Planning for Success

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Abstract

In 1996 Launceston General Hospital (LGH) established a pressure ulcer resource group (PURG) using a small project framework based on Thomsett's [1] small project model. By adopting a systematic and planned framework, the PURG was able to articulate the hospital's, staff's and patients' needs in relation to pressure ulcer assessment, management and prevention. With planning and networking within the organisation, project objectives were successfully achieved. Using a project framework, proposals for the allocation of resources to the value of $165,000, to manage pressure ulcers and wounds, were put to the hospital executive.

Introduction

LGH, a 300-bed teaching facility associated with the University of Tasmania and the second largest public hospital in the state, is situated in the north of the island. Prior to commencement of this project there was anecdotal evidence of an increase in pressure ulcer development. The hospital did not utilise a risk-assessment tool, reporting mechanisms or preventive strategies and guidelines and was unable to identify either prevalence or incidence rates. In other words, there were were no formalised risk management strategies for the prevention of pressure ulcers.

Therefore, in 1995 the PURG was formed. It comprised nurses, a physiotherapist, an occupational therapist and a nutritionist from the acute sector, nurses within the community practising in the areas of wound and continence management and palliative care, and representatives of the University of Tasmania School of Nursing. The committee was convened in June 1996 and adopted the small project framework as a guide to progress on issues related to pressure ulcers and their management.

Thomsett [1] describes a project as encompassing team involvement in the definition of tasks to be undertaken. Most tasks are unique to a particular project and reflect its objectives and outcomes. Project work can change existing processes, create new ones and provide the impetus for what and how organisations do things [1]. Degeling and Anderson [2] state that those who promote change need to create, establish and maintain new coalitions and linkages, encourage new frameworks of meaning and negotiate and establish new forms of practice.

Each stage in the plan will be described, to demonstrate how a framework could be used to prepare similar projects. Applying such a framework, however, does not guarantee the project's success and/or funding, and more work may be necessary to guide it through various processes, which will be discussed. Key people must be kept informed, in order to gain their active sup-port and ensure success. Major components of our project were:

- the introduction of a risk assessment tool and education on its use;
- a pressure ulcer prevalence survey;
- an audit of the condition of the hospital's mattresses;
- the development of a pressure ulcer notification form;
- incidence reporting of pressure ulcers;
- the development of pressure-relieving and pressure- reducing mattress specifications, and
- an audit of pressure-relieving equipment.

Mapping the Project

From the first meeting, a Gantt chart was used to map targets and timeframes for the activities the PURG would undertake in the first 6 months. A useful tool, the Gantt chart uses horizontal bars to illustrate which tasks can be done simultaneously over the life of a project [3]. However, it fails to show which tasks

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depend specifically on another. A staged approach which prioritised the activities of the group was undertaken.

The Small Project Framework

The steps described by Thomsett [1] enhanced understanding of the structured framework within which the PURG operated. Time spent preparing for tasks associated with a project is likely to pay dividends and will help achieve the desired results. According to Pareto [3], 20 per cent of sources cause 80 per cent of any problem. This means that 80 per cent planning and 20 per cent implementation will increase the likelihood of a project's success. Planning helped the PURG undertake appropriate and time-effective activities.

The Steps

Step 1 – acknowledgement

The organisation needed to acknowledge that a pressure ulcer prevention strategy would result in positive outcomes for both it and the patients. In 1995 a discussion document was circulated to all senior clinical nurse managers for review. Nursing management support facilitated initiation of the PURG and the director of nursing acted as the project's sponsor.

Step 2 – establishing the team

By calling for expressions of interest throughout – and targeting key people within – the organisation and community, the team was established. Membership was not limited to any specific number from clinical areas – some produced three or four participants. Membership was thus fluid and all interested staff were welcome.

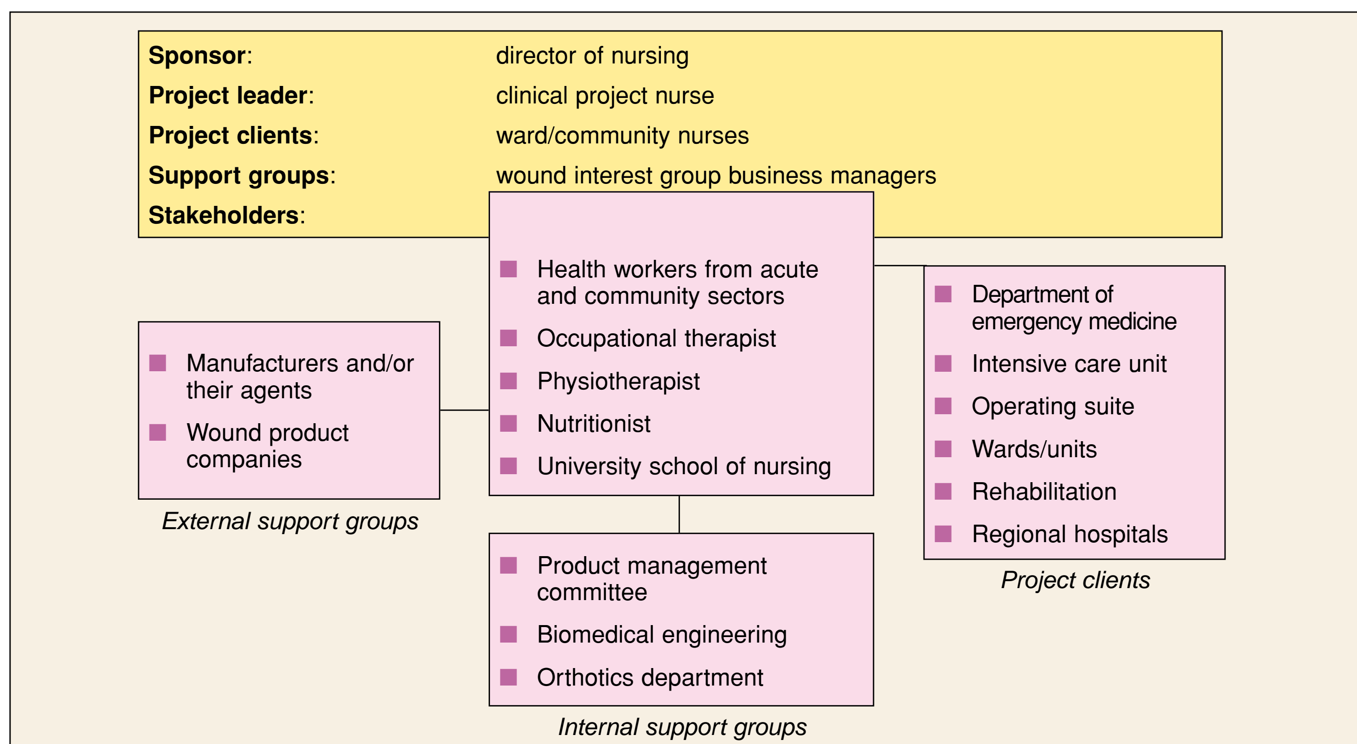
Step 3 – team roles

The committee was required to define the scope of the project and its objectives and formulate a project plan. Within the group, the following key personnel, and their respective roles, were identified:

- **project sponsor** – responsible for project resourcing, costs incurred and its overall success;
- **project leader** – accountable for project outcomes;
- **project clients** – those affected by the change;
- **support groups** – those providing specialist support to the project team (either internal or external to the organisation);
- **key stakeholders and team members** – those directly involved in undertaking project tasks, whose service is vital to the project and who are a pivotal link to the clinical areas.

Table 1 identifies key support people in the organisation at the commencement of the project. A multidisciplinary group

Table 1. The PURG.



provided invaluable insights into the role of other health professionals and enhanced networks both within and outside the organisation [4, 5, 6].

Step 4 – defining the scope of the project

This involved defining the project's boundaries and, in so doing, clearly defining what it sought to achieve. This helped the group stay focused on the project's overall objectives.

Step 5 – defining project objectives

The objectives and desired outcomes, which were put in writing, were specific and measurable, and the terms of reference (Table 2) guided the group during the life of the project.

Step 6 – project risk assessment

Committee members identified factors that could affect the success of the project. These included dysfunctional teams or individuals, differing levels of knowledge and skills and perceived and actual reactions to change.

Step 7 – strategic planning

This provided an identifiable plan for the life of the project. As each activity was undertaken, key members were asked to become involved in smaller subgroups to carry out or supervise activities and assist in producing a written report.

Step 8 – task identification and estimation

Brainstorming within the group allowed key members greater involvement in the tasks to be undertaken and specified who should complete them. Matching group members' expertise and skills took into account estimates of the time required to achieve planned activities and goals.

Table 2. Terms of reference for the PURG.

Role

To develop, implement and evaluate a pressure ulcer prevention policy within the northern region.

Terms of reference

- Develop a project timeframe, roles and responsibilities and reporting mechanism for team members.
- Develop a pressure-ulcer prevention policy based on best practice.
- Implement pressure-ulcer prevention guidelines in the northern region.
- Evaluate the pressure-ulcer prevention program in the northern region.

Step 9 – project schedule

For sequencing and allocation of tasks to members and stakeholders, activities were structured in three separate stages and a new Gantt chart used for each. This simplified the list of activ-ities and illustrated for members their successful completion. Task networks and critical paths were used to monitor activities.

Step 10 – project stabilisation

The team provided open-ended consultation and education on, and support for, changes and procedures.

Step 11 – project tracking

This was useful for determining whether estimated timeframes were too short or too long. Allowing for manageable flexibility in order to reschedule activities does not indicate poor performance on the part of the group.

Step 12 – project reporting

At the completion of each activity or on reaching a milestone, a report was submitted to the director of nursing, the project's sponsor. Reports and minutes contained detailed project plans, variations to those plans, team actions and requests for action.

Step 13 – post-implementation review

This period marked the end of the project but not necessarily the end of the group. As the level of consultation declined it became time to measure the success of the project.

It is important to note than when a project is underway, any new ideas generated – and which could themselves lead to the implemenatation of another project – are best deferred. Other-wise, there is a tendency to incorporate them into the existing project and thereby impose unachievable timelines. To avoid losing the ideas and members' commitment, the setting up of a separate project is advisable in such a situation Having acted on a variety of business plans which used a small project framework, LGH's executive approved the provision of $165,000 to fund the project. This led to the purchase of pressure-relieving and -reducing mattresses and duvets and the establishment of a wound care clinic.

Discussion

The first activity commenced – that of ward/unit-based eduction related to pressure-ulcer risk assessment – was under-taken by PURG members. While no pre-education research was carried out within the organisation to evaluate staff nurses' knowledge of pressure injury, it became apparent during the inservice and education sessions that many had only limited knowledge of, and clinical practice in, pressure management. A review of the literature supports the notion that, through edu-cation, nurses can increase their knowledge of, and implement, prevention strategies [5, 6, 7].

The Waterlow risk assessment tool was selected, primarily for its ease of use. While it has been reported in interrater reliability tests [8] to over-predict risk, its use has been instrumental in providing definitive assessments. Flanagan [8] has noted that the inconclusiveness of studies examining the validity and reliability of various risk assessment tools is worrying and makes selecting a definitive score virtually impossible.

PURG members provided the clinical link and accepted res-ponsibility for introduction of the risk assessment tool in their clinical areas. Inservice on the Waterlow risk assessment tool included the aetiology and staging of, and management and prevention strategies for, pressure ulcers. The need for a hospital-wide incident form for notification of pressure ulcers was identified early in the project, and risk assessment was documented on patient risk-assessment charts, wall charts, critical paths and nursing care plans. Once designed, the notification form incorporated a diagram of pressure ulcer stages 1 to 5, with descriptions of correct staging, data considered important for accurate incident reporting.

The next step was to identify mattresses in use in the hospital, the condition of which made them unsuitable for use. An audit of all mattresses was undertaken over several days, with their condition evaluated by assessing the continuity of and repairs to covers, and any 'bottoming out' and/or hardness. The manufacturer and type of mattress were also noted. A method of testing for bottoming out, as described in the literature [9], was used. Each mattress was labelled by ward and numbered, to assist in any replacement program. The audit revealed that near-ly 50 per cent of the mattress stock needed replacing.

Literature on the need to evaluate hospital mattresses prior to their purchase was supported by limited objective data to assist prospective purchasers [10-14]. No Australian standard for hospital mattresses was identified. The United Kingdom was also deficient in the application of standards, apart from fire-retardant properties. Criteria for the selection of replacement mattresses were developed and expressions of interest from hospital mattress manufacturers called for. Companies were asked to supply research material to support their product claims. Each mattress was then assessed against the PURG criteria. Eventually, the purchase of Vernon-Carus Transfoam 5 TM matt-resses was recommended.

An audit of the pressure-relieving/-reducing equipment available in each clinical area was also undertaken. Recommend-ations as a result of this report highlighted the need to continue inservice education, to help nurses define the difference be-tween pressure relief and reduction. Broken and unsuitable equipment such as foam rings was disposed of and further pur-chases of foam overlay toppers and sheepskins cautioned against.

Selection and purchase of pressure-relieving devices was made on the basis of each product's ability to meet stipulated criteria, as well as evidence from published evaluations. The number of patients identified as at risk in the first prevalence survey in November 1996 formed the basis for determining the number of pressure-relieving mattresses required within the hospital. The recommendation that 10 AlphaXcell TM and four Nimbus II TM mattresses be purchased from Huntleigh Health-care was subsequently accepted.

Prior to introduction of the new pressure-relieving systems, the then current guidelines for risk assessment, critical paths for preventive interventions and the management of pressure ulcers, and tools for product selection and use were collated to produce a chart (Huntleigh Healthcare kindly agreed to cover the cost of printing this). Distribution of the chart to clinical areas coincided with the launch of and inservice for these mattresses, with hospital aides and ward areas receiving additional inservice on their use and care of the devices. Further, a system of borrowing from the central store and sterilising department was put in place to enable equitable access of equipment, as determined by the criteria for use. The Waterlow risk assessment score provides the main criteria for mattress selection, with the addition of the following – the patient's weight and the presence of any pressure ulcers (and, if so, its or their stage(s)).

Tasks still to be completed by the PURG include developing guidelines for pressure relief/reduction for heels and seating. A process similar to that used for pressure-reducing and -relieving mattresses is underway, to review the types of products available. The introduction of a four-stage pressure ulcer system [15]

has now been completed and should enable the organisation to grade ulcers uniformly for both prevalence and incidence reporting. Completion of these tasks will see the end of the project, with all goals achieved. The PURG will continue to meet and review products, audit existing equipment, determine the incidence and prevalence of pressure ulcers and maintain an awareness of pressure ulcers and risk assessment strategies.

Conclusion

While the principles of Thomsett's project framework [1] can be applied universally and will facilitate a project plan, they are no guarantee of success. Putting forward a well-written business plan is vital in garnering support for a project from those with influence within an organisation. A multidisciplinary work group is also critical to a project's success. That group should have in place reporting mechanisms to outline its actions to clinical members and heads of departments.

During the planning process, seek within the organisation those with the skills necessary to assist the project. Support and advice often come from unlikely sources. Finally, do not be afraid to ask for help – it may come from within the organisation or through networking by 'phone or fax with others interested in and/or working on the same subject.

Using a systematic and planned framework, the PURG was able to articulate its goals through strategic planning and networking within the organisation. It successfully competed for fiscal resources, implemented the project and achieved the majority of its objectives. Nurses at LGH have made a difference through acts of commission rather than omission. By focusing on strategies for better access to and management of patients with or at risk of developing a pressure ulcer, they ensured that the organisation as well as the patients benefited from appropriate resource management.

Acknowledgements

We thank key members of the PURG for their commitment and effort; also Fiona Stoker, Director of Nursing, and AC Professor Berni Einoder, former Chief Executive Officer, for believing in and supporting the project.

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Notices

AGM of AWMA

The next AGM of the AWMA takes place at 0800 hours on Saturday, 22 May 1999 at the Adelaide Convention Centre.

Change to Constitution

Motion that Rule 4 section to be changed to read "Committee shall comprise 17 members."

"Seven state representatives ... "

New South Wales
Australian Capital Territory
Northern Territory (one representative)
Queensland
Western Australia
Tasmania
Victoria
South Australia

Moved by Linda Murray (Western Australia); seconded by Jeff Rowland (New South Wales).