PUPPI-C
The quality continues
PUPPI-C

. Pressure
. Ulcer
. Prevention
. Pediatric
. Interdisciplinary
. Committee
PUPPI-C

The committee consists of:

- Cindi LaPorte—nurse manager
- PICU and Pediatric staff nurses
- Dr. Wang—Pediatric Intensivist
- Laura Buerger—Dietician

- Nanci Stark and Kathy Theisse—Wound/ostomy nurses
- Katie Holish—nurse educator
- Judy McHugh—Nursing quality
- Dana Fortado—OT

NICU Staff
The committee was formed because Loyola did not have a skin assessment tool for the pediatric population.
- Insurance or Medicaid does not pay for hospital acquired pressure ulcers
Aim Statement

- Prevent and minimize risk for hospital-acquired pediatric pressure ulcers by creating an interdisciplinary team to analyze past pressure ulcer patterns, evaluate current trends, and implement an evidence-based pediatric pressure ulcer prevention system.
Evidence-Based Approach

1. Collected retrospective data for all pediatric patients that had documented skin issues

2. Looked at data for each individual patient to find similarities (example: intubated, central lines, vasopressors used, etc.)
Evidence-Based Approach

3. Performed a literature review of 14 articles on pediatric pressure ulcers
Evidence-Based Approach

4. Following the University of Iowa Model for Evidence-based practice: adopted the Modified Braden-Q Skin Assessment Tool
After further review of the literature, PUPPI-C found that there was no Pediatric Skin Intervention Tool. PUPPI-C developed the Loyola Pediatric Skin Intervention Tool for low, moderate, and high risk patients. This tool was based off of the Braden Intervention tool that was being used at Loyola for adult patients which is an evidence-based tool.
• The most compelling fact from our research showed that an occipital pressure ulcer with alopecia is a permanent hair loss for life
Goal

• Reduce hospital-acquired pediatric pressure ulcers to zero
Implementation of a Pediatric Pressure Ulcer Prevention Tool
Promoting Directed Interventions and Alleviating Risk

PUPPI-C Team Members: Marsi Appleby BSN, RN (PICU), Chairperson; Judy McHugh MSN, RN, Facilitator; Cintia M LaPorte BSN, RN, Manager Pediatrics, Pediatric Critical Care and Child Life; Renee Niznik BSN, RN (Peds); Melinda Mars, BSN, RN (PICU); Jodi Blaszczyk BSN, RN, CWOCN, Skin Consultant; Katie Hollish MSN, RN, Educator; Samantha Sage BSN, RN (Peds); Ewa Hofstad BSN, RN (PICU); Kathy Thiesse BSN, RN, CWOCN, Skin Consultant; Dana Fortado, Occupational Therapist; Jeanna Sadlik, EUHS Librarian; Jenny Wang MD, Assistant Professor, Department of Pediatrics

Project Aim Statement:
Prevent and minimize risk for hospital-acquired pediatric pressure ulcers by creating an interdisciplinary team to analyze past pressure ulcer patterns, evaluate current trends, and implement an evidence-based pediatric pressure ulcer prevention system.

Goal:
Reduce hospital-acquired pediatric pressure ulcers to zero.

Management Procedures Implemented:
- Adopted Braden Q Pressure Ulcer Risk Assessment Scale
- Incorporated Braden Q Scale into the Electronic Medical Record (EMR)
- Developed and incorporated into the EMR Loyola Pediatric Skin Intervention Tool for low, moderate, and high risk patients
- Created E-Learning module for all staff
- Educated all pediatric nurses on assessment scale and intervention tool, and placed resource binder in each unit
- Began development and implementation of the Pediatric Occipital Preservation Program

Braden Q Pressure Ulcer Risk Assessment Scale: Documentation:
- 100% on admission
- 100% daily

Data Collection And Analysis Systems:
- Collection of data through the EMR reports
- Collection of data through quarterly NDNQI surveys of all hospitalized pediatric patients at Loyola.
- Analyze identified pressure ulcer cases to ascertain specific causal factor(s)

Lessons Learned:
- Every nurse takes responsibility for each hospital-acquired pressure ulcer, actively investigates solutions, and inservices colleagues on specific causal factors
- Nurses ensure that the patient and/or the family is properly educated regarding pressure ulcers and specific risk factors
- Every nurse is empowered to help find evidence-based solutions to this and all other identified health problems in their patients

PICU-Time Between Pressure Ulcers
*No pressure ulcer cases were found on the floor
PICU-Time Between Pressure Ulcers

*No pressure ulcer cases were found on the floor

**As of 8/25/2013 there have been no pressure ulcers for 522 days
Next Steps

• Continue to look at risk factors that possibly precipitate formation of pressure ulcers or DTI’s
  – Examples
  • Prolonged OR time
  • Traction
  • Vasopressors
  • Medical hypothermia
Next Steps

- Continue to follow-up and share information with other departments that service pediatric patients

  - OR
  - PAR
  - NICU
  - Burns
  - ER
Next Steps

• Continue to monitor new products already implemented for infant pressure ulcer prevention
  – Gel head pillows
  – Sheepskin pads
Next Steps

• Continue to pilot and implement new pediatric products
  – Example: MediHoney products for skin and wound care