Indiana Patient Safety Center
of the Indiana Hospital Association

Pressure Ulcer Prevalence Review

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Objectives

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- Review Prevalence data definition and HIIN data to ensure correct measurement
- Discuss barriers to preventing skin injuries
- Review resources to assist with harm reduction

HIIN Definition-Prevalence

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Hospital Improvement Innovation Network
Improve Quality and Patient Safety at your Hospital and Impact National Health Outcomes

Hospital Acquired Pressure Ulcer Prevalence, Stage 2+ NQF0201 (HIIN-PrU–2)

Numerator	• Number of patients that have at least one stage 2 hospital acquired pressure ulcer/injury, unstageable and/or deep tissue injury on the day of the prevalence study. Tip – Count patients, not number of ulcers
Denominator	• Number of patients surveyed on the day of the study
Numerator Inclusion	• Medical, Surgical, Step-Down, Med-Surg combined, and Intensive Care units • Patients aged 18 years and older
Numerator Exclusion	• Ulcers/injuries present on admission • Patients refusing assessment • Patients who are off the unit at the time of the study (x-ray, therapy) • Medically unstable patients or those for whom assessment is contraindicated • Patients who are actively dying and pressure ulcer prevention is no longer a treatment goal • Moisture associated skin damage • Skin Tears • Venous or arterial stasis ulcers • Mucosal membrane ulcers
Data Sources	• Prevalence study observations
Frequently Asked Questions	Q: Are unstageable pressure ulcers included in the numerator? A: Yes Q: We usually collect this data quarterly. Do we have to report this data monthly? A: Hospitals are strongly encouraged to report pressure ulcer prevalence monthly. Preferred: Monthly, beginning Oct 2016 Alternate: Quarterly, beginning with 4Q 2016 (report in last month of each quarter)

AHRQ PSI 3 measure detail: https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD10/TechSpecs/PSI_03_Pressure_Ulcer_Rate.pdf

NQF 0201 Pressure Ulcer Prevalence measure detail: http://www.qualityforum.org/QPS/0201

Note: "hospital acquired on the day of the prevalence episode"

National Quality Forum Definition

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0201 **Pressure ulcer prevalence (hospital acquired)**

STEWARD: The Joint Commission

Measure Description:

The total number of patients that have hospital-acquired (nosocomial) category/stage II or greater pressure ulcers on the day of the prevalence measurement episode.

Numerator Statement:

Patients that have at least one category/stage II or greater hospital-acquired pressure ulcer on the day of the prevalence measurement episode.

Denominator Statement:

All patients surveyed for the measurement episode.

Exclusions:

Excluded Populations:

- Patients who refuse to be assessed
- Patients who are off the unit at the time of the prevalence measurement, i.e., surgery, x-ray, physical therapy, etc.
- Patients who are medically unstable at the time of the measurement for whom assessment would be contraindicated at the time of the measurement, i.e., unstable blood pressure, uncontrolled pain, or fracture waiting repair.
- Patients who are actively dying and pressure ulcer prevention is no longer a treatment goal.

State HIIN CDS Data-Prevalence

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- Baseline Rate: 5.25
- Monthly Baseline Numerator: 50.72
- Monthly Baseline Denominator: 9,661

- Current Rate: 5.18
- Project thru August Numerator: **723**
- Project thru August Denominator: 122,136
- October 2016 thru August 2019

Target Rate (for 20% improvement): 4.20

Percent Improvement thru July: 1%

Project Trend

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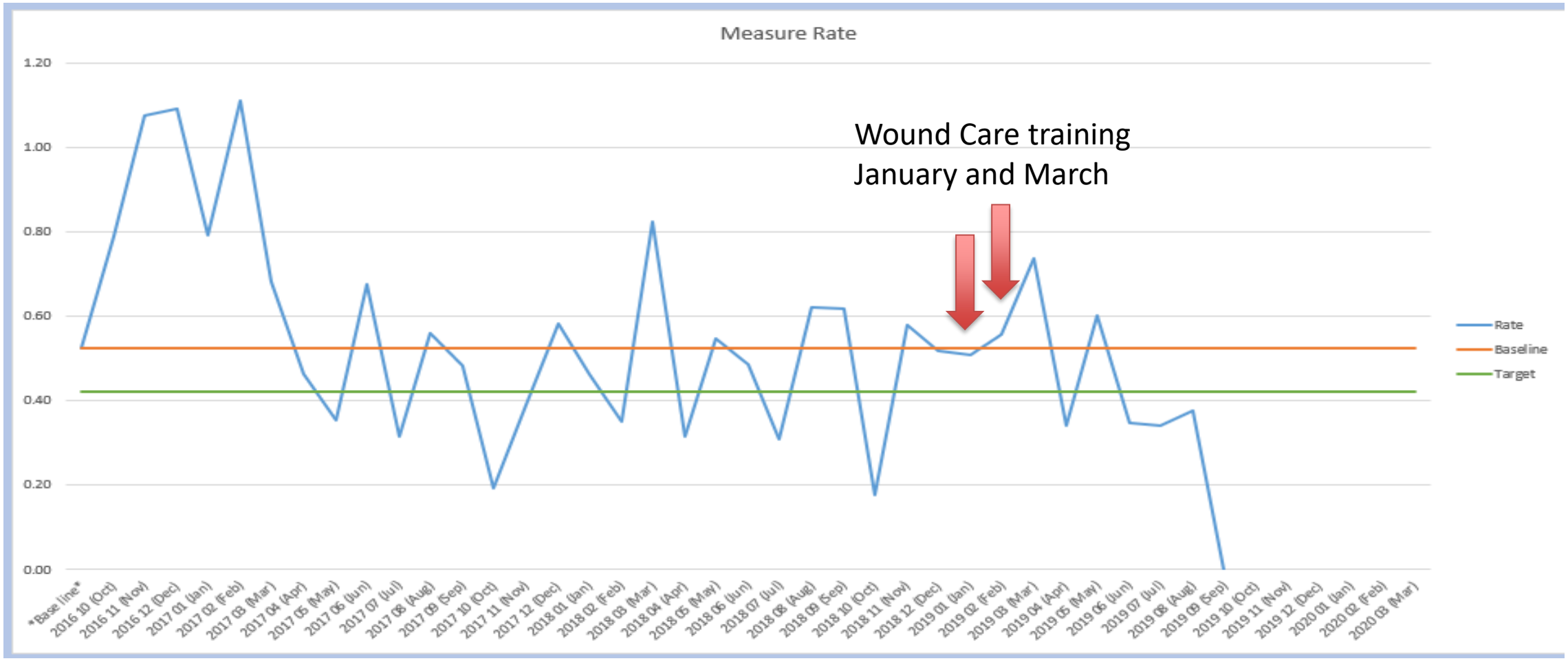

Numbers in DataLink

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- To date: 891 documented Stage 2+ hospital acquired pressure injuries found during one day prevalence studies.

Stage 3+ Definition

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HRET HEALTH RESEARCH & EDUCATIONAL TRUST

Pressure Ulcer / Injury Data Collection Fact Sheet

Pressure Ulcer Rate, Stage 3+ AHRQ PSI-03 (HIIN-PrU-1)

Numerator	• Discharges with any secondary diagnosis codes for pressure ulcer stage 3, 4, or unstageable.
Numerator Inclusion	• Medical or surgical discharges • Patients aged 18 years and older
Numerator Exclusion	• Ulcers/injuries present on admission • Any diagnosis of hemiplegia, paraplegia or quadriplegia, spina bifida, or anoxic brain damage • Transfers from another hospital, skilled nursing, or intermediate care facility • Length of stay (LOS) less than 3 days (except for CAHs who may choose to submit on LOS less than 3 days) • Psychiatric or obstetric discharges • Moisture associated skin damage • Skin tears • Venous or arterial stasis ulcers • Mucosal membrane ulcers
Denominator	• Medical and surgical discharges (as defined in the AHRQ measure specifications, Appendix C and E) aged 18 years and older
Data Sources	• Administrative data • Incident or occurrence reports
Frequently Asked Questions	Q: How is present on admission (POA) defined? A: The cut off for determining POA is 24 hours from the time of admission, unless the hospital has specified a shorter time frame. Q: Are unstageable pressure ulcers included in the numerator? A: Yes Q: Are Critical Access Hospitals (CAHs) required to report on this measure given their patients' short length of stay? A: The measure specifications exclude stays less than three days. While CAHs are required to maintain an annual average length of stay of 96 hours or less (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctsht.pdf), CAHs are encouraged to use the AHRQ PSI specifications to track pressure ulcers for appropriate inpatient stays in their facilities, even if the inpatient stay is less than three days.

- **For most HIIN hospitals, IHA submits your data into CDS on your behalf.**
- **This data is abstracted from your claims file submitted monthly to IHA and numbers are tallied according to coding.**
- **Are you validating this data with your internal data?**
- **Are you reporting Stage 3 and 4 to ISDH?**

State HIIN Data-Stage 3+

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Project numerator to date: **118**
Project denominator to date: 462,347

Definition: Stage 3, 4, and unstable hospital acquired pressure injuries.

Question: Do we really have that many Stage 2 *hospital acquired* pressure injuries?

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Sprint Results

Results from HRET HAPI Sprint

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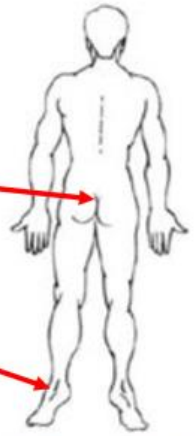
Anatomical Location

- Sacral
- Buttocks
- Coccyx
- Heel



Unit Type

- Discovered in ICU
- Is your **ED** Contributing?

Image

Greatest Opportunities Overall

- Educate and engage patients and families
- Improve early detection
- Activate support surface in ED
- Evaluate necessity of HOB elevation
- Use of Barrier Cream when moisture present
- Early placement on appropriate support surface
- Protect heels from pressure and shear
- Mobilize patients using equipment to minimize friction and shear

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HAPI PI Tool

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HRET HIIN PROCESS IMPROVEMENT DISCOVERY TOOL

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HOSPITAL ACQUIRED PRESSURE INJURY (HAPI)

The Process Improvement Discovery Tool is meant to help hospitals provide safer patient care by completing an assessment to identify process improvement opportunities. Hospitals can use the results to develop specific strategies to address gaps and identify resource needs. Please complete the tool using patient charts that align with this specific topic.

Instructions: Focus on hospital acquired pressure injuries stage 2 or greater within the last 12 months. Audit chart documentation 72 hours prior to the HAPI discovery and 72 hours after it was discovered if applicable. Enter N/A for questions that do not apply

1. If the answer to the question is "YES", mark an X in the box. Leave the box empty if there is no documentation that this important process occurs.
2. The processes with the most blank boxes could be a priority focus.

Do NOT spend more than 20-30 minutes per chart!

HAPI DETAIL — briefly document HAPI details	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #
Anatomical Location of HAPI										
Length of stay (LOS) when discovered										
Stage when discovered										
The patient was transferred prior to discovery										
Unit patient was on when HAPI discovered										
PROCESS										
Risk Screening										
A standard HAPI risk screening tool was used to assess this patient's risk.										
Support Surface										
Support surface — the patient was on a specialty support surface.										
Patient was placed on specialty surface in ER.										
If patient was not on a specialty surface in the ED, what was their length of stay?										
Patient was placed on specialty mattress in the OR.										
If OR specialty surface was not used, what was the OR length of stay?										
Skin Assessment										
Head to toe skin assessment is documented per policy on admission										
Skin Inspection is conducted per policy										

http://www.hret-hiin.org/resources/display/hospital-acquired-pressure-injury-hapi-process-improvement-discovery-tool

HAPI PI Tool

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Redness is recognized before skin breakdown occurs and is alleviated with pressure relief										
Keep Moving										
Mobilization — patient is mobilized to their highest ability										
Pressure redistribution is documented Q2H for immobile patients										
Patient is mobilized in a way to prevent friction and shear. Immobilized patients are moved with equipment, glide sheets used										
Heels are floated for immobile patients										
Sacral foam dressing in place to protect from shear and moisture (N/A if injury is not on sacrum)										
Head of bed (HOB) not greater than 30 degrees										
Incontinence/Moisture										
Moisture — incontinence managed optimally — external catheters, fecal collection devices										
Barrier cream used										
Moisture from drainage and interiginous skin related issues is managed										
If moisture score 1 or 2, or incontinence or moisture present, patient is placed on a low air-loss mattress										
Nutrition/Hydration										
Nutritional consult completed or nutritional interventions in place for high risk patient										
Food intake documented and addressed. i.e. supplements provided if intake documented as inadequate or poor										
Patient's fluid intake was addressed										
Medical Devices: trach, O2, cervical collar, orthotics — hand or foot braces										
Protective measures were taken to prevent device-related injury: foam padding, protective dressings, repositoning of the device										
Patient and Family Engagement (PFE)										
Documentation present that the patient's HAPI risk was discussed with patient and/or family										
Documentation present that the patient's or family's understanding of the need for HAPI prevention is validated using teach-back										
Documentation present that the patient and/or family have been educated about repositioning, protective skin care measures, hygiene and nutriton/hydration.										
Documentation present that the patient and family are actively engaged in preventative skin care via use of teach-back or patient or family member's active engagement in preventative care.										

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Prevention

What Matters

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Partnering with Patients

Focus on the Basics

+

- **S** Skin Inspection
- **K** Keep Moving
- **I** Incontinence
- **N** Nutrition Hydration

=

Healthy Skin

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Nutrition is Very Important!

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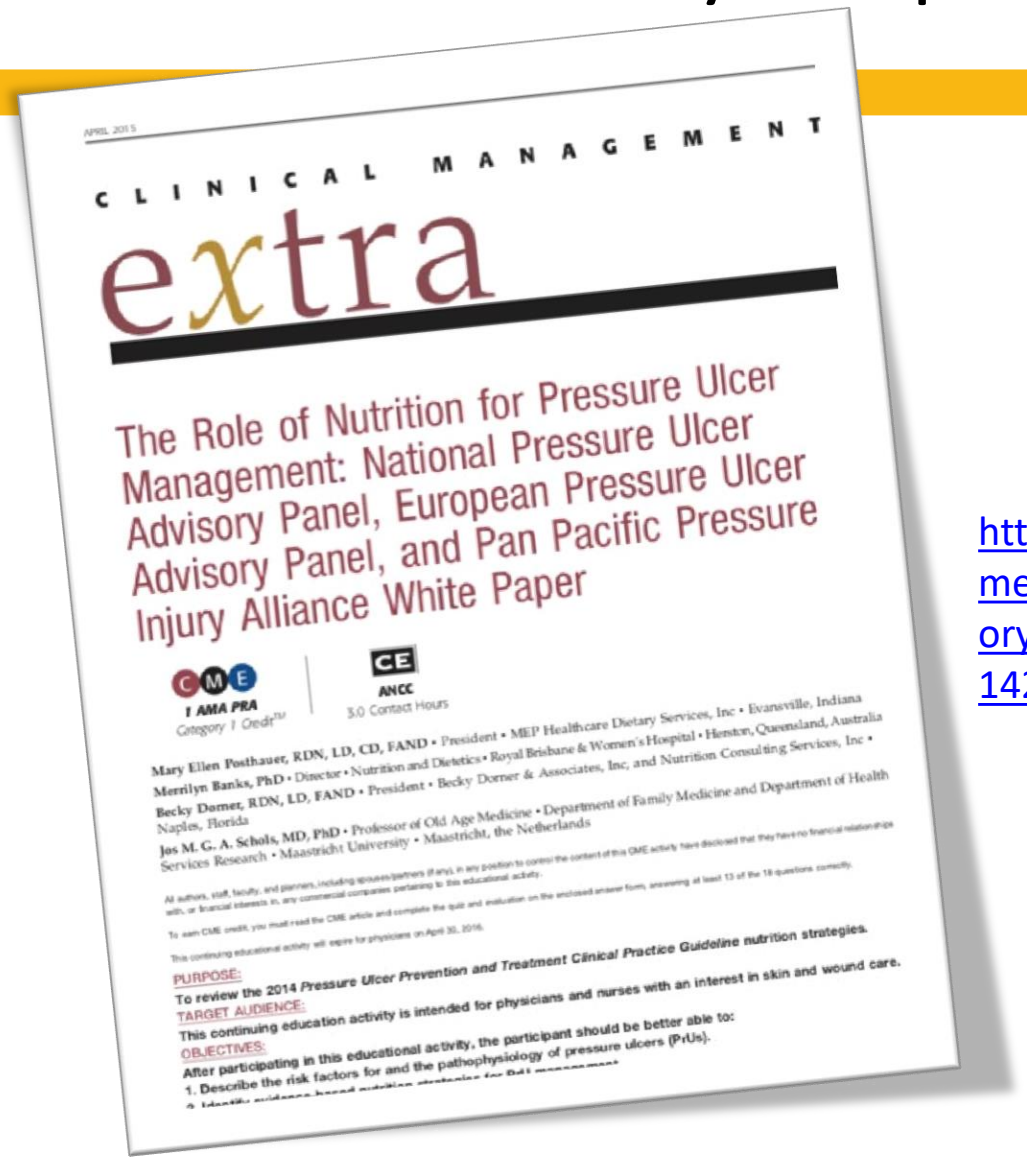

CLINICAL MANAGEMENT extra

The Role of Nutrition for Pressure Ulcer Management: National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel, and Pan Pacific Pressure Injury Alliance White Paper

CME 1 AMA PRA Category 1 Credit™ | CE ANCC 3.0 Contact Hours

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Becky Dorner, RDN, LD, FAND • President • Becky Dorner & Associates, Inc, and Nutrition Consulting Services, Inc • Naples, Florida
Jos M. G. A. Schols, MD, PhD • Professor of Old Age Medicine • Department of Family Medicine and Department of Health Services Research • Maastricht University • Maastricht, the Netherlands

PURPOSE:
To review the 2014 *Pressure Ulcer Prevention and Treatment Clinical Practice Guideline* nutrition strategies.
TARGET AUDIENCE:
This continuing education activity is intended for physicians and nurses with an interest in skin and wound care.
OBJECTIVES:
After participating in this educational activity, the participant should be better able to:
1. Describe the risk factors for and the pathophysiology of pressure ulcers (PrUs).

https://cme.lww.com/files/TheRoleofNutritionforPressureUlcerManagementNationalPressureUlcerAdvisoryPanelEuropeanPressureUlcerAdvisoryPanelandPanPacificPressureInjuryAllianceWhitePaper-1426768197512.pdf

Patient & Family Engagement Matters

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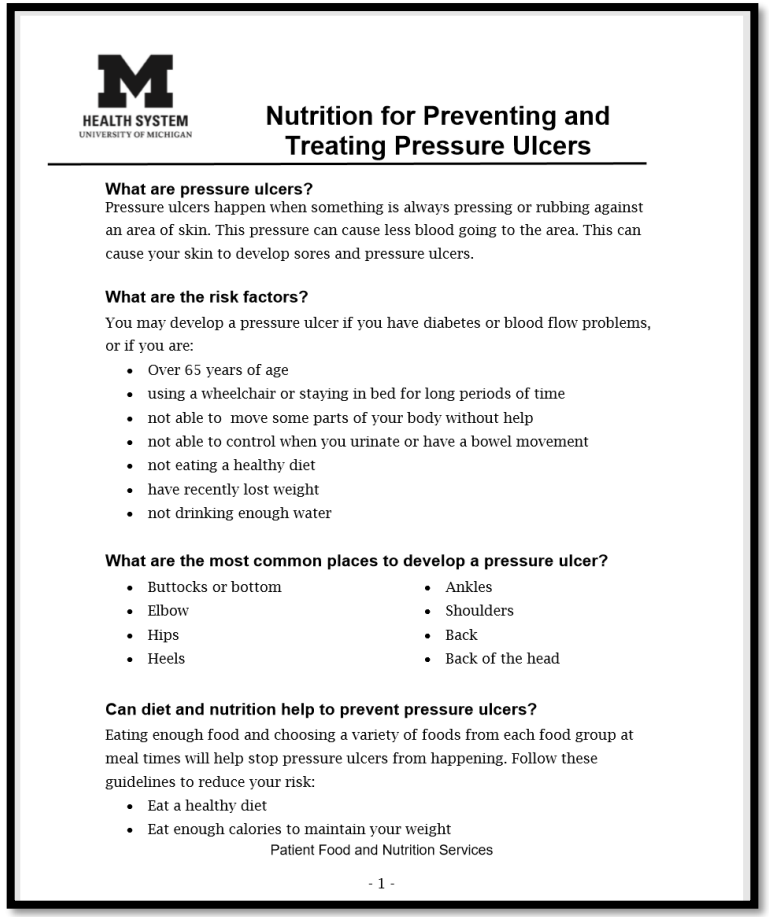


HEALTH SYSTEM
UNIVERSITY OF MICHIGAN

Nutrition for Preventing and Treating Pressure Ulcers

What are pressure ulcers?

Pressure ulcers happen when something is always pressing or rubbing against an area of skin. This pressure can cause less blood going to the area. This can cause your skin to develop sores and pressure ulcers.

What are the risk factors?

You may develop a pressure ulcer if you have diabetes or blood flow problems, or if you are:

- Over 65 years of age
- using a wheelchair or staying in bed for long periods of time
- not able to move some parts of your body without help
- not able to control when you urinate or have a bowel movement
- not eating a healthy diet
- have recently lost weight
- not drinking enough water

What are the most common places to develop a pressure ulcer?

- Buttocks or bottom
- Elbow
- Hips
- Heels
- Ankles
- Shoulders
- Back
- Back of the head

Can diet and nutrition help to prevent pressure ulcers?

Eating enough food and choosing a variety of foods from each food group at meal times will help stop pressure ulcers from happening. Follow these guidelines to reduce your risk:

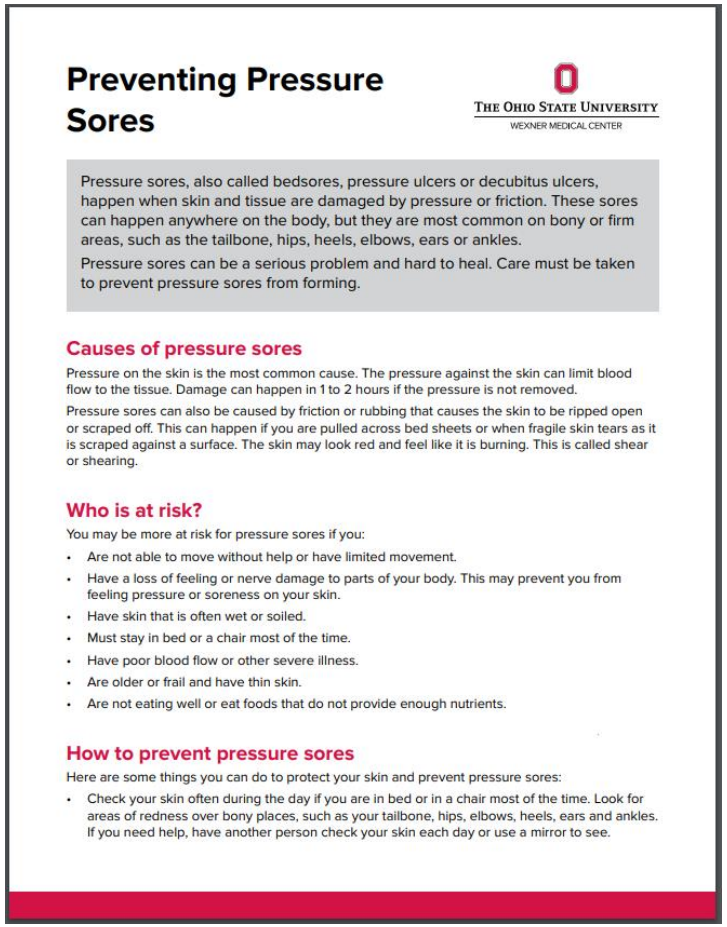
- Eat a healthy diet
- Eat enough calories to maintain your weight

Patient Food and Nutrition Services

- 1 -

http://www.med.umich.edu/1libr/Nutrition/DietPressureUlcers.pdf

https://patienteducation.osumc.edu/Documents/PreventingPressureSores.pdf



Preventing Pressure Sores

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Pressure sores, also called bedsores, pressure ulcers or decubitus ulcers, happen when skin and tissue are damaged by pressure or friction. These sores can happen anywhere on the body, but they are most common on bony or firm areas, such as the tailbone, hips, heels, elbows, ears or ankles.

Pressure sores can be a serious problem and hard to heal. Care must be taken to prevent pressure sores from forming.

Causes of pressure sores

Pressure on the skin is the most common cause. The pressure against the skin can limit blood flow to the tissue. Damage can happen in 1 to 2 hours if the pressure is not removed.

Pressure sores can also be caused by friction or rubbing that causes the skin to be ripped open or scraped off. This can happen if you are pulled across bed sheets or when fragile skin tears as it is scraped against a surface. The skin may look red and feel like it is burning. This is called shear or shearing.

Who is at risk?

You may be more at risk for pressure sores if you:

- Are not able to move without help or have limited movement.
- Have a loss of feeling or nerve damage to parts of your body. This may prevent you from feeling pressure or soreness on your skin.
- Have skin that is often wet or soiled.
- Must stay in bed or a chair most of the time.
- Have poor blood flow or other severe illness.
- Are older or frail and have thin skin.
- Are not eating well or eat foods that do not provide enough nutrients.

How to prevent pressure sores

Here are some things you can do to protect your skin and prevent pressure sores:

- Check your skin often during the day if you are in bed or in a chair most of the time. Look for areas of redness over bony places, such as your tailbone, hips, elbows, heels, ears and ankles. If you need help, have another person check your skin each day or use a mirror to see.

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Resources

IHAconnect.org/Quality-Patient-Safety

HRET Change Package

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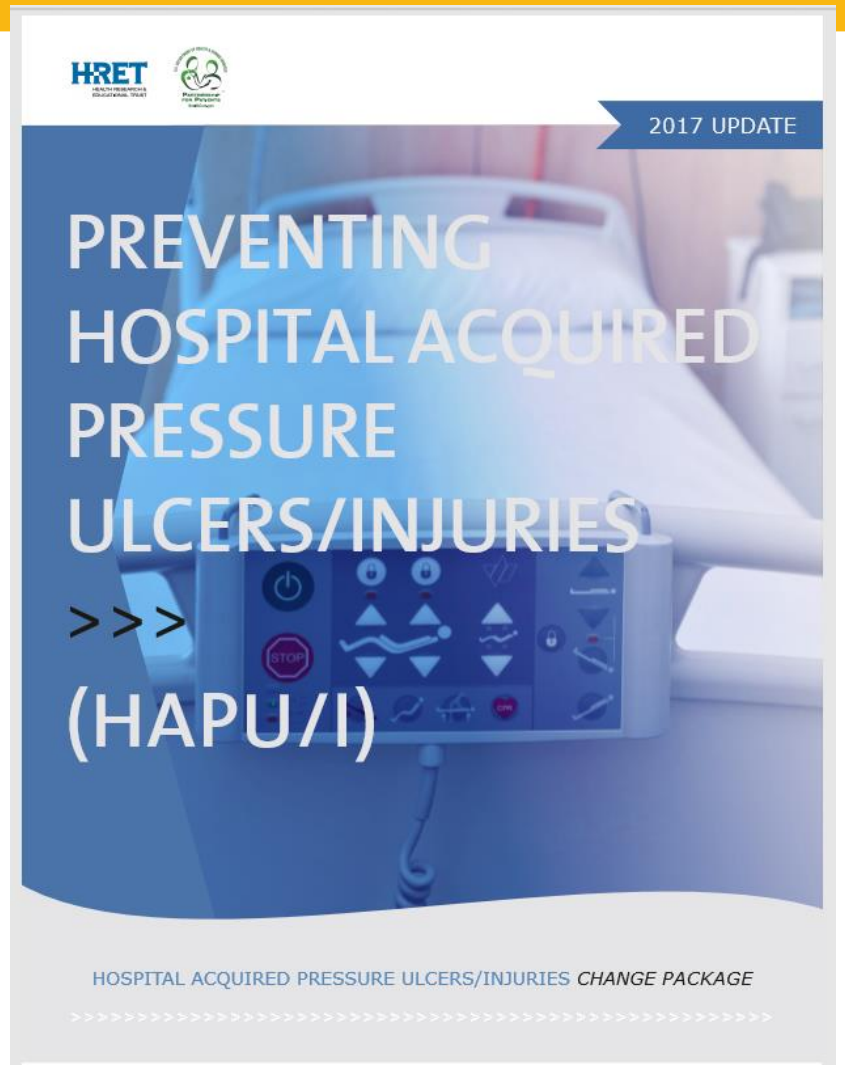

http://www.hret-hiin.org/Resources/pressure-ulcers/17/hospital-acquired-pressure-ulcers-injuries-hapu-change-package.pdf

Education-AHRQ Video & Learning Modules

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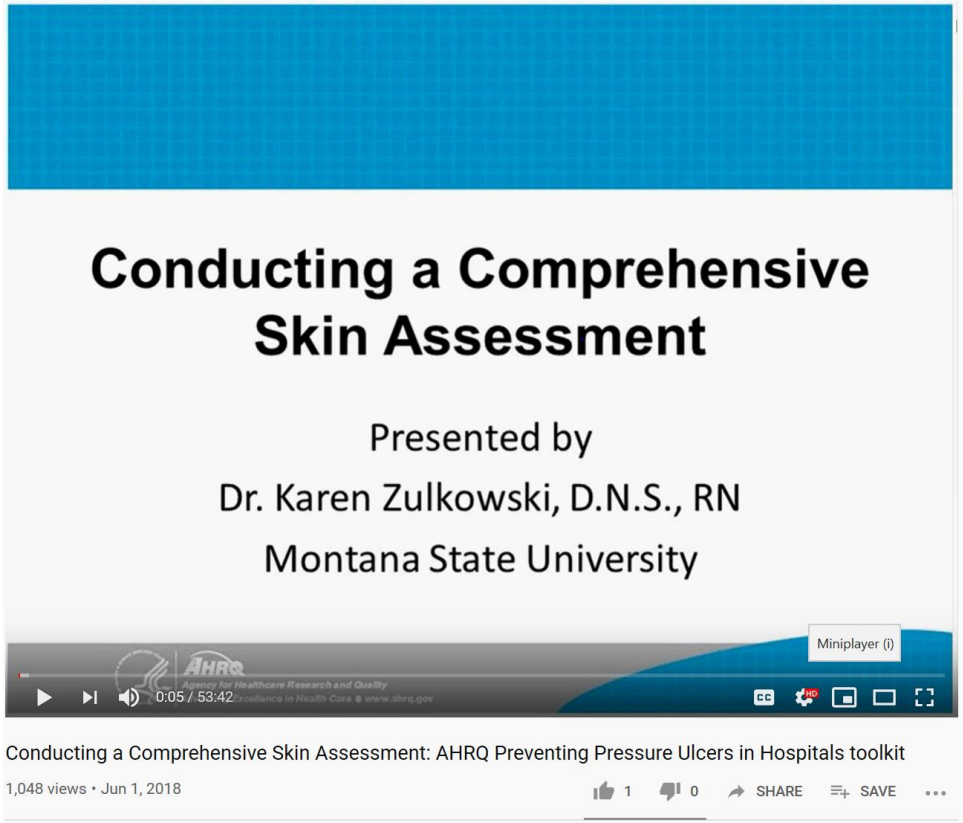
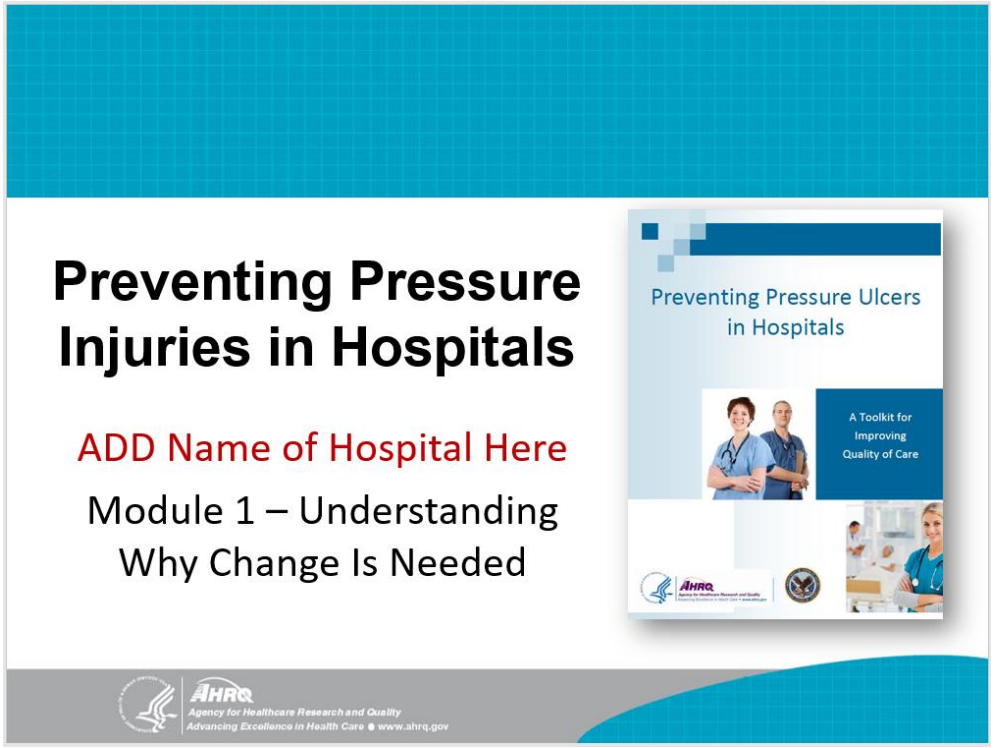


https://www.youtube.com/watch?v=JyqBwGds6o4&feature=youtu.be

https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureinjury/workshop/guide1.html



Help

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- *If you have found that your numbers are not accurately reflected, please let me know and we will work to correct your data. It is a simple fix.*

Indiana Hospital Association

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