**Pressure Ulcer Prevention**

Establish standard processes to prevent pressure ulcers (a Centers for Medicare & Medicaid Services "never event").

**Domain**

- **Patient Care Processes:**
  Clinical processes that ensure delivery of high-quality care to individual patients

**Aims**

- **Patient Centered:**
  Care throughout a patient's experience that is coordinated, informed, and grounded in respectful interactions with care providers that are consistent with the patient's values, expectations, and care decisions

- **Safe:**
  Delivery of care in a manner that minimizes any risk of harm to a patient

**Process Attributes**

- **Cost to Implement**
  The monetary resources required to implement this process
  - **Minimal:** Just the cost of the improvement effort itself

- **Time to Implement**
  The amount of time, from months to years, it will take on average to establish this process
  - **Fewer than 12 months**

- **Difficulty to Implement**
  The challenges of implementing this process
  - **Most Challenging:** Involves multiple units or disciplines AND requires a substantial shift in culture and/or operations

- **Level of Evidence**
  The degree to which the actions in this process are supported by research and experience; based on the Cochrane scale
  - **Some Evidence:** Level III — Studies published with some control included
Details

Elements

- Conduct a pressure ulcer admission assessment for all patients
  - Perform an admission risk assessment on every patient.
  - Include reliable, detailed skin assessment for all patients.

- Reassess risk for all patients daily
  - Use a standardized tool to assess risk for all patients, at all levels of care.
  - Use visual cues to identify patients at risk, such as stickers on charts, logos on door and on the chart, etc.
  - Standardize interventions for at-risk patients.

- Inspect skin daily
  - Standardize documentation tools to ensure details of assessment are documented consistently.
  - Develop a process for daily skin assessment, and allow staff to develop a standard time of day to assess and document skin assessment.
  - Ensure that all staff are consistent with skin inspection and documentation standards.

- Manage moisture on skin
  - Develop a process (such as hourly rounds) for ensuring that patients are clean and dry.
  - Standardize skin care products, utilizing products that wick away or block moisture.
  - Use tools to ensure that appropriate supplies and products are at the bedside of at-risk patients (e.g., a skin care kit that includes supplies to clean patients, change pads, skin care products, etc.).

- Optimize nutrition and hydration
  - Develop a reliable process to consult the dietician when nutritional elements contribute to risk.
  - Ensure fluid balance by providing fluids and supplements as appropriate.

- Minimize pressure
  - Ensure a reliable process for redistributing pressure (e.g., use a turn clock as a reminder to staff, implement turn rounds, etc.).
  - Triage use of pressure redistributing beds and mattresses.

Outcomes

- Harm: Decreased harm to patient (e.g., Harms per 100 patient days, as measured by the IHI Global Trigger Tool)
- Cost of Care: Decreased cost per inpatient case

Service Lines and Critical Functions

- Applies in All Patient Settings
- Nursing
- Transitions and Continuity

Key Measures

- Percent of At-Risk Patients Receiving Full Pressure Ulcer Preventative Care
  This includes: Inspect Skin Daily, Manage Moisture, Optimize Nutrition, Reposition, Use Pressure-Redribution Surfaces

- Pressure ulcer incidence

Reasons and Implications

Importance for Patients and Families
Patients and families are aware that pressure ulcers are painful and slow to heal, and are often seen as an indication of poor quality of care. When caregivers practice the best care every time, patients can avoid suffering.
Requirement, Standards, Policies, and Guidelines

- **Agency for Healthcare Research and Quality (AHRQ)**
  Patient Safety Indicator #3
- **Centers for Medicare & Medicaid Services (CMS)**
  Never Events:
  Eliminating Serious, Preventable, and Costly Medical Errors
- **National Quality Forum (NQF)**
  Safe Practice for Better Healthcare—2010 Update
  Safe Practice 27: Pressure Ulcer Prevention
- **National Quality Forum (NQF)**
  Serious Reportable Events
- **The Joint Commission (TJC)**
  National Patient Safety Goal (NPSG) 14

Financial Implications

- Expense reduction can occur due to decrease in cost of pressure ulcer treatment and litigation events.

Prerequisites

None for this process
Resources

Additional Resources

- **American Hospital Association (AHA)**
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Stepping it up: Reducing Pressure Ulcers
  Fairfield Medical Center

- **American Hospital Association (AHA)**
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Save Our Skin: Preventing Pressure Ulcers
  OSF St. Francis Medical Center

- **Agency for Health Care Policy and Research (AHCPR)**
  AHCPR Supported Clinical Practice Guidelines
  Pressure Ulcers in Adults: Prediction and Prevention, Clinical Practice Guideline Number 3

- **US Department of Health and Human Services**
  Partnership for Patients

- **Agency for Healthcare Research and Quality (AHRQ)**
  Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care

- **National Pressure Ulcer Advisory Panel**

- **Agency for Healthcare Research & Quality (AHRQ)**
  National Guideline Clearing House: Pressure Ulcer Prevention

- **American Hospital Association (AHA)**
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Decreasing Pressure Ulcers Through Skin Care
  Buena Vista Regional Medical Center

- **American Hospital Association (AHA)**
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Senior Management Support to Reduce Pressure Ulcers
  Lawrence & Memorial

- **American Hospital Association (AHA)**
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Reducing Pressure Ulcers
  Bronson Methodist Hospital

- **PatientCareLink (PCL)**
  Massachusetts Hospital Association (MHA) and Massachusetts Organization of Nurse Executives (MONE)
  PatientCareLink: Pressure Ulcers

- **Agency for Healthcare Research and Quality (AHRQ)**
  AHRQ National Guideline Clearinghouse: Risk Assessment and Prevention of Pressure Ulcers

- **Agency for Healthcare Research and Quality (AHRQ)**
  On-Time Pressure Ulcer Healing Project [July 2009]

- **Agency for Healthcare Research and Quality (AHRQ)**
  Pressure Ulcer Toolkit

- **Agency for Healthcare Research and Quality (AHRQ)**
  Patient Safety and Quality: An Evidence-Based Handbook for Nurses [2008]

- **Wound, Ostomy, and Continence Nurses Society (WOCN)**
  WOCN Library

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