The Appropriate Care Score: Leveraging Process Metrics to Drive Outcomes

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**Aim**
Decrease the prevalence of Hospital-Acquired Pressure Injuries (HAPI) in an urban academic medical center

**Background**
- HAPIs are a critical nursing quality indicator (Kelleher et al., 2012)
- Evidence-based HAPI prevention in the hospitalized patient begins with foundational nursing care including mobility and moisture management (Kelleher et al., 2012)
- In late 2015, an increase in HAPI prevalence in our hospital triggered initiation of focused improvement work
- Interventions generated from retroactive root cause analysis of severe HAPIs were not effective in reducing prevalence despite intensive work throughout 2016

**Actions Taken**
- Re-focused the team in late 2016 to target foundational, evidence-based, measurable aspects of HAPI prevention care (Kelleher et al., 2012)
- Designed and implemented the Six Simple Steps (SSS) HAPI prevention checklist for all at-risk patients in the hospital setting (Chen et al., 2017)
- Initiated hospital-wide weekly SSS audits performed by unit-based RN skin champions
  - Provided feedback, education and intervention at the patient level in real time (Kelleher et al., 2012)
  - Aggregated data into the actionable, process-based Appropriate Care Score
  - Implemented interventions at the unit and hospital-level based on Appropriate Care Score data (Stadnyk et al., 2018)

**Summary of Results**
- Aggregate Appropriate Care Score increased from 85% to 95%
- Prevalence decreased to 0% (sustained over 2 quarters)

**Discussion**
- Engaging unit-level RN skin champions, certified wound nurses, nursing leaders, patient safety, and senior leadership through weekly dashboards supported visibility and a shared mental model of current state and opportunities
- Improvement work generated from actionable process metrics based on a simple evidence-based checklist was effective in reducing our HAPI prevalence to 0%

**Next Steps**
- Expand on the SSS checklist to include standard interventions for the very high risk patient

**References**
Stadnyk B, Mordoch E, Martin D. Factors in facilitating an organizational culture to prevent pressure ulcers among older adults in health-care facilities. *Journal of Wound Care*, 2018;27(Sup 7):S4-S10.