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)

Braden 18 or less?

Six Simple Strategies to Protect Patients from Skin Injury

Relieve pressure

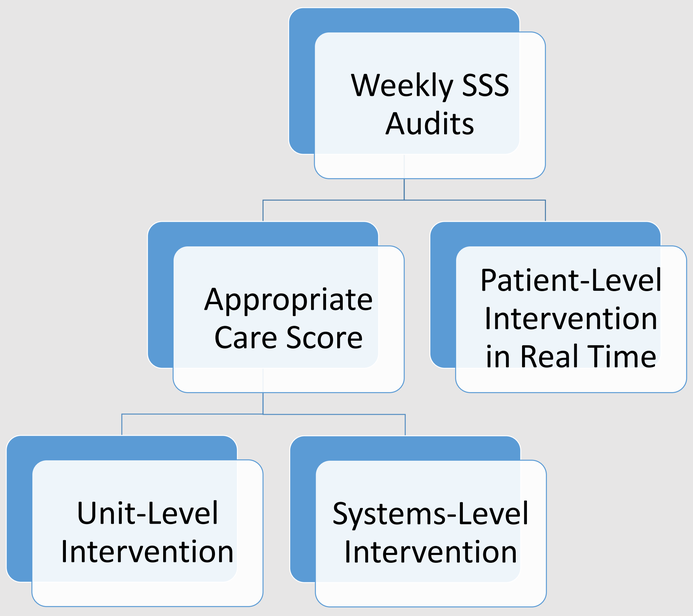
- ☐ Float sacrum and heels in bed (30 degree side-lying position)
- ☐ Offload medical devices
- ☐ Waffle cushion in chair

Reduce moisture

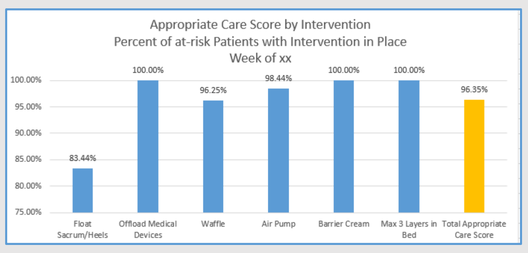
- ☐ Barrier cream for incontinence or drainage
- ☐ Maximum 3 layers between patient and surface
- ☐ Low air loss pump hooked up and turned on

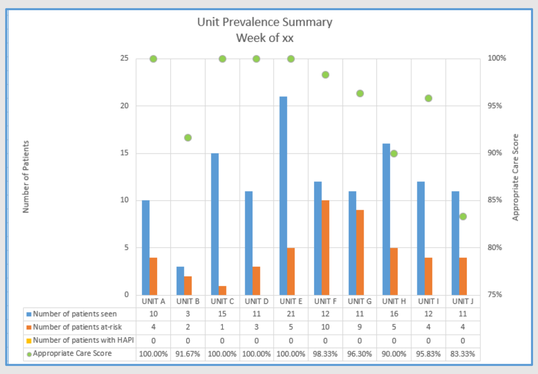
$$\text{Appropriate Care Score (\%)} = \frac{\text{Number of patients at risk for HAPI with SSS in place}}{\text{Number of patients at risk for HAPI}}$$

Process Overview

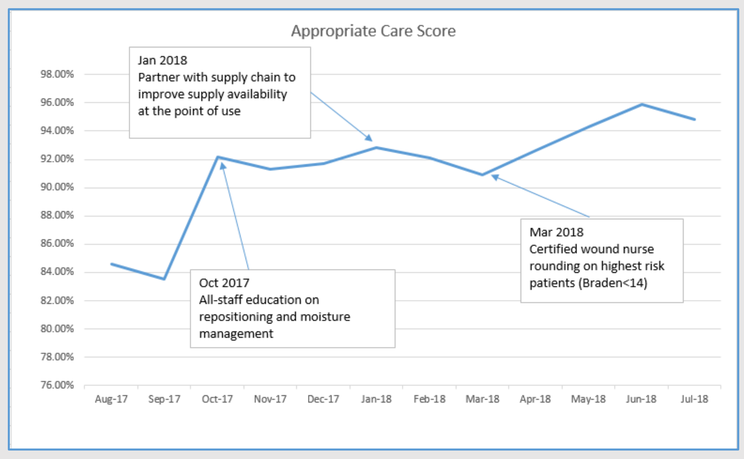


Weekly Dashboards (Example)





Data Tracking Over Time



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 champs, 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

Chen HL, Cao YJ, Shen WQ, Zhu, B. Construct validity of the Braden Scale for pressure ulcer assessment in acute care: A structural equation modeling approach. *Ostomy Wound Management,* 2017;63(2):38-41.

Kelleher AD, Moorer A, Makic MF. Peer-to-peer nursing rounds and hospital-acquired pressure ulcer prevalence in a surgical intensive care unit. *J Wound Ostomy Continence Nurs,* 2012;39(2):152-157.

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.