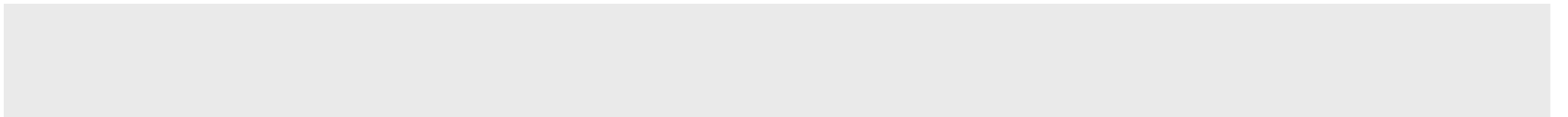




**St. Vincent's
Intensive
Care
Quality
Improvement
Committee**



The following case study has been re-printed with the permission of St. Vincent Hospital, Indianapolis, Indiana. This 15-month project was completed by St. Vincent's Intensive Care Quality Improvement Council, and was presented in October, 1993 at the 6th Annual Quality Assurance and Improvement Conference in Las Vegas, Nevada. The following is the original abstract and results. It was not funded by any of the manufacturers represented.

ST. VINCENT'S INTENSIVE CARE QUALITY IMPROVEMENT COMMITTEE

St. Vincent's Hospital and Health Care Center Indianapolis, Indiana

St. Vincent's is a 900 total bed facility, and has had shared governance since 1988. Our unit is a 32-bed Medical and Surgical Intensive Care. We have a 110 member all R.N. staff, and our average patient age is 65. In April 1992, our Management Committee informed our Quality Improvement Council that our unit had an exceedingly high usage of specialty beds. With some back tracking and investigative work, we found that we still had a high incidence of skin breakdown.

First we monitored the patients in our unit for one month to see what common traits could be found in all of our patients and especially those already on a specialty bed. After evaluating the data, a specialty bed criteria list was designed for our staff to assist them in choosing the right bed therapy for our patients. During the same time frame, our Management Committee purchased pressure reduction mattresses for our new beds, After introducing the criteria list to staff, we began to see significant decrease in the specialty bed usage and time period that the patient actually stayed on the specialty bed.

Staff input was a significant part of our process. After our criteria was in place the staff began to complain about how difficult it now was to turn an unstable patient. Our Materials Management Consultant was brought into the picture. She selected several overlay mattress products for our staff to

trial. Our final selection, the WAFFLE® Mattress was based on staff input of "user friendliness" and cost effectiveness to both the hospital and the patient.

We continued to monitor our patient's skin integrity and the course of the patient's breakdown during the time in ICU. Our final selection in an overlay mattress fit the criteria we had established and was readily accepted by the staff.

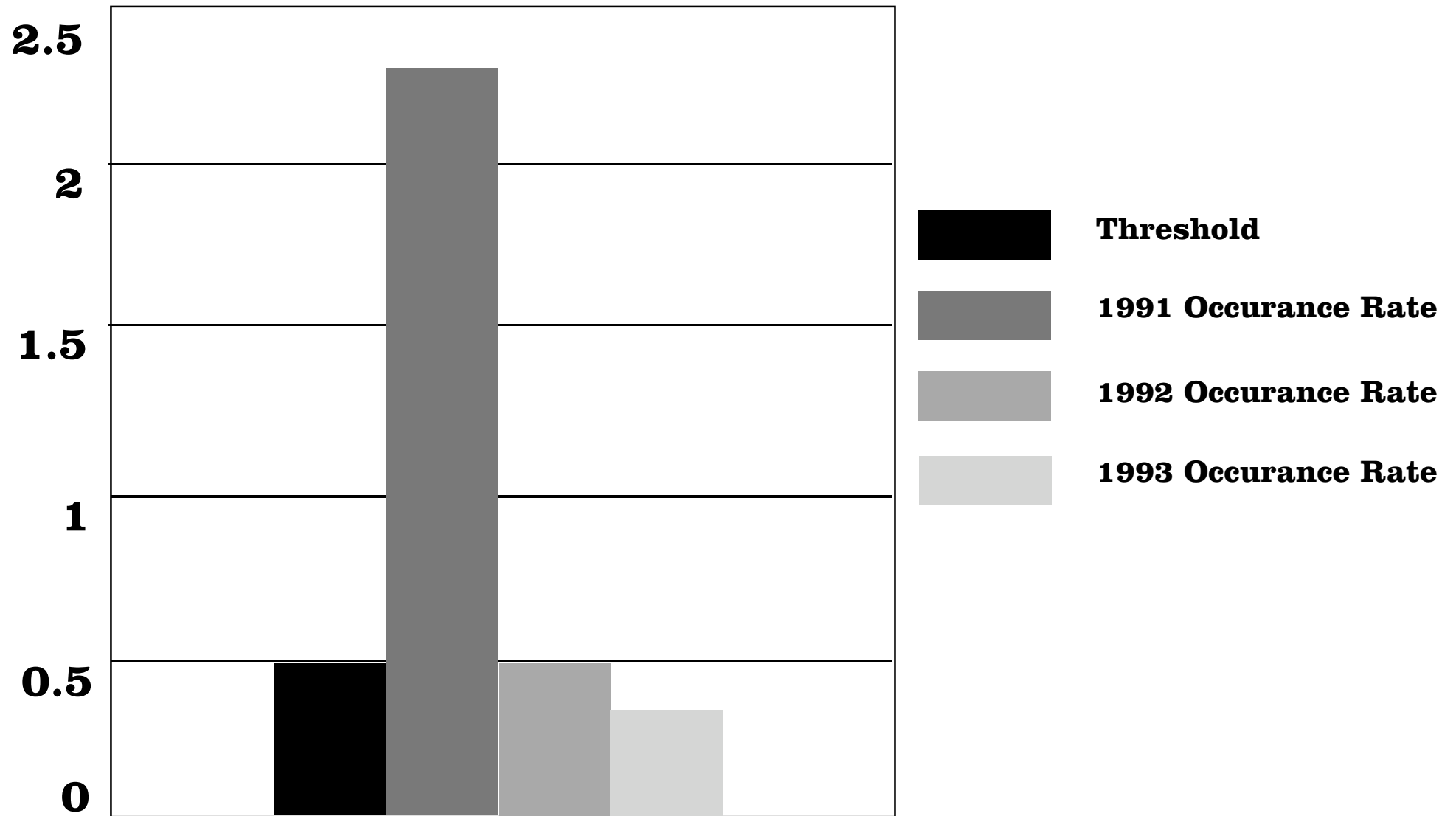
After 15 months of trialing products and trying to find the right combination to satisfy our staff, be cost effective and not compromise our patient's skin integrity, our goals were realized. Our monitoring results showed a decrease in our incidence of skin breakdown by two-thirds and saved both the patient and hospital \$500,000 in a six-month period of time.

Our project is now 15 months old, and we continue to make improvements to ensure quality patient care. We continue to trial new skin care products and educate the staff on changing modes in skin care therapy.

Our council feels that we have significantly impacted our patient care in a positive manner and that the project can be replicated in any intensive care, coronary care or step down unit where the patient's skin integrity is at risk, due to age and immobility.

Intensive Care Unit Hospital Skin Break 1991 - 1003

Incidence per
100 patient
discharges

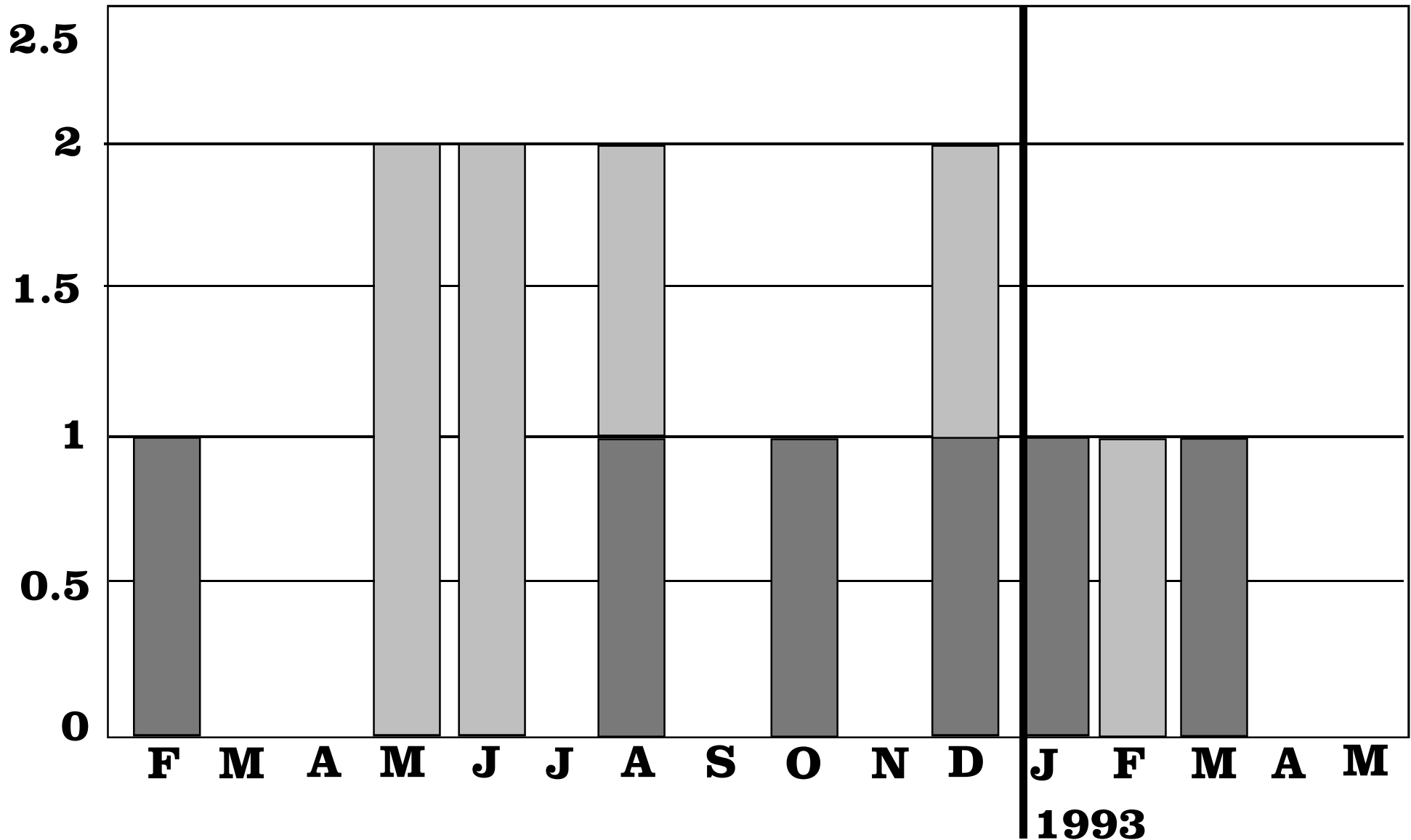


This chart illustrates our threshold limit of skin breakdown. In 1991, we exceeded our threshold. Increased specialty bed use in 1992 allowed us to meet our goal. In 1993, even though we dramatically decreased our specialty bed usage with the WAFFLE® Mattress, our incident rate was lower still.

Skin Breakdown Community and Hospital Acquired

Incidence per
100 patient
discharges

Community
 Hospital



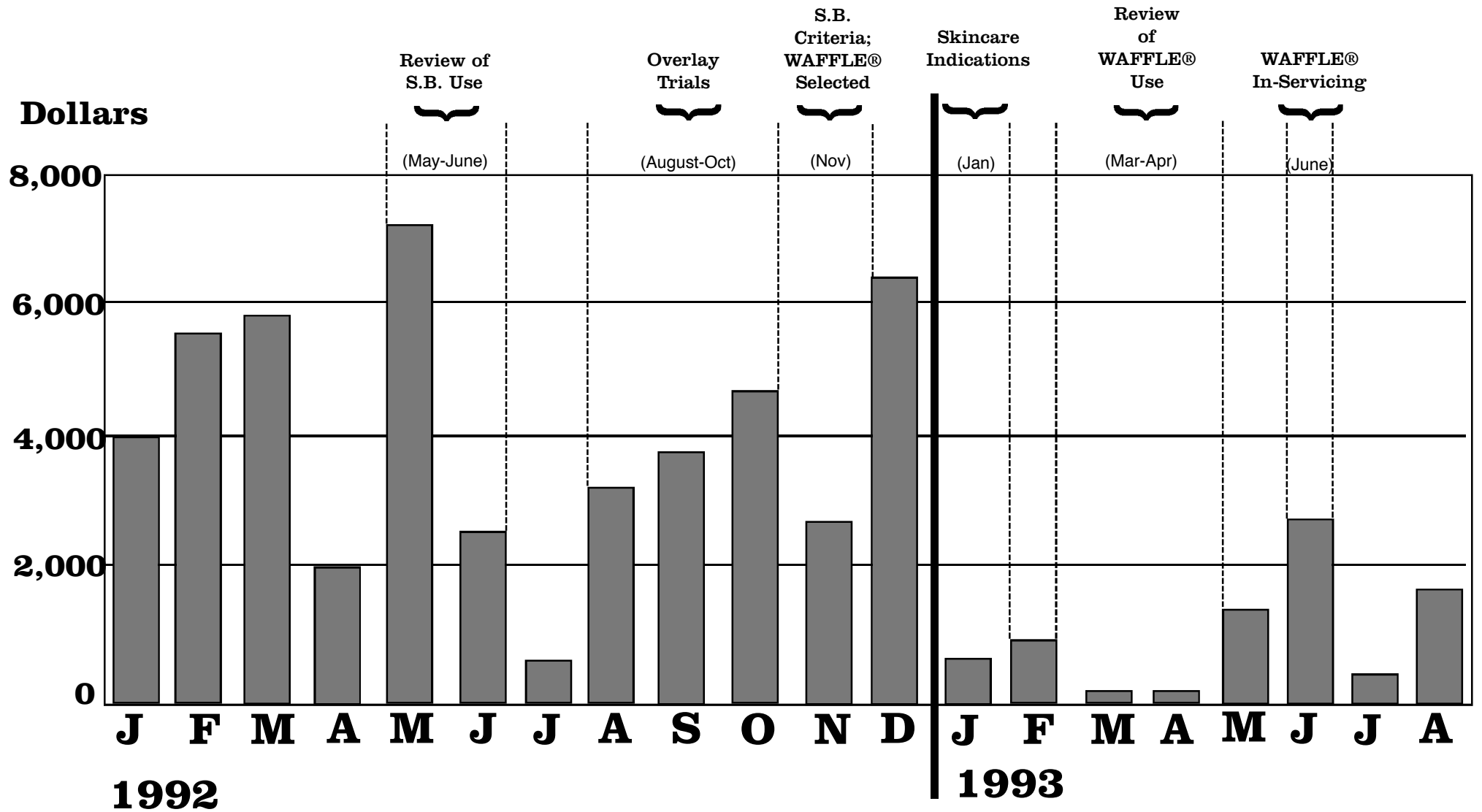
This chart illustrates that patients' skin integrity was not compromised in 1993, when WAFFLE® Mattress usage was increased, and specialty bed usage decreased.

The following 3 charts depict the average bed change, total patients placed on specialty beds, and average days spent on specialty beds in the Intensive Care Unit. There is an overall decline in these variables as specialty bed use is reviewed and overlays are trialed in 1992.

With the implementation of the WAFFLE® Mattress in 1993, these variables drop dramatically due to earlier transfer of patients from specialty beds to WAFFLE® Mattresses, and earlier implementation of WAFFLE® Mattresses in overall care.

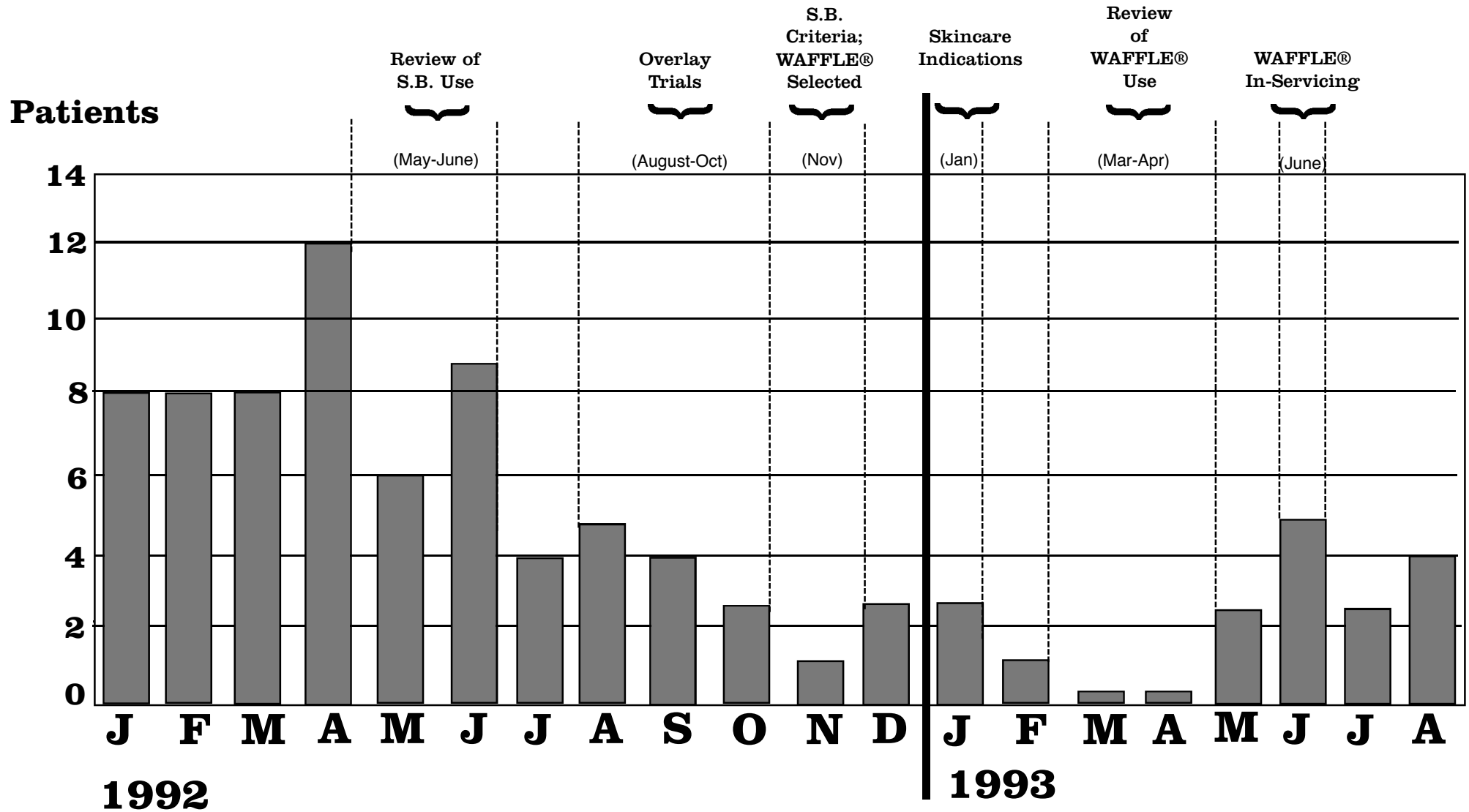
Average Specialty Bed Charge Per Patient

Factors Affecting Specialty Bed Usage



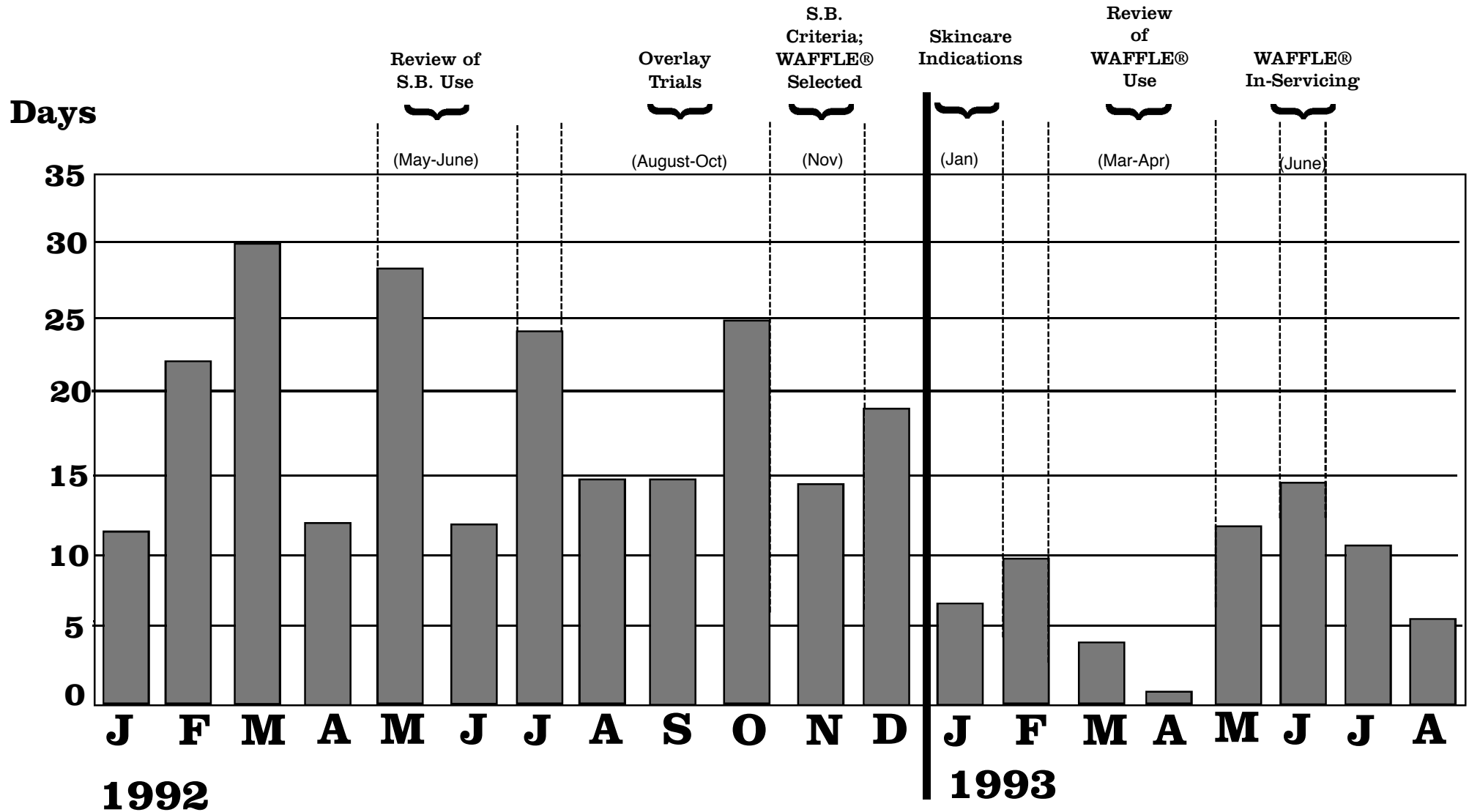
Patients Placed On Specialty Beds Per Month

Factors Affecting Specialty Bed Usage



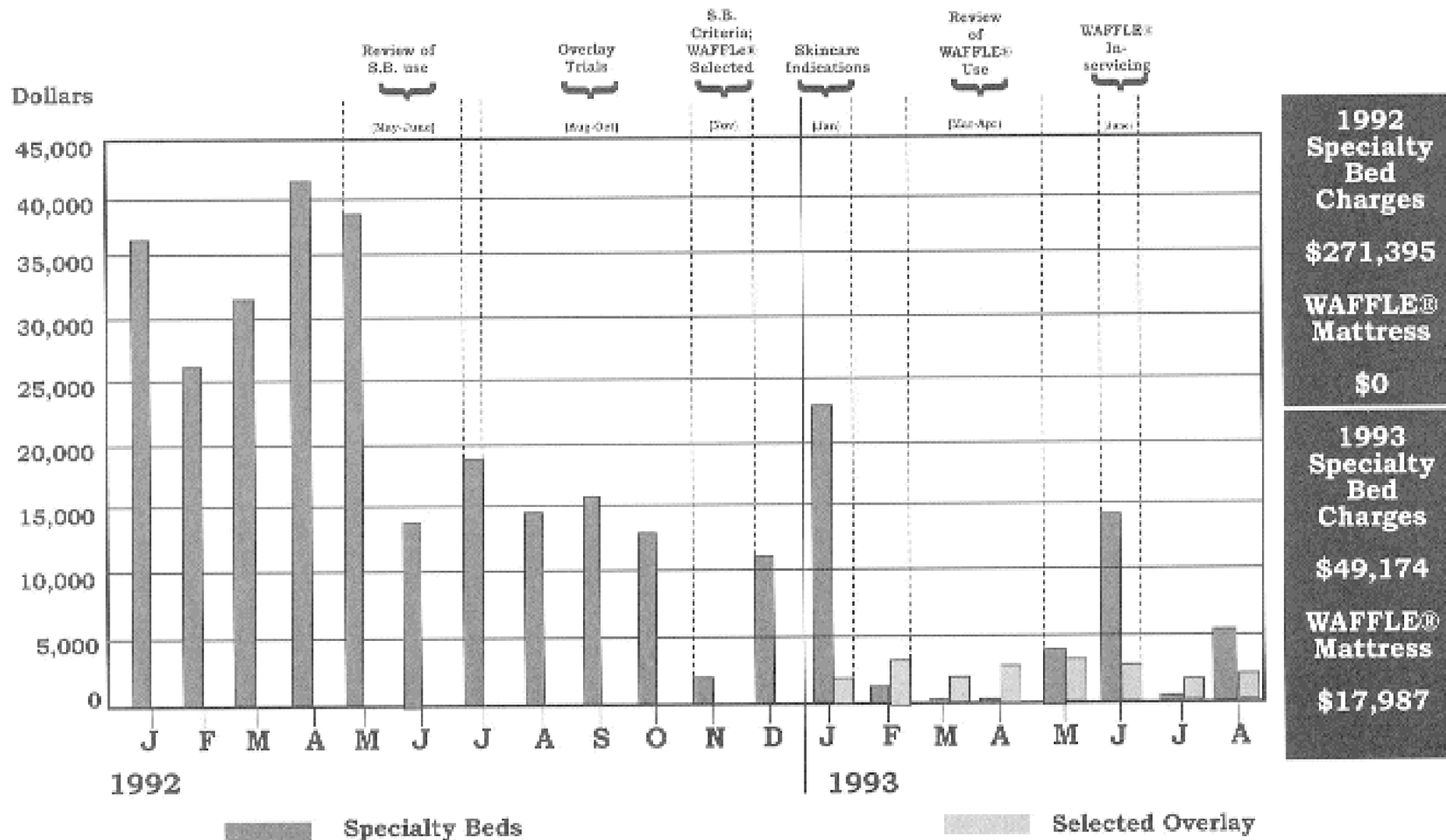
Average Days on Specialty Bed Per Patient

Factors Affecting Specialty Bed Usage



Charges For Specialty Beds and WAFFLE® Mattress

1992 - 1993 Year To Date



Although other charts show a dramatic decrease in Specialty Bed usage after the implementation of Specialty Bed criteria and overlay education, this chart reflects an increase in charges for January 1993. This is due to the increased length of stay on Specialty Beds in October and December, 1992 and these charges were paid out in January 1993.

Note the total charges for specialty beds and the WAFFLE® Mattress for 1992-1993 in right columns.

Special Thanks

Quality Improvement Council in ICU

Nursing Staff of ICU

Kathy Peoples, Manager of Intensive Care Unit

Deb Swope, R.N., Materials Management

Lou Ann Wright, RN

Barb Wagers, Coordinator Nursing QA

Janet Carter, Quality Review

Dr. McAdams, Critical Care Director

Dr. Reisman, Critical Care Physician

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