Decreasing Hospital Acquired Pressure Ulcers (HAPU) Through the Implementation of an Evidence-Based (EB) Prevention Bundle

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Background

Patients with pressure ulcers (PU) have poor outcomes, including severe pain.1
- Approximately 60,000 patients die from pressure ulcers each year.1
- Patients with darkly pigmented skin have a significantly greater risk of pressure ulcer (PU) development2 and are more likely to die than patients with light skin.2
- The development of HAPU can have a significant financial impact to healthcare organizations including loss of payment and potential litigation.
- Medicare does not pay for hospital-acquired Stage III-IV pressure ulcers.3
- The cost of a Stage IV HAPU patient averaged $129,248 during 1 hospital stay.4
- Pressure ulcer lawsuits are second only to wrongful death with more than 17,000 pressure lawsuits filed each year.1
- HAPU is a harm event identified as a key measure of quality in the UCM Annual Operating Plan.

The Intervention

An analysis of current practices, processes and outcomes was conducted by the WOCN (RN). The WOCN led a SWOT analysis of current HAPU prevention interventions with a team of staff RNs from units throughout the hospital. This analysis confirmed areas of strengths, weaknesses, as well as areas where opportunities or “quick wins” might occur. Based on this analysis a comprehensive, EB HAPU Prevention bundle was developed and implemented.

1. Comprehensive Skin Assessment
- Improve differential assessment of PU in dark and light skinned patients
- Improve differential assessment of PU vs Moisture Associated Skin Damage (MASD) as MASD is often misidentified/staged as a PU
- All new RN hires receive training on differential assessment
- 1,059 RNs received Computer Based Training (CBT) on differential assessment
- 486 RNs attended in-service training on skin assessment/differential assessment

2. Perform Routine Pressure Ulcer Risk Assessment
- Increase awareness of subscale score as an indicator of risk
- Improve identification of additional risk factors
- Tailor prevention interventions to Braden Subscale
- All new RN/NSA hires receive training on Braden Scale/PU prevention
- 1,159 nursing staff (RN/NSA) completed the CBT on Braden Scale/PU prevention
- 1 hour pressure ulcer prevention course completed by all NASAs
- 486 RNs attended in-service training on Braden Scale/PU prevention

3. Management of Moisture
- Briefed used to contain incontinence can lead to MASD and increase risk of HAPU development
- Lack of incontinence pad to wick moisture
- Disposable incontinence pad trial underway

4. Repositioning
- Lack of wedges, pillows for repositioning
- Positioning wedges obtained for inpatient units
- To reduce incidence of Stage III-IV due to shearing force
- Increase staff awareness of silicone dressing protocol
- Evaluate inclusion criteria which is currently too restrictive
- Working with Purchasing to evaluate alternative dressings and cost
- HAPU Awareness/Root Cause
- Create formal process for analysis/reporting
- WOCN analyzes each HAPU occurrence from Prevalence Survey
- 8. Education/Awareness of Patient/Family Member
- Create patient/family education brochure
- Brochure created and distributed
- 9. Redesign of Skin Care Team
- Evaluate role/requirements of Skin Care Team members
- Didactic and clinical training planned for all members including competencies
- 10. Validation of all identified HAPU/MASD during Prevalence Survey
- Perform WOCN validation to increase reliability
- Beginning January 2014, validation of all patients identified during survey

Aims

- To reduce the prevalence of HAPUs to below the National Database of Nursing Quality Indicators (NDNQI) 25th percentile for academic medical centers

Total # Patients with a HAPU Pre- and Post-Bundle Implementation

HAPU Rates

Results

- Following implementation of the EB Prevention Bundle, consistent decreases in HAPU rates were noted month over month.
- Outperformed 25th percentile March/April 2014
- MASD has been identified as a clinical challenge, which if not addressed will effect the successful reduction of HAPUs.

Lessons Learned

- A comprehensive EB Prevention Bundle can effectively decrease the prevalence of HAPU.
- Multiple methods of education may be necessary to implement an EB bundle (e.g., CBT, in-services, posters, Skin Care Team/unit level champions).
- The validation of potential MASD/HAPU by an experienced WOCN was successful in not only identifying the high prevalence of MASD, but also in accurately portraying the prevalence of HAPU.

Next Steps

- Implement EB Prevention Bundle in the adult ED and Peri-Operative Services areas.
- Tailor EB Prevention Bundle for specific patient populations (e.g, transplant, critical care, etc.).
- Develop EB Prevention Bundle for pediatric population.

References:

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