Electronic Documentation of Pressure Injury Prevention by Medical-Surgical Nurses: Diverse and Incomplete

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Disclosures and Objectives

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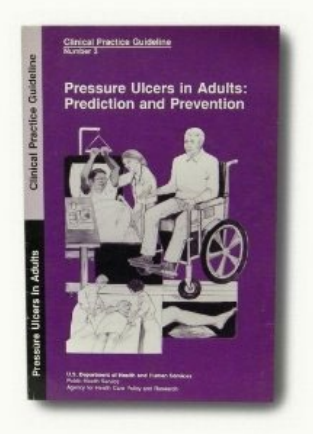
Objectives

- 1. Define hospital-acquired unavoidable pressure injury (HAPI).
- 2. List 2 themes related to HAPI and electronic documentation.
- 3. Discuss future recommendations for nursing practice, education, and administration in relationship to PI prevention electronic documentation.

State of the Science of Pressure Ulcer (Injury)

- 1992: US Agency for Healthcare Research and Quality (AHRQ), formerly the Agency for Health Care Policy and Research, published clinical practice guidelines
  - Risk Assessment
  - Support Surfaces
  - Body Repositioning
  - Nutritional Support
  - Moisture Control



- 1997 ANA: National Data Base of Nursing Quality Indicators (NDNQI)
- 2008: Federal Initiative Hospital-Acquired Conditions Reasonably Preventable
  - Centers for Medicare and Medicaid Services (CMS): Stage III and IV

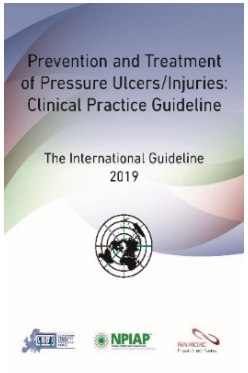
UNAVOIDABLE PRESSURE ULCER (INJURY)

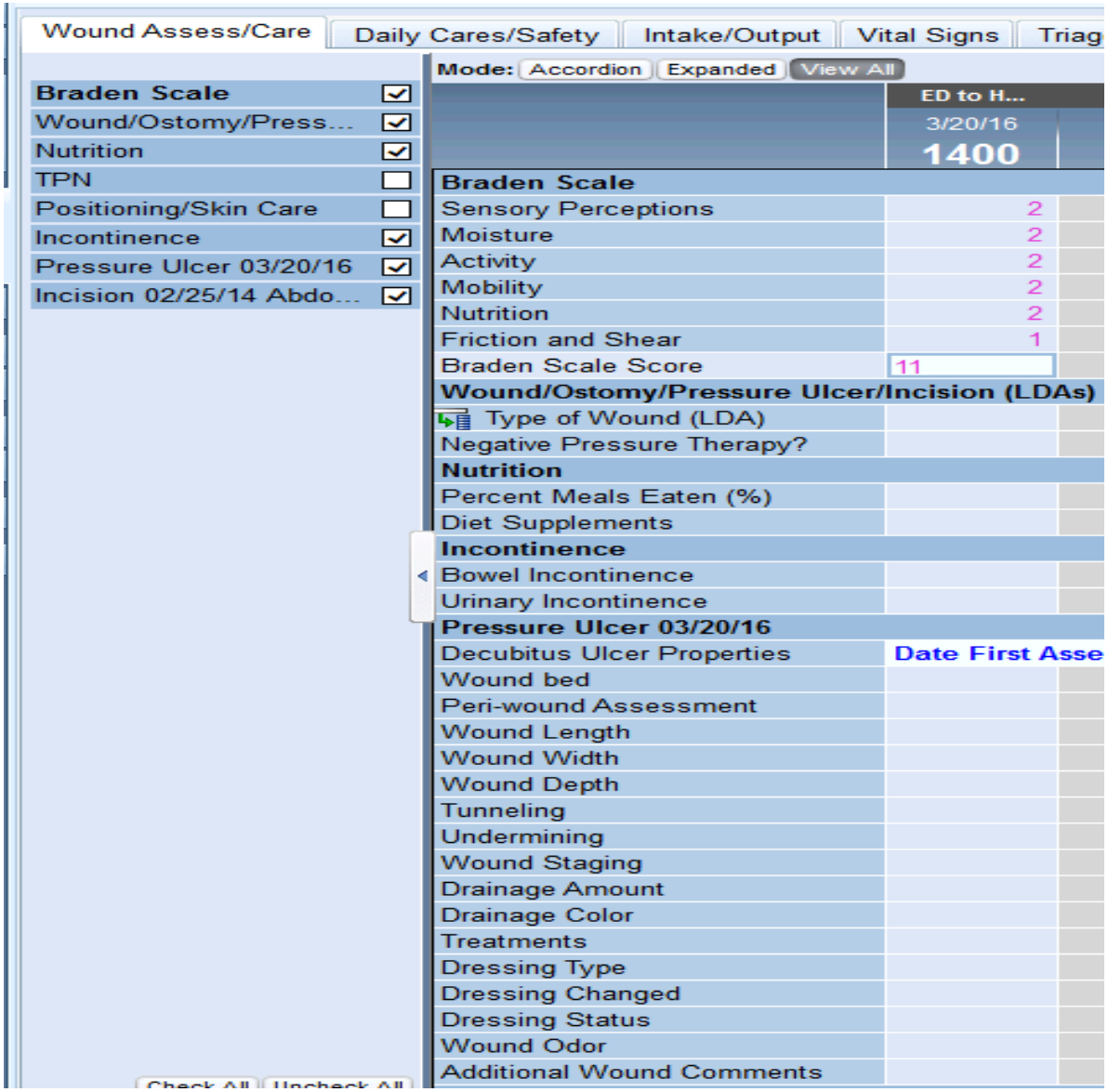
- 2010 National Pressure Ulcer Advisory Panel (NPUAP)
  - Unavoidable means that the individual developed a pressure ulcer even though the provider had evaluated the individual's clinical conditions and pressure ulcer risk factors; defined and implemented interventions that are consistent with individual needs goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate (Black et al., 2011, p. 30).

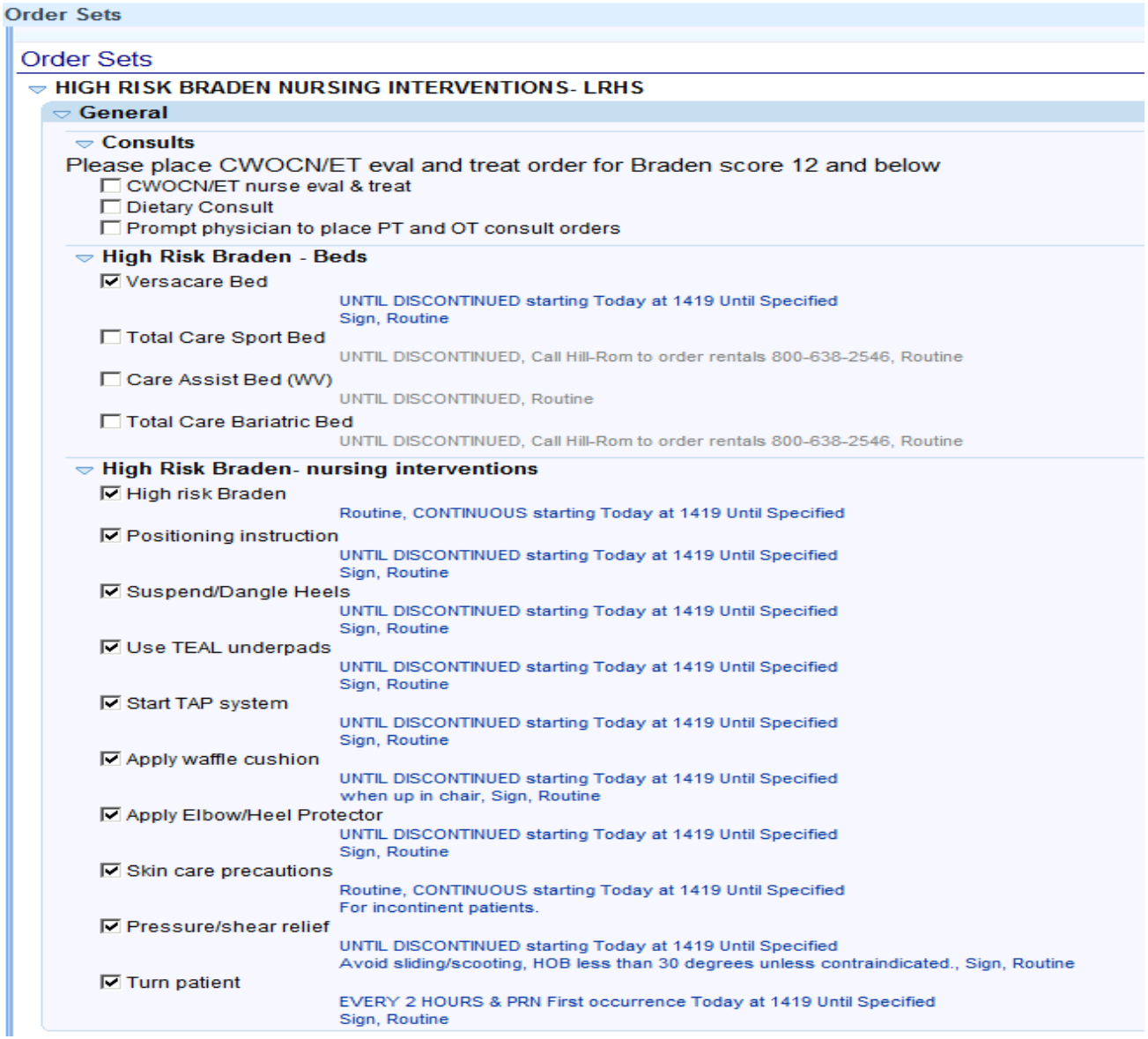
- Pressure Ulcers are unavoidable because the magnitude and severity of risks are overwhelming high or preventive measures are contraindicated (Edsberg, Langemo, Baharestani, Posthauer, & Goldberg, 2014, p. 314).

State of the Science of Pressure Injury

- 2016: National Pressure Ulcer Advisory Panel (NPUAP)
  - Replaced the term pressure ulcer with pressure injury to reflect both intact and ulcerated skin
  - Stages 1-4 and Unable to Stage
  - Deep Tissue injury (DTI)
  - Medical Device Related Pressure Injury (MDRPI)
  - Mucosal Membrane Pressure Injury
- 2019: International Clinical Practice Guideline for the Prevention and Treatment of Pressure Injuries (NPUAP, EPUAP, Pan Pacific Pressure Injury Alliance [PPPIA])




Wound Assess/Care
Daily Cares/Safety
Intake/Output
Vital Signs
Triag
Mode: Accordion Expanded View All
Braden Scale
Wound/Ostomy/Press...
Nutrition
TPN
Positioning/Skin Care
Incontinence
Pressure Ulcer 03/20/16
Incision 02/25/14 Abdo...
ED to H...
3/20/16
1400
Braden Scale
Sensory Perceptions 2
Moisture 2
Activity 2
Mobility 2
Nutrition 2
Friction and Shear 1
Braden Scale Score 11
Wound/Ostomy/Pressure Ulcer/Incision (LDAs)
Type of Wound (LDA)
Negative Pressure Therapy?
Nutrition
Percent Meals Eaten (%)
Diet Supplements
Incontinence
Bowel Incontinence
Urinary Incontinence
Pressure Ulcer 03/20/16
Decubitus Ulcer Properties
Date First Asse
Wound bed
Peri-wound Assessment
Wound Length
Wound Width
Wound Depth
Tunneling
Undermining
Wound Staging
Drainage Amount
Drainage Color
Treatments
Dressing Type
Dressing Changed
Dressing Status
Wound Odor
Additional Wound Comments


Order Sets

Order Sets

HIGH RISK BRADEN NURSING INTERVENTIONS- LRHS

General

Consults

Please place CWOCN/ET eval and treat order for Braden score 12 and below

- ☐ CWOCN/ET nurse eval & treat
- ☐ Dietary Consult
- ☐ Prompt physician to place PT and OT consult orders

High Risk Braden - Beds

- ☑ Versacare Bed
  UNTIL DISCONTINUED starting Today at 1419 Until Specified
  Sign, Routine
- ☐ Total Care Sport Bed
  UNTIL DISCONTINUED, Call Hill-Rom to order rentals 800-638-2546, Routine
- ☐ Care Assist Bed (WV)
  UNTIL DISCONTINUED, Routine
- ☐ Total Care Bariatric Bed
  UNTIL DISCONTINUED, Call Hill-Rom to order rentals 800-638-2546, Routine

High Risk Braden- nursing interventions

- ☑ High risk Braden
  Routine, CONTINUOUS starting Today at 1419 Until Specified
- ☑ Positioning instruction
  UNTIL DISCONTINUED starting Today at 1419 Until Specified
  Sign, Routine
- ☑ Suspend/Dangle Heels
  UNTIL DISCONTINUED starting Today at 1419 Until Specified
  Sign, Routine
- ☑ Use TEAL underpads
  UNTIL DISCONTINUED starting Today at 1419 Until Specified
  Sign, Routine
- ☑ Start TAP system
  UNTIL DISCONTINUED starting Today at 1419 Until Specified
  Sign, Routine
- ☑ Apply waffle cushion
  UNTIL DISCONTINUED starting Today at 1419 Until Specified
  when up in chair, Sign, Routine
- ☑ Apply Elbow/Heel Protector
  UNTIL DISCONTINUED starting Today at 1419 Until Specified
  Sign, Routine
- ☑ Skin care precautions
  Routine, CONTINUOUS starting Today at 1419 Until Specified
  For incontinent patients.
- ☑ Pressure/shear relief
  UNTIL DISCONTINUED starting Today at 1419 Until Specified
  Avoid sliding/scooting, HOB less than 30 degrees unless contraindicated., Sign, Routine
- ☑ Turn patient
  EVERY 2 HOURS & PRN First occurrence Today at 1419 Until Specified
  Sign, Routine

- Purpose: To explore the beliefs, values, and practices of the acute care medical-surgical nurses' electronic documentation of PI prevention interventions.

- Method: Ethnonursing Method (Leininger, 2006)
  - Midwest medical center
  - Seven-months of observation and informal conversations
    - Field notes (75 pages)
  - Twenty-three participant interviews audio recorded & transcribed
    - Key Informants: Seven acute care medical-surgical nurses
    - General informants: Sixteen multidisciplinary health care
  - Rigorous and in-depth qualitative content analysis
  - Collected until recurrent patterns became pervasive enough to confirm saturation

Sample Characteristics

- Protection of Human Subjects
  - Patients'
  - Participants'
  - Confidentiality
- Key – Registered Nurses
  - Seven (6 female, 1 male)
  - Degrees (4 ADN, 3 BSN)
  - Ages (23-52)
- General – Knowledge of HAPI
  - Sixteen: 12 female, 4 male
  - Degrees: PT, Nurse Educator, CWOCN, RT, CRNA, Dietician, 2 Nurse Managers, Director, Resource Nurse, Hospitalist, 2 NA/CNA
  - Ages (24-60)

Key	HAPI Site	Stage	Factors/Unit	General	
K01	Heel	Unable	End of life	G1a	PT
			Ortho Neuro	G1b	NA
				G1c	Educator
K02	Ear	4	MDR O2 tubing	G2a	CWOCN
			Med Onc	G2b	RT
K03	Chin	DTI	Surgery	G3a	CRNA
			Ortho Neuro	G3b	Circulator
				G3c	NA
K04	Coccyx	3	Acuity	G4a	Dietician
			Post Surg	G4b	Manager
K05	Thigh	Unable	MDR Ace Wrap	G5a	Director
			CTU/Surgery	G5b	Resource
K06	Coccyx	2-3	End of Life	G6a	MD
			Post Surg	G6b	CNA
K07	Coccyx	3	End of Life	G7a	Resource
			Med Onc	G7b	Manager

THEME: Care of adults experiencing a HAPI included diverse and incomplete documentation regimes of pressure injury prevention interventions by the medical-surgical nurse influenced by:

- Nursing care rationing practices (Jones, 2015)
  - We're running and we have to tag team and move to the next patient. I can't say that we honestly document every single time.
  - When the nursing assistants do the turns, a lot of times they get charted on the white board in the room, not in computer
  - Sometimes I'll write it down on paper and save it for the end of the day and then chart it all at once in the computer and then it's hard to remember what I did.
- Technical factors causing confusion on where or how to document
  - There are three different places you can put what their actual position is. The chart can't tell the story or maybe it can but it's hard to follow.
  - Nurses don't document enough when patients refuse care. We've had a couple patients recently that have refused to be turned and they just don't want to eat. I look in the charting and there's nothing there
  - I'll actually be in a room doing rounds and hear things being said like explaining the risks of not being turned and then when I'm auditing charts, I don't see any documentation

THEME: Care of adults experiencing a HAPI included diverse and incomplete documentation regimes of pressure injury prevention interventions influenced by:

- Silo social structures
  - Nursing RN to NA
  - Multidisciplinary
    - Respiratory Therapist and oxygen tubing
    - Dietician and nutritional supplements
    - Physical Therapist and heel relief
  - Departments
    - CRNA and awareness of HAPI from surgical procedure
    - Information Technology (IT) department not “nursing centered”

THEME: Care of adults experiencing a HAPI included incomplete skin assessments by the medical-surgical nurse influenced by:

- Priority setting practices
  - Respiratory, your breathing, your cardiac status, your vital signs, would take precedent over skin at that point. Once your patient is stable, a little down the road, you can look at the bony prominences.
  - Doing a full head-to-toe skin assessment on every admission depends on their risk.

- Kinship Relationship
  - I feel like the CWOCN nurses are a big help. I know I can put in that consult on my own.
  - I did not have time to take off the patient's wound dressings to do a complete skin assessment, so I was leaving this for the CWOCN.

UNIVERSAL THEME

Care of adults experiencing a HAPI was impacted by the medical-surgical nurse's inability to implement pressure injury prevention interventions influenced by:

- Economical staffing patterns
  - Sometimes, to be completely honest this isn't what we strive for, but staffing isn't as good as it should be. You try as hard as you can to get in there and turn patients every two hours, but sometimes it's not every two hours.
  - With the CAUTI initiative, they may be dry when you check them but five minutes later, they could be incontinent again and you don't know it because you just checked them. So to prevent catheter infections we put our patients at risk for more skin breakdown.
  - Aggressive turning and cleaning doesn't get done as often as it should because workers are so overwhelmed with not enough help. I don't think it's malicious by any means or lack of care, I think it's just the inability.

Unique Finding

- Participants did not recognize the importance of documenting unusual care occurrences somewhere within the patient record.
  - Narrative charting
  - Progress notes

Personal Discovery

- OLD view - If it was not charted, it was not done.
- NEW view - Just because it was not charted, does not mean it was not done.

LIMITATIONS OF THE STUDY

- Midwest region
- One hospital system
- Acute care medical-surgical units

Nursing Practice Implications

- Recognize their role and accept the responsibility of completing and documenting an admission skin assessment.
- Recognize the importance of accurate and timely documentation of evidence-based pressure injury prevention interventions or provide an explanation of why such interventions were contraindicated.

Nursing Education Implications

- Assessment and documentation of the skin on admission
- Documentation of pressure injury prevention interventions
- Instruction of how to write narrative notes
- Where to document contraindications of or refusal of care

Nursing Administration Implications

- Factor in the patient's clinical condition and risk for complications when staffing the units.
  - (Cho, Chin, Kim & Hong, 2016)
- Evaluate the CWOCN practice and utilization.
  - (Soban, Finley, & Miltner, 2016)
- Improve collaborative efforts between nursing and the IT department.
  - (Lavin, Harper, & Barr, 2015)
- Recognize that pressure injury prevention is a multidisciplinary responsibility.
  - (Cutugno, Hozak, Fitzsimmons, & Ertogan, 2015; Hajek, 2013)

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Thank You

Questions

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