Putting the Pressure on Wound Care

CRMC Focus Drives Down Pressure Wounds

A problem can define and defeat an organization or serve as the impetus to enhance and improve.

Faced with a higher-than-optimal number of pressure ulcers in their inpatient population, Cookeville Regional Medical Center opted for the latter course of action and totally changed the approach to treating and preventing these persistent wounds.

Buffy Key
Vice President of Quality

"Recognizing we have a problem is a good thing, but recognizing we're going to solve the problem is our commitment," said Buffy Key, MMHC, MT (ASCP), vice president of Quality for CRMC. "We have not always had really good numbers in pressure ulcers," she continued. "It's not because people weren't trying to do great with this, but we quickly recognized that we had opportunities for improvement regarding documentation and communication, as well as the fact that we didn't have our own resident CWOCN."

While the medical center might not have had a Certified Wound Ostomy Continence Nurse on staff at the time, they did have an RN who was keenly interested in the field and willing to undergo the rigorous training and certification process. Deborah A. Nelson, RN, CWOCN left her post in Cookeville to study at Emory University in Atlanta before returning to CRMC in 2013 to design and launch updated wound protocols.

"We had great nurses and had protocols in place, but it just didn't approach the level of the program we have now," Nelson said. "It's a multi-faceted issue to control pressure ulcers, and it takes coordinated care. We want to prevent it … that's our first thought is prevention."

"They started focusing on the leading efforts with prevention as opposed to just the lagging efforts of recovery," Key agreed of the more rigorous protocols now in place.

Key, who said CRMC joined the Tennessee Hospital Association HEN at its inception, noted the focus on quality metrics and oversight added another level of accountability. "Obviously the clinical need was there, and the staff recognized it, but it made us more accountable on an administrative level, as well, because we were reporting these numbers on a monthly basis and drilling down like never before when we would have a pressure ulcer that reared its head."

Nelson said that level of administrative support is crucial to moving numbers on the clinical front. "Our administration recognized this wasn't just a singular problem at our facility but was an issue across the country, and they wanted to aggressively address it."

Jeanie Austin, risk manager for CRMC, added, "We realized we didn't have a process as far as what to do when we recognized a patient had a pressure ulcer … even it if was a stage one." She added that when a patient admitted two days ago now has a stage three pressure ulcer, that process began long before the patient arrived at the hospital. However, without proper documentation, the clinical staff couldn't get an accurate picture of the ulcer's pathology.

Nelson said optimal wound care crosses numerous departments and staff members including product services, clinical coordinators, floor nurses, physicians and coders. "There's a lot of collaboration that goes into getting your facility's formulary right so that you can get optimal patient outcomes."

Nelson added education and consistent reporting and staging was also of critical importance to addressing the numbers. "There has been a lot of support in this hospital for integrating wound care into all our programming … even at orientation," she said.

One way the administration showed support for the much more rigorous protocol was to empower nurses to see a risk and act on it, according to Nelson. "We set it up so that when a patient on admission has any areas at risk of developing into a pressure ulcer, by documenting it in the record it initiates an automatic wound consultation referral," Austin added.

With the new definitions and changes in terminology announced in April 2016 by the National Pressure Ulcer Advisory Panel to more accurately describe pressure injuries to intact and ulcerated skin, Nelson knows she has more education ahead of her. However, she sees what could be a daunting task as an exciting new opportunity. "As we learn more in my specialty, we're learning more about how to prevent and treat pressure wounds," she said with clear enthusiasm for the progress being made.

Deborah Nelson, RN, CWOCN

That forward momentum is on display at CRMC, as well. Key noted the medical center has gone months and months without having a stage three or four pressure ulcer. Now, attention is being turned to filling gaps at hand-offs. "One of the things from an administrative standpoint that we are trying to work towards, like everyone else in the country, is transitional care," said Key, adding CRMC has launched an extension of their inpatient protocols to the outpatient setting.

"When a facility recognizes a need and acts on it, that's huge," summed up Nelson. "I'm here because our administration saw this need. Having that support is priceless."

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