Objectives

The main objective of this study is to define current practice variations in VA facilities within VISN 1 from clinical practice guidelines developed by the Consortium for Spinal Cord Medicine on prevention of pressure ulcers (PU) following spinal cord injury (SCI).

We will also define determinants of this variation and identify compliance barriers and facilitators and propose interventions to promote adherence to guideline recommendations Research Design

Spinal Cord Injury care is an area of special emphasis in the VA. It is estimated that there are 250,000 persons with SCI in the US, and 10,000 more sustain these injuries annually. About 40,000 of these are veterans eligible for VA care. Pressure Ulcers are a frequent and costly complication of SCI and it is estimated that 50-80% of persons with SCI will develop a pressure ulcer. Although mostly preventable, pressure ulcers can be potentially life threatening, and often result in prolonged hospitalizations. Guidelines for pressure ulcer prevention following SCI have been developed and the Consortium for Spinal Cord Medicine has published evidence-based clinical practice guidelines on Pressure Ulcer Prevention and Treatment Following Spinal Cord Injury. This was accomplished through a stringent process involving literature search and rigorous evidence analysis. The extent to which guidelines are implemented and related barriers are unknown. Although these guidelines were published in 2000, there are no reports of efforts to address practice variations from these guidelines. Our plan is to use patient interviews, chart reviews and provider focus groups to identify barriers and facilitators to pressure ulcer prevention and guideline use.

Methodology

We will:

Use administrative databases to identify the target SCI patient population in all VISN 1 facilities. Modify a chart abstraction tool previously developed for assessing compliance with PU prevention in nursing home patients to make it specific for use with SCI.

- Use this tool to review medical records of 100 patients with SCI to determine provider adherence to PU prevention guidelines.

- Assign a trained observer to conduct focused observations for certain elements of the guidelines e.g. to observe for compliance with specific elements recommended for positioning patients with SCI in bed, and for assessing adherence to the recommended use of special support surfaces.

- Conduct focus groups with providers to identify barriers to implementing guidelines and to determine best practices.

Perform patient interviews including those with and without pressure ulcers to determine differentiating factors between the two groups that contribute to successful prevention of PU.

Document crucial elements of non-compliance with guidelines in current practice.

Define implementation strategies based on identified barriers and determine operational requirements.

Utilize information gathered in this project to develop another proposal for submission at the end of the 6-month period to implement identified interventions to promote compliance with guideline recommendations and disseminate information and lessons learned for integration of successful interventions into VA policies and procedures related to care of veterans with SCI. Findings There are no findings as yet.