Reducing Incidence of Hospital Acquired Pressure Ulcers at Henry Ford West Bloomfield Hospital (HFWB)

Cristina A. Raymundo, BSN, RN and Heather Y. Ainsworth, BSN

HFWB MISSION AND VISION

Mission
Improving people's lives through excellence in the science and art of health care and healing.

Vision
Transforming lives and communities through health and wellness, one person at a time.

AIM

Henry Ford West Bloomfield, in alignment with the no harm campaign, and Henry Ford Health System's mission to improve patient safety and increase patient satisfaction implemented an initiative to decrease hospital acquired pressure ulcers.

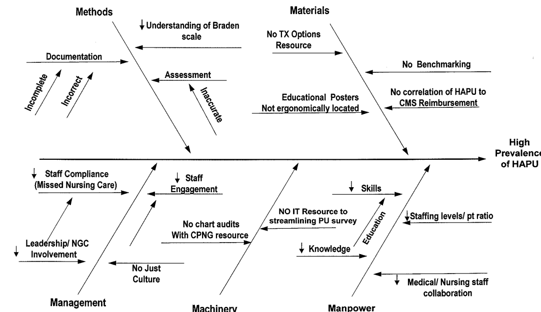
A team of clinical skin innovators (CSI) was created to spearhead innovative strategies to decrease and sustain hospital acquired pressure ulcers by 50% in 2012.

ANALYSIS

In May, 2010 to April, 2011, Henry Ford West Bloomfield Hospital noted that hospital acquired pressure ulcers had consistently been above the national benchmark.

Root cause data analysis identified contributing factors that directly contributed to high prevalence of HAPU:
•Improper documentation
•Incorrect identification of HAPU
•Lack of education in evidence based nursing practice regarding treatment and prevention of HAPU
•Lack of evidence base practice
•Insufficient collaboration with the leadership and medical team

BASELINE DATA



STRATEGY AND IMPLEMENTATION

•CSI: West Bloomfield. Created a TEAM known as Clinical Skin Innovators on March, 2011. Each team member has to complete NDNQI PU certification.

• Monthly skin audits initiated as recommended by NDNQI on April, 2011 allowing for dynamic changes in implementations according to real-time data in conjunction with Lean/PDCA.

•May, 2011. Pressure ulcer staging and treatment posters ergonomically placed where the flow of nursing care and treatment products are located. Medical team was inserviced and collaboration for treatment was established

•Single Point lessons on a mobile education cart given by CSI members, rotated among the units in June, 2011.

•Partnership with a) Nursing governance to engage nursing staff in safety mentality. Missed Nursing Care, May 2011 b) Information services regarding electronic data application streamlining process for faster reporting and action optimization in Dec, 2011 c) Nursing administration in promoting "just culture" when coaching staff in assessment and documentation. Just culture conference May, 2012.

EVALUATION

Monthly surveys showed decline close to 80% of HAPU sustained for 6 months.

Monthly graphs reflected cost savings reduction of reimbursement denials for every HAPU stage I and above. The highest saving is $ 520,000 all HAPU and $280,000 for stage II and above in one survey alone.

2010 and 2011 DATA

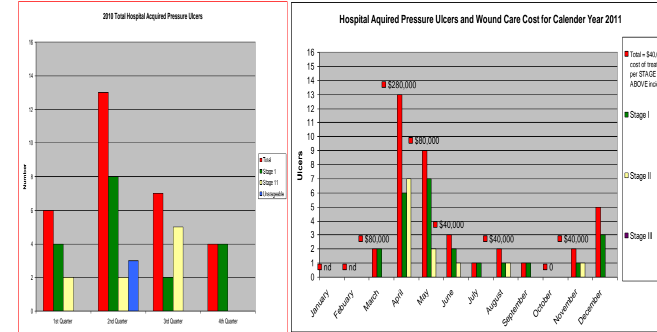


Figure 1. Hospital Acquired Pressure Ulcers and Reimbursement $ Lost Calendar Year 2010-2011

2012 DATA

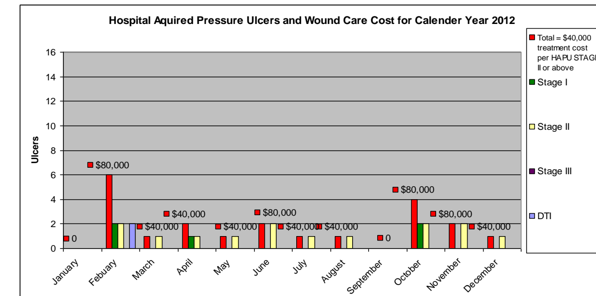


Figure 2 Hospital Acquired Pressure Ulcer and Reimbursement $ Lost Calendar Year 2012

IMPLICATIONS TO PRACTICE

- 2 RN's skin assessment on documentation
- Knee high ted hose replaced thigh high
- Limb position during surgery enhanced
- Nurses influenced doctors to reference pressure ulcer treatment poster
- Staff nurses integration of assessment data with the family promoted engagement
- Staff awareness on the Hospital Acquired Conditions implication on reimbursement
- Proper use of products to the appropriate pressure ulcer, hence cost savings on wasteful usage.