WHAT’S THE PROBLEM WITH PRESSURE ULCERS?

- **PAINFUL** for the patient
  - Cost $355,471,200 for Wisconsin

CURRENT PREVALENCE AND COST DATA FOR PU

- Prevalence rate for hospitals: 7% hospital-acquired pressure ulcers
  - In Wisconsin = 32,914 patients
- Rate of pressure ulcers in long term care: 12%
  - In Wisconsin = 3,876 residents
- COST: $10,845 Medicare extra payment for PU
  - Hospital prospective payment system per patient (Zhan, et al., 2006)
CURRENT RESEARCH DATA

- Causes endless pain & a restricted life (Hopkins, et al., 2006; Spilsbury, et al., 2007)
- More RN hours per patient day decreases adverse events (Saleh, 2008)
- Need to simplify current PU interventions (Hagle & Senk, 2008)

WHAT IS A PRESSURE ULCER?

- A localized injury to the skin and/or underlying tissue usually over a bony prominence or vulnerable pressure points, as a result of pressure, or pressure in combination with shear and/or friction (2007 NPUAP)
  - May also be injury to the skin under medical devices (TJC, NDNQI)
- The tissue injury and destruction is a result of soft tissue compression, which interferes with the tissue’s blood supply, leading to vascular insufficiency, tissue anoxia, and cell death.

WHO WANTS TO KNOW ABOUT PU?

- CMS
- The Joint Commission
- National Quality Forum
- Medicare
- IHI, Leapfrog
- ANA
  - NDNQI, Magnet
- Patients
- Quality organizations, Administration, Nurses
NATIONAL INITIATIVES – CMS FOR HOSPITALS AND NDNQI
- All inpatient admissions
  - Electronic data based on physician documentation and Present on Admission flag
  - PU Stage based on nursing documentation
- October 1, 2008 – Hospital acquired, Stage III or IV
- All PU are coded; reimbursement issues: Stage III or IV
- NDNQI: National Database for Nursing Quality Indicators
  - Benchmarking

NATIONAL INITIATIVES – JOINT COMMISSION (TJC) AND AHRQ
- TJC: Pressure ulcer prevalence: hospital-acquired
- AHRQ: Decubitus ulcer; rate per 1,000 discharges

NATIONAL INITIATIVES – IHI: INSTITUTE FOR HEALTHCARE IMPROVEMENT
- Percent of at-risk patients receiving full pressure ulcer preventive care (Must meet all of following):
  - Daily inspection of skin
  - Proper management of moisture
  - Optimize nutrition
  - Reposition every 2 hours
  - Use pressure relieving surfaces
STATE INITIATIVES:
WISCONSIN PRESSURE ULCER COALITION

- Prevention of pressure ulcers across the continuum of care accomplished by involving providers from all communities of practice to participate in a one-year initiative that emphasizes ways to prevent pressure ulcers across settings.

- Sponsored by:
  - MetaStar – WI Quality Improvement Organization
    www.metastar.com

STATE INITIATIVES: PRESSURE ULCER REDUCTION COMMUNITY OF PRACTICE

- Community of Practice:
  - Includes both nursing homes and hospitals
  - Designed to educate providers
  - Encourage the use of evidence-based methodology in pressure ulcer reduction

- Sponsored by:
  - MetaStar – WI Quality Improvement Organization

POINT PREVALENCE SURVEYS

- Survey Definition:
  - One point in time survey (point prevalence) of all inpatients for whole hospital, on one day, for pressure ulcers

- Patient sample:
  - Include: All inpatients of all ages (this includes Observation or short stay patients)
  - Exclude: Women’s health units (Birth Centers, OB, nurseries, or NICU), patient refuses, unstable, off unit

- Hospital-Acquired: Skin breakdown shown to have developed after the time of admission OR any non-documented skin breakdown identified after admission.
WHAT CAN BE DONE NOW

- Conduct regular prevalence surveys
  - Formal: 2-4 times per year
  - Informal: monthly, weekly, daily -- Look at every patient
- Share prevalence data with unit -- ALL caregivers
  - ACT if there are hospital-acquired PU
- Part of unit goals? Annual review?

ACT

- Simplify risk levels: at risk or not at-risk
- Skin assessment as soon as possible
- Braden risk assessment within 4 hours of admission
- Specialty bed or overlay for all patients at risk
- Rounding
- Involve patients and families

ACT

- Inspect skin DAILY
- TURN every 2 hours -- Turning Clock
- Verify pressure ulcer with wound care expert
  - NOT: Perineal dermatitis from incontinence
  - NOT: Venous ulcers, Arterial ulcers, Skin tears
  - NOT: Diabetic ulcers, Surgical wounds
  - NOT: Other non-pressure related skin breakdown
ACT
- Follow-up on ALL pressure ulcers we caused!
- Stage III and IV hospital-acquired PU:
  - Write an incident report or significant event
  - Clinical review in real time
  - Prevent the next one!
- Mattress replacement
- TURN, TURN, TURN
- Skin care if incontinent

WHAT ELSE IS WORKING?
- Surfaces and frames
  - Systematic evaluation and reporting
- QI methodology
  - Days / months until occurrence
  - Rate of turning
  - Use data to make changes, acquire equipment

THANK YOU!
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Appreciation to Aurora-Cerner-UW/Milwaukee:
Knowledge Based Nursing Initiative