

HAPI Hour:

An Initiative to Decrease Pressure Injuries in the PICU



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Background

- Hospital Acquired Pressure Injuries (HAPI) are a challenging problem in the care of medically complex children. Children were recognized as high-risk population in the latest prevention and treatment of pressure injuries clinical practice guideline.
- The Pediatric Intensive Care Unit (PICU) at Nicklaus Children's Hospital utilizes a Pressure Injury Bundle that includes:
 - Braden QD
 - Skin assessments every two-hours
 - Device rotation every six-hours
 - Repositioning the patient every two-hours
 - Skin barrier cream with each diaper change
 - Appropriate bed surfaces
- Compliance of bundle documentation significantly decreased to 64% in Quarter 2 followed by a rise in pressure injuries in Quarter 3.

PICO Statement

Does the use of a standardized patient turn clock as opposed to standard care decrease the incidence of hospital-acquired pressure injuries in the PICU?

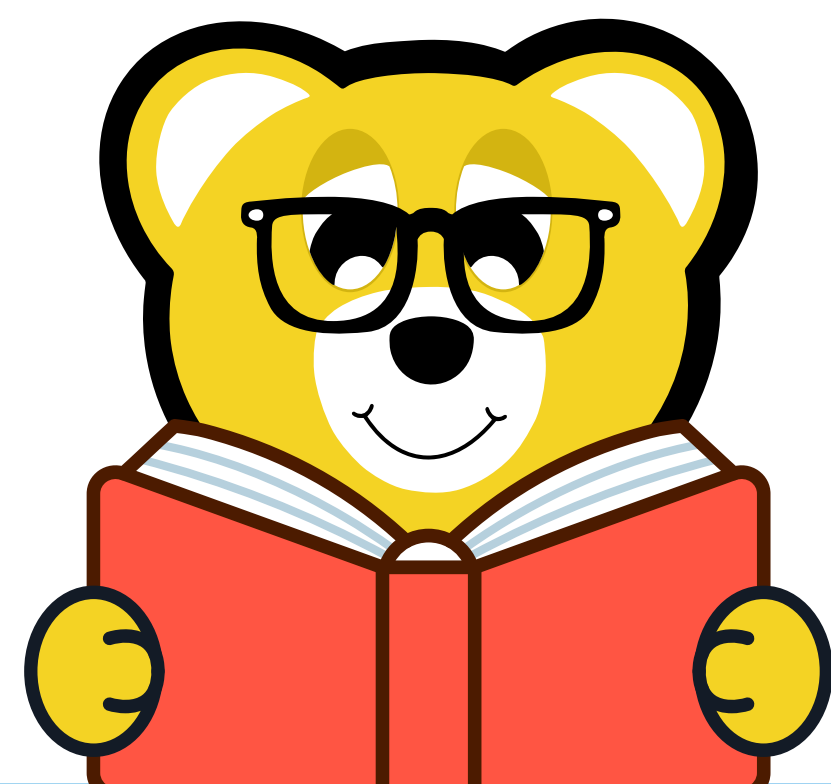
Literature Review & Evaluation

Inclusion criteria: complex medical history, sedated and/or paralyzed, immobile, pre-existing pressure injuries, devices, Braden QD greater than or equal to 12

Exclusion criteria: repositions self/mobile, Braden QD less than 12
Keywords: pressure injuries, turn clock, pediatric pressure injuries

Limitations: Not enough strong supporting evidence about patient specific turn clocks to implement a quality improvement project, therefore a pilot is indicated.

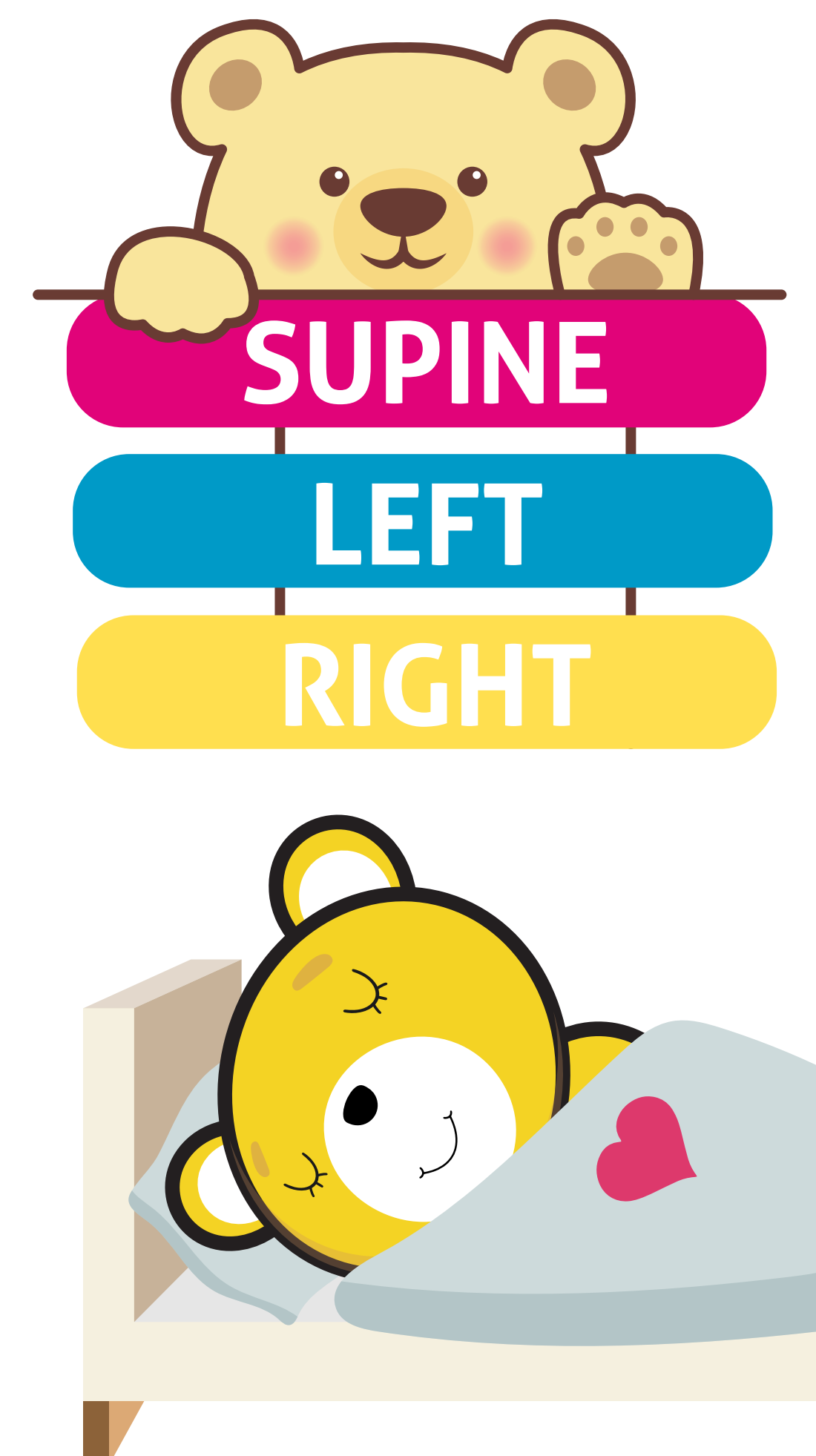
Level of Evidence	# of Studies	Overall Quality
I	1	High
II	2	Good/High
III	3	Good
IV	-	-
V	-	-



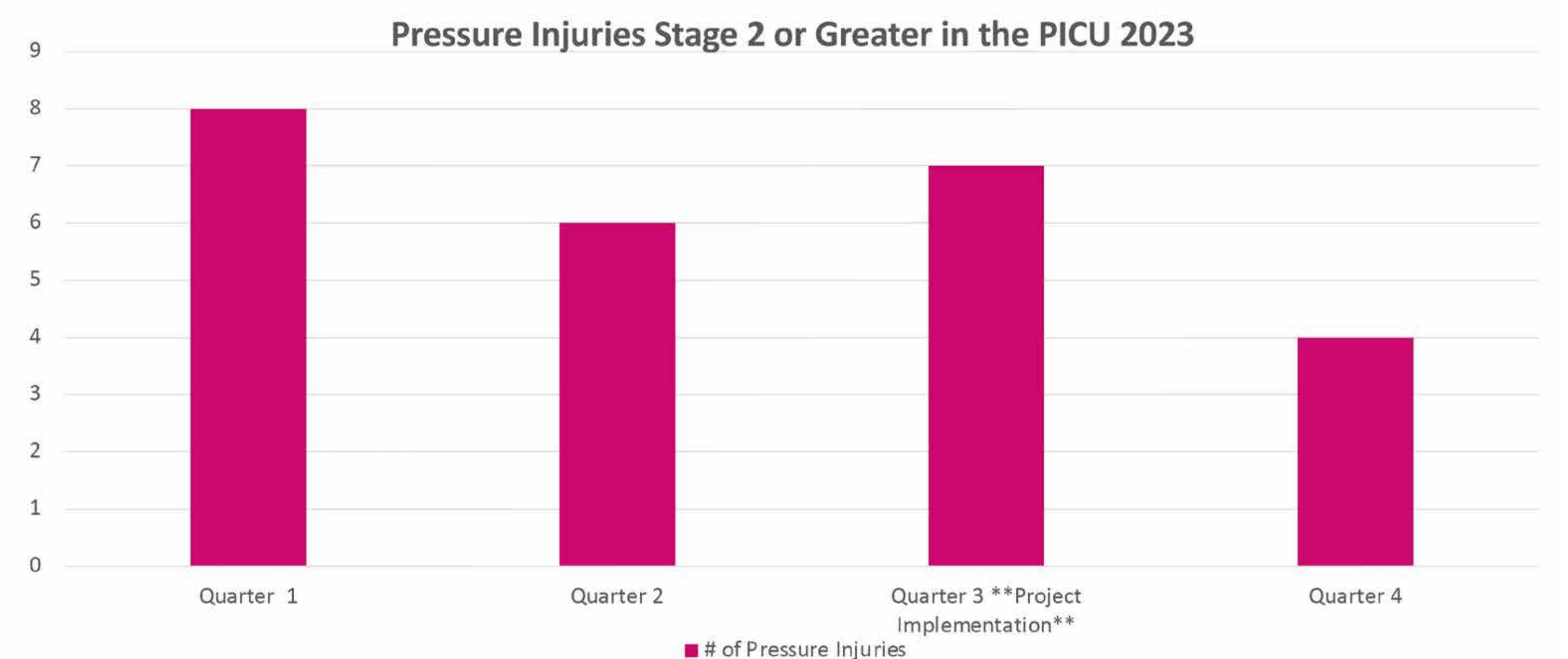
Methods/Implementation

- Plan** To decrease incidence of hospital acquired pressure injuries and enhance bundle compliance.
- Do** Implement a two-phase approach by initially re-educating bedside nurses on the PI Bundle components and auditing for documentation compliance, and secondly initiating a pilot study by utilizing a patient turn clock with audits comparing patient position to the turn clock recommended position.
- Study** Analyze results of implemented actions in Quarter 3 and Quarter 4. Determine barriers for compliance and adjust workflow as needed.
- Act** Continue to utilize the standardized patient turn clock, adjusting practice as needed, with emphasis on high-risk patients and adjust according to unit needs and on-going feedback.

Patient Turning Schedule



Results



Conclusion

- Pressure injury bundle compliance increased from 64% to 90% with re-education, awareness, and shift-by-shift audits.
- The incidences of pressure injuries are anticipated to continue to decrease with a standardized patient turning schedule, with an emphasis on high-risk patients, awareness and shift-by-shift audits.

Practice Implications

- Implementing a standardized patient turn schedule for high-risk patients within the PICU decreased the incidences of pressure injuries in Quarter 4.
- Re-education on the pressure injury bundle components was the foundational aspect of pressure injury prevention with the PICU.
- Potential future improvements could include: implementing a registered nurse (RN) turn team to assist bedside nurses with high-risk repositioning.

References available upon request