Getting Started Kit: Prevent Pressure Ulcers

How-to Guide

A national initiative led by IHI, the 5 Million Lives Campaign aims to dramatically improve the quality of American health care by protecting patients from five million incidents of medical harm between December 2006 and December 2008. The How-to Guides associated with this Campaign are designed to share best practice knowledge on areas of focus for participating organizations. For more information and materials, go to www.ihi.org/IHI/Programs/Campaign.

This How-to Guide is dedicated to the memory of David R. Calkins, MD, MPP (May 27, 1948 – April 7, 2006) -- physician, teacher, colleague, and friend -- who was instrumental in developing the Campaign’s science base. David was devoted to securing the clinical underpinnings of this work, and embodied the Campaign’s spirit of optimism and shared learning. His tireless commitment and invaluable contributions will be a lifelong inspiration to us all.

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How to cite this material:
The Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. IHI helps accelerate change by cultivating promising concepts for improving patient care and turning those ideas into action. Thousands of health care providers participate in IHI’s groundbreaking work.

Campaign Donors

The 5 Million Lives Campaign is made possible through the generous leadership and support of America’s Blue Cross and Blue Shield health plans. IHI also acknowledges the support of the Cardinal Health Foundation, and the support of the Blue Shield of California Foundation, Rx Foundation, the Aetna Foundation, Baxter International, Inc., The Colorado Trust, and Abbott Point-of-Care.

![Blue Cross Blue Shield Association](image1.png) ![Cardinal Health Foundation](image2.png)

This initiative builds on work begun in the 100,000 Lives Campaign, supported by Blue Cross Blue Shield of Massachusetts, the Cardinal Health Foundation, the Rx Foundation, the Gordon and Betty Moore Foundation, The Colorado Trust, the Blue Shield of California Foundation, the Robert Wood Johnson Foundation, Baxter International, Inc., The Leeds Family, and the David Calkins Memorial Fund.

Contributors

The work of leading organizations has informed the development of this guide. These include National Pressure Ulcer Advisory Panel (NPUAP), Ascension Health, Advancing Excellence in America’s Nursing Homes, the New Jersey Hospital Association (NJHA), OSF St. Francis Medical Center, and Owensboro Medical Health System.
Goal:
Prevent hospital-acquired pressure ulcers by reliably implementing the six components of care recommended in this Guide.

What Is a Pressure Ulcer?
A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. Because muscle and subcutaneous tissue are more susceptible to pressure-induced injury than skin, pressure ulcers are often worse than their initial appearance. Pressure ulcers are then staged to guide clinical description of the depth of observable tissue destruction.


The Case for Preventing Hospital-Acquired Pressure Ulcers
Although pressure ulcers are preventable in most every case, the prevalence of pressure ulcers in health care facilities is increasing. Pressure ulcer incidence rates vary considerably by clinical setting—ranging from 0.4% to 38% in acute care, from 2.2% to 23.9% in long-term care, and from 0% to 17% in home care.


It is estimated that pressure ulcer prevalence (the percentage of patients with pressure ulcers at any one point in time) in acute care is 15%, while incidence (the rate at which new cases occur in a population over a given time period) in acute care is 7%.

It is estimated that 2.5 million patients are treated for pressure ulcers in US health acute-care facilities each year.


Pressure ulcers cause considerable harm to patients, hindering functional recovery, frequently causing pain and the development of serious infections. Pressure ulcers have also been associated with an extended length of stay, sepsis, and mortality. In fact, nearly 60,000 US hospital patients are estimated to die each year from complications due to hospital-acquired pressure ulcers. The estimated cost of managing a single full-thickness pressure ulcer is as high as $70,000, and the total cost for treatment of pressure ulcers in the US is estimated at $11 billion per year.


The US Department of Health and Human Services document, *Healthy People 2010: Understanding and Improving Health*, lists reducing pressure ulcer incidence as an objective for all health care providers.

Six Essential Elements of Pressure Ulcer Prevention

Most pressure ulcers are preventable.

*Advances in Skin and Wound Care*. 2001;14(5):244-248.

Preventing pressure ulcers boils down to two major steps: first, identifying patients at risk; and second, reliably implementing prevention strategies for all patients who are identified as being at risk.

1. **Conduct a Pressure Ulcer Admission Assessment for All Patients**

The admission assessment should include both a risk assessment (to evaluate risk of developing a pressure ulcer) and a skin assessment (to detect existing pressure ulcers). These two assessments should be thought of as a single process step: a pressure ulcer admission assessment.

Many patients are at risk for developing a pressure ulcer. Key factors contributing to the development of pressure ulcers include the following: age, immobility, incontinence, inadequate nutrition, sensory deficiency, device-related pressure, multiple co-morbidities, circulatory abnormalities, and dehydration.


The AHCPR (the predecessor agency of AHRQ) clinical practice guidelines on pressure ulcer prevention recommend that initial pressure ulcer risk assessment be done on admission and that reassessment be done periodically based on patient condition.

The prompt identification of at-risk patients using a validated risk assessment tool is essential for accurate, prompt identification of at-risk patients and timely implementation of prevention strategies. The risk assessment must include an assessment of several components: mobility, incontinence, sensory deficiency, and nutritional status (including dehydration). The Braden Scale is the most widely utilized assessment tool in the US. Additional tools to assist with a comprehensive assessment include the Norton Scale, Gosnells Scale, Knoll Scale, and Waterlow Scale. An age-appropriate pressure ulcer risk assessment tool should be used in pediatrics.


>> What processes can be put in place to ensure the pressure ulcer admission assessment of all patients?
Hospitals can test the following process changes to ensure compliance with the assessment and identification of any patient at risk for pressure ulcers:

- Improve processes to ensure that risk assessment is conducted within four hours of admission for all patients.
- Include a visual cue on each admission documentation record for the completion of a total skin assessment and risk assessment.
- Agree on the use of a standard risk assessment tool (for example, Braden Scale); facilities may wish to adapt the tool to allow for easy completion, using check-boxes and short phrases to ensure completion.
- Utilize multiple methods to visually cue staff as to which patients are at risk. For example, consider using stickers in the patient chart or on the patient’s door so that all who enter will realize the patient is at risk for pressure ulcer development. This allows for a quick identification by any staff of patients at risk, both in the patient’s room or while the patient is in other departments, and prompt implementation of prevention strategies.
Build shared pride in progress. Post “Days since Last Pressure Ulcer” data.

2. Reassess Risk for All Patients Daily
The complexity and acuity of hospitalized patients require daily reassessment of the potential and degree of risk of pressure ulcer development. For example, changes in mobility, incontinence, or nutrition may change the patient’s risk of developing pressure ulcers. Assessing risk daily provides caregivers the opportunity to adjust prevention strategies according to the changing needs of the patient. The degree of risk, as specified in several standardized risk assessments, allows providers to implement targeted strategies for each patient. For example, after several days in the hospital, a patient’s nutritional intake may diminish, either due to patient preferences or condition. A daily risk assessment would enable caregivers to quickly identify the patient as having a nutritional need and initiate a consult to the clinical dietician.


>> What processes can be put in place to ensure daily reassessment of risk?

- Adapt documentation tools to prompt daily risk assessment, documentation of findings, and initiation of prevention strategies as needed. For example, include this information in daily clinical notes.
- Educate all levels of staff about potential risk factors of pressure ulcer development and the process for implementing prevention strategies.
- Use validated risk assessment tools for staff to easily identify degree of risk and potential prevention strategies.
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Implement steps 3-6 for all patients identified (in steps 1 and 2) as being at risk for pressure ulcers:

3. Inspect Skin Daily
Skin integrity may deteriorate in a matter of hours in hospitalized patients. Because risk factors change rapidly in acutely ill patients, daily skin inspection is crucial. Patients identified as being at risk need a daily inspection of all skin surfaces, “from head to toe.” Special attention should be given to areas at high risk for pressure ulcer development such as the sacrum, back, buttocks, heels, elbows, and areas subjected to device-related pressure. Ideally, staff should incorporate a skin inspection into their work, every time they assess the patient.


>> What processes can be put in place to ensure daily inspection of the skin?
- Adapt documentation tools to prompt daily skin inspection, documentation of findings, and initiation of prevention strategies as needed.
- Educate all levels of staff to inspect the skin any time they are assisting the patient, for example, when assisting patient to the chair, moving from one area to the other, while bathing, and when repositioning devices such as nasal oxygen tubing, oxygen masks, etc. Upon recognition of any change in skin integrity, notify staff so that appropriate interventions can be put in place.
4. Manage Moisture: Keep the Patient Dry and Moisturize Skin

Wet skin is conducive to the development of rashes, is softer, and tends to break down more easily. Skin should be cleansed at time of soiling and at routine intervals. The process of cleaning the skin should include gentle use of a mild cleansing agent that minimizes irritation and dryness of the skin. Treating dry skin with moisturizers has been shown to be especially effective in preventing pressure ulcers.


Care should be taken to minimize exposure of the skin to moisture due to incontinence, perspiration, or wound drainage. When these sources of moisture cannot be controlled, use underpads made of materials that absorb moisture and present a quick-drying surface to the skin. Also use topical agents that act as moisture barriers and moisturize the skin.


>> What changes can we make to ensure effective management of moisture?

- Look for opportunities to design a process for periodic activities such as repositioning, assessing for wet skin, applying barrier agents, offering toileting opportunity, and even offering P.O. fluids (water). By combining routine activities in a protocol such as a “pressure ulcer prevention protocol,” staff can complete multiple tasks while in the room every two hours and document them all at once.
• Provide supplies at the bedside of each at-risk patient who is incontinent. This provides the staff with the supplies that they need to immediately clean, dry, and protect the patient’s skin after each episode of incontinence.
• Provide underpads that pull the moisture away from the skin, and limit the use of disposable briefs or containment garments if at all possible.
• Provide pre-moistened, disposable barrier wipes to help cleanse, moisturize, deodorize, and protect patients from perineal dermatitis due to incontinence.
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5. Optimize Nutrition and Hydration

Assessment of the patient for possible risk of pressure ulcer development should include a review of nutritional factors and an assessment of hydration. Patients who are assessed with deficits in nutritional intake and hydration may have muscle mass loss and weight loss, making the bones more prominent and making it hard for patients to be mobile. Often with nutrition deficits and fluid imbalance there may be edema and reduced blood flow to the skin, causing ischemic damage, which contributes to skin breakdown.


Patients who are malnourished may be twice as likely to develop skin breakdown.


Fluid, protein, and caloric intake are important aspects of maintaining adequate general nutrition. Nutritional supplements or support may be needed if dietary intake is insufficient. If a patient is identified with significant nutritional needs, a registered clinical dietician should be consulted to assess and suggest feasible nutritional interventions.

>> What changes can we make to optimize nutrition and hydration?

- Assist patient with meals, snacks, and hydration. Every effort should be made to allow patient preferences when medically appropriate.
- Document the amount of nutritional intake, and notify the dietitian or physician if the patient does not have adequate intake.
- Offer water to every patient who is scheduled to be turned. The process could include these steps: offer toileting, assess for needs of cleanliness, change wet surfaces, and offer water.
6. Minimize Pressure
Redistribution of pressure, especially over bony prominences, is of primary concern. Patients with limited mobility are especially at risk for the development of pressure ulcers. Every effort should be made to redistribute the pressure on the skin, either by repositioning or by utilizing pressure-redistribution surfaces.


Two key components have proven especially effective in minimizing pressure:

- **Turn/reposition patients every two hours.**
The aim of repositioning is to redistribute pressure, thereby maintaining circulation to areas of the body at risk for pressure ulcers. The literature does not suggest how often patients should be turned to prevent ischemia of soft tissue, but two hours in a single position is the maximum duration of time recommended for patients with normal circulatory capacity. Turning patients every two hours is a foundational element in most pressure ulcer prevention protocols. The turning, or repositioning, of the at-risk patient temporarily shifts or relieves the pressure on the susceptible areas, diminishing the risk of pressure ulcer development.

Pillows and blankets are simple, readily available supplies that may be utilized to assist in pressure redistribution. When used wisely, they may expand the weight-bearing surface by molding to the body. Use pillows under the calf to elevate the patient’s heels off the bed surface. Place cushioning devices between the legs/ankles to maintain alignment and prevent pressure on bony prominences (NPUAP clinical guidelines,
1992). Often the skin of patients identified at risk for pressure ulcers is easily torn inadvertently during repositioning. Clinicians should take care while actually turning the patient to protect the skin. Clinicians should consider using lift devices or “drawsheets” to move, rather than drag, individuals who are not able to assist during transfers and position changes.

- **Use pressure-redistribution surfaces.**

Specialized support surfaces (such as mattresses, beds, and cushions) redistribute the pressure that the patient’s body weight exerts on the skin and subcutaneous tissues. If a patient’s mobility is compromised and this interface pressure is not redistributed, the pressure can lead to impaired circulation and ulcer formation. Many studies have examined the benefits demonstrated by pressure-redistribution surfaces in the prevention of pressure ulcers.

Pressure-redistributing surfaces may be classified as powered or non-powered, reactive or active. A powered support surface is one requiring or using external sources of energy to operate. A non-powered support surface does not require external energy sources of energy for operation. Reactive support surfaces are powered or non-powered, possessing the capability to change their load distribution properties only in response to an applied load. An active support surface is a powered support surface, with the capability to change its load distribution properties, with or without applied load.


Because surgical patients who are under anesthesia for extended periods of time often have an increased risk of developing pressure ulcers, all surgical patients (pre-operative, intra-operative, post-anesthesia) should receive a skin assessment and a risk assessment. Caregivers should then implement prevention strategies such as ensuring repositioning and placing patients on appropriate redistribution surfaces for all surgical patients who are identified as being at risk.


>> What changes can we make to minimize pressure?

- Use tools inside the patient room to remind caregivers to turn/reposition the patient every two hours.
- Utilize unit- or hospital-wide “musical” cues (for example, setting caregiver beepers to sound every two hours) to remind staff to turn/reposition all at-risk patients at two-hour intervals.
- Utilize positioning, transferring, and turning techniques to minimize friction/shear injury.
- Use pressure redistribution mattresses/overlays to assist with minimizing pressure.
Examples of Success

Hospitals have reported significant improvement in the prevention of pressure ulcers by developing and implementing a systematic approach to the identification of patients at risk of developing pressure ulcers and implementing standardized actions for at-risk patients. For example, OSF Saint Francis Medical Center (Peoria, IL) utilized Six Sigma methodologies to develop a treatment process and reduce the incidence of pressure ulcers. This led to the development of the “Save Our Skin” (SOS) project, an effort to reduce the number of hospital-acquired pressure ulcers in adults by 50% within one fiscal year.


The run chart below shows the reduction in hospital-acquired pressure ulcers at OSF Saint Francis – from 9.4% in 2001 (baseline) to 1.8% in December 2005.
Hospital Acquired Pressure Ulcers

Baseline 7.3%
After quick win
4.2% 5.2% 4.80%
3.1% 3.2% 4.06%
5.50%
1st quarter 3.3% 2.3% 3.1% 3.20%
1.8% 2.6%
1.5% 1.4%
1.50%
Owensboro Medical Health System (OMHS) in Owensboro, Kentucky, developed processes to ensure admission assessment and prevention strategies for all admitted patients. Process changes included hospital-wide education, changes in documentation processes, and the use of pressure-relieving surfaces for the highest-risk patients. OMHS also tested and implemented innovative strategies to assist staff in the continuous prevention processes, including placing turn-clock posters in each at-risk patient’s room and setting hospital caregiver beepers to alarm every two hours to remind staff to reposition high-risk patients. Incidence in acute care dropped 93% in just over two years of focusing on the prevention of pressure ulcers. The run chart below shows the reduction in pressure ulcer incidence at OMHS from March 2004 through June 2006.
Forming the Team
IHI recommends a multidisciplinary team approach to the prevention of pressure ulcers. Teams offer the value of bringing diverse personnel together, all with a stake in the outcome and working to achieve the same goal. All the stakeholders in the process must be included, to gain the buy-in and cooperation of all parties.

In order to be most effective, a core team of no more than five to seven people should oversee the work. As different changes are tested, other key people in the organization can be included on an ad hoc basis, especially if they can offer some special expertise that is limited to one area of the work. Team members for preventing pressure ulcers may include the following:

- Team Leader/Champion
- Nursing (for example, RN, assistant, technicians, staff representing different levels of care, etc.)
- Education
- Performance Improvement
- Dietary/Dietician
- Materials Management staff

(Note: In addition, consider including a patient or family member on the team.)

Some suggestions to attract and retain excellent team members include using data to define and solve the problem; identifying champions within the hospital who are passionate about preventing pressure ulcers and have credibility with staff and administration; and working with those who want to work on the project, rather than trying to convince those who do not.

The team needs encouragement and commitment from senior leadership; an administrative representative on the team is powerful in keeping the team focused and relieving barriers. Identifying a champion increases a team’s motivation to succeed. When measures are not improving, the champion readdresses the problems with staff and helps to keep everyone on track toward the aims and goals.
Another approach to the improvement work is to create sub-teams to work on specific care components or groups of care components. For example, one sub-team might work on education strategies for all staff. Another sub-team might focus on the supplies, availability of equipment needed as options for patients at risk, such as pads, cleansing wipes, and bed surfaces. A third team might be responsible for the testing and piloting of tools and standard processes. These are just a few examples of sub-groups, which can be an effective way to divide the work and achieve improvement more quickly. The sub-groups should report their work and results to the core team, which oversees the entire project and ensures coordination.

**Setting Aims**

Improvement requires setting aims. An organization will not improve without a clear and firm intention to do so. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected. Agreeing on the aim is crucial; so is allocation of people and resources necessary to accomplish the aim.

The overall goal of this Campaign intervention is to prevent pressure ulcers. Hospitals may set specific aim statements in pursuit of this overall goal. These aim statements might specify percentage reductions within a set timeframe. A sample aim statement might be:

- Reduce the incidence of hospital-acquired pressure ulcers by 50% by December 2008.

Teams are more successful when they have unambiguous, focused aims. Setting numerical goals clarifies the aim, helps to create tension for change, directs measurement, and focuses initial changes. Once the aim has been set, the team needs to be careful not to back away from it deliberately or "drift" away from it unconsciously.

This is only meant to be an example; your team should develop its own aim statement so that the team will feel ownership of the aim.
Using the Model for Improvement

In order to move this work forward, IHI recommends using the Model for Improvement. Developed by Associates in Process Improvement, the Model for Improvement is a simple yet powerful tool for accelerating improvement that has been used successfully by hundreds of health care organizations to improve many different health care processes and outcomes.

The model has two parts:

- Three fundamental questions that guide improvement teams to 1) set clear aims, 2) establish measures that will tell if changes are leading to improvement, and 3) identify changes that are likely to lead to improvement.

- The Plan-Do-Study-Act (PDSA) cycle to conduct small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.

Implementation: After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale — for example, for an entire pilot population or on an entire unit.

Spread: After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or to other organizations.

You can learn more about the Model for Improvement on [www.IHI.org](http://www.IHI.org)

The sample PDSA Worksheet that follows illustrates how an improvement team might document the first test cycle using this tool.
**Project:** Pressure Ulcer Prevention

**Objective for this PDSA Cycle:** Test the process for completing a pressure ulcer risk assessment on admission to the hospital.

**PLAN:**

**Questions:** How can we ensure total compliance with completion of a pressure ulcer risk assessment on each admission to the hospital?

**Predictions:** Adding cues to the admission packet will help ensure compliance with identification of patients at risk for pressure ulcers on admission.

**Plan for change or test – who, what, when, where:**
- **What:** Add a risk assessment tool to admission packet.
- **Who:** Bonnie (nurse) to do a risk assessment on each patient admitted on 4 North.
- **Where:** Admission packets (Make up 3 packets for pilot test.)
- **When:** January 15

**Plan for collection of data – who, what, when, where:**
- **Who:** Bonnie (nurse)
- **What:** Compliance with any patient admitted
- **When:** January 15
- **Where:** 4 North

**DO:** Carry out the change or test. Collect data and begin analysis.
Four patients were admitted to 4N on 1/15; the assessments and the risk assessments were completed by Bonnie.

**STUDY:** Complete analysis of data:
- **How did or didn’t the results of this cycle agree with the predictions that we made earlier?**
- **Summarize the new knowledge we gained by this cycle:** All assessments of risk were completed as designed for these four patients.

**ACT:**
- **List actions we will take as a result of this cycle:** Test for all admissions to 4N for the week of January 20.
- **Plan for the next cycle (adapt change, another test, implementation cycle?):** Will see if additional cues are needed, look for completion and compliance with all elements of tools.
**Tips and Tricks**

- Use pressure ulcer prevalence data to assist with the choice of a pilot unit. (Start with the units, and the populations, with the highest prevalence.)
- Use process measures to drive change, not outcome measures (e.g., prevalence and incidence). Collect data on process measures weekly (10 charts/week) on units piloting and implementing strategies until reliability is achieved.
- Begin with one pilot unit, design specific processes for compliance with strategies, and roll out by units.
- Set a schedule to bring on units systematically, and keep to the schedule.
- Match the education schedule with the roll-out schedule.
- Develop a “pocket guide” for staff, containing helpful tips for patients at risk for pressure ulcers.
- Include the patient and family in education regarding pressure ulcer prevention. Include an overview of the patient’s risk factors and the importance of nutrition and fluid intake, appropriate repositioning, attention to high-risk areas for skin breakdown, and the need to keep the patient dry. (A [patient and family fact sheet](https://www.ihi.org) is available on [www.ihi.org](http://www.ihi.org))


- Consider designating a team leader/champion for each unit or area. This person would be the unit resource for skin breakdown prevention and coordination of the process with the unit manager.

Weekly Operations Team Meetings

- Nurse Unit Leader, Unit Champion, and key staff from the pilot unit attend weekly operations meeting to report hospital-acquired pressure ulcers identified during the previous week.


- Nurse Unit Leader and Unit Champion report results of weekly chart audits for compliance with components of pressure ulcer prevention for pilot unit, and as units roll out, compliance measures are measured until reliability is demonstrated.

Measurement

Teams should measure compliance with each of the key components of evidence-based pressure ulcer care. Document that each component of care was provided or contraindicated; these are “process measures”: Improvement in an individual measure indicates that the processes surrounding that care element have improved. However, improvement in patient outcomes requires improvement in all component measures. (See Appendix A for detailed information about the measures for this intervention.)

We recommend three process measures for pressure ulcer care:

- Percent of Patients Receiving Pressure Ulcer Admission Assessment (Skin Assessment, Risk Assessment)
- Percent of At-Risk Patients Receiving Full Pressure Ulcer Preventative Care (Inspect Skin Daily, Manage Moisture, Optimize Nutrition, Reposition, Use Pressure-Redribution Surfaces)
- Percent of Patients Receiving Daily Pressure Ulcer Risk Reassessment

Note that the first two measures listed here follow an “all-or-none” format. All components must be performed (or contraindications documented) for compliance to be recorded. This sets a high standard, and is somewhat unforgiving for new teams beginning the work, but the approach has worked well in improvement projects to achieve highly reliable delivery of all components of an intervention. For a discussion of this “all-or-none” approach to measurement, see Nolan T, Berwick DM, “All-or-none measurement raises the bar on performance” (JAMA. 2006;295(10):1168-1170).

In addition to the process measures for each of the key components of pressure ulcer care, we recommend that teams measure pressure ulcer incidence (patients that develop pressure ulcers during their admission) as an outcome measure:

- Pressure Ulcer Incidence per 100 Admissions
- Pressure Ulcer Incidence per 1000 Patient Days
There are different strategies for collecting the data needed to calculate this measure; these options are described in the body of the Measure Information Form (MIF) linked to in Appendix A.

Prevalence (patients with pressure ulcers at a point in time, regardless of whether the pressure ulcer developed during or before the current admission) is a widely used outcome measure for pressure ulcer tracking, particularly in epidemiological studies. We have chosen to recommend use of incidence instead of prevalence as an intervention-level measure because incidence is more focused on the hospital improvement work suggested in this intervention. Of course, hospitals may use prevalence for their internal measurement if they believe it is more meaningful.
Appendix A: Recommended Intervention-Level Measures

The following measures are relevant for this intervention. The Campaign recommends that you use some or all of them, as appropriate, to track the progress of your work in this area. In selecting your measures, we offer the following advice:

1. Whenever possible, use measures you are already collecting for other programs.
2. Evaluate your choice of measures in terms of the usefulness of the results they provide and the resources required to obtain those results; try to maximize the former while minimizing the latter.
3. Try to include both process and outcome measures in your measurement scheme.
4. You may use measures not listed here, and, similarly, you may modify the measures described below to make them more appropriate and/or useful to your particular setting; however, be aware that modifying measures may limit the comparability of your results to others’. (Note that hospitals using different or modified measures should not submit those measure data to IHI.)
5. Remember that posting your measure results within your hospital is a great way to keep your teams motivated and aware of progress. Try to include measures that your team will find meaningful, and that they would be excited to see.

**Process Measure(s):**

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<th>Percent of At-Risk Patients Receiving Full Pressure Ulcer Preventative Care</th>
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Percent of Patients Receiving Daily Pressure Ulcer Risk Reassessment

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Outcome Measure(s):

Pressure Ulcer Incidence per 100 Admissions

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Pressure Ulcer Incidence per 1000 Patient Days

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Alignment with Other Measure Sets:

No known use of these measures in other national measure sets (e.g., JCAHO, CMS, CDC, NQF, etc.)