



NR584 Week 7: Applying Quality Improvement (QI) to Clinical Practice

Name: [REDACTED]

Assigned Topic: Hospital Acquired Pressure Ulcers (HAPUs)

General Instructions

Carefully read the assignment guidelines and rubric and complete each section of the assignment below using your assigned topic. Assume the role of a member of a QI team in charge of reviewing facility policies and procedures related to your assigned topic. Using the topic assigned to you, answer the following questions to explore and apply the QI process to improve client safety and care outcomes.

Section 1: Identify

- Describe your assigned topic and why it is a concern in healthcare.

Hospital-Acquired Pressure Ulcers (HAPUs) occur when pressure is sustained on the skin and tissue, usually over an area of a bony prominence, for extended periods of time leading to reduced blood flow to the area and skin breakdown creating wounds/ulcers (Roderman et al., 2024). HAPUs cause patient harm, discomfort, and increases patient mortality rates (Roderman et al., 2024). HAPUs are often preventable and it is a concern to healthcare because approximately 2.5 million occur in the U.S. yearly, prolonging patient stay as well as readmissions and cost the hospital up to 150K per patient per pressure injury (Roderman et al., 2024).

- Summarize a current policy or procedure at your facility related to this issue. How is this issue currently addressed?

At my current hospital, it is a policy to evaluate every patient's skin on admission, transfer to another unit, and post-procedure with another nurse. The nurse utilizes the Braden Scale and determines if the patient is at risk for skin breakdown and if they were admitted with a pressure ulcer. The Braden Score is assessed every shift. Any patient admitted with a pressure ulcer needs to have documentation of the type of pressure ulcer, the size, and the dressing that is applied. In addition, a wound care consult and general surgery consult must be placed per policy. For any patient scoring an 18 and under on the Braden Scale, its policy for skin prevention measures must be enacted including allevyns (foam dressing), zinc oxide creams, and pressure redistribution cushions. The specific prevention measures used are determined by the nurse.

- What inconsistencies exist between your facility's current policies, actual nursing practice, and best evidence related to your assigned topic? What evidence (data, observation, incident reports) suggests a need for improvement?

Current policy mandates that two nurses complete a patient skin check to ensure proper documentation of any potential ulcers especially on admission. This helps to determine whether the patient came to the hospital with a pressure ulcer or acquired one during the hospitalization. The two RN skin checks are reliable but when dealing with assessments of wounds, there can be inconsistencies as each nurse may assess, document, and treat wounds differently. Evidence suggests that interventions to prevent pressure injuries should be implemented immediately for patients at moderate to high risk and that staff need to be educated on proper wound assessment, documentation, and appropriate pressure injury interventions (Roderman et al., 2024). Standardizing wound assessments and documentation of pressure ulcers can help reduce variation across care and improve patient outcomes.

Section 2: Analyze

- Review national safety resources related to your topic. Name at least two national organizations or initiatives (e.g., Centers for Medicare & Medicaid Services (CMS), Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Institute for Health (IHI), National Patient Safety Goals (NPSG)) and summarize the guidance they provide related to your topic.

The Agency for Health Care Research and Quality (AHRQ) and the Center for Medicare and Medicaid Services (CMS) provide guidance on Hospital-Acquired Pressure Ulcers (HAPUs). More than 2.5 million people in the U.S. develop pressure ulcers every year, because of this the AHRQ has developed a pressure injury prevention toolkit. This toolkit is used by hospitals across the U.S. as it guides hospitals on planning and implementing a pressure ulcer prevention program, it details evidence-based practices in prevention care for ulcers, and it provides essentials for staff such as checklists and strategies to utilize in prevention (AHRQ, n.d.). This toolkit aids hospital organizations in implementing systemic changes to improve pressure ulcer prevention and treatment to lead to better patient outcomes and reduce associated hospital costs of pressure injury development. Another organization that provides guidance on HAPUs is CMS. CMS plays an important role in HAPU prevention as CMS classifies these ulcers as Hospital-Acquired Conditions and ties reimbursement to performance in reducing hospital-acquired conditions, so any condition such as a stage 3 or stage 4 pressure ulcer that was not present on admission, the hospital organization will not be reimbursed for the care of that ulcer (CMS, 2024). If hospitals have high numbers of pressure ulcers, they may be faced with medicare payment reductions, leading to hospitals having a significant financial incentive to prevent these conditions.