GOLD STAMP: Action Plan and Outcomes
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NYS Health Foundation: Gold STAMP
Collaborative NYC #2

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Collaborative Coordinator: Brendez Wineglass

Collaborative Action Plan for Pressure Ulcer Quality Improvement

1. Findings from Organizational Profiles: Self-Assessment of Key Processes Tool: (Common Organizational Gaps)
   - Four organizations responded “No” to communication of all contributing risk factors during transitions within the organization and across settings.

2. Identified Areas for Improvement (prioritized by level of importance):
   - Common to all or most in collaborative/subjects of Aim statements
     - Compliance with use of the communication tool to communicate contributing risk factors during transitions within the organization and across settings.
     - Need for a process to engage physicians in pressure ulcer improvement.
     - Communication with the family about the patient’s/resident health status and pressure ulcer-related risk factors, clinical goals, plan of care, and the family’s expectations.
Collaborative Action Plan for Pressure Ulcer Quality Improvement

3. Identified Strengths in Current Process/System:
   - All organizations are using the same Pressure Ulcer Communication Tool
   - All organizations are using the Braden Risk Assessment Tool

4. Aim Statement(s): (common collaborative goal(s))
   - Develop a process for use of the standardized communication tool and achieve 100% compliance in transfers from the Gold STAMP pilot units.
   - Develop a process to engage key members of the interdisciplinary team during transfers and ensure 100% of patients/residents in the Gold STAMP pilot units go home with needed pressure ulcer relief equipment.
   - Engage every organization’s Physician Champion(s) in collaborative meetings and dialogue regarding pressure ulcer improvement.
   - Develop a process to involve and educate all available family members regarding the patient’s/resident’s health status, pressure ulcer-related risk factors, clinical goals, and plan of care, and clarify the family’s expectations.

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**Action Plan**

**Intervention Actions (Prioritized):** (Collaborative actions need to be addressed by all organizations)

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible Persons</th>
<th>Monitoring Approaches (and Frequency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify all contacts for residents in each facility.</td>
<td>Organizational leaders</td>
<td>Track the number of patients with difficulty reaching key contacts at another facility/monitor monthly.</td>
</tr>
<tr>
<td>Increase usage of care with use of PI Communication Tool as an interdisciplinary team.</td>
<td>Wound Care Physicians and the Home Care Wound Care Nurses</td>
<td>Track the number of patients’ initial contact with the interdisciplinary team. Monitor monthly.</td>
</tr>
<tr>
<td>Discuss strategies to improve coordination between clinicians and monitor if needed.</td>
<td>ALL RNs, Wound Care Providers, Home Care Wound Care Nurses</td>
<td>Track the number of months’ worth of communication/monitor monthly.</td>
</tr>
<tr>
<td>Identify key family members to be involved in the development of care including discharge planning and on-going follow-up care.</td>
<td>Nurse Managers, Wound Care Nurses, and Physicians</td>
<td>Track the number of times a patient/ resident is contacted without equipment. Monitor monthly.</td>
</tr>
<tr>
<td>Identify subcommittee members who will be responsible for discussing and planning the process to ensure that the patient is in the patient’s home prior to discharge.</td>
<td>Organizational leaders</td>
<td>Track the number of months’ worth of subcommittee meetings. Monitor monthly.</td>
</tr>
<tr>
<td>Schedule a meeting among sub-committee members to discuss a process to ensure patients/ residents go home with needed pressure ulcer relief equipment.</td>
<td>Alliance Members</td>
<td>Track the number of times a patient/ resident and family are contacted prior to discharge for the subcommittee meetings. Monitor monthly.</td>
</tr>
</tbody>
</table>

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**Action Plan (Continued)**

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Evaluation: Examples

Responsible Person(s): All Collaborative Participants.
Results: Finalized collaborative action plan and key contacts list distributed to team Members.

Review of Plan: Re: DME Sub-committee met and discussed a process to ensure patients/residents go home with needed pressure ulcer relief equipment.
Responsible Person(s): Collaborative participants.
Results: Timeline extended to complete the finalized process.

Review of Plan: Re: Improving communication between Hospital Wound Care Consultants and Home Care Wound Care Nurses.
Responsible Person(s): Collaborative Participants.

Collaborative Outcomes

✓ Standardized PU Communication Tool used by all organizations, compliance during transfers improving
✓ Braden scale used by all organizations
✓ Strong Collaborative Coach (Kathryn Santos)
✓ Commitment and consistent participation by all organizations at the meetings;
✓ 2 Physician Champions attended 2 meetings
✓ Email address: goldstampconsortium@kingsbrook.org
✓ Pressure Ulcer Response Team (“PURT”) dedicated ext. 7878 to begin bedside consultations on 6/3/13
✓ Pressure Ulcer Fair (TBD)

Results

Kingbrook Jewish Medical Center

![Graph showing HAPU rates per 1000 patient days by quarter 2012]
Thank You!