Utilizing Lean Methodology in Reduction of Hospital Acquired Pressure Ulcers (HAPUs)

Presenter: Carol Brewer, RN, BSN, CHRN, CWS, FACCWS
Collaborator: Beth Petty, BSN, RN, CPHQ
Baylor Medical Center at Garland

Abstract

Baylor Medical Center at Garland was above the NDNQI mean for Hospital Acquired Pressure Ulcers (HAPUs). HAPUs are an avoidable injury that CMS regards as a never event. HAPUs can increase a patient’s length of stay; decrease their quality of life and decrease patient satisfaction. HAPUs also impact a hospital financially by increased cost and reduced reimbursement.

A multi-disciplinary team was formed to research and identify gaps in patient care that could result in a pressure ulcer. Each area where a gap occurred that issue was evaluated and a best practice was identified to address the issue.

Objective

A multi-disciplinary team will use Lean methodology to assess the patient care process on the nursing unit with the highest incidence of HAPUs to identify gaps, implement key changes, and monitor for improvements.

Methods/Measurement

Methods:
Lean Methodology

Process included:
Frontline approach
Collaborative problem solving

Three Phases:
Diagnosis Phase
Treat Phase
Sustain Phase

Measurement:
Data collected during the monthly NDNQI Pressure Ulcer Prevalence Study

Prioritization of solutions were made by identifying those with the highest impact and ease of implementation.

HAPU Solutions Impact 2x2

Easy
Difficult

Minimal
Maximum

Results

Training provided to all nurses and patient care technicians. Training methods included PowerPoint presentation, video messages from nursing and medical leaders, and role playing.

Training focused on gaps identified in the Lean diagnosis phase; Patient Assessment, Knowledge Deficit, Communication, Teamwork, and Patient Safety.

New education materials also implemented in new hire orientation.

Online NDNQI Pressure Ulcer training became an annual competency for all nursing staff

Audited patients with a Braden Score of 18 or less to ensure proper nursing interventions implemented.

Audited for turning of patient, correct documentation, number of linen layers, no diapers in bed, and use of whiteboard communication.

Formation of Skin Wound Assessment Team (SWAT) to create nursing champions for each floor. They serve as the resident expert, conduct monthly NDNQI Prevalence studies, and continually educate staff.

Outcomes

Reprinted with permission of NDNQI

Conclusions/Lessons Learned

Implementing best practices and resulting culture change proved to be a challenge

Regular audits reinforce best practice

Educate, educate, educate

Hold staff accountable

Tools

Commitment Statement Signed by Staff

Every nurse and patient care technician pledges to prevent pressure ulcers. The commitment statement was shared at the end of Lean HAPU training and is now distributed in new hire orientation. The commitment statement is part of each nurse and patient care technician’s employee file.

Patient and Family Education Tool

Patients and their family members need to understand the risks and complications of pressure ulcers. They also need to know that there are interventions to prevent pressure ulcers. An informational brochure is provided in admission packets.

SWAT Champions Easily Identifiable

Each Skin Wound Assessment Team (SWAT) champion wears a lapel pin to make them easily identifiable to nursing staff.

Reference