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**Quality Improvement Activity: Documentation of Pressure Injury Progression**

On February 15th, 2021 a patient was readmitted to the Surgical ICU due to post COVID-19 complications. The patient was placed on a mechanical ventilator after O2 saturations continued to drop and the patient proceeded to decline. Because the SICU is severely understaffed, the night shift nurse was assigned too many patients and was preoccupied with their care. On the patients second day on the floor, the night shift nurse failed to turn the patient every 2 hours as required and did not assess for pressure injuries. The next morning, the night shift nurse didn't follow policy by failing to provide a bedside report because she was behind with her interventions and assessments. Also, the nurse did not document the absence or presence of pressure ulcers in their documentation. While performing a head-to-toe assessment, the oncoming nurse noticed the beginning stages of skin breakdown on the patient's sacrum. Although the oncoming nurse did properly clean and treat the pressure ulcer by applying a dressing, this nurse did not document the presence of the sore because she did not want to have conflict with the night shift nurse who she is close friends with. She also did not document the ulcer because she was afraid that her and her friend would be reported for patient care negligence. Since the previous nurses did not document the occurrence of skin breakdown, the following nurses who took care of this particular patient were not aware of the severity or the length of time that the pressure ulcer had been there. After several days of neglecting to thoroughly document the decubitus ulcer, the wound progressed to the point of infection and the patient was ultimately diagnosed with a hospital acquired pressure ulcer injury in addition to their underlying initial illnesses.

**In what way did the patient care or environment lack?**

In the scenario above the patient was not cared for efficiently. For example, the patient was not turned every two hours as required and the proper policy for documenting pressure ulcers was not followed. Best practice was not adhered to in treating the pressure ulcer, therefore causing the wound to progress to an infectious state. This scenario was caused by not only negligence upon the nurse, but also failure of the nurse manager to adequately staff the floor. Since the nurses were overwhelmed with the number of patients they had, proper care was compromised.

**Is this a common occurrence?**

It is common for nurses to not prioritize pressure ulcers or the documentation of them when they are overloaded with too many patients. It is easy for nurses to think of pressure ulcers as a small problem compared to the overall issue that is going on, like the post COVID-19 complications in this specific patient. Unfortunately, pressure ulcers develop quickly when left untreated, and this is an issue that all floors in all hospitals face. However, it is our jobs as caregivers to thoroughly assess and document any changes in our patients in order to provide them with quality care.

**What circumstances led to the occurrence?**

One of the circumstances that led to this occurrence was the overloaded nurse as well as the nurse protecting her friend instead of having integrity and reporting the pressure ulcer. In addition, the presence of the ulcer was not documented or given in report to the oncoming nurses. The wound should have been documented, reported to the charge nurse, and photographed and attached to the patient's chart. Since these things were not done, the healthcare team was not aware of the progression of the wound or the severity of the issue.

**In what way could you measure the frequency of the occurrence? (interviewing nurses, examining charts, patient surveys, observation, etc)**

The frequency of occurrence of decubitus ulcers could be measured in multiple ways: reporting pressure ulcers to the unit supervisor, filling out incident reports to record the rate of occurrence, and recording point prevalence for the number or percentage of people having a pressure ulcer while on the unit. Point prevalence reflects the number of pressure ulcers on admission and developed during their time in the hospital. These interventions could ultimately decrease the number of pressure ulcers that are acquired during a hospital stay, as well as letting us know how effective our care is in preventing them.

**What evidence-based ideas do you have for implementing interventions to address the problem?**

- Educate nurses on the importance of giving a detailed bedside report during shift change
- Require the leaving and oncoming nurses to assess patient's bony prominences and backside together before the previous nurse leaves and the oncoming nurse starts her shift
- Arrange for bimonthly meetings with the staff on the floor to assess if prevention measures are being effective and if the nurses are documenting correctly
- Provide incentives for the employees on the unit if goals for pressure ulcer prevention and documentation are met

**How will you measure the efficacy of the interventions?**

Measuring the efficacy of the interventions can be done by reflecting on the number of pressure ulcers that were developed on the floor and seeing if the incidence rates have dropped. If the amount of decubitus ulcers decreases, then that indicates that the interventions are working.