

Effectively Addressing Hospital-Acquired Pressure Injuries With a Multidisciplinary Approach

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Abstract

Background

Hospital-acquired pressure injuries (HAPIs) result in patient harm, discomfort, and even death, with an estimated 2.5 million HAPIs occurring annually in the United States. These pressure injuries from prolonged pressure on the skin and deeper tissues cause reduced blood flow and the breakdown of skin and tissues, resulting in wounds. Additionally, these injuries contribute to longer hospital stays and increased health care costs. Hospitals have programs aimed at reducing HAPIs as well as ongoing surveillance to identify new trends early on. This ongoing monitoring revealed a trend early at our institution that HAPIs were 66% higher than the national HAPI rate of 3.5% of observed patients. In rapid response, a multidisciplinary team was formed to address and improve the HAPI rate via a quality improvement project.

Methods

To achieve the goal of decreased pressure injuries or ulcers, a team of nurses, patient care technicians, nutritionists, infectious disease specialists, radiologists, surgeons, vascular technicians, supply chain administrators, case management and social workers, hyperbaric medicine specialists, and wound care experts was created. The team completed a gap analysis and discovered inconsistencies in documentation and care practices that led to HAPI rates above the national average. The team then standardized a policy, standardized documentation of wounds, and provided staff education. Measures were implemented to proactively prevent pressure injuries.

Results

There was a 4.2 percentage point decrease in HAPIs from the beginning of the project (5.76%) to the last survey (1.59%). However, this difference was not statistically significant ($P = .07$). Overall, there were 6 fewer patients (8 vs 2 patients) with hospital-onset observed injury. Additionally, the length of stay decreased by 46%. Documentation of skin assessments within 24 hours of admission improved to 100%.

Conclusion

We implemented a quality improvement program across 10 service lines, monitoring pressure injuries, HAPI incidence, and length of stay in 480 patients over 2 years. Although the reduction in HAPI was not statistically significant ($P = .07$), our program positively impacted the hospital's response to pressure injuries and warrants further replication.

Keywords

HAPI; pressure injury; wound care; patient safety; prevention; quality improvement