



Getting Started Kit: Prevent Pressure Ulcers

How-to Guide

5 Million Lives Campaign

We invite you to join the 5 Million Lives Campaign, a national initiative to dramatically improve the quality of American health care. The Institute for Healthcare Improvement (IHI) and its partners seek to engage thousands of U.S. hospitals in an effort to reduce harm for five million American patients between December 2006 and December 2008. This ambitious work builds upon the great energy and commitment shown by hospitals during the 100,000 Lives Campaign, a national, IHI-led initiative that focused on reducing unnecessary mortality and ran from December 2004 to June 2006. Complete details, including materials, contact information for experts, and web discussions, are on the web at <http://www.ihl.org/IHI/Programs/Campaign/>.

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This How-to Guide is dedicated to the memory of David R. Calkins, MD, MPP (May 27, 1948 – April 7, 2006) -- physician, teacher, colleague, and friend -- who was instrumental in developing the Campaign's science base. David was devoted to securing the clinical underpinnings of this work, and embodied the Campaign's spirit of optimism and shared learning. His tireless commitment and invaluable contributions will be a lifelong inspiration to us all.

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How-to Guide: Prevent Pressure Ulcers

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The Institute for Healthcare Improvement extends its sincere gratitude to the distinguished group of individuals, foundations, and companies whose generous contributions support the 5 Million Lives Campaign:

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- Blue Cross Blue Shield of Massachusetts
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- The Leeds Family
- David Calkins Memorial Fund

Contributors

The work of leading organizations has informed the development of this guide. These include Ascension Health and Advancing Excellence in America's Nursing Homes.

Goal:

Prevent hospital-acquired pressure ulcers by reliably implementing the six components of care recommended in this Guide.

What Is a Pressure Ulcer?

A pressure ulcer is defined as any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed. Because muscle and subcutaneous tissue are more susceptible to pressure-induced injury than skin, pressure ulcers are often worse than their initial appearance. Pressure ulcers are also called decubitus ulcers or bed sores and range in severity from mild to severe.

Pressure Ulcers in Adults: Prediction and Prevention. Clinical Practice Guideline Number 3. AHCPR Publication No. 92-0047. Rockville, MD: Agency for Health Care Policy and Research; May 1992.

The Case for Preventing Hospital-Acquired Pressure Ulcers

Although pressure ulcers are preventable in most cases, the prevalence of pressure ulcers in health care facilities is increasing. Pressure ulcer incidence rates vary considerably by clinical setting—ranging from 0.4% to 38% in acute care, from 2.2% to 23.9% in long-term care, and from 0% to 17% in home care.

Lyder CH. Pressure ulcer prevention and management. *JAMA*. 2003;289(2):223-226.

- It is estimated that pressure ulcer prevalence (the percentage of patients with pressure ulcers at any one point in time) in acute care is 15%, while incidence (the rate at which new cases occur in a population over a given time period) in acute care is 7%.

National Pressure Ulcer Advisory Panel. Cuddigan J, Ayello EA, Sussman C, Editors. *Pressure Ulcers in America: Prevalence, Incidence, and Implication for the Future*. Reston, VA: NPUAP; 2001.

5 Million Lives Campaign

How-to Guide: Prevent Pressure Ulcers

- It is estimated that 2.5 million patients are treated for pressure ulcers in US health acute-care facilities each year.

Lyder CH. Pressure ulcer prevention and management. *JAMA*. 2003;289(2):223–226.

Reddy M, Gill SS, Rochon PA. Preventing pressure ulcers: A systematic review. I. 2006;296:974-984.

- Pressure ulcers cause considerable harm to patients, hindering functional recovery, frequently causing pain and the development of serious infections. Pressure ulcers have also been associated with an extended length of stay and mortality. In fact, nearly 60,000 US hospital patients are estimated to die each year from complications due to hospital-acquired pressure ulcers. The estimated cost of managing a single full-thickness pressure ulcer is as high as \$70,000, and the total cost for treatment of pressure ulcers in the US is estimated at \$11 billion per year.

Reddy M, Gill SS, Rochon PA. Preventing pressure ulcers: A systematic review. *JAMA*. 2006;296:974-984.

- The US Department of Health and Human Services document, *Healthy People 2010: Understanding and Improving Health*, lists reducing pressure ulcer incidence as an objective for all health care providers.

US Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*, 2nd ed. Washington DC: US Government Printing Office; November 2000.

Six Essential Elements of Pressure Ulcer Prevention

Most pressure ulcers are preventable.

Brandeis GH, Berlowitz DR, Katz P. Are pressure ulcers preventable? A survey of experts. *Advances in Skin and Wound Care*. 2001;14(5):244-248.

Preventing pressure ulcers boils down to two major steps: first, identifying patients at risk; and second, reliably implementing prevention strategies for all patients who are identified as being at risk.

1. Conduct a Pressure Ulcer Admission Assessment for All Patients

The admission assessment should include both a risk assessment (to evaluate risk of developing a pressure ulcer) and a skin assessment (to detect existing pressure ulcers). These two assessments should be thought of as a single process step: a pressure ulcer admission assessment.

Many patients are at risk for developing a pressure ulcer. The key factors contributing to the development of pressure ulcers include the following: age, immobility, incontinence, inadequate nutrition, sensory deficiency, multiple co-morbidities, circulatory abnormalities, and dehydration.

The AHCPR (the predecessor agency of AHRQ) clinical practice guidelines on pressure ulcer prevention recommend that initial pressure ulcer risk assessment be done on admission and that reassessment be done periodically based on patient condition.

Pressure Ulcers in Adults: Prediction and Prevention. Clinical Practice Guideline Number 3. AHCPR Publication No. 92-0047. Rockville, MD: Agency for Health Care Policy and Research; May 1992.

The prompt identification of at-risk patients using a validated risk assessment tool is essential for accurate, prompt identification of at-risk patients and timely implementation of prevention strategies. The risk assessment must include an assessment of several components: mobility, incontinence, sensory deficiency, and nutritional status (including

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How-to Guide: Prevent Pressure Ulcers

dehydration). The Braden Scale is the most widely utilized assessment tool in the US. Additional tools to assist with a comprehensive assessment include the Norton Scale, Gosnell Scale, Knoll Scale, and Waterlow Scale.

Ayello EA, Braden B. How and why to do pressure ulcer risk assessment. *Advances in Skin & Wound Care*. 2002;15(3):125-131.

>> What processes can be put in place to ensure the pressure ulcer admission assessment of all patients?

Hospitals can test the following process changes to ensure compliance with the assessment and identification of any patient at risk for pressure ulcers:

- Improve processes to ensure that risk assessment is conducted within four hours of admission for all patients.
- Include a visual cue on each admission documentation record for the completion of a total skin assessment and risk assessment.
- Agree on the use of a standard risk assessment tool (for example, Braden Scale); facilities may wish to adapt the tool to allow for easy completion, using check-boxes and short phrases to ensure completion.
- Utilize multiple methods to visually cue staff as to which patients are at risk. For example, consider using stickers in the patient chart or on the patient's door so that all who enter will realize the patient is at risk for pressure ulcer development. This allows for a quick identification by any staff of patients at risk, both in the patient's room or while the patient is in other departments, and prompt implementation of prevention strategies.
- Build shared pride in progress. Post "Days since Last Pressure Ulcer" data.

2. Reassess Risk for All Patients Daily

The complexity and acuity of hospitalized patients require daily reassessment of the potential and degree of risk of pressure ulcer development. For example, changes in mobility, incontinence, or nutrition may change the patient's risk of developing pressure ulcers. Assessing risk daily provides caregivers the opportunity to adjust prevention strategies according to the changing needs of the patient. The degree of risk, as specified in several standardized risk assessments, allows providers to implement targeted strategies for each patient. For example, after several days in the hospital, a patient's nutritional intake may diminish, either due to patient preferences or condition. A daily risk assessment would enable caregivers to quickly identify the patient as having a nutritional need and initiate a consult to the clinical dietician.

Ayello EA, Braden B. How and why to do pressure ulcer risk assessment. *Advances in Skin & Wound Care*. 2002;15(3):125-131.

Bergstrom N, Braden BJ, Boynton P, Brunch S. Using a research-based assessment scale in clinical practice. *Nursing Clin North Am*. 1995;3:539-551.

>> What processes can be put in place to ensure daily reassessment of risk?

- Adapt documentation tools to prompt daily risk assessment, documentation of findings, and initiation of prevention strategies as needed. For example, include this information in daily clinical notes.
- Educate all levels of staff about potential risk factors of pressure ulcer development and the process for implementing prevention strategies.
- Use validated risk assessment tools for staff to easily identify degree of risk and potential prevention strategies.

Implement steps 3-6 for all patients identified (in steps 1 and 2) as being at risk for pressure ulcers:

3. Inspect Skin Daily

Skin integrity may deteriorate in a matter of hours in hospitalized patients. Because risk factors change rapidly in acutely ill patients, daily skin inspection is crucial. Patients identified as being at risk need a daily inspection of all skin surfaces, “from head to toe.” Special attention should be given to areas at high risk for pressure ulcer development such as the sacrum, back, buttocks, heels, and elbows. Ideally, staff should incorporate a skin inspection into their work, every time they assess the patient.

National Pressure Ulcer Advisory Panel. Cuddigan J, Ayello EA, Sussman C, Editors. *Pressure Ulcers in America: Prevalence, Incidence, and Implication for the Future*. Reston, VA: NPUAP; 2001).

>> What processes can be put in place to ensure daily inspection of the skin?

- Adapt documentation tools to prompt daily skin inspection, documentation of findings, and initiation of prevention strategies as needed.
- Educate all levels of staff to inspect the skin any time they are assisting the patient, for example, when assisting patient to the chair, moving from one area to the other, and while bathing. Upon recognition of any change in skin integrity, notify staff so that appropriate interventions can be put in place.

4. Manage Moisture: Keep the Patient Dry and Moisturize Skin

Wet skin is conducive to the development of rashes, is softer, and tends to break down more easily. Skin should be cleansed at time of soiling and at routine intervals. The process of cleaning the skin should include gentle use of a mild cleansing agent that minimizes irritation and dryness of the skin. Treating dry skin with moisturizers has been shown to be especially effective in preventing pressure ulcers.

Pressure Ulcers in Adults: Prediction and Prevention. Clinical Practice Guideline Number 3. AHCPR Publication No. 92-0047. Rockville, MD: Agency for Health Care Policy and Research; May 1992.

Care should be taken to minimize exposure of the skin to moisture due to incontinence, perspiration, or wound drainage. When these sources of moisture cannot be controlled, use underpads made of materials that absorb moisture and present a quick-drying surface to the skin. Also use topical agents that act as moisture barriers and moisturize the skin.

Reddy M, Gill SS, Rochon PA. Preventing pressure ulcers: A systematic review. *JAMA.* 2006;296:974-984.

Gibbons W, Shanks HT, Kleinhalter P, Jones P. Eliminating facility-acquired pressure ulcers at Ascension Health. *Joint Commission Journal on Quality and Patient Safety.* 2006;32:488-496.

Ayello EA, Braden B. Why is pressure ulcer risk assessment so important? *Nursing.* 2001;31(11):74-80.

>> What changes can we make to ensure effective management of moisture?

- Look for opportunities to design a process for periodic activities such as repositioning, assessing for wet skin, applying barrier agents, offering toileting opportunity, and even offering P.O. fluids (water). By combining routine activities in a protocol such as a “pressure ulcer prevention protocol,” staff can complete multiple tasks while in the room every two hours and document them all at once.

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How-to Guide: Prevent Pressure Ulcers

- Provide supplies at the bedside of each at-risk patient who is incontinent. This provides the staff with the supplies that they need to immediately clean, dry, and protect the patient's skin after each episode of incontinence.
- Provide underpads that pull the moisture away from the skin, and limit the use of disposable briefs or containment garments if at all possible.
- Provide pre-moistened, disposable barrier wipes to help cleanse, moisturize, deodorize, and protect patients from perineal dermatitis due to incontinence.

5. Optimize Nutrition and Hydration

Assessment of the patient for possible risk of pressure ulcer development should include a review of nutritional factors and an assessment of hydration. Numerous nutritional factors such as impaired intake, low body weight or unintentional weight loss, and dehydration may contribute to development of pressure ulcers.

Reddy M, Gill SS, Rochon PA. Preventing pressure ulcers: A systematic review. *JAMA*. 2006;296:974-984.

Gibbons W, Shanks HT, Kleinhalter P, Jones P. Eliminating facility-acquired pressure ulcers at Ascension Health. *Joint Commission Journal on Quality and Patient Safety*. 2006;32:488-496.

Fluid, protein, and caloric intake are important aspects of maintaining adequate general nutrition. Nutritional supplements or support may be needed if dietary intake is insufficient. If a patient is identified with significant nutritional needs, a registered clinical dietician should be consulted to assess and suggest feasible nutritional interventions.

>> What changes can we make to optimize nutrition and hydration?

- Assist patient with meals, snacks, and hydration. Every effort should be made to allow patient preferences when medically appropriate.
- Document the amount of nutritional intake, and notify the dietitian or physician if the patient does not have adequate intake.
- Offer water to every patient who is scheduled to be turned. The process could include these steps: offer toileting, assess for needs of cleanliness, change wet surfaces, and offer water.

6. Minimize Pressure

Relieving pressure, especially over bony prominences, is of primary concern. Patients with limited mobility are especially at risk for the development of pressure ulcers. Every effort should be made to redistribute the pressure on the skin, either by repositioning or by utilizing pressure-relieving surfaces.

Pressure Ulcers in Adults: Prediction and Prevention. Clinical Practice Guideline Number 3. AHCPR Publication No. 92-0047. Rockville, MD: Agency for Health Care Policy and Research; May 1992.

Reddy M, Gill SS, Rochon PA. Preventing pressure ulcers: A systematic review. *JAMA.* 2006;296:974-984.

Gibbons W, Shanks HT, Kleinhalter P, Jones P. Eliminating facility-acquired pressure ulcers at Ascension Health. *Joint Commission Journal on Quality and Patient Safety.* 2006;32:488-496.

Two key components have proven especially effective in minimizing pressure:

- **Turn/reposition patients every two hours.**

The aim of repositioning is to reduce or eliminate pressure, thereby maintaining circulation to areas of the body at risk for pressure ulcers. The literature does not suggest how often patients should be turned to prevent ischemia of soft tissue, but two hours in a single position is the maximum duration of time recommended for patients with normal circulatory capacity. Turning patients every two hours is a foundational element in most pressure ulcer prevention protocols. The turning, or repositioning, of the at-risk patient temporarily shifts or relieves the pressure on the susceptible areas, diminishing the risk of pressure ulcer development.

Pillows and blankets are simple, readily available supplies that may be utilized to assist in pressure reduction. When used wisely, they may expand the weight-bearing surface by molding to the body. Use pillows under the calf to elevate the patient's heels off the bed surface. Place cushioning devices between the legs/ankles to maintain alignment and prevent pressure on bony prominences (NPUAP clinical guidelines, 1992). Often

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How-to Guide: Prevent Pressure Ulcers

the skin of patients identified at risk for pressure ulcers is easily torn inadvertently during repositioning. Clinicians should take care while actually turning the patient to protect the skin. Clinicians should consider using lift devices or “drawsheets” to move, rather than drag, individuals who are not able to assist during transfers and position changes.

■ **Use pressure-relieving surfaces.**

Specialized support surfaces (such as mattresses, beds, and cushions) reduce or even relieve the pressure that the patient’s body weight exerts on the skin and subcutaneous tissues. If a patient’s mobility is compromised and this interface pressure is not relieved, the pressure can lead to impaired circulation and ulcer formation. Many studies have examined the benefits demonstrated by pressure-reducing surfaces in the prevention of pressure ulcers.

Pressure-reducing surfaces may be either static support surfaces or dynamic support surfaces. Static support surfaces include mattresses, or mattress overlays filled with air, water, gel, foam or a combination of any of these. Dynamic support surfaces mechanically vary the pressure beneath the patient, thereby reducing the duration of any applied pressure.

Reddy M, Gill SS, Rochon PA. Preventing pressure ulcers: A systematic review. *JAMA*. 2006;296:974-984.

Courtney BA, Ruppman JB, Cooper HM. Save our skin: Initiative cuts pressure ulcer incidence in half. *Nursing Management*. 2006;37(4):35-46.

Gibbons W, Shanks HT, Kleinhalter P, Jones P. Eliminating facility-acquired pressure ulcers at Ascension Health. *Joint Commission Journal on Quality and Patient Safety*. 2006;32:488-496.

Because surgical patients who are under anesthesia for extended periods of time often have an increased risk of developing pressure ulcers, all surgical patients (pre-operative, intra-operative, post-anesthesia) should receive a skin assessment and a risk assessment. Caregivers should then implement prevention strategies such as ensuring repositioning and placing patients on appropriate redistribution surfaces for all surgical patients who are identified as being at risk.

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How-to Guide: Prevent Pressure Ulcers

Courtney BA, Ruppman JB, Cooper HM. Save our skin: Initiative cuts pressure ulcer incidence in half. *Nursing Management*. 2006;37(4):35-46.

>> What changes can we make to minimize pressure?

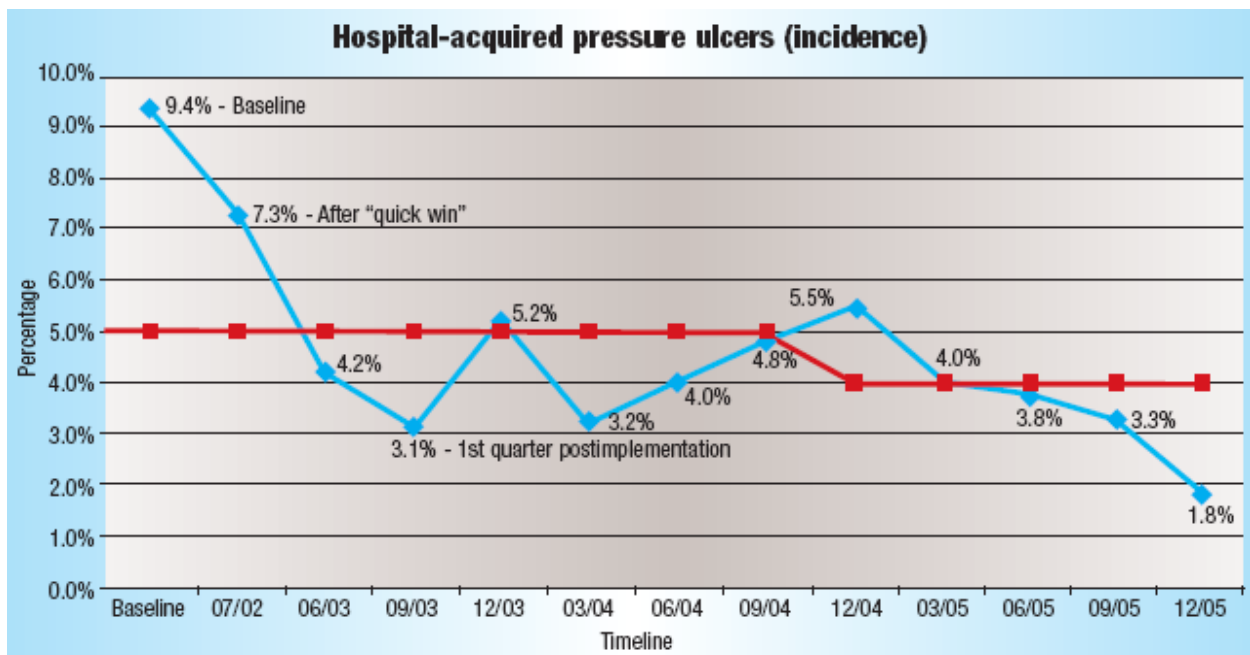
- Use tools inside the patient room to remind caregivers to turn/reposition the patient every two hours.
- Utilize unit- or hospital-wide “musical” cues (for example, setting caregiver beepers to sound every two hours) to remind staff to turn/reposition all at-risk patients at two-hour intervals.
- Utilize positioning, transferring, and turning techniques to minimize friction/shear injury.
- Use pressure redistribution mattresses/overlays to assist with minimizing pressure.

Examples of Success

Hospitals have reported significant improvement in the prevention of pressure ulcers by developing and implementing a systematic approach to the identification of patients at risk of developing pressure ulcers and implementing standardized actions for at-risk patients. For example, OSF Saint Francis Medical Center (Peoria, IL) utilized Six Sigma methodologies to develop a treatment process and reduce the incidence of pressure ulcers. This led to the development of the “Save Our Skin” (SOS) project, an effort to reduce the number of hospital-acquired pressure ulcers in adults by 50% within one fiscal year.

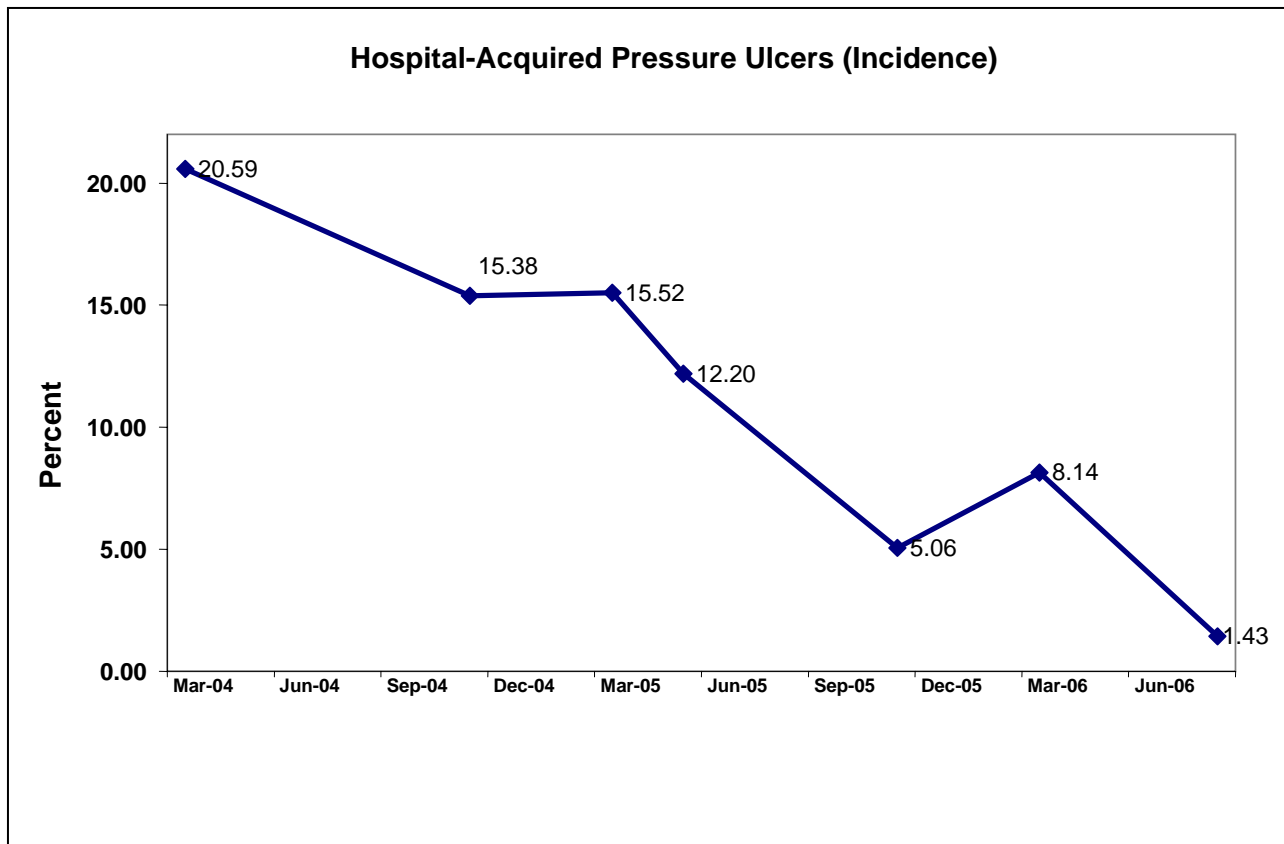
Courtney BA, Ruppman JB, Cooper HM. Save our skin: Initiative cuts pressure ulcer incidence in half. *Nursing Management*. 2006;37(4):35-46.

The run chart below shows the reduction in hospital-acquired pressure ulcers at OSF Saint Francis – from 9.4% in 2001 (baseline) to 1.8% in December 2005.



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How-to Guide: Prevent Pressure Ulcers

Owensboro Medical Health System (OMHS) in Owensboro, Kentucky, developed processes to ensure admission assessment and prevention strategies for all admitted patients. Process changes included hospital-wide education, changes in documentation processes, and the use of pressure-relieving surfaces for the highest-risk patients. OMHS also tested and implemented innovative strategies to assist staff in the continuous prevention processes, including placing turn-clock posters in each at-risk patient's room and setting hospital caregiver beepers to alarm every two hours to remind staff to reposition high-risk patients. Incidence in acute care dropped 93% in just over two years of focusing on the prevention of pressure ulcers. The run chart below shows the reduction in pressure ulcer incidence at OMHS from March 2004 through June 2006.



Forming the Team

IHI recommends a multidisciplinary team approach to the prevention of pressure ulcers. Teams offer the value of bringing diverse personnel together, all with a stake in the outcome and working to achieve the same goal. All the stakeholders in the process must be included, to gain the buy-in and cooperation of all parties.

In order to be most effective, a core team of no more than five to seven people should oversee the work. As different changes are tested, other key people in the organization can be included on an ad hoc basis, especially if they can offer some special expertise that is limited to one area of the work. Team members for preventing pressure ulcers may include the following:

- Team Leader/Champion
- Nursing (for example, RN, assistant, technicians, staff representing different levels of care, etc.)
- Education
- Performance Improvement
- Dietary/Dietician
- Materials Management staff

(Note: In addition, consider including a patient or family member on the team.)

Some suggestions to attract and retain excellent team members include using data to define and solve the problem; identifying champions within the hospital who are passionate about preventing pressure ulcers and have credibility with staff and administration; and working with those who want to work on the project, rather than trying to convince those who do not.

The team needs encouragement and commitment from senior leadership; an administrative representative on the team is powerful in keeping the team focused and relieving barriers. Identifying a champion increases a team's motivation to succeed. When measures are not improving, the champion readdresses the problems with staff and helps to keep everyone on track toward the aims and goals.

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How-to Guide: Prevent Pressure Ulcers

Another approach to the improvement work is to create sub-teams to work on specific care components or groups of care components. For example, one sub-team might work on education strategies for all staff. Another sub-team might focus on the supplies, availability of equipment needed as options for patients at risk, such as pads, cleansing wipes, and bed surfaces. A third team might be responsible for the testing and piloting of tools and standard processes. These are just a few examples of sub-groups, which can be an effective way to divide the work and achieve improvement more quickly. The sub-groups should report their work and results to the core team, which oversees the entire project and ensures coordination.

Setting Aims

Improvement requires setting aims. An organization will not improve without a clear and firm intention to do so. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected. Agreeing on the aim is crucial; so is allocation of people and resources necessary to accomplish the aim.

The overall goal of this Campaign intervention is to *prevent pressure ulcers*. Hospitals may set specific aim statements in pursuit of this overall goal. These aim statements might specify percentage reductions within a set timeframe. A sample aim statement might be:

- Reduce the incidence of hospital-acquired pressure ulcers by 50% by December 2007.

Teams are more successful when they have unambiguous, focused aims. Setting numerical goals clarifies the aim, helps to create tension for change, directs measurement, and focuses initial changes. Once the aim has been set, the team needs to be careful not to back away from it deliberately or "drift" away from it unconsciously.

This is only meant to be an example; your team should develop its own aim statement so that the team will feel ownership of the aim.

Using the Model for Improvement

In order to move this work forward, IHI recommends using the Model for Improvement. Developed by Associates in Process Improvement, the Model for Improvement is a simple yet powerful tool for accelerating improvement that has been used successfully by hundreds of health care organizations to improve many different health care processes and outcomes.

The model has two parts:

- Three fundamental questions that guide improvement teams to 1) set clear aims, 2) establish measures that will tell if changes are leading to improvement, and 3) identify changes that are likely to lead to improvement.
- The Plan-Do-Study-Act (PDSA) cycle to conduct small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.

Implementation: After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale — for example, for an entire pilot population or on an entire unit.

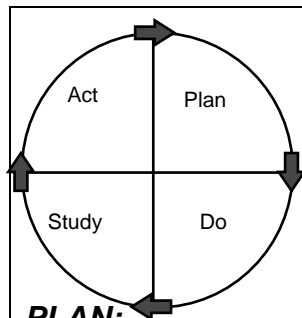
Spread: After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or to other organizations.

You can learn more about the Model for Improvement on www.IHI.org

The sample PDSA Worksheet that follows illustrates how an improvement team might document the first test cycle using this tool.

PDSA WORKSHEET

CYCLE: 1 DATE: 1/10/06



Project: Pressure Ulcer Prevention

Objective for this PDSA Cycle: Test the process for completing a pressure ulcer risk assessment on admission to the hospital.

PLAN:

Questions: How can we ensure total compliance with completion of a pressure ulcer risk assessment on each admission to the hospital?

Predictions: Adding cues to the admission packet will help ensure compliance with identification of patients at risk for pressure ulcers on admission.

Plan for change or test – who, what, when, where:

What: Add a risk assessment tool to admission packet.

Who: Bonnie (nurse) to do a risk assessment on each patient admitted on 4 North.

Where: Admission packets (Make up 3 packets for pilot test.)

When: January 15

Plan for collection of data – who, what, when, where:

Who: Bonnie (nurse)

What: Compliance with any patient admitted

When: January 15

Where: 4 North

DO: Carry out the change or test. Collect data and begin analysis.

Four patients were admitted to 4N on 1/15; the assessments and the risk assessments were completed by Bonnie.

STUDY: Complete analysis of data:

How did or didn't the results of this cycle agree with the predictions that we made earlier?

Summarize the new knowledge we gained by this cycle: All assessments of risk were completed as designed for these four patients.

ACT:

List actions we will take as a result of this cycle: Test for all admissions to 4N for the week of January 20.

Plan for the next cycle (adapt change, another test, implementation cycle?):

Will see if additional cues are needed, look for completion and compliance with all elements of tools.

Tips for Getting Started

- Use pressure ulcer prevalence data to assist with the choice of a pilot unit. (Start with the units, and the populations, with the highest prevalence.)
- Begin with one pilot unit, and roll out by units.
- Set a schedule to bring on units systematically, and keep to the schedule.
- Match the education schedule with the roll-out schedule.
- Develop a “pocket guide” for staff, containing helpful tips for patients at risk for pressure ulcers.
- Include the patient and family in education regarding pressure ulcer prevention. Include an overview of the patient’s risk factors and the importance of nutrition and fluid intake, appropriate repositioning, attention to high-risk areas for skin breakdown, and the need to keep the patient dry.

Zeller JL. Patient pages: Pressure ulcers. *JAMA*. 2006;296(8):1020.

- Consider designating a team leader/champion for each unit or area. This person would be the unit resource for skin breakdown prevention and coordination of the process with the unit manager.

Courtney BA, Ruppman JB, Cooper HM. Save our skin: Initiative cuts pressure ulcer incidence in half. *Nursing Management*. 2006;37(4):35-46.

Weekly Operations Team Meetings

- Nurse Unit Leader and Unit Champion from each unit where rollout has occurred attends weekly operations meeting to report hospital-acquired pressure ulcers identified during the previous week.

Gibbons W, Shanks HT, Kleinhelter P, Jones P. Eliminating facility-acquired pressure ulcers at Ascension Health. *Joint Commission Journal on Quality and Patient Safety*. 2006;32:488-496.

- Nurse Unit Leader and Unit Champion report results of weekly chart audits for compliance with components of pressure ulcer prevention.

Courtney BA, Ruppman JB, Cooper HM. Save our skin: Initiative cuts pressure ulcer incidence in half. *Nursing Management*. 2006;37(4):35-46.

Measurement

Teams should measure compliance with each of the key components of evidence-based pressure ulcer care. Document that each component of care was provided or contraindicated; these are “process measures”: Improvement in an individual measure indicates that the processes surrounding that care element have improved. However, improvement in patient outcomes requires improvement in all component measures. (See Appendix A for detailed information about the measures for this intervention.)

We recommend three process measures for pressure ulcer care:

- Percent of Patients Receiving Pressure Ulcer Admission Assessment (Skin Assessment, Risk Assessment)
- Percent of At-Risk Patients Receiving Full Pressure Ulcer Preventative Care (Inspect Skin Daily, Manage Moisture, Optimize Nutrition, Reposition, Use Pressure-Relieving Surfaces)
- Percent of Patients Receiving Daily Pressure Ulcer Risk Reassessment

Note that the first two measures listed here follow an “all-or-none” format. All components must be performed (or contraindications documented) for compliance to be recorded. This sets a high standard, and is somewhat unforgiving for new teams beginning the work, but the approach has worked well in improvement projects to achieve highly reliable delivery of all components of an intervention. For a discussion of this “all-or-none” approach to measurement, see Nolan T, Berwick DM, “All-or-none measurement raises the bar on performance” ([JAMA. 2006;295\(10\):1168-1170](#)).

In addition to the process measures for each of the key components of pressure ulcer care, we recommend that teams measure pressure ulcer incidence (patients that develop pressure ulcers during their admission) as an outcome measure:

- Pressure Ulcer Incidence per 100 Admissions
- Pressure Ulcer Incidence per 1000 Patient Days

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How-to Guide: Prevent Pressure Ulcers

There are different strategies for collecting the data needed to calculate this measure; these options are described in the body of the Measure Information Form (MIF) linked to in Appendix A.

Prevalence (patients with pressure ulcers at a point in time, regardless of whether the pressure ulcer developed during or before the current admission) is a widely used outcome measure for pressure ulcer tracking, particularly in epidemiological studies. We have chosen to recommend use of incidence instead of prevalence as an intervention-level measure because incidence is more focused on the hospital improvement work suggested in this intervention. Of course, hospitals may use prevalence for their internal measurement if they believe it is more meaningful.

Appendix A: Recommended Intervention-Level Measures

The following measures are relevant for this intervention. The Campaign recommends that you use some or all of them, as appropriate, to track the progress of your work in this area. In selecting your measures, we offer the following advice:

1. Whenever possible, use measures you are already collecting for other programs.
2. Evaluate your choice of measures in terms of the usefulness of the results they provide and the resources required to obtain those results; try to maximize the former while minimizing the latter.
3. Try to include both process and outcome measures in your measurement scheme.
4. You may use measures not listed here, and, similarly, you may modify the measures described below to make them more appropriate and/or useful to your particular setting; however, be aware that modifying measures may limit the comparability of your results to others'. (Note that hospitals using different or modified measures should not submit those measure data to IHI.)
5. Remember that posting your measure results within your hospital is a great way to keep your teams motivated and aware of progress. Try to include measures that your team will find meaningful, and that they would be excited to see.

Process Measure(s):

Percent of Patients Receiving Pressure Ulcer Admission Assessment
Owner: IHI
Owner Measure ID: N/A
Measure Information: [Campaign MIF]
Comments:

Percent of At-Risk Patients Receiving Full Pressure Ulcer Preventative Care
Owner: IHI
Owner Measure ID: N/A
Measure Information: [Campaign MIF]
Comments:

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How-to Guide: Prevent Pressure Ulcers

Percent of Patients Receiving Daily Pressure Ulcer Risk Reassessment
Owner: IHI Owner Measure ID: N/A Measure Information: [Campaign MIF] Comments:

Outcome Measure(s):

Pressure Ulcer Incidence per 100 Admissions
Owner: IHI Owner Measure ID: N/A Measure Information: [Campaign MIF] Comments:

Pressure Ulcer Incidence per 1000 Patient Days
Owner: IHI Owner Measure ID: N/A Measure Information: [Campaign MIF] Comments:

Alignment with Other Measure Sets:

No known use of these measures in other national measure sets (e.g., JCAHO, CMS, CDC, NQF, etc.)