Digging Deeper: Attempts to Achieve an Irreducible Minimum of Hospital Acquired Pressure Ulcer Rates

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Background

Pressure ulcers are defined by the National Pressure Ulcer Advisory Panel (NPUAP) as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. Pressure ulcers are a common condition, affecting an estimated 3 million adults in the United States. In 2006, pressure ulcers were reported in more than 500,000 hospital stays.

- Estimates of pressure ulcer prevalence in acute care ranges 4.7% to 32.1% .
- Centers for Medicare and Medicaid Services (CMS) financial consequences for hospital acquired pressure ulcers have provided incentive for acute care facilities to focus on preventative measures and protocols.
- CMS and The Joint Commission (TJC) reporting mandates has resulted in hospital's increasing innovative strategies in pressure ulcer prevention programs. Many acute care facilities have successfully implemented national guidelines and tool kits within their organization improving HAPU rates. The question now is what else can organizations do beyond this to drive rates to an irreducible minimum?

Purpose

Implementation of evidence based guidelines has translated into improvement at Virginia Commonwealth University (VCU) Medical Center; a level 1 trauma Magnet certified, academic medical center in Richmond, Virginia. The HAPU point prevalence rate was 8.1% in 1Q2007 and five years later is 2.3% in 1Q2013.

- 2013 monthly data collection January – September range is 3.06% - 1.58%.
- To achieve these goals it was necessary to move away from simple unit based quality improvement projects and instead facilitate sustainable reductions via organizational culture change.

Method

Through the creation of the Champion of Skin Integrity (C.S.I.) unit based skin champions team, the HAPU strategy team and collaboration with our WOC Team, house-wide HAPU reduction strategies became comprehensive. They included:

- Monthly prevalence studies
- Facility Wide and Unit Specific Mandatory PUP Competency Education: "HAPU Train-the-Trainer" Program
- ICU skin bundle implementation
- Protocol driven prophylactic use of dressings
- 100% pressure redistribution mattresses throughout the hospital
- Stretcher & OR table upgrades
- EMR enhancements capturing present on admission PU
- Daily risk and skin assessments
- Patient education tools.
- Care Partner Education: "Back to Basics"


Back to Basics: Care Partner PUP Program


CSI Team Monthly Data Collection Strategy


DO YOUR PART. Patient/Family Pressure Ulcer Education. Used when patient's refuse to turn as part of the escalation of care and documentation package for refusal.


HAPU Train-the-Trainer unit specific competency education

From Traditional PUP Strategies to Sustained Change: Focused Interventions via Culture Change

While achieving sustained reductions in HAPU over the past fiscal year and in an effort to help prepare us for more stringent upcoming healthcare reform regulations, our primary emphasis has shifted from a traditional prevention program to a targeted, detailed focus, specifically:

Digging Deeper: Culture Change to Sustain HAPU Reduction

Device Related HAPU:
- Using monthly data to identify areas in need of focused interventions.

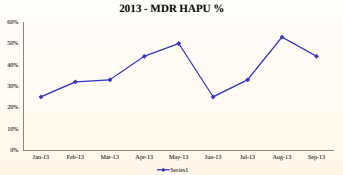
Unique Partnership with the Operating Room:
- Monthly, announced rounds with MD Director of the OR and WOCN.
- Evaluate safe positioning, use of protective H.O.L.Ds, Mepilex Border ® products for prevention, and occipital offloading.

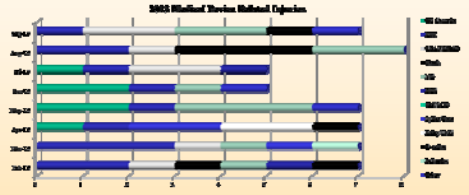
Hospital Acquired Pressure Ulcer M&M Rounds:
- WOC Nurses prepare and present HAPU M&M rounds to multidisciplinary staff on nursing units to draw attention to unit specific cases and stimulate interaction and develop actions plans. This activity doubles as a required competency for the WOC Nurses.

Procedural & Diagnostic Area Pressure Ulcer Prevention:
Endoscopy, dialysis, interventional radiology, and the emergency department are all represented now on the CSI Team.
- Specific pressure ulcer educational competencies were developed for staff working in these areas.
- Patient's skin risk score and status are part of the handoff communication.
- Endoscopy nurses have implemented a practice change of turning patients every 2 hours pre and post procedure and application of barrier cream.
- Wedges and extra pillows for positioning are now available on supply carts in short stay areas and pressure reducing mattresses have been purchased for procedural tables.

Pre-Bill Chart Review on all HAPU by Coders & WOC Team:
- The WOC Team has partnered with the coding department to review every chart coded with at Stage II, III, or IV hospital acquired pressure ulcer at time of discharge for accuracy.
- Discrepancies are cross checked with the provider of record for validation. This verification process ensures clinical confidence in the publicly reported data.

Executive & Nurse Manager Accountability for Unit Acquired/Avoidable HAPU:
- Annual performance evaluations and salary raises are linked to patient outcomes.
- The Nurse Managers are held accountable for maintaining unit based pressure ulcer rates below the NDNQI benchmark through disclosure of unit specific HAPU rates on individual annual evaluations.





Conclusion

Once a standard pressure ulcer prevention program is implemented and hardwired into a health system, further HAPU reduction requires focused attention.

- Routine and effective data collection , using a customized data collection tool is necessary to guide interventions toward areas of need in your facility.
- PU point prevalence studies should be at least monthly. Our EMR is currently being utilized to also create a daily HAPU rate.
- Initiating action in each area requires oversight, strategy, and buy-in from area management guided by the WOC N team.
- The involvement of the EXECUTIVE TEAM to ensure culture change, plus a facility wide focus must occur to achieve a sustained irreducible minimum HAPU rate.

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