



Zero HAPU in the MICU: Nursing best practices reduces hospital acquired pressure ulcers in the Medical Intensive Care Unit

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Introduction

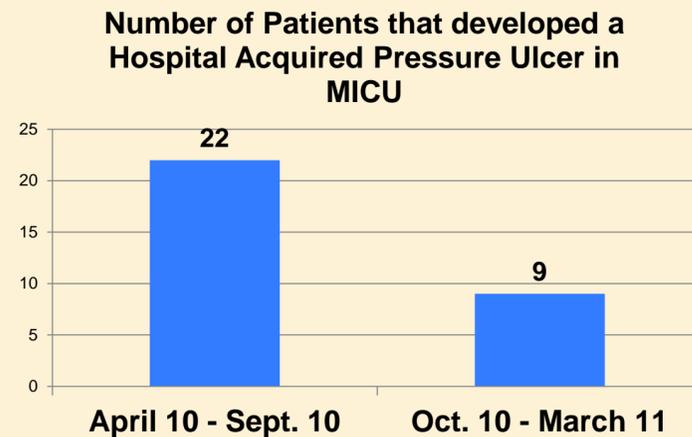
Hospital acquired pressure ulcers (HAPU) have been associated with an increased length of stay, sepsis and mortality. The total treatment cost in the United States is over \$11 billion/year². During a 6 month period (April 2010-September 2010) 22 patients acquired a pressure ulcer (PU) while in the Medical Intensive Care Unit (MICU). It is essential for nurses to assess for the increased risk for HAPU and implement strategies for prevention¹. Utilizing a shared governance model, our MICU practice council initiated a campaign to reduce our HAPU rate to zero.

Methods

The practice council fostered increased staff awareness by tracking each patient with a MICU HAPU. Staff was educated on skin assessment and proper documentation, promotion of best practices, and teamwork. Timely consults with certified wound ostomy nurses (CWON) were encouraged in order to answer questions and address specific skin breakdown and conditions.

Results

The monthly occurrence of HAPUs in the MICU was reduced to zero for 2 months from October 2010 to March 2011. Overall, only 9 HAPUs occurred in this same period, which is nearly a 60% reduction compared with the prior period (April to September, 2010). From April-December, 2011 our monthly HAPU has been 0 to 4. The results demonstrate that the MICU HAPU rate improved through a change in nursing practice that was focused on detailed skin assessment and documentation, increased frequency and quality of patient repositioning, attentive skin care, use of specialty beds/equipment, and optimal mobilization.



Discussion

“IT TAKES 2” was our motto for initial skin assessment performed by 2 nurses on all patients admitted to the MICU. Not only was skin breakdown less likely to be missed, but this change in practice was an educational opportunity for less experienced staff to identify skin conditions and to correctly stage pressure ulcers through mentorship of more experienced nurses.

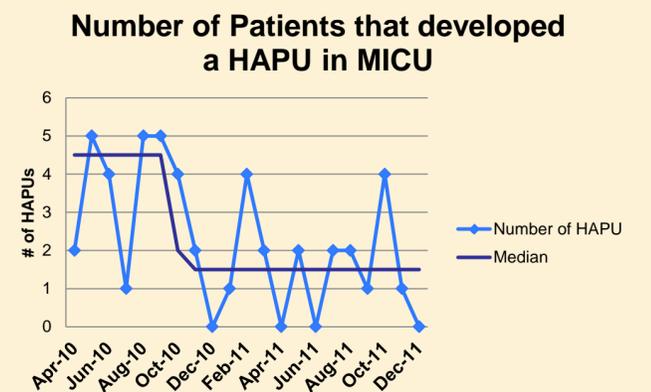
“NEVER TURN DOWN A TURN!” was our promotional slogan to encourage the frequency and quality of turning patients. Charge nurses and clinical practice group leaders made turn rounds, using wedges for optimal positioning. Early mobilization of vented and non-vented patients was encouraged as a team effort, utilizing lifts when necessary.

MICU specific case studies were presented every month. These emphasized increased risk factors for PU development, as well as, appropriate prophylaxis, such as pressure reduction beds, chair cushions, plus incontinence devices and skin care products.

Conclusions

Even in our present advanced technological era, it is still possible to change patients’ outcomes by cultivating fundamental bedside nursing care. HAPU in the MICU decreased by over half following focused improvements in best practices.

Staff accountability, ongoing education, and peer recognition continue to foster our MICU team approach to reducing HAPU. Our goal is always ZERO!



References

- Cox, J. (2011). Predictors of pressure ulcers in adult critical care patients. *American Journal of Critical Care*, 20(5), 364-374.
- How-to Guide: *Prevent Pressure Ulcers*. Cambridge, MA: Institute for Healthcare Improvement; 2011. (Available at www.ihl.org).