Organization: University of Maryland Rehabilitation & Orthopaedic Institute

Solution Title: Taking the Pressure Off: Reducing the Incidence of HAPUs

Program/Project Description, including Goals: What was the problem to be solved? How was it identified? What baseline data existed? What were the goals—how would you know if you were successful?

The University of Maryland Rehabilitation & Orthopaedic Institute (UMROI) is a 144 bed specialty hospital. Our inpatient units include the following rehabilitation specialty areas: Stroke, Traumatic Brain Injury, Spinal Cord/Multi Trauma, and Comprehensive Medical Rehabilitation. In addition, we have a Progressive Care Unit inclusive of the following levels of care: ICU, IMC, Med-Surg, & Rehabilitation.

The goal of the program was to decrease the incidence of Hospital Acquired Pressure Ulcers (HAPU). The target utilized was obtained from a National Database for Nursing Quality.

UMROI has been participating in a National Nursing Quality Database, and benchmarking for several years. Participation requires completion of quarterly pressure ulcer surveillance surveys. During the timeframe previous to this project, UMROI HAPU rates exceeded the database target. UMROI’s two most recent pressure ulcer surveillance surveys reflect rates that are below the database target (see graph below).

Process: What methodology or process was used to develop the Solution?

Two individual HAPU cases were reviewed by the Risk Manager and Quality Department Staff. Information regarding this review was provided to the CNO, who convened a group of wound care nurses and educators. A Plan of Action was developed following review of the individual case information, as well as information gathered regarding UMROI practices related to wound care, and incidence data.

Plan – Do – Study – Act methodology was utilized.

Please refer to “Solution” section that follows for details.

Solution: What Solution was developed? How was it implemented?

A comprehensive Pressure Ulcer Reduction Plan was developed.

To facilitate utilization by the clinicians, our Wound Care Policy was redesigned into the following 5 separate polices:

- Skin Assessment & Braden Scale
- Pressure Ulcer Prevention
- Pressure Ulcer Staging
- Wound care Consults & Referrals
- Wound Care Treatment
Plan elements implemented as of this date follow.
RNs completed a mandatory Wound Care Program inclusive of the following:
- Assessment (initial & ongoing): wounds & pressure ulcers
- Prevention: pressure ulcers
- Treatment & Interventions: wounds & pressure ulcers
- Documentation: wounds & pressure ulcers

NTs, CNAs, LPNs completed a mandatory Wound Care Program inclusive of the following:
- Prevention: pressure ulcers
- Skin: observation & evaluation
- Documentation: interventions

Orientation:
- Orientation presentation revised
- Nurses are scheduled for a Wound Team shadow experience

An edition of Fast Facts for Patient Safety (UMROI Newsletter) was dedicated to Pressure Ulcer Reduction. Fast Facts is circulated electronically to all UMROI staff.

Interdisciplinary Wound Care Rounds were piloted on the unit with the highest HAPU incidence. Wound Care Rounds are now completed every other week on the four inpatient rehabilitation units. A member of the Wound Care Team selects a patient and/or related topic. Round format may be a sit down discussion, and/or at the patient’s bedside. Focus and content is specific as appropriate to each unit/patient.

**Measurable Outcomes: What are the results of implementing the Solution? Provide qualitative and/or quantitative results to data. (Please include graphs, charts, or tools).**

As indicated on the graph below, the HAPU rate for UMROI’s two most recent quarters has dropped from 9% to 2%, which is below the National Nursing Database target comparative of 3%.
Sustainability: What measures are being taken to ensure that results can be sustained and spread?

One strategy to assist with sustaining our improvement is the placement of UMROI HAPU incidence on several dashboards. Dashboards are shared with both internal and external stakeholders.

UMROI HAPU incidence is reflected on the following:

- University of Maryland Medical System Corporate Report Card
- UMROI Dashboard
- Unit Based Report Cards, which are reviewed by the Unit Based Quality Teams, and shared at nursing & therapy staff meetings

Interdisciplinary wound care rounds are completed on each rehabilitation unit every other week.

Regular reporting on implementation of the plan of action and outcome measures assist in holding staff accountable. Implementation and outcomes are reported to the Patient Safety Steering Committee (PSSC). The PSSC is composed of the CEO, CMO, CNO, and Quality Director.

Additional plan components not yet implemented include the following:

- Revise the Annual Competency for all nursing staff.
- Evaluation of the formulary for wound care products
- Completion of documentation audits: admission skin assessment, prevention interventions, and daily skin assessment
- Random monitor to determine accuracy of Braden Score
- Monitoring of the time from wound care consult request to completion
- Development of Medical Executive Committee approved protocols for implementation by the Wound Care Team
Role of Collaboration and Leadership: What role did teamwork and collaboration play in the Solution? What partners and participants were involved? Was the organization’s leadership engaged and did they share the vision for success? How was leadership support demonstrated?

The Wound Care Team, in collaboration with the Chief Nursing Officer took the lead in development of the action plan. Following action plan development, the professional development staff assisted in identification of best practice learning opportunities. The Patient Care Managers and Patient Therapy Managers encourage and facilitate staff attendance at the unit based interdisciplinary wound care rounds.

The Nursing Clinical Practice Council reviewed the wound care policies. The policies then went to the Clinical Review Board (CRB), which is composed of members of the interdisciplinary leadership team (Nursing, Quality, Pharmacy, OT, PT, Medical Staff). The interdisciplinary engagement in the review and responsibility for wound care policies helps to supports a comprehensive approach to the prevention of HAPUs.

Innovation: What makes this Solution innovative? What are its unique attributes?

The involvement of the interdisciplinary team makes this solution innovative. Occupational Therapy, Physical Therapy, Nursing, Pharmacy, and Medical Staff were, and continue to be engaged.

Related Tools and Resources
NDNQI:  www.nursingquality.org

Contact Person Donna Raimondi, RN, MS
Title Director, Quality & Regulatory
Email draimondi@umm.edu
Phone 410-448-6733