

The Clinical Scene Investigator (CSI) Academy Project Toolkit



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Children's Mercy Hospitals and Clinics:

P.E.P. It Up! Pain Education for Pediatric Patients and Parents

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GOALS

The goals of this project were to increase NDNQI compliance on the indicator for Pediatric Pain Assessment and to improve patient/parent satisfaction scores in regards to pain management for their children or for the patient, if applicable.

OUTCOMES

The CSIs used a survey to determine if parents had the information necessary to understand their child's pain management. Results on the pilot unit had a large majority of the parents answering that they did, while units without the book had many parents answering that they did not have the necessary information. Because of this positive feedback, the books were customized for other units and rolled out to ten other inpatient units.

How We Achieved These Goals:

Project:

To begin, the CSIs first determined what it is that parents want to know about their child's pain. The CSIs created a brief survey to gather this information.

Parent Survey

1. Did your child have surgery during his/her hospital stay? If yes, what surgery was performed?
2. Did your child experience pain during his/her hospital stay?
3. Do you feel that your child's pain was controlled during his/her hospital stay? If no, why not?
4. Did your child use a pain scale to rate his/her pain (e.g. Faces, 1-10 scale)? If yes, did your child understand how to use it?
5. Were you informed, by the nurse, what medication was being given for pain relief and what the side effects of the medication were?
6. When you or your child asked for pain medicine, do you feel it was given in a timely manner?
7. Were techniques used for pain relief that did not involve pain medication (such as walking, distraction, repositioning, ice bags, etc.)? If yes, do you feel they were successful in pain relief for your child?
8. Is there anything different the staff nurse could have done to provide better pain relief for your child? Please explain.

After analyzing the results of this survey, the CSIs created a notebook containing educational materials focused on pediatric pain. This book was presented to the pilot unit staff, the Family Advisory Board (composed of families who are or were primary caregivers for a child cared for at CMH), and the Comfort Task Force. Each group gave feedback and revisions were made accordingly.

The notebooks were accompanied by a roll-out party, as well as gifts for the staff. The gifts were designed to promote awareness of the new pain education model, including badge holders, like the one shown below:



The notebook has also been translated into Spanish.

After its success on the pilot unit, the notebook was customized for additional units and rolled out to ten inpatient units.

PEP: Pain Education for Pediatrics Notebook

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PEP



Pain Education for
Pediatrics

PEP



The staff on 2 Henson has developed this Pain Education for Pediatrics (PEP) book to better educate patients, parents and families about pain.



This resource contains information on ways you can help your child as well as other services available to help your child with pain control. Our goal is to involve everyone and do everything to keep your child comfortable.

As always, the nurses and doctors on 2 Henson are available to answer any questions and do all we can to make this experience as comfortable as possible.



**Pain Education for
Pediatrics**



PEP Talk About...

General Pain Information

What is pain?

Pain is a feeling of discomfort from an injury, illness or surgery. It can affect the physical and emotional well-being of a child. It is important to control pain so that your child can sleep and participate in normal activities. Pain that is poorly controlled can delay healing, depress the immune system and cause sleepiness, anxiety, fear and fatigue. Our staff is committed to offering the best pain management possible.

What you need to know about your child's pain

Most children will have at least some pain after surgery. This is called post-operative pain. How much pain your child will have and for how long, will depend on the child and the type of surgery he/she had.

Here is some important information about your child's post-operative pain:

- Your child will most likely have pain after his operation
 - Not all children feel pain the same way
- In the days following the surgery, the pain should get better, not worse
 - Pain medication will help your child hurt LESS
 - Pain medication probably will not make ALL the pain go away
 - Comforting your child will help him/her relax and relieve pain
 - Distracting your child can also help relieve pain

Chronic and Acute Pain

Acute pain is pain that is not long-lasting. The pain may be caused by an operation, injury, illness or medical procedure. The pain may last a few seconds through a few weeks or months. Pain from an operation is normal and part of the whole healing process. Acute pain from an operation can be helped with medications. A parent or caregiver can also help acute pain by using non-drug methods like relaxation or distraction.

Chronic pain is continuous pain that continues beyond the time of normal healing. It ranges from mild to severe. The cause of chronic pain is not always known and can come and go. Chronic pain can often interfere with a patient's quality of life, sleep, and productivity.



Pain Education for Pediatrics



PEP Talk About...



Pain Myths vs. Facts



The following is a list of common myths regarding pain in children:

Myth: *Infants cannot feel pain. Years ago it was believed a newborn baby's nervous system was not developed enough to process pain messages and therefore feel pain.*

Fact: The nervous system of a 26-week-old fetus is sufficiently developed to feel pain.

Myth: *Children are less sensitive to pain than adults.*

Fact: Younger children can have higher levels of pain than older children and adults. Pain sensitivity seems to decrease with age for some people.

Myth: *Children will tell you if they are in pain.*

Fact: For various reasons, children do not always report their pain. They may be fearful of another painful procedure, such as a needle stick, or simply have a desire to please those around them. Older children may not want to appear weak to others, especially peers, by showing their pain.

Myth: *If a child can be distracted, he is not really in pain.*

Fact: Distraction is a very effective way for people to cope with pain. If a child is able to be distracted, this does not mean the pain is not real.

Myth: *If a child says he is having pain, but does not appear to be, there is no need for pain relief.*

Fact: A child's behavior does not always indicate his pain intensity. Children cope with pain in different ways. A school age child may play video games as a way to distract himself from the pain.

Myth: *Children get used to pain.*

Fact: Children often experience increased anxiety and perception of pain with repeated procedures. Over time, children with chronic pain may become more sensitive to pain and other sensations due to changes in the nervous system.

Pain Education for Pediatrics

PEP Talk About...

How Much Does it Hurt?



The Nurses on 2 Henson use special tools to determine how much pain your child is feeling, these tools are pain scales. Your child's age and ability to understand and communicate will help determine which scale is used.

Behavioral Pain Scale

FLACC (Faces, Legs, Activity, Cry, Consolability)

This scale is used on children who are unable to speak. The nurse will assess your child and determine the pain rating based on their physical appearance.

Faces Pain Scale

This pain scale is used on children 3 and older.



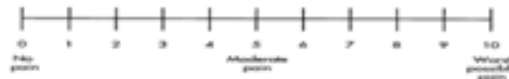
You and your nurse can help determine your child's pain by asking how he/she feels based on the face pictures.

Face 0 is very happy because he/she doesn't hurt at all.

Face 10 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask your child to choose the face that best describes how he/she is feeling.

Numeric Pain Rating Scale

This scale is for children who are able to understand numbers 1-10.



You and your nurse can help determine your child's pain by asking, "If 0 is no pain and 10 is the worst possible pain, please give me a number that indicates the amount of pain you are having now."

Pain Education for Pediatrics

PEP Talk About...

Commonly Used Oral Pain Medications



The following are medications commonly prescribed by the doctor for help with pain control. They are given orally (or by mouth). Your child will begin taking these after he/she can eat and drink. These medications take longer to start helping the pain, but last longer in the body.

The doctor decides which medication is best for your child based on many factors.

Acetaminophen (Tylenol)

- o Anti-inflammatory medication (decreases swelling)
 - o Starts to work in 30-60 minutes
 - o Lasts in the body for 3-4 hours

Ibuprofen (Motrin)

- o Anti-inflammatory medication (decreases swelling)
 - o Starts to work in 30-60 minutes
 - o Lasts in the body for 4-6 hours

Oxycodone (Roxicodone)

- o Narcotic pain medication
 - o Starts to work in 30-60 minutes
 - o Lasts in the body for 4-6 hours
- o Should be taken with food to prevent nausea and/or vomiting
 - o Common side effects are constipation and drowsiness

Acetaminophen and Codeine (Tylenol with Codeine or Tylenol #3)

- o Narcotic pain medication
 - o Starts to work in 30-60 minutes
 - o Lasts in the body for 4-6 hours
- o Should be taken with food to prevent nausea and/or vomiting
 - o Common side effects are constipation and drowsiness

Pain Education for Pediatrics

PEP Talk About...



Commonly Used Oral Pain Medications Continued

The following are medications commonly prescribed by the doctor for help with pain control. They are given orally (or by mouth). Your child will begin taking these after he/she can eat and drink. These medications take longer to start helping the pain, but last longer in the body.



The doctor decides which medication is best for your child based on many factors.

Hydrocodone and Acetaminophen (Lortab)

- Narcotic pain medication
- Starts to work in 10-20 minutes
- Lasts in the body for 3-4 hours
- Should be taken with food to prevent nausea and/or vomiting
- Common side effects are constipation and drowsiness

Oxycodone and Acetaminophen (Roxicet)

- Narcotic pain medication
- Starts to work in 15-30 minutes
- Lasts in the body for 3-6 hours
- Should be taken with food to prevent nausea and/or vomiting
- Common side effects are constipation and drowsiness

Pain Education for Pediatrics

PEP Talk About...



Commonly Used I.V. Pain Medications



The following are medications commonly prescribed by the doctor for help with pain control. They are given through the intravenous (I.V.) line. These medications help control the pain quickly, but do not stay in the body for very long.

The doctor decides which medication is best for your child based on many factors.

Fentanyl

- o Narcotic pain medication
- o Starts to work almost immediately
- o Lasts in the body for 30-60 minutes
- o Common side effects are constipation, itching and drowsiness

Hydromorphone (Dilaudid)

- o Narcotic pain medication
- o Starts to work in 15-30 minutes
- o Lasts in the body for 4-5 hours
- o Common side effects are constipation, itching and drowsiness

Morphine Sulfate (Morphine)

- o Narcotic pain medication
- o Starts to work in 5-10 minutes
- o Lasts in the body for 3-5 hours
- o Common side effects are constipation, itching and drowsiness

Naluphine (Nubain)

- o Narcotic pain medication
- o Starts to work in 2-3 minutes
- o Lasts in the body for 3-6 hours
- o Common side effects are constipation, itching and drowsiness

Ketorolac (Toradol)

- o Anti-inflammatory medication (decreases swelling)
- o Starts to work in 10-30 minutes
- o Lasts in the body 4-6 hours
- o Common side effects abdominal pain

Pain Education for Pediatrics

PEP Talk About...



Patient Controlled Analgesia (PCA)



What is PCA?

PCA pumps give the patient control of his/her pain medication. It is very easy to use and understand. When your child is feeling pain, medication can be given by pushing the button. THE PATIENT AND/OR NURSE ARE THE ONLY ONES ALLOWED TO PUSH THE BUTTON.

How does the PCA work?

The pain doctors decide which is the best medication and dose for your child. The nurse will set the computer inside the PCA pump for that dose. Then, your child is free to push the button ANYTIME he/she feels pain. The computer will only allow the correct dose to be given to your child.

How often can the button be pushed?

The button could and should be pushed as much as your child feels he/she needs pain medication. The computer will only allow your child to actually receive medication at timed intervals determined by the pain doctor. The nurses track the number of times your child pushes the button to determine how well the PCA is working. THE PATIENT AND/OR NURSE ARE THE ONLY ONES ALLOWED TO PUSH THE BUTTON.

Other PCA information

- o The PCA pump is safe and **WILL NOT** give your child too much medication
- o Your child should feel pain relief very quickly after pushing the button
- o Your child may receive medication continuously as well as pushing the button
- o The PCA medication will not take the pain away completely, but will help your child feel comfortable
- o Potential side effects of PCA medication are nausea, itching, increased sleepiness, constipation and/or irritation. Medications are available to help relieve any of these side effects.
- o The PCA will be turned off when your child is eating and drinking

Pain Education for Pediatrics

PEP Talk About... Commonly Used Medications to Assist with Pain Control



The following are medications commonly prescribed by the doctor to help relieve the side effects of prescribed pain medications. The doctor decides which medication is best for your child based on many factors.

Naloxone (Narcan)

- Narcotic Reversal to help with itching & nausea
 - Starts to work in 2 minutes
 - Lasts in the body for 20-60 minutes

Ondansetron (Zofran)

- Anti-nausea medication
 - Starts to work in 15-30 minutes
 - Lasts in the body for 4-6 hours

Diphenhydramine (Benadryl)

- Anti-histamine medication to help with itching
 - Can be taken orally or IV
- Starts to work in 30-60 minutes if taken orally and 15-30 minutes if IV
 - Lasts in the body for 4-7 hours
 - Common side effects are drowsiness

Pain Education for Pediatrics



PEP Talk About...

Ways to Comfort your Child



In addition to medication, here are some ways that you or other caregivers can help your child feel better.

- **Honesty and Control:** Telling your child the truth about what might happen, and/or allowing him/her to make choices will help reduce pain.
- **Touch:** Therapeutic massage by rubbing your child's back, arms, legs or feet may help to take his/her mind off of the pain. Touching also includes stroking, swaddling, holding, rocking, massaging, and cuddling.
- **Reposition:** Changing position to promote a more comfortable position can help to relieve pain.
- **Heat, Cold and Vibration:** Cold packs can help reduce swelling and relieve short-term pain. Warm packs can soothe aching muscles and stiff joints. Vibration by gently patting or use of a mechanical device, like an infant seat, can help soothe pain.
- **Relaxation:** Deep and steady breathing can help reduce pain and gain self control. Older children can be taught to inhale and exhale slowly and deeply. Younger children can use bubbles to assist with slow breathing.
- **Imagery:** Help your child use his/her imagination to think of something that makes him/her happy. Have your child describe his/her favorite place using the senses. Questions to ask - What does it look like?, What can you smell, hear, or taste there?, How does it feel?, etc.
- **Distraction:** To help your child refocus attention away from the pain, provide toys, games, music, T.V., movies or any other means that will help him/her relax.

If you have questions or need assistance with comfort measures for your child, please ask your child's Nurse or Child Life Specialist.

Pain Education for Pediatrics

PEP Talk About...



Alternative Services Available to Help Manage Pain



The following is a list of services Children's Mercy Hospital and Clinics offers to help provide the best pain management possible.

Child Life

- o Offers age appropriate activities so your child can focus on other things than pain
- o Can be present during tests and procedures to provide distraction techniques
- o Provides materials and guidance for developmentally appropriate play, preparing children for medical experiences, advocating for patient and family rights, and promoting a non-threatening environment.

Physical Therapy

- o Offers routine treatments/therapy specific to working the area affected by pain
- o Works side by side in order to provide each child and his/her family with an integrated, coordinated, high quality, family centered therapy

Behavioral Medicine

- o Specialize in counseling for patients with chronic or long term pain
 - o May be involved if your child's pain is difficult to control

Chaplain Services

- o Offers comfort and support to both the patient and family when your child is in pain

Integrative Pain Management

- o Coordinates various services listed above, but also incorporates other services such as osteopathic manipulation, acupuncture, massage, and self-regulation techniques into the care of children with pain.
- o This service can be used for patients with acute or chronic pain

Pain Education for Pediatrics

Kansas City VA Medical Center

Heels' Angels Reducing Heel Ulcers

Created by:

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GOAL:

The goal of this project was to decrease the incidence of heel pressure ulcers. This would, in turn, decrease pain and suffering of the patients, decrease hospital stays, infection rates and amputations, and increase the quality of patient care.

OUTCOMES:

Over the 19 months since the project began, the number of heel pressure ulcers decreased from 43 to 21 ulcers (51%). The Center for Medicaid and Medicare Services (CMS) estimates that it can cost between \$3,000 and \$43,000 to treat a pressure ulcer, depending on the severity. Therefore, the CSIs saved between \$66,000 and \$946,000. Since the kick-off campaign in November of 2009, heel ulcers decreased by 80%. The orientation continues for new staff. Pressure ulcer data continues to be collected on a regular basis.

HOW WE ACHIEVED THESE GOALS:

Project:

This project combined the use of a heel lift device with education and awareness for staff regarding heel pressure ulcers.

In order to increase awareness, the CSI designed a logo (shown below), and created a gift bag for staff, including T-shirts with the logo. Staff was encouraged to wear these T-shirts on Thursdays, which was designated heel ulcer day.



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Educational Activities included:

- Held 15 Mandatory Wound/Skin Care classes between January and October of 2009.
- Increased orientation for wound/skin care for new nurses
- Held monthly wound/skin care multidisciplinary team meetings
- Hosted a community-wide seminar, "Best Practice for Pressure Ulcer Prevention and Treatment," featuring both local and national speakers.

Heel Lift Devices:

The VA Medical Center used the Prevalon® Pressure-Relieving Heel Protector from Sage Products, Inc. (<http://www.sageproducts.com/>). There are other heel lift devices from other vendors.

An example of a heel lift device is shown below:



In addition to the boots, the CSIs used educational materials like the ones below in order to remind staff how to use the boots.

Heel Boot Decision Tree:

PREVENTION AND TREATMENT OF HEEL PRESSURE ULCERS

PREVALON BOOT CRITERIA...
If your patient has a Braden scale of 18 or less
and one or more of the following:

1. NON-AMBULATORY	7. DIABETICS AND/OR NEUROPATHY
2. UNRESPONSIVE	8. PERIPHERAL VASCULAR DEASEASE(PVD)
3. VENTILATOR SUPPORT	9. HEMI-PARESIS (STROKES)
4. MULTI-SYSTEM ORGAN FAILURE	10. HIP FRACTURES/ REPLACEMENT
5. SPINAL CORD INJURY (paraplegia, quadraplegia)	11. KNEE REPLACEMENTS
6. AMPUTEES	KC VA IM# 52490







REMEMBER:

- Remove the boot every shift and prn to inspact feet/skin.
- Keep skin clean and moisturized.
- Extend or retract foot of bed so heels are 2 inches away from the footboard.

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Pressure Ulcer Staging Chart:

					
STAGE 1	STAGE 2	STAGE 3	STAGE 4	UNSTAGEABLE	SUSPECTED DEEP TISSUE INJURY
<p>Non-blanchable redness of intact skin in a localized area, usually over a bony prominence. Darkly pigmented skin may not blanch; its color may differ from surrounding tissue.</p>	<p>Partial thickness loss of dermis; presents as shallow open ulcer with a red pink wound bed, no slough present. May be an intact open/ruptured serum-filled blister.</p>	<p>Full thickness tissue loss. May be able to see subcutaneous fat; can NOT see bone, tendon or muscle. Slough may be present but you can still see the depth of tissue loss. Undermining and tunneling may be present.</p>	<p>Full thickness tissue loss with exposed bone, tendon or muscle. May have slough or eschar but still can see base of wound. Undermining and tunneling often present.</p>	<p>Full thickness tissue loss but the wound bed is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black).</p>	<p>Local area of purple or maroon discoloration in intact skin or blood-blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.</p>
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Lafayette Regional Health Center

Fast Track to Success

Created by::

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Terri Fletcher, RN

Kim Leakey, Chief Nursing Officer

GOAL:

The goal of this project was to improve bed management and patient care hand-offs related to inpatient admissions through the Emergency Department at a critical access hospital. Other goals included improved communication, increased patient satisfaction, decreased time from admission order to inpatient bed, and increased patient safety.

OUTCOMES:

The hospital hired a float nurse for peak times in both the ED and the Med/Surg department. They bought pagers, so there was no longer overhead paging, which reduced overall hospital noise and contributed to patient privacy. They also found that they had improved satisfaction relating to admission/discharge timeliness.

HOW WE ACHIEVED THESE GOALS:

Project:

The CSIs first held brainstorming sessions to generate ideas on how to accomplish their goals. One of the most important components of their project was to involve Housekeeping, Case Management, and Rural Health Clinic Providers. They knew that in order to be successful, everyone with a stake in the outcomes and processes had to be involved in the project.

In order to help generate ideas and to add to the credibility of the team, the CSIs also engaged an outside consultant to assist.

General Solutions:

- Pagers were distributed to reduce overhead noise and increase patient privacy.
- Communication was increased between a supervisor and the ED to assess staffing and bed needs.
- Case Management was employed to manage discharges in a timelier manner.

Emergency Department Solutions:

- The ED began to notify med/surg “early and often” as to upcoming admissions.
- The ED also began to notify patients of the estimated wait times, and to offer them food, beverages, and hospital beds for extended ED stays.
- Inpatient care was expedited by being admission history in the ED.

Providence Medical Center

Practice Partners: Model of Care Delivery

Created by:

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Tricia Schwind, RN, BSN

GOAL:

The goal of this project was to develop and implement a model of nursing care delivery in which the RN and CNA function as practice partners to achieve optimal patient outcomes, improve patient safety, and improve patient and staff satisfaction.

OUTCOMES:

On the pilot unit, change of shift communication errors significantly decreased. Staff satisfaction with the change of shift report also increased. After rolling it out to the department, the projected annual salary savings was \$230,096. Between February-May of 2009 to May of 2010, medication errors, falls with injury and restraint usage were all reduced. RN and CNA satisfaction also increased post-project for questions, such as “CNA has enough times to perform tasks,” “RN and CNA are a team” and “Call lights are answered promptly.”

HOW WE ACHIEVED THESE GOALS:

Project:

Using the theme, “Dive into our Model of Care,” the CSIs presented several “wading pools.” This refers to the different components of the project rolled out in smaller, manageable parts.

The basic idea of this project was to create team based nursing, with one RN matched with one CNA. In order to accomplish this, the hospital held Enhanced CNA competency days. These wading pools gave increased skills to the CNAs, which allowed them to take over certain tasks previously completed by RNs, giving the RNs time to take on more patients.

The CSIs also standardized the CNA and RN change-of-shift format. In order to create the best format possible, a CNA was included in the project.

Standardized CNA Change-of-Shift Format

- Exchange of information
- Walking rounds
- Verification of information
- Collaborative discussion

Standardized RN Change-of-Shift Format

- Demographics
- Assessment
- Tests and Procedures
- Alerts
- Status

After the initial success on the pilot team, the team-based nursing model was rolled out from a single team to a whole department (“The Olympic Pool”).

Saint Luke's Hospital of Kansas City

Increasing Professional Nursing Certification Breaking Down Barriers and Raising Up Nursing

Created by:

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GOAL:

The goal of this project was to create a culture that recognizes the importance of professional nursing certification for the RN and those they service, while improving patient outcomes, through the benefits of professional certification.

OUTCOMES:

At the end of the project, 19 nurses had attained certification. The percentage of certified nurses on the unit increased from 3% to 54%, with 7 more nurses committing to attaining certification. Fall rates with injury and patient identification errors were reduced in the second quarter of 2010 after the CSI project. In addition, 6 patient satisfaction indicators improved after the project was implemented.

HOW WE ACHIEVED THESE GOALS:

Project:

In order to increase med/surg certification, the CSIs first had to understand what the barriers to certification were. They surveyed the RNs to find out what the greatest barriers were. Barriers on the survey were:

- Expenses
- Lack of awareness of how certification would benefit them personally and/or professionally.
- Test anxiety or fear of not passing
- Difficulty with scheduling (studying and testing)
- Inadequate study/preparation resources
- Lack of recognition of certification status
- Lack of support of unit/peers and the hospital

Once the CSIs understood the barriers to certification, they could begin to address them. Examples of how the barriers were mitigated are presented below:

Expenses: The grant paid for the exam fees in advance of passing and also for membership in the local and national organization aligned with the certification.

Lack of Awareness of the Benefits of Certification: The CSIs searched the literature to identify benefits of certification and held education efforts to circulate the findings.

Text Anxiety: The CSIs promoted education about test taking strategies and held group study efforts.

Scheduling: The hospital leadership became engaged with the project and allowed flexible scheduling for test taking and review courses.

Inadequate Study Resources: The grant was used to purchase study materials. The CSIs also offered sample test questions and the hospital library offered additional resource materials.

Lack of Recognition: The CSIs gave handouts and poster presentations to highlight certification. In addition, the hospital held a Certified Nurses Day and certification credentials were placed on the name badge (see picture below).

Lack of Support: Role modeling and certification champions helped to change the unit culture in favor of certification. Also, the CSIs encouraged friendly competition around certification.

Information on CMSRN certification, including exam dates, applications, and study materials, is available on the Academy of Medical-Surgical Nurses (AMSN) website: www.amsn.org.



Truman Medical Centers

Show Me Your Skin:

Reducing Pressure Ulcers

Created by:

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GOAL:

The goal of this project was to reduce hospital acquired pressure ulcers and to obtain 100% documentation of all pressure ulcers present upon admission.

OUTCOMES:

All patients on the pilot units had a Risk Assessment within 24 hours of admission. The number of pressure ulcers on those units decreased from 31 to 11 after the implementation of the CSI project. The Center for Medicaid and Medicare Services (CMS) estimates that it can cost between \$3,000 and \$43,000 to treat a pressure ulcer, depending on the severity. Therefore, the CSIs saved between \$60,000 and \$860,000. The cameras and printers have now been placed on all inpatient units on both hospital locations, and skin program education has been incorporated into a biweekly nursing orientation.

HOW WE ACHIEVED THESE GOALS:

Project:

Cameras and Printers

In order to increase documentation, the CSIs purchased digital cameras and printers, which allow the nurses to photograph all wounds that are present upon admission. The picture is then printed and placed in the patient's chart and notice is sent to the physician. This hospital is in the process of implanting electronic medical records, and will incorporate the digital pictures into they system.



Green Bars

Green Bars were placed outside the rooms of all patients that were at risk of developing a pressure ulcer. This alerted the medical staff to take appropriate action.

Turn Schedule and Turn Teams

All at-risk patients were placed on a 2-hour turn schedule. This allowed the staff to be able to track all patients and to keep them on the same schedule. These clocks were placed in the patients’ rooms to remind nurses of the turn schedule.

Front

Back



Turn Schedule

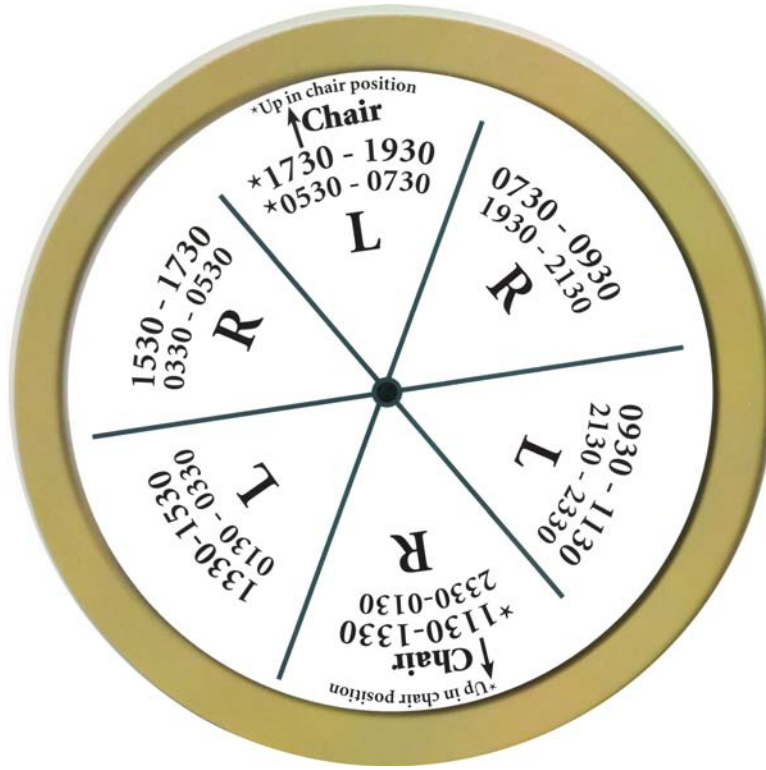
- 0730 R
- 0930 L
- 1130 R and ↑ chair position
- 1330 L
- 1530 R
- 1730 L and ↑ chair position
- 1930 R
- 2130 L
- 2330 R
- 0130 L
- 0330 R
- 0530 L and ↑ chair position

- Place turn schedule clock on identified patient doors
- Every 2 hour staff meets to form 2-4 person turn teams
- Turn patients to ensure they all face the same direction at the same time no matter what time the patient arrives on unit
- Up↑ in chair position TID
- Assist Wound Care Nurse and discuss skin care plan
- Use only dry flow pads. May use draw sheet if needed
- Obtain Dietician consult to assess nutritional needs
- Elevate heels with pillow under calves
- May have bath almost complete so turn team can help finish
- Use rotation therapy modules. Avoid using pillows. Interrupt scheduled rotation Q 2 hours to assess skin condition
- Patients in Full or C-Spine precautions must be turned Q 2 hours unless contraindicated by Doctor’s order

TMC Clinical Scene Investigators
“Show Me Your Skin Campaign”
 TMC Better Skincare for Everyone



Turn Clock



University of Kansas Hospital

The Amazing Race to Unit Excellence

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GOAL:

The goal of this project was to develop a culture of Share Governance by creating a Unit Practice Council that is empowered to initiate quality improvement projects. By achieving this type of “unit excellence,” the CSIs hoped that patient care would be improved.

GOAL:

Several outcomes were used to measure success. Staff attendance at meetings was consistently higher during the project, and maintained at greater than 30%. A survey specifically targeting Shared Governance was given to staff. This survey showed strong improvement in several components, including “The staff is excited to be involved in patient care decisions” and “I have the skills and information I need to support the Practice Council.” In addition to staff satisfaction, Press Ganey patient satisfaction scores steadily improved throughout the project, and is now higher than the PG mean. Nurse turnover also decreased, with the staff that started the Race, finishing the Race.

HOW WE ACHIEVED THESE GOALS:

Project:

Please download *The Amazing Race Booklet* from our website:

www.nursinginnovation.org/programs for information on how to create an Amazing Race to Unit Excellence.

