across the organisation including all pressure injuries	Ensure **incidents** (and near misses) relating to Pressure Injuries are reported on VHIMS- including all pressure injuries present on admission Ensure incident data, investigation outcomes and audit results are reported to staff at ward meeting and actions are developed to address noncompliance or areas of concern
	8.2.2 Administrative and clinical data are used to regularly monitor and investigate the frequency	Each NSQHS clinical governing committee review audit results and relevant clinical incidents (including trending) and develop recommendations for organisational process improvement and changes. Including the Skin Integrity Committee	Nil



Bendigo Checklists

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Standard 8 - Preventing and Managing Pressure Injuries Checklist			Date: September 2016
	Completed	By whom	Date
Governance			
• Departmental Staff Meeting includes standard agenda item – feedback, incidents and audit results including actions and recommendations for improvement • All relevant competencies for all clinical staff are completed (evidence this) • Orientation manual includes information relating to pressure injuries			
Audits			
• Audits are completed, including action page – any questions answered which do not meet compliance level requires an action to be taken, documented and completed • Saved the audit to your departments G: drive and email a copy to audit@bendigohealth.org.au • Communicated results to manager and staff via departmental meeting and results on visual display boards • Quality Improvement activities are actioned			
Audit matrix (to determine which audits your Department must do)			
Does your department/program undertake Pressure Injury screening on admission? if yes →	• Braden Scale screening & Intervention Audit		
Is your program/department an inpatient area or residential care facility? if yes →	• Skin Inspection Audit		
Does you department /program perform complex wound dressings? if yes →	• Wound Chart Audit		
Consumer			
• Ensure that there is a process for managing the feedback/ suggestion box, emptied, followed up and escalated as appropriate			
Visual Display Board			
• Download and print Standard 8 Pressure Injuries Visual Display information from Quality@ BH site and reminded staff to review this information			
Policies and Procedures			
• Ensure all staff have access to PROMPT • Staff are aware of the following P&P's to staff to review: ➢ Pressure Injury Assessment & Management ➢ Vacuum Assisted Closure (VAC) Basic Dressing (reviewed Sept last year) ➢ Clinical Photography & Video Imaging Consent Protocol ➢ Wound Drain Tube Removal			
Education			
• Staff can access iLearn • Staff are aware of training opportunities via display board and email • Updated evidence of training and competencies for wound management of all staff (as required)			
Posters, Brochures & Handouts			
• Ensure access to Move, Move, Move pamphlets http://www.health.vic.gov.au/pressureulcers/downloads/move/english.pdf			

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Visual Display Boards

Standard 8

OFF LOAD those HEELS

Reduce your patient's risk

Improvements to Engage Clinicians

Simplifying audit questions

Structure audit tool

Reporting & Feedback processes

Accountability

Ownership by Departments

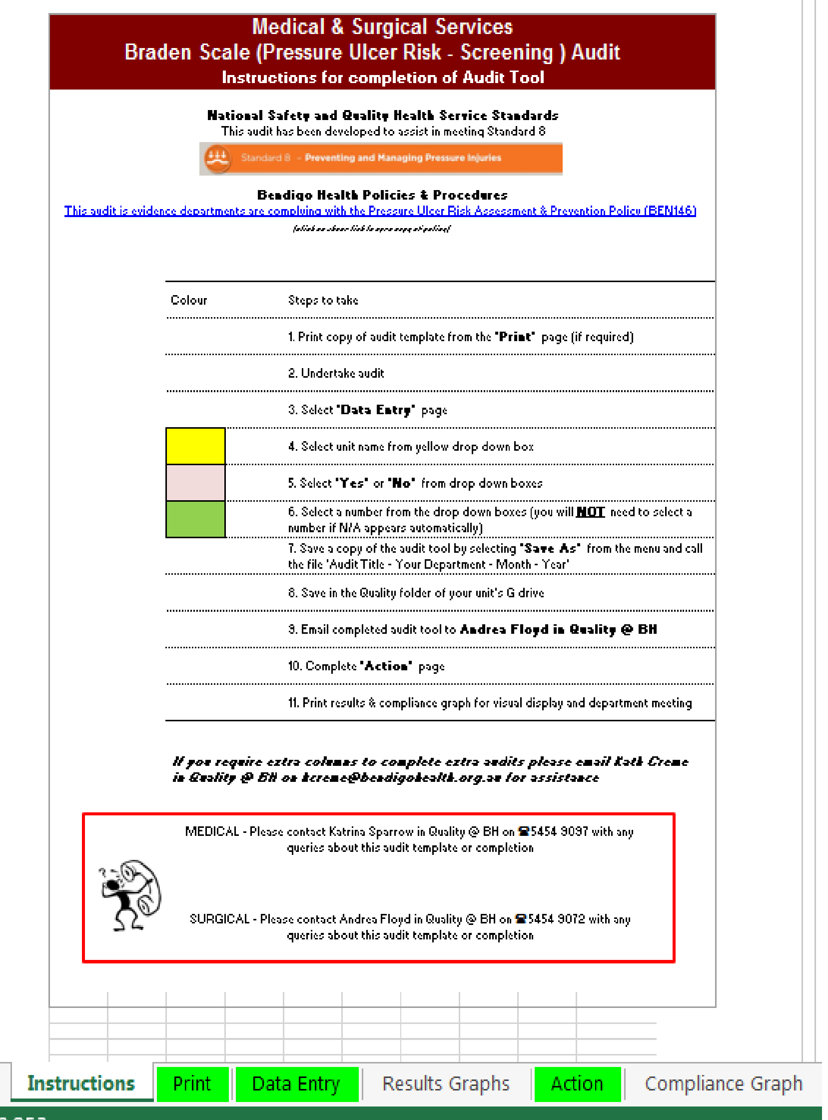
Audit Questions simplified

2010 – 15 questions in comprehensive audit relating to Pressure Injury screening

2013 – 7 questions

2015 & 2016 – 4 questions

Automated Audit Tools



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Audit Tool – print page

HEALTH	Medical & Surgical Services Braden Scale (Pressure Ulcer Risk - Screening) Audit		Business Unit			
	Date:					
	Person completing audit and Designation		Print page only			
		Minimum number of audits to be completed				
	Audit Number	1	2	3	4	5
	Patient UR Number:					
1	Patient Length of Stay (in days)					
2	Admission Type (Elective or Emergency)					
3	Braden Scale ticked on admission form MR 92					
4	Braden Scale recorded					
5	If yes, what score was recorded					
6	Did the patient have a Braden scale assessment repeated after 2 days					
7	Does the patient have any pressure relieving devices in place					

Audit Tool – data entry

Medical & Surgical Services Braden Scale (Pressure Ulcer Risk - Screening) Audit

Business Unit

**** Select Unit Name ****

**** Enter Date ****

Person completing audit and Designation

Number of Patients Sampled: 5

Overall Compliance 85%

Insufficient audits undertaken

		Minimum number of audits to be completed							
	Audit Number	1	2	3	4	5	6	7	8
	Patient UR Number:								
1	Patient Length of Stay (in days)	4							
2	Admission Type	Emergency							
3	Braden Scale ticked on admission form MR 92	Yes	No	No	No	Yes			
4	Braden Scale recorded	Yes							
5	If yes, what score was recorded	14							
6	Actual Braden Scale	MODERATE RISK	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
7	Did the patient have a Braden scale assessment repeated after 2 days	Yes							
8	Does the patient have any pressure relieving devices in place	Yes							

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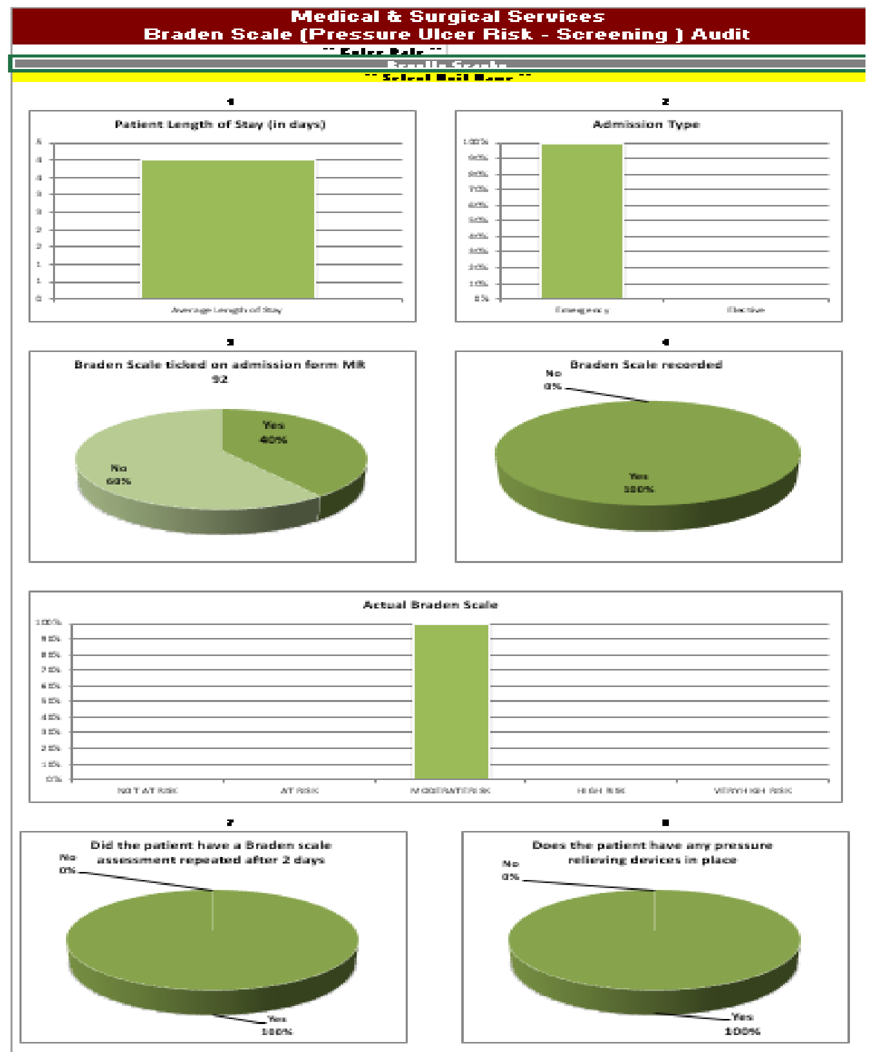
Audit Tool – automated graphs



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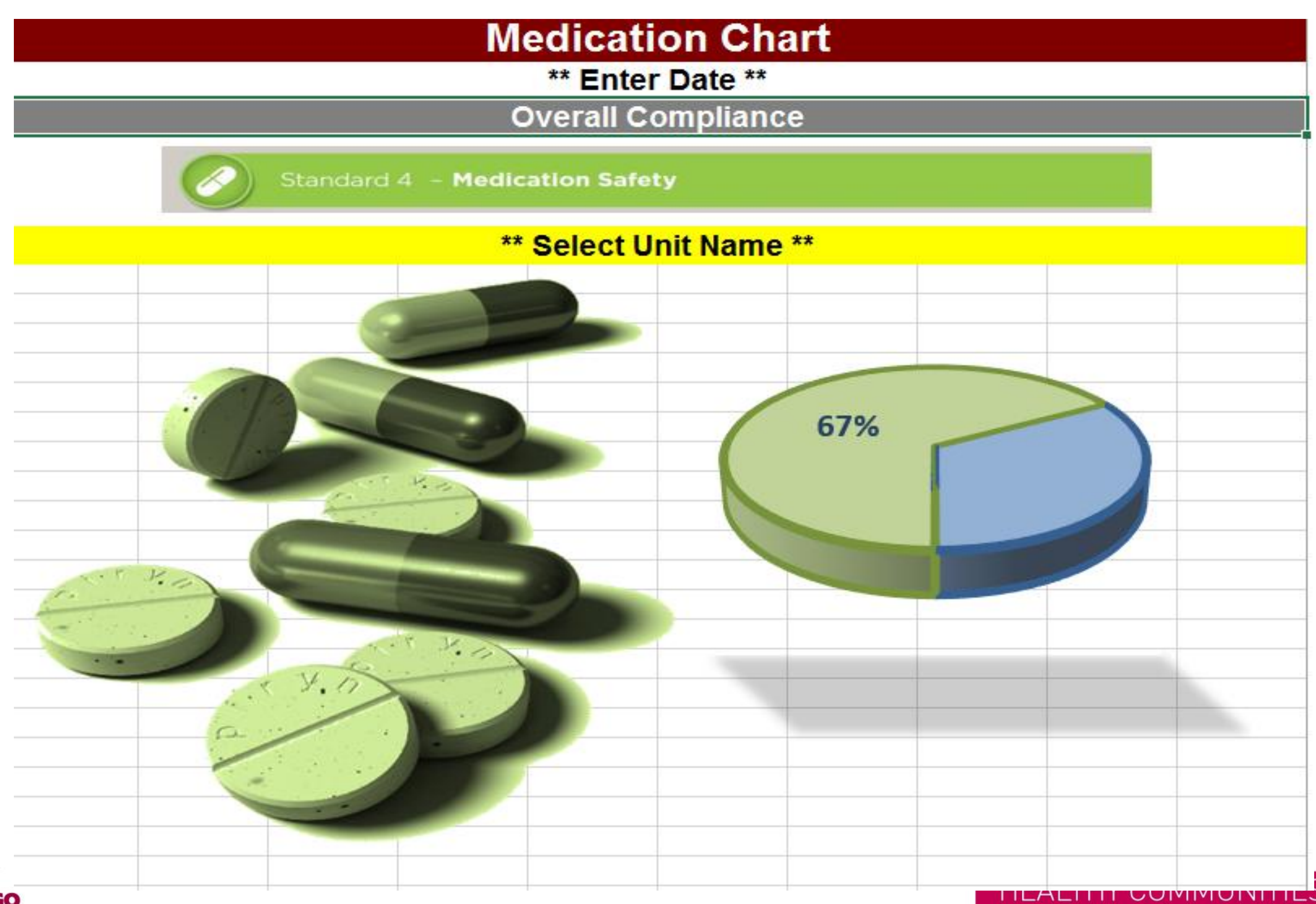
Std 4 Medication Safety



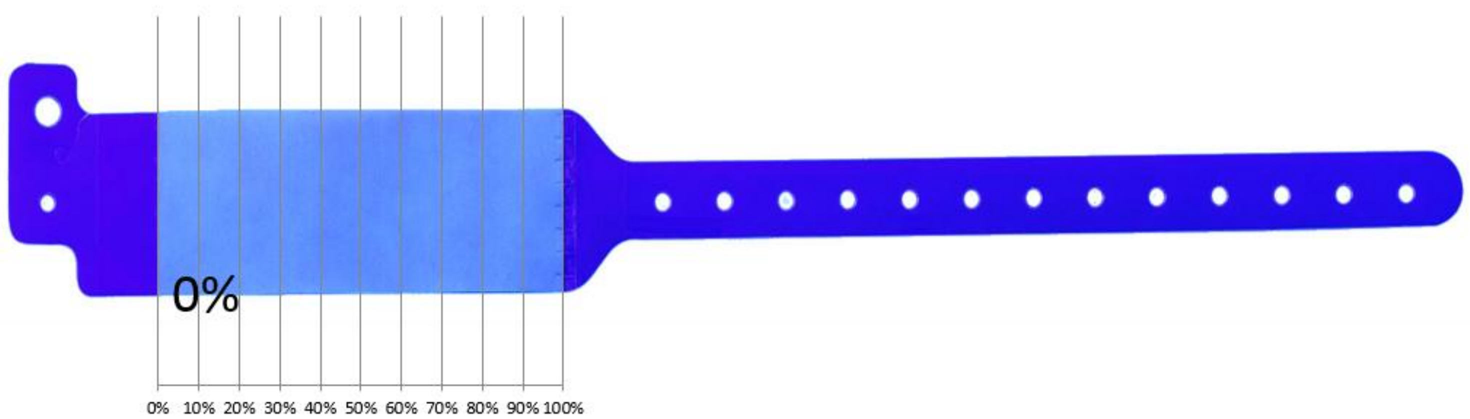
Std 5 Patient Identification & Procedure Matching

Inpatient (>2 yrs) ID Band Audit - excluding time of transfer audit

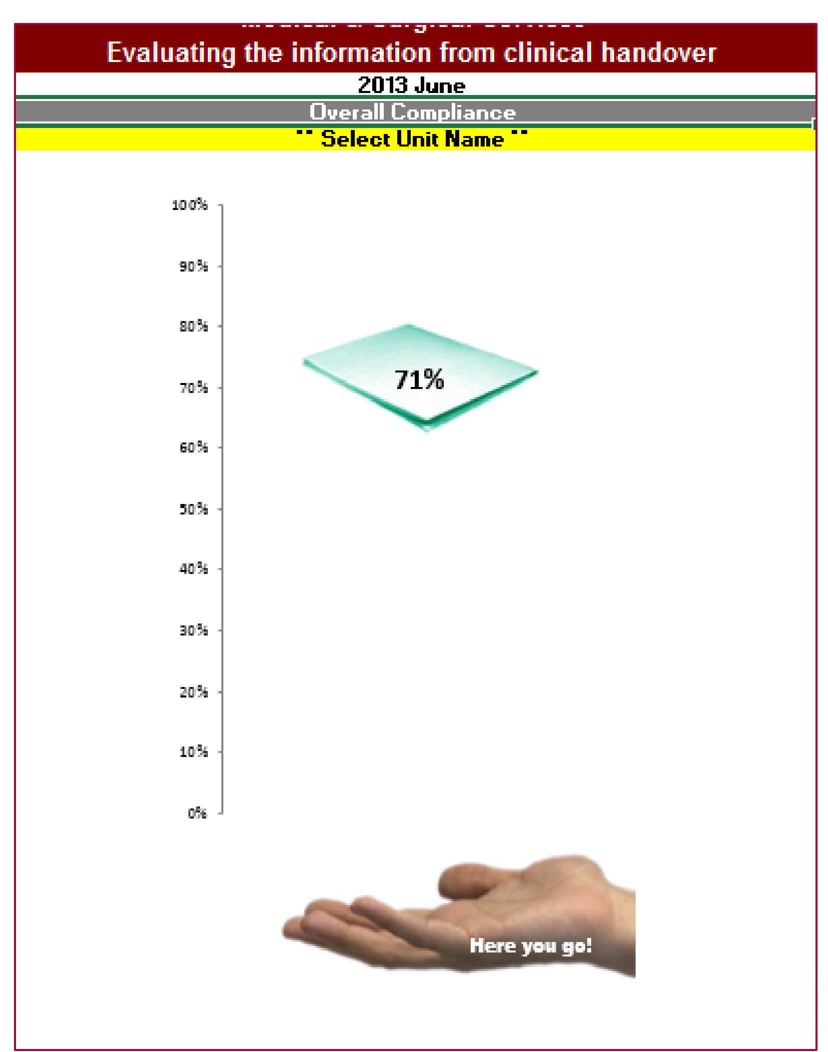
** Enter Date **

Overall Compliance

** Select Unit Name **



Std 6 Clinical Handover



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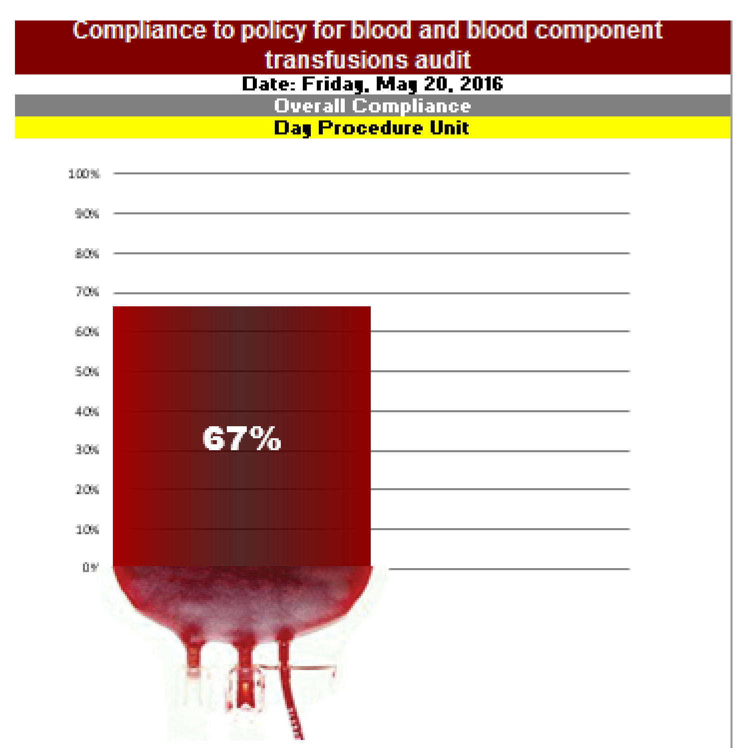
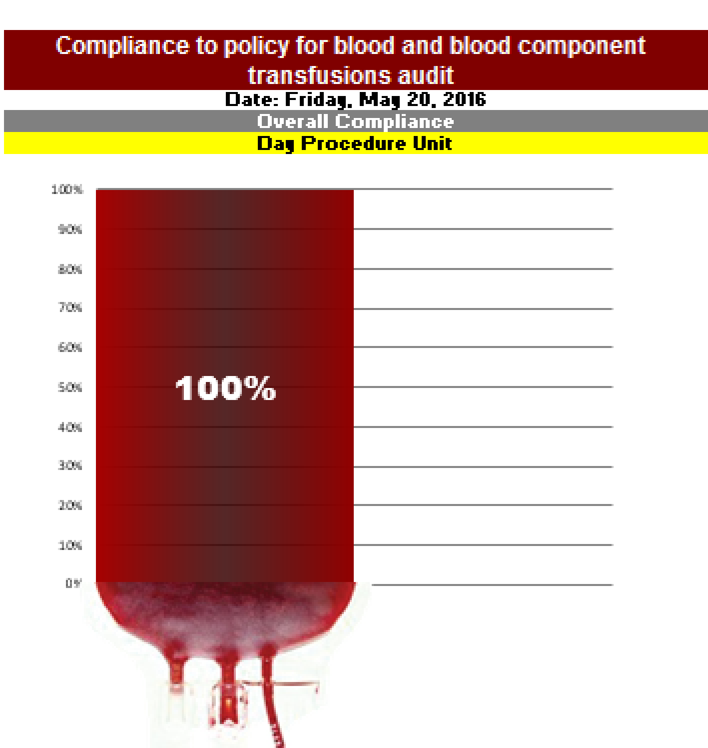
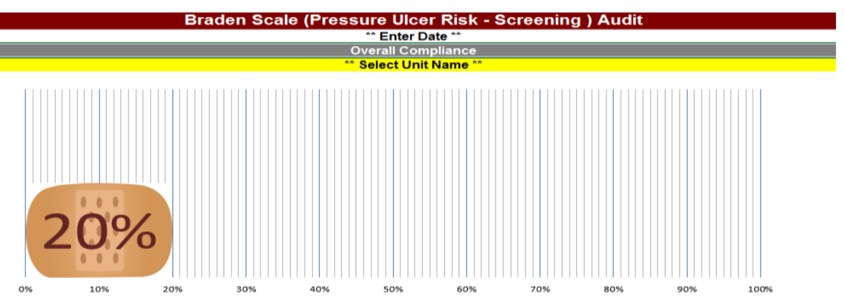
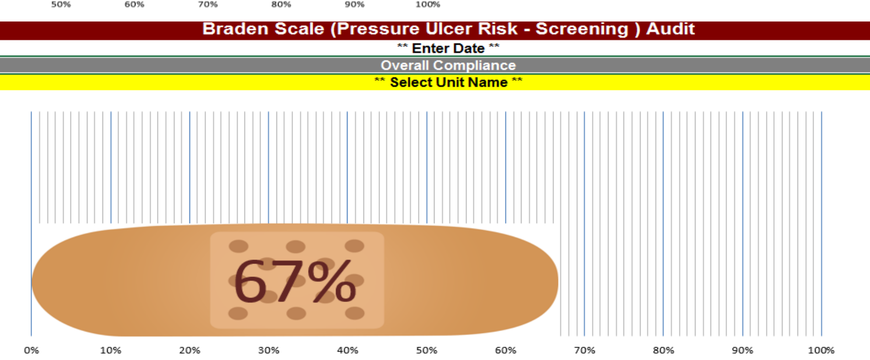
Std 7 Blood & Blood Products

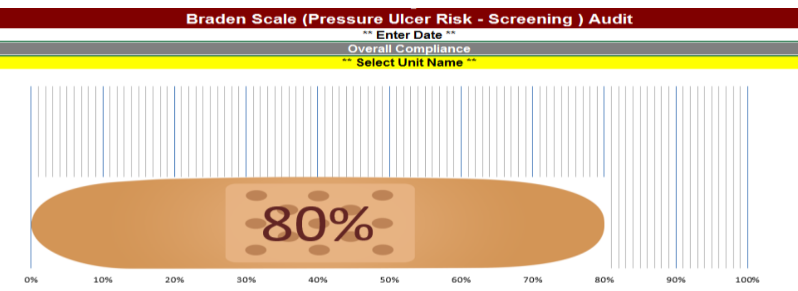




Std 8 Preventing & Managing Pressure Injuries





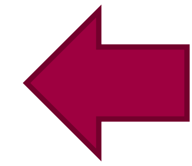


Audit Tools – Action Page

Medical & Surgical Services
Braden Scale (Pressure Ulcer Risk - Screening) Audit

** Enter Date ** ** Select Unit Name **

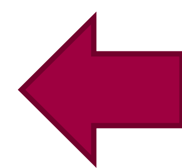
ACTION SHEET



Question		Action Required	Action To Be Taken	By whom	By when (Date)	Completed (✓ box)
3	Braden Scale ticked on admission form MR 92	Yes				☐
4	Braden Scale recorded					☐
6	Did the patient have a Braden scale assessment repeated after 2 days					☐
7	Does the patient have any pressure relieving devices in place					☐

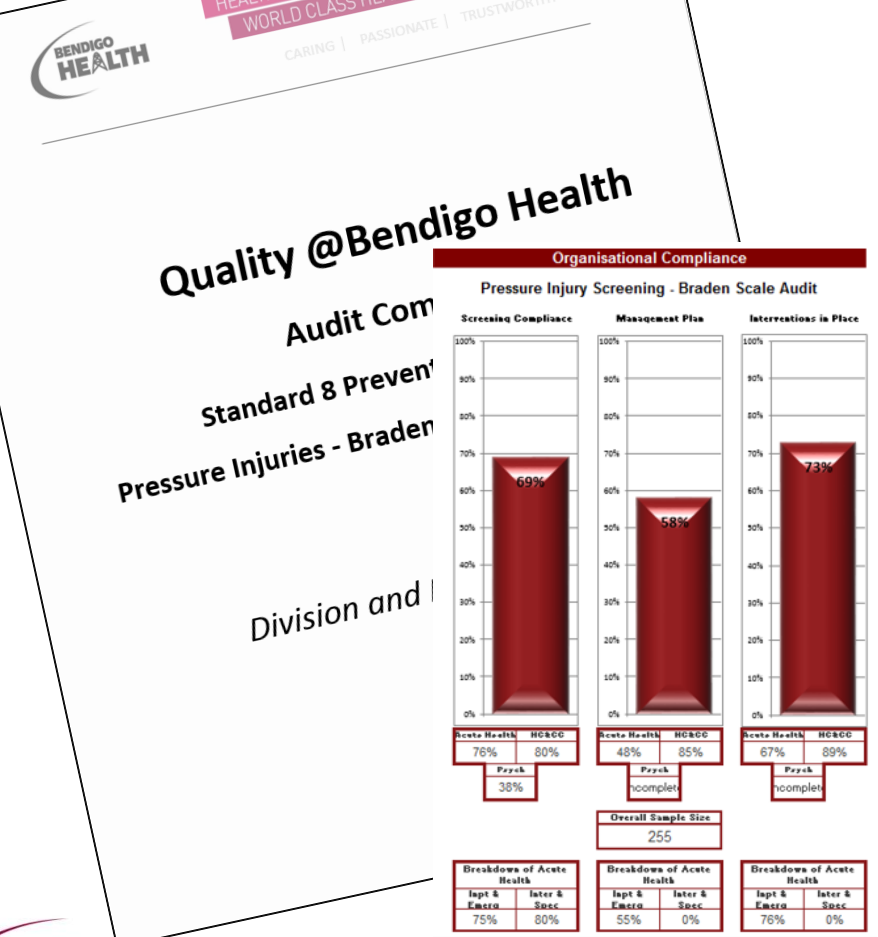
Were any actions from this audit developed into a quality improvement project? ☐

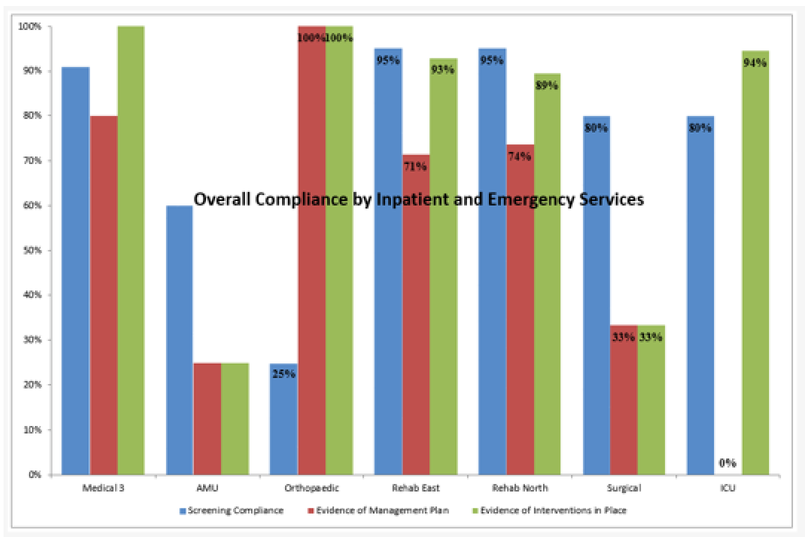
If quality improvement projects have been developed, please provide details



GOVERNANCE Audit Results / Action Required is to be reported to (✓ the appropriate boxes)			
Ward/Departmental Meeting	☐	Consumer Advisory Committee - Nina Hakamies	☐
Visual Display Board	☐	IPU Consultant	☐
Business Manager	☐	Clinical Handover & Patient ID Committee - David Rosaia	☐
Email All Ward/Department Staff	☐		☐
Quality Consultant	☐	Medication Safety Committee - Matthew James	☐
Quality Working Group	☐	Transfusion Committee - Meryand Jodoin	☐
Medical Operation Meeting/Surgical SMG	☐	Skin Integrity Committee - TBA	☐
DON	☐	Clinical Deterioration Committee - TBA	☐
Stream Executive Director	☐	Falls Committee - Kim Hall	☐
Medical Surgical Quality & Risk Meeting	☐		

Improved Reporting & Accountability





BENDIGO HEALTH

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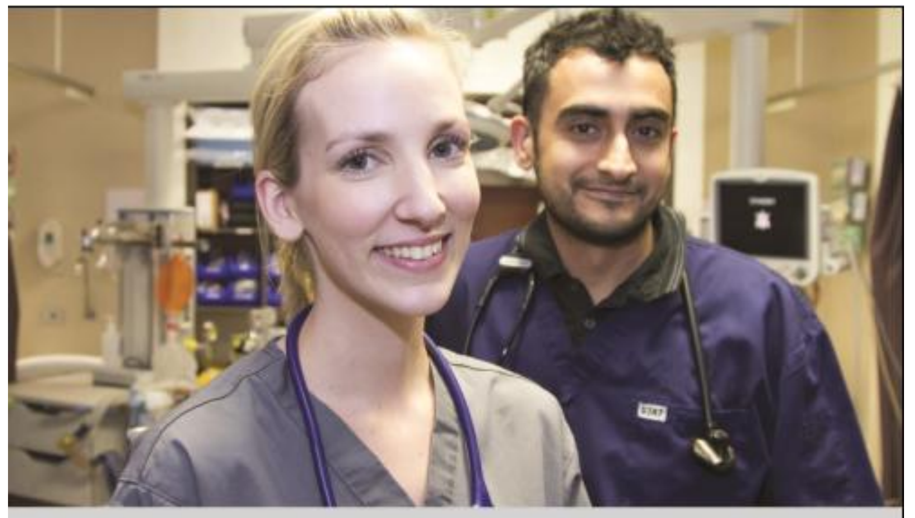

CARING

WE CARE FOR OUR COMMUNITY

PASSIONATE

WE ARE PASSIONATE ABOUT DOING OUR BEST

TRUSTWORTHY

WE ARE OPEN, HONEST AND RESPECTFUL

HEALTHY COMMUNITIES AND
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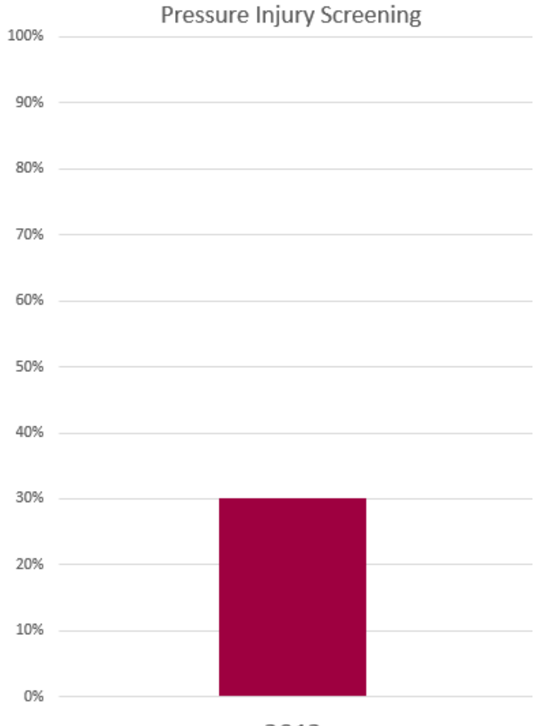
Pressure Injury Screening Data

2013

30% compliance

Only 2 departments did not submit



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FBH 412 050

PRESSURE INJURY PREVENTION & MANAGEMENT PLAN

SURNAME: .... UR NO: ....
GIVEN NAMES: ....
D.O.B: .... SEX: ....
ADMISSION DATE: ....
CONSULTANT: .... WARD/CLINIC: ....
USE LABEL IF AVAILABLE

LOOK

BRADEN SCORE ☐ RISK LEVEL(circle) VERY HIGH HIGH MODERATE AT RISK NO RISK

Level of RISK may increase according to clinical judgement

SKIN INSPECTION must be performed on all patients with a Braden score ≤ 18

- On admission (within 8 hrs) **AND**
- Daily until risk is reduced

Mark all skin inspection findings on diagram below & daily changes in progress notes (Include: pressure injury, wounds, redness, swelling, bruising)

VHIMS ☐ Commence individual wound chart for each wound ☐ Photograph ☐

Pressure Injury Present?
No ☐ Yes ☐
If yes: Stage 1 ☐
Stage 2 ☐
Stage 3 ☐
Stage 4 ☐
Suspected deep tissue injury ☐
Unstageable pressure injury ☐

Nose, Chin, Iliac Crest Right, Iliac Crest Left, Hand Right, Hand Left, Greater Trochanter Right, Greater Trochanter Left, Knee Right, Knee Left, Malleolus Right, Malleolus Left, Toe(s) Right, Toe(s) Left, Occiput, Ear Left, Ear Right, Scapula Left, Scapula Right, Spinous Process, Elbow Left, Elbow Right, Sacrum/Coccyx, Ischium/Buttocks Left, Ischium/Buttocks Right, Heel Left, Heel Right, Foot Left, Foot Right

Remember you must look under the following tubes & devices to complete a comprehensive assessment.

- Tubing,
- Probes,
- Electrodes,
- Face masks
- Catheters
- Compression stockings
- Hosiery

PROTECT

Moisture problems No Yes If yes list intervention/tick below

( ) Use of absorbent sheets (eg Kylies) ( ) Continence Aids ....
( ) Use of barrier wipes & or creams list ....
( ) Use of pH appropriate skin cleanser / soap substitute ....

Bed Surface	( ) Alternating air surface (type) .... ( ) High specification reactive foam mattress / hybrid
Chair	( ) Roho ( ) Alternating cushion ( ) Specialist seating devised by OT (please list) ....
Heels	( ) Place pillows lengthways under lower limb and 'float heels' ( ) Heel wedge or other device (please list) ....

POSITION

Repositioning Plan: ( ) Prompt only ( ) Assistance Required ( ) x1 ( ) x2 ( ) Lifting device

PRODUCT	VERY HIGH	HIGH RISK	MODERATE RISK	AT RISK	
High density foam mattress	1 hourly	2 hourly	3 hourly	3hourly	DATE Day 1 Circle in BLUE SIGNATURE
Static air filled mattress overlay	2 hourly	3 hourly	4 hourly	4 hourly	DATE Day__ Circle in BLACK SIGNATURE If further changes commence new chart
Alternating pressure overlay (2 cycle)	4 hourly	5 hourly	6 hourly	6 hourly	
Alternating pressure mattress (2 cell cycle)	6 hourly	6 hourly	8 hourly	8 hourly	
Alternating pressure mattress (3 cell cycle)	8 hourly	8 hourly	8 hourly	8 hourly	

COMMUNICATE

Update Patient status on Patient Flow Manager
Referrals as per "Recommended Intervention" (see over)
On Discharge / transfer complete
- Braden Scale Braden Score .... Risk Level ....
- Skin inspection (for high to very high risk pts/s) - document finding on transfer document & patient clinical record

May 2014

PRESSURE INJURY PREVENTION & MANAGEMENT PLAN

MR1 20

BENDIGO HEALTH

PRESSURE INJURY PREVENTION & MANAGEMENT PLAN

SURNAME: .... UR NO: ....
GIVEN NAMES: ....
D.O.B: .... SEX: ....
ADMISSION DATE: ....
CONSULTANT: .... WARD/CLINIC: ....
USE LABEL IF AVAILABLE

Braden Scale					Date & Score					
Criteria	Assessments: Scores are calculated by identifying the appropriate assessment score from each criteria and the combining the total assessments.									
SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body extremities.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.						
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.						
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chair fast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours						
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.						
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.						
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.							
Copyright Barbara Braden and Nancy Bergstrom, 1988 All rights reserved				TOTAL SCORE						
Recommended Interventions				STAFF INITIAL						

≥19 No Risk	15 – 18 At Risk	13 to 14 Moderate risk	10 to 12 High risk	9 or below Very high risk
All unless patient condition alters	PROTECT • Minimize shear and friction damage to skin by correct use of manual handling devices POSITION • Protect boney prominences and maintain body alignment • Place pillows length ways under lower limb so heels are elevated and off loaded • Reposition patients to reduce duration and magnitude of pressure over vulnerable areas • Consider dynamic support surfaces i.e. low air loss, alternating pressure, or air-fluidized mattress COMMUNICATE • Provide education and information to patients & carers • "Move, Move, Move" pamphlet	All of the previous plus: PROTECT • Use high specification reactive (constant low pressure) foam mattress or an active (alternating pressure) mattress on operating theatre tables to ensure pressure is adequately offloaded. POSITION • Provide a pressure reducing support surface if the patient is bedfast or chair fast, preferably dynamic type support surface. • Provide foam wedges for 30 degree lateral positioning	All of the previous plus: LOOK • Full skin inspection daily PROTECT • Unstable fractures – discuss with Medical staff prior to using alternating air mattress. POSITION • Use re-positioning plan to communicate frequency of turning	All of the previous plus: POSITION Provide a dynamic air-filled pressure reducing support surface- either low air loss, alternating pressure, or air fluidized mattress
REFERRALS	• Refer to continence advisor if moisture subscale ≤1 • Refer to dietician if nutrition subscale ≤ 2 • Refer to physiotherapist if combine score activity & mobility ≤ 7	• Refer to Occupational Therapy for assessment of need or type of pressure relieving device/s	• Wound Consultant if patient has a PI stage 3 or above • Podiatry if patient has a lower limb PI stage 3 or above	

Between the Sheets

Issue 1 Newsletter – May 2013

Do you know the 6 stages of pressure injury?

Stage I pressure injury: non-blanchable erythema

Stage II pressure injury: partial thickness skin loss

Stage III pressure injury: full thickness skin loss

Stage IV pressure injury: full thickness tissue loss

Suspected deep tissue injury: depth unknown

Unstageable pressure injury: depth unknown

What is Braden????

A screening tool used by BH to assess our patients risk of developing pressure injury.

When do we do Braden on Acute?

- On admission
- Then second daily for duration of inpatient stay

Important Change

The Braden Screening Tool Sticker is to be used for all patients and placed on current observation chart where the urinalysis information goes.

Braden Scale	
SENSORY PERCEPTION	
NUTRITION	
MOISTURE	
ACTIVITY	
FRICTION & SHEAR	
TOTAL	

In-service education to follow

Education

Free VAC therapy skills training days.

Dates - 23rd or the 24th July

Time - 0830-1600hrs

Venue - Tutorial room 2 Monash University Mercy Street.

Register online at - www.kci-medical.com.au

Your new wound consultant

Sarah Ketterer has been seconded from the surgical unit as the new wound consultant for the acute campus at Bendigo Health.

The position is part time working Mondays and Fridays and every second Tuesday.

The role is to provide support for all staff in wound care and assist in providing a consistent approach with wound management and product selection.

Contact

Pager - 2824

Mobile – 0418 716 402

Email - sketterer@bendigohealth.org.au

Standard 8 - **Preventing and Managing Pressure Injuries**

Pressure Injury Screening Data

Pressure Injury Screening

	2013	2016

HEALTHY COMMUNITIES AND
WORLD CLASS HEALTHCARE

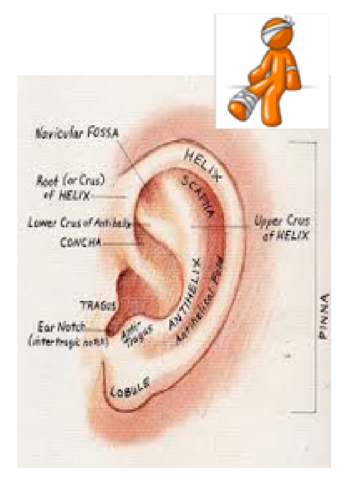
CARING | PASSIONATE | TRUSTWORTHY

Improvement in PI prevalence

2014

Skin Inspections revealed 16 % had Pressure Injuries

8 % of those were on patient ears



Reducing oxygen tubing related pressure injury to ears.

- Aim to secure straps with least amount of tension.
- Replacing soiled devices.
- Ensure good ear hygiene to prevent build-up of sweat and or secretions
- Protect behind helix of ear with barrier creams (Cavalon Barrier or Sudocream).
- May use foams to assist with offloading pressure – be mindful that this may cause further friction and rubbing.
- Monitor site if areas does break down as it can become infected especially in immunocompromised patients.

MESALT:

A sodium chloride-impregnated dressing that helps stimulate the cleansing of moist necrosis (slough) and draining of infected wounds.

Used as a primary dressing.

Can macerate wound edge, so ensure cut to size.

Daily dressing change.

Comes in ribbon or flat

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Improvement in PI screening

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Skin Inspections revealed **16 % had Pressure Injuries**

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2015

Skin Inspections revealed **8% had Pressure Injuries**

NO Pressure Injuries found on patient ears

Increased Engagement & Improved Patient Outcomes