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Reducing Hospital Acquired Pressure Injuries on an Advanced Care Unit

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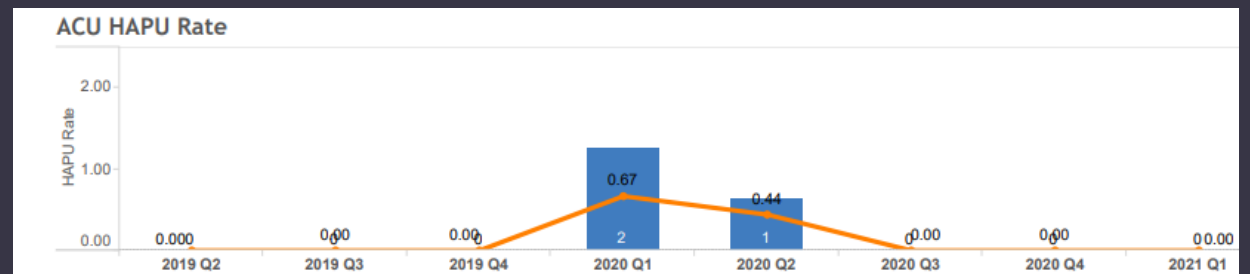
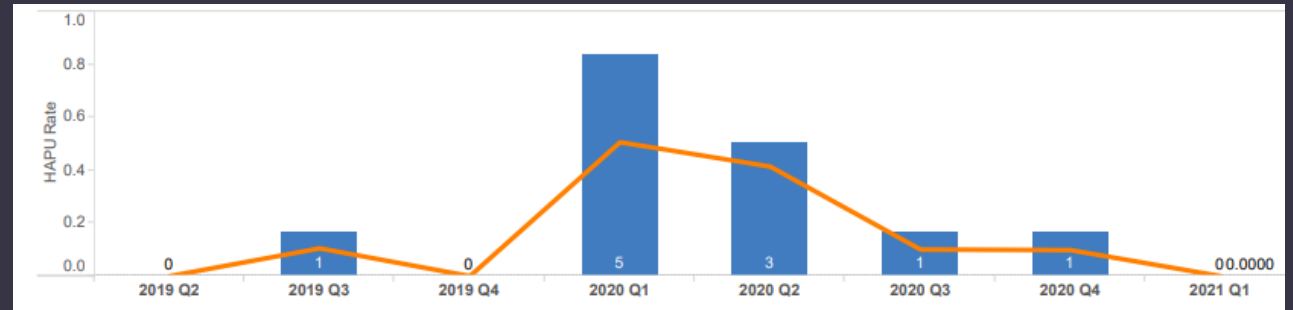
Reducing Hospital Acquired Pressure Injuries (HAPI) on an Advanced Care Unit (ACU)

Dawn Doud, DNP, MSN, RN, PCCN-K

Lynn Stapleton, MSN, RN-BC

Background

- HAPI rates on the ACU increased in early 2020
- National cost of treating HAPI's ranged from \$3.3 - \$11 billion annually (Padula & Delarmente, 2019)
- HAPI events are costly to hospitals
 - \$500-\$70,000 per event (Padula & Delarmente, 2019)



Purpose/Goals

Decrease hospital costs associated with HAPI

Decrease HAPI rates on the ACU

Educate registered nurses on HAPI prevention

Methods

- Root cause analyses conducted by nurse manager and all nurses involved in HAPI events
 - Nurses were assigning different Braden Scores
 - Nurses applied different interventions to protect skin integrity
- Nurse educator developed patient case studies for assigning a Braden score
 - Each nurse responsible to electronically complete this task
- Nurse educator developed comprehensive HAPI education PowerPoint
- HAPI rates and Braden Score case study responses assessed before and after intervention
- Descriptive statistics and independent sample t-tests assessed for changes in outcomes

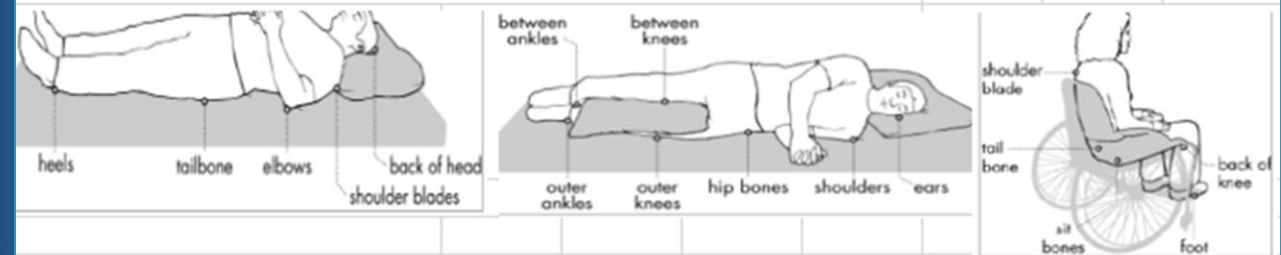
Intervention

- ACU nurses completed pre- and post-intervention Braden scale case studies
- Nurses received education via email and one-on-one meetings with educator
- Two-RN check (Figure 1) implemented for:
 - Patients newly admitted to ACU
 - Patients transferred to the ACU from another inpatient unit
 - Patients with a Braden scale < 18
 - Patients receiving oxygen
- Three months after the interventions, nurses repeated the cases studies

High Risk Skin Assessment

This patient has been identified as high risk for skin breakdown. Please circle yes or no that the following criteria has been assessed. If you unable or unsure of the answer please see your charge or ANM for clarification. We appreciate your diligence to provide optimal outcomes for our patients.

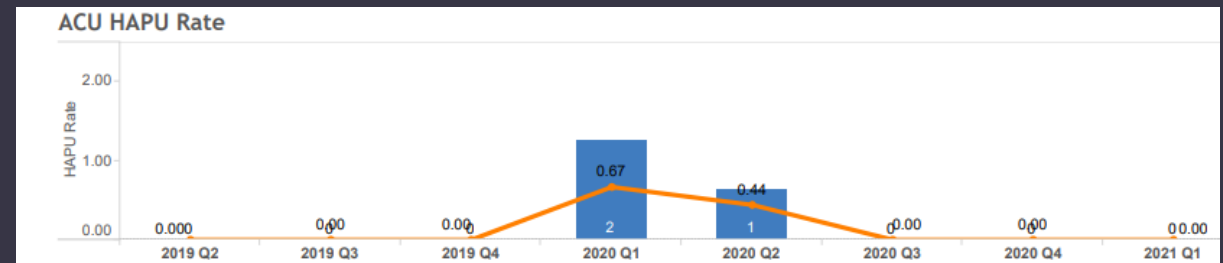
Braden Score complete	Yes	No
Plan of care updated	Yes	No
Nutrition status and daily weight reviewed	Yes	No
Bony prominences assessed and protected as applicable	Yes	No
Bony prominences assessed during bedside report between outgoing and incoming RN	Yes	No
All dressings, ted hose, boots removed unless otherwise ordered every shift for skin assessment, oxygen device areas assessed	Yes	No



Signature _____ Date _____

Outcomes

- HAPI rates on the ACU significantly decreased post-intervention and have sustained over time
- The range in differing Braden scale assessment scores among nurses decreased post-intervention
 - Pre-intervention Braden score for high-risk case averaged 13.1 with a standard deviation of 2.3
 - Post survey Braden scores significantly improved to reflect higher skin risk (m=12.1±1.4, p>0.001)



Implications for Practice

Education on HAPI prevention and a 2-RN skin assessment approach may reduce HAPI's

Nurse leadership and educators may play a role in supporting nursing skin surveillance practices

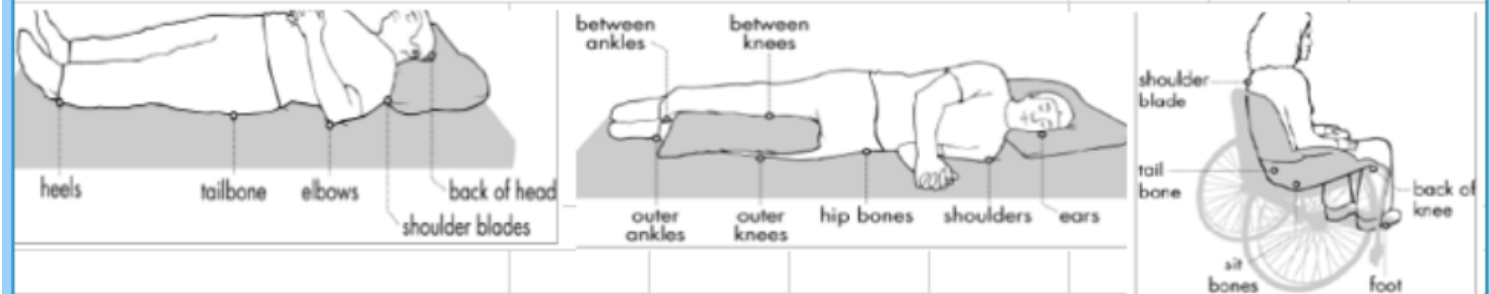
Appendices / Tools

2-RN Skin check tool

High Risk Skin Assessment

This patient has been identified as high risk for skin breakdown. Please circle yes or no that the following criteria has been assessed. If you unable or unsure of the answer please see your charge or ANM for clarification. We appreciate your diligence to provide optimal outcomes for our patients.

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All dressings, ted hose, boots removed unless otherwise ordered every shift for skin assessment, oxygen device areas assessed	Yes	No



Signature

Date

Appendices / Tools

HAPI Investigation Tool

As soon as a HAPI is identified, please complete this information:			
Patient Demographics	Course of Care		Wound Care
Facility: _____	Admit Date: _____ Admit Dx: _____		Date HAPI identified: _____
Patient Name: _____	Where did patient enter facility?		Site and type of HAPI: _____
MRN Number: _____	<input type="checkbox"/> ED <input type="checkbox"/> Imaging <input type="checkbox"/> MOR <input type="checkbox"/> DBS <input type="checkbox"/> Direct Admit to room _____ <input type="checkbox"/> Other		Date of Wound Care Consult: _____
Age: _____	_____		Per Wound Care, stage of HAPI: _____
Unit: _____	Please record the patient transfer history (one unit to another):		Was a Datix completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
List names of the staff involved (last 72hrs of care):	Date: _____ Date: _____ Date: _____		
_____	_____ to _____ _____ to _____ _____ to _____		

Chart Review			
<u>Surgery Procedure:</u>	<u>ADL:</u>	<u>Nutrition:</u>	<u>Skin Assessment:</u>
Patient a surgical patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the pt. ambulating? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the pt. a diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date initial skin assessment documented: _____
Date of Surgery: _____	No If no, what was turning schedule? Q _____ hrs.	Was the pt. on tube feedings? <input type="checkbox"/> Yes <input type="checkbox"/> No	Unit/Location of initial skin assessment: _____
	Is the turning schedule documented? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the pt. on TPN/Lipids? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of RN (initial skin assessment): _____
	Did they have an overlay or specialty bed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the pt. NPO? <input type="checkbox"/> Yes <input type="checkbox"/> No	Braden score day of admit: _____
Model/type of bed: _____		If yes, for what length of time? _____ (days)	Braden score on day HAPI identified: _____
		Did they have a nutrition consult? <input type="checkbox"/> Yes <input type="checkbox"/> No _If yes, consult date: _____	Did the Braden scale accurately reflect patient condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
			If no, please describe: _____

Appendices / Tools

HAPI Investigation Tool

Quality Improvement Review

Please attach any additional documentation/communications/notes

Were skin protection/HAPI prevention measures in place prior to the HAPI identification?

Yes No

What do you believe contributed to the patient acquiring a pressure ulcer?

Please mark any root cause you believe may be related to this event.

Provide a detailed comment for any root cause marked.

Inadequate/Incomplete Patient Assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Inadequate Staff Training/Competency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Lack Staff Compliance with Policy/Procedure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Non-functioning/Incorrect Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Communication/Handoff Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Other		Comment: _____

In your opinion, what actions need to be completed to avoid another patient acquired pressure ulcer?

Questions / Author Contact

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