Objectives

• 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**

**Hospital Acquired Pressure Ulcer Prevalence, Stage 2+ NQF0201 (HIIN-P-U-2)**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>• 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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>• Number of patients surveyed on the day of the study</td>
</tr>
<tr>
<td>Numerator Inclusion</td>
<td>• Medical, Surgical, Step-Down, Med-Surg combined, and intensive Care units</td>
</tr>
<tr>
<td></td>
<td>• Patients aged 18 years and older</td>
</tr>
<tr>
<td>Numerator Exclusion</td>
<td>• Ulcers/injuries prevented on admission</td>
</tr>
<tr>
<td></td>
<td>• Patients refusing assessment</td>
</tr>
<tr>
<td></td>
<td>• Patients who are off the unit at the time of the study (x-ray, therapy)</td>
</tr>
<tr>
<td></td>
<td>• Medically unstable patients or those for whom assessment is contraindicated</td>
</tr>
<tr>
<td></td>
<td>• Patients who are actively dying and pressure ulcer prevention is no longer a treatment goal</td>
</tr>
<tr>
<td></td>
<td>• Moisture associated skin damage</td>
</tr>
<tr>
<td></td>
<td>• Skin Tears</td>
</tr>
<tr>
<td></td>
<td>• Venous or arterial stasis ulcers</td>
</tr>
<tr>
<td></td>
<td>• Mucosal membrane ulcers</td>
</tr>
<tr>
<td>Data Sources</td>
<td>• Prevalence study observations</td>
</tr>
</tbody>
</table>

**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?

AHRQ PSI 3 measure detail: [https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/VI0-ICO10TechSpecs/PSI_03_Pressure_Ulcer_Rate.pdf](https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/VI0-ICO10TechSpecs/PSI_03_Pressure_Ulcer_Rate.pdf)

NQF 0201 Pressure Ulcer Prevalence measure detail: [http://www.qualityforum.org/QPS/0201](http://www.qualityforum.org/QPS/0201)

Note: “hospital acquired on the day of the prevalence episode”
National Quality Forum Definition

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

- 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

Wound Care training
January and March
• To date: 891 documented Stage 2+ hospital acquired pressure injuries found during one day prevalence studies.
**Stage 3+ Definition**

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?

### Pressure Ulcer / Injury Data Collection Fact Sheet

**Pressure Ulcer Rate, Stage 3+ AHRQ PSI-03 (HIIN-PRU-3)**

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
<th>Discharges with any secondary diagnosis code for pressure ulcer stage 3, 4, or unstageable.</th>
</tr>
</thead>
</table>
| **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, spine 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 non-acute discharges  
Musculoskeletal disorders  
Skinitis  
Venous or arterial stasis ulcers  
Musosal membrane ulcers |
| **Denominator** | Medical and surgical discharges (as defined in the AHRQ measure specifications, Appendix C and E) aged 18 years and older |
| **Data Source** | Administrative data  
Incident on 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 50 hours or less (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network/MLN/MLN160389/downloads/CriticalAccessHospital.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.
State HIIN Data-Stage 3+

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?
Sprint Results
Results from HRET HAPI Sprint

Anatomical Location
- Sacral
- Buttocks
- Coccyx
- Heel

Unit Type
- Discovered in ICU
- Is your ED Contributing?

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

Image
HAPI PI Tool

HRET HIIN PROCESS IMPROVEMENT DISCOVERY TOOL
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 resources needed. 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 22 hours prior to the HAPI discovery and 22 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!

<table>
<thead>
<tr>
<th>HAPI DETAIL</th>
<th>Chart #</th>
<th>Chart #</th>
<th>Chart #</th>
<th>Chart #</th>
<th>Chart #</th>
<th>Chart #</th>
<th>Chart #</th>
<th>Chart #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ANATOMICAL LOCATION OF HAPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of stay (LOS) when discovered</td>
</tr>
<tr>
<td>Stage when discovered</td>
</tr>
<tr>
<td>The patient was transferred prior to discovery</td>
</tr>
<tr>
<td>Unit patient was on when HAPI discovered</td>
</tr>
</tbody>
</table>

**PROCESS**

<table>
<thead>
<tr>
<th>Risk Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>A standard HAPI risk screening tool was used to assess the patient’s risk.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support Surface</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support surface — the patient was on a specialty support surface.</td>
</tr>
<tr>
<td>Patient was placed on specialty surface in ER.</td>
</tr>
<tr>
<td>If patient was not on a specialty surface in the ED, what was their length of stay?</td>
</tr>
<tr>
<td>Patient was placed on specialty mattress in the OR.</td>
</tr>
<tr>
<td>If OR specialty surface was not used, what was the OR length of stay?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head to toe skin assessment is documented per policy on admission.</td>
</tr>
<tr>
<td>Skin inspection is documented per policy.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Redness is recognized before skin breakdown occurs and is alleviated with pressure relief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep Moving</td>
</tr>
<tr>
<td>Mobilization — patient is mobilized to their highest ability</td>
</tr>
<tr>
<td>Pressure redistribution is documented (GHV) for immobile patients</td>
</tr>
<tr>
<td>Patient is repositioned in a way to prevent friction and shear. Immobilized patients are moved with equipment, glide sheets used</td>
</tr>
<tr>
<td>Heels are floated for immobile patients</td>
</tr>
<tr>
<td>Sacral foam dressing in place to protect from shear and moisture (H/A if injury is not on sacral)</td>
</tr>
<tr>
<td>Head of bed (HOB) not greater than 30 degrees</td>
</tr>
<tr>
<td>Incontinence/Moisture</td>
</tr>
<tr>
<td>Moisture — incontinence managed optimally — external catheters, local collection devices</td>
</tr>
<tr>
<td>Barrier cream used</td>
</tr>
<tr>
<td>Moisture from drainage and intertrigous skin related issues is managed</td>
</tr>
<tr>
<td>If moisture score 1 or 2, or incontinence or moisture present, patient is placed on a low air-loss mattress</td>
</tr>
<tr>
<td>Nutrition/Hydration</td>
</tr>
<tr>
<td>Nutritional consult completed or nutritional interventions in place for high risk patient</td>
</tr>
<tr>
<td>Food intake documented and addressed, i.e. supplements provided if intake documented as inadequate or poor</td>
</tr>
<tr>
<td>Patient’s fluid intake was addressed</td>
</tr>
<tr>
<td>Medical Devices: trach, O2, cervical collar, antibiotics — band or foot brakes</td>
</tr>
<tr>
<td>Protective measures were taken to prevent device-related injury: foam padding, protective dressings, reposisioning of the device</td>
</tr>
<tr>
<td>Patient and Family Engagement (PFE)</td>
</tr>
<tr>
<td>Documentation present that the patient’s HAPI risk was discussed with patient and/or family</td>
</tr>
<tr>
<td>Documentation present that the patient’s or family’s understanding of the need for HAPI prevention is validated using teach-back</td>
</tr>
<tr>
<td>Documentation present that the patient and/or family have been educated about repositioning, protective skin care measures, hygiene, and nutrition/hydration</td>
</tr>
<tr>
<td>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</td>
</tr>
</tbody>
</table>
Prevention
What Matters

Partnering with Patients

Focus on the Basics

Skin Inspection
Keep Moving
Incontinence
Nutrition
Hydration

= Healthy Skin

IHAnet.org/Quality-Patient-Safety
Nutrition is Very Important!

Patient & Family Engagement Matters

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 15 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
- Having very fast weight loss
- Not drinking enough water

What are the most common places to develop a pressure ulcer?
- Buttocks or bottom
- Elbow
- Hip
- Forehead

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

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

Preventing Pressure Sores

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 wear off. This can happen if you are pulled across bed sheets or when fragile skin wears as it is scraped against a surface. The skin may leak and feel like it is burning. This is called a 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 low or normal body weight.
- Have 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 (like the bed sheet area, back of the shoulder, sides of the hips, heels, ears and ankles). If you need help, have another person check your skin each day or use a mirror to see.
HRET Change Package

PREVENTING HOSPITAL ACQUIRED PRESSURE ULCERS/INJURIES

>>> (HAPU/I)

Education-AHRQ Video & Learning Modules

Conducting a Comprehensive Skin Assessment

Presented by
Dr. Karen Zulkowski, D.N.S., RN
Montana State University

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

Preventing Pressure Injuries in Hospitals

ADD Name of Hospital Here
Module 1 – Understanding Why Change Is Needed


IHAconnect.org/Quality-Patient-Safety
Help

• 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.
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Email: mwilson@IHAconnect.org

Indiana Hospital Association
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