**STOP Pressure Ulcers Campaign**  
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### Purpose

To reduce hospital acquired pressure ulcers by introducing a house-wide STOP Pressure Ulcers campaign that includes new alert signage, electronic dashboard indicators, tools for monitoring compliance with prevention interventions, current number of patients with pressure ulcers, and a tool to review every newly documented pressure ulcer.

### Significance

Hospital acquired pressure ulcers (HAPU) increase patient discomfort and may contribute to morbidity and mortality as well as length of stay and cost of care. Developing new strategies and tools for prevention will improve patient outcomes, length of stay, healthcare costs, and possibly contribute to decreased readmissions.

### Contact Information

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### Strategy and Implementation

- **Nursing Care Indicator Report**

  - Assessment of skin integrity
  - Pressure ulcer documentation in the current admission

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<tr>
<th>Pt Name</th>
<th>Bed</th>
<th>Attd.Phys.</th>
<th>POA Ulcer</th>
<th>admUlcer</th>
<th>Ulcer Stage</th>
<th>Score</th>
<th>newUlcer</th>
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  - **Critical Event Analysis (CEA): Hospital Acquired Pressure Ulcer (HAPU)**

  - Date
  - Time
  - Ulcer Stage
  - Score
  - New Ulcer
  - POA Ulcer
  - admUlcer
  - Attd.Phys.
  - Pt. Label
  - HOB
  - Bed

  *Critical event review tool we are beginning to use for review of hospital acquired pressure ulcers.*

- **MONITORING TOOLS:**
  - Monitoring of Braden Score
  - Monitoring of Brink Score
  - Pressure ulcer documentation in the current admission

- **MONITORING TOOLS:**
  - Electronic Medical Record indicators
  - Real time - patient specific

- **REPORTING:**
  - Review pressure ulcer analysis data and report trends
  - Identify opportunities for improvement - local and across VUH
  - Recommend and Implement necessary changes
  - Continue PDSA cycle to improve outcomes

### Evaluation

- **STOP Pressure Ulcer door alert signs are now in use on all 21 inpatient units, bedside staff have been educated, all unit managers receive a daily unit performance and status report, an electronic Braden indicator is displayed on all clinical work stations. Since the implementation the number of patients with hospital acquired pressure ulcers has decreased 50 percent per NDNQI data from may 2011 to May 2012.**

### Implications for Practice

The use of multiple strategies to improve a culture of safety was successful in reducing pressure ulcers in our patients. These strategies (education, monitoring, reminders, and feedback) may be used to improve other problems impacting patient safety as well.

*The outline of the pressure ulcer dashboard available in the electronic medical record listing all patients with pressure ulcer documentation in the current admission at various data points.*