# HHS and AHRQ logos.Pressure Injury Prevention Program Implementation Guide

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## About the Pressure Injury Prevention Program Implementation Guide

### Purpose of the Guide

This Pressure Injury[[1]](#footnote-1) Prevention Program Implementation Guide is for hospital leaders and others who want to launch a structured pressure injury prevention initiative based on quality improvement (QI) principles. It tells how to implement the Agency for Healthcare Research and Quality’s (AHRQ’s) Pressure Injury Prevention Program and the associated training curriculum*.* The Guide focuses on the tasks your hospital’s Implementation Team will perform during the initiative.

### How To Use This Guide

Throughout this Guide, you’ll find strategies for using AHRQ’s training curriculum, along with links to webinars, tools, and other helpful resources. It has the following sections:

* [Overview](#_Overview)
* [AHRQ’s Pressure Injury Prevention Program](#_AHRQ’s_Pressure_Injury)
* [Training Curriculum](#_Training_Curriculum)
* [Get Ready](#_Get_Ready)
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* [Appendix F: Hospital Practice Insights—Challenges and Solutions](#_Appendix_F._Hospital)

To ensure that you understand the timeline and activities associated with AHRQ’s Pressure Injury Prevention Program, please read through the entire Guide before launching your hospital’s initiative. Revisit relevant sections as your Implementation Team carries out each phase.

## Overview

This section provides an overview of AHRQ’s Pressure Injury Prevention Program and the associated training curriculum.

### AHRQ’s Pressure Injury Prevention Program

AHRQ’s Pressure Injury Prevention Program grew out of a 3-year AHRQ-funded pilot initiative whose purpose was threefold:

* To develop training resources that provide guidance on how to use and implement into practice the tools and strategies outlined in AHRQ’s [*Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care*](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html)
* To provide training and ongoing technical assistance—using the newly developed training curriculum—to a cohort of hospitals selected to implement the Toolkit
* To evaluate the impact of implementing AHRQ’s Toolkit, combined with training and technical assistance, on participating hospitals’ pressure injury-related outcomes

AFYA, Inc., led the project team, with support from partners ECRI Institute and Stratis Health. During the first year of the initiative, AFYA and its partners designed and developed a focused training curriculum based on AHRQ’s Toolkit (see **Training Curriculum** below). In addition, they recruited 11 varied and geographically diverse hospitals to participate in a 2-year pilot implementation program. Quality improvement specialists (QISs) supported hospital implementation through structured training and ongoing technical assistance. The project team developed this Guide to share participating hospitals’ implementation strategies, experiences, and lessons learned with hospitals like yours.

### Training Curriculum

The training curriculum is designed to help hospitals implement [AHRQ’s Pressure Ulcer Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html). It is composed of an in-person training and supplementary webinars.

#### In-Person Training

This 6-hour interactive working meeting provides an opportunity to discuss your hospital’s current needs, policies, and procedures. The training supports adult learning and allows participating staff to immediately apply their new knowledge to their pressure injury reduction efforts.

Thein-person training has the following objectives:

* Educate your hospital leadership and Implementation Team on the [AHRQ Pressure Ulcer Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html) to facilitate the change process in your hospital.
* Develop hospital-specific action plans for implementing a Pressure Injury Prevention Program using the Toolkit.
* Identify some of the specific challenges for pressure injury prevention in your hospital.
* Use and adapt the tools and resources contained in the Toolkit to implement the Pressure Injury Prevention Program.

The in-person training is broken into five training modules that are aligned with key sections of the [AHRQ Pressure Ulcer Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html):

* Module 1: Understanding Why Change Is Needed
* Module 2: How To Manage Change
* Module 3: Best Practices in Pressure Injury Prevention
* Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization
* Module 5: How To Measure Pressure Injury Rates and Prevention Practices

Each module includes participant slides. It also includes an instructor training guide with the following sections:

* Module Aim
* Module Goals
* Timing
* Learning Methodology Checklist
* Materials Checklist
* Additional Related Training Resources
* Instructor Preparation
* Script
* Supplementary Webinars
* These 12 recorded webinars (six training webinars and six Learning Network webinars) are intended to supplement the in-person training. Training participants should view them **outside** of the in-person training.
* It is strongly recommended that participants view all six training webinars during the Training Phase (see **Pressure Injury** **Prevention Program Phases: Training Phase**). The Learning Network webinars are intended for use by relevant staff on an as-needed basis. **Appendix C** describes the supplementary webinars in more detail.

#### Alignment With Toolkit

The training modules and supplementary webinars were designed to align with [AHRQ’s Pressure Ulcer Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html). **Table 1** shows how they align.

Table 1. Training Module and Webinar Alignment With Toolkit

| Toolkit Chapter Guiding Question | Training Module | Training Webinar | Learning Network Webinar |
| --- | --- | --- | --- |
| **Chapter 1**Are we ready for this change?  | [Module 1](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/workshop/module1/mod1-trguide.html): Understanding Why Change Is Needed |  | [Sustainability](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning) |
| **Chapter 2**How will we manage change?  | [Module 2](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/workshop/module2/mod2-trguide.html): How To Manage Change  |  |  |
| **Chapter 3**What are the best practices in pressure ulcer prevention that we want to use?  | [Module 3](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/workshop/module3/mod3-trguide.html): Best Practices in Pressure Injury Prevention | [Conducting a Comprehensive Skin Assessment](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html)[Using Pressure Ulcer Risk Assessment Tools in Care Planning](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html) | [Risk Factors for Pressure Ulcers: Going Beyond Validated Instruments](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning) [The Power of Nutrition for Pressure Ulcer Prevention](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning)[Putting the Nutrition Guidelines Into Practice for Pressure Injury Prevention](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning)[Device-Related Pressure Injury](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning)  |
| **Chapter 4**How do we implement best practices in our organization?  | [Module 4](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/workshop/module4/mod4-trguide.html): How To Implement the Pressure Injury Prevention Program in Your Organization  | [Staff Roles and Training for Your Pressure Ulcer Prevention Program](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html)  |  |
| **Chapter 5**How do we measure our pressure ulcer rates and practices? | [Module 5](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/workshop/module5/mod5-trguide.html): How To Measure Pressure Injury Rates and Prevention Practices  | [Wound Classification](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html)[Measuring Pressure Ulcer Rates and Prevention Practices](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html) | [Measurement](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning)  |
| **Chapter 6**How do we sustain the redesigned prevention practices? | [Module 1](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/workshop/module1/mod1-trguide.html): Understanding Why Change Is Needed (and throughout training modules)  | [Sustaining Pressure Ulcer Prevention Practices at Your Hospital](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html) |  |

## Get Ready

Before launching your Pressure Injury Prevention Program, make sure your hospital is ready. Assess your organization’s readiness for such a program.

### Assess Your Organization’s Readiness

To assess your organization’s readiness to launch AHRQ’s Pressure Injury Prevention Program, review Section 1 of [AHRQ’s Pressure Ulcer Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html). Then assess your organization’s readiness for change.

One option for assessing your organization’s readiness for this initiative is to complete the [*Organizational Readiness Checklist*](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool1.html#17)at the end of Section 1 in the Toolkit*.*

As an alternative, your hospital leadership and potential Implementation Team leaders may want to answer the questions in **Table 2** below. These questions were developed based on the checklist included in the Toolkit but were expanded for the AHRQ pilot initiative (see **AHRQ’s Pressure Injury** **Prevention Program** above), and are more specific to elements of this prevention initiative.

Table 2. Assess Your Hospital’s Readiness To Launch AHRQ’s Pressure Injury Prevention Program

| Question | Answer |
| --- | --- |
| Does your hospital have a culture that focuses on a systems approach to error reduction? |  |
| Has your hospital identified hospital-specific reasons to change how it manages the prevention of pressure injuries? |  |
| Has your hospital assessed staff attitudes about pressure injuries? |  |
| If yes, has your hospital analyzed assessment results to identify awareness-building needs? |  |
| On a scale of 1 to 5, with 5 being the highest level of support, rate the overall medical staff support for implementing AHRQ’s Pressure Injury Prevention Program at your hospital. |  |
| Has your hospital identified supporters who have a sense of urgency for addressing pressure injury prevention? |  |
| If no, and a sense of urgency is lacking, has your hospital begun efforts to show stakeholders that pressure injuries are a significant safety concern for many reasons and that prevention efforts are needed? |  |
| Has your hospital assessed leadership support for pressure injury prevention? |  |
| If leadership support for pressure injury prevention is lacking, has your hospital begun efforts to generate it? |  |
| Has your hospital identified a senior leader who can serve as a champion for the pressure injury prevention effort? |  |
| Has your hospital identified a leader for the AHRQ pressure injury prevention effort? |  |
| Is this leader currently involved in the planning steps to participate in this program? |  |
| Has your hospital done baseline measurement of your pressure injury rate? |  |
| If yes, have you done it by each unit? |  |
| If yes, have you identified a goal for improvement? |  |
| If no, will you be able to measure the baseline rate before beginning your efforts and have the resources to continue to measure monthly or at a minimum, quarterly, throughout your improvement efforts? |  |
| Has your hospital done baseline measurement of at least two pressure injury process measures on your target units? (To learn more about measurement, see the supplementary training webinars *Wound Classification* and *Measuring Pressure Ulcer Rates and Prevention Practices* and the Learning Network webinar *Measurement*.) |  |
| If yes, have you identified a goal for improvement? |  |
| If yes, do you have the resources to continue to measure the processes monthly throughout your improvement efforts? |  |
| If no, will you be able to measure two process measures monthly throughout your improvement efforts? |  |
| Has your hospital developed a preliminary list of needed human (e.g., specific staff required) and material resources? |  |
| Is this leader currently involved in the planning steps to participate in this program? |  |
| Has your hospital obtained commitments or intentions from senior leadership to provide those resources? |  |

### Develop a Plan To Build and Support Readiness

Review your responses to the [checklist](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool1.html#17) in Section 1 of the Toolkit (or the questions in **Table 2** above), paying particular attention to “no” responses or low ratings. Then develop a plan to address those areas before launching AHRQ’s Pressure Injury Prevention Program; failure to do so can imperil program success. Section 1 of the Toolkit suggests ways to build and support readiness. Share your results with those who will plan and facilitate the in-person training.

## Pressure Injury Prevention Program Phases

Now your hospital is ready to launch AHRQ’s Pressure Injury Prevention Program. The program has five phases. Each phase is listed below with approximate timeframes for each:

* Pretraining Phase (lasts approximately 1–2 months)
* Training Phase (lasts approximately 1–5 weeks)
* Preimplementation Phase (lasts approximately 1-4 months)
* Implementation Phase (lasts approximately 8–12 months)
* Sustainment Phase (ongoing)

### Pretraining Phase

The Pretraining Phase lasts approximately 1–2 months. The purpose of this phase is to prepare your hospital for a successful Training Phase.

#### Develop a Project Charter

It’s a good idea to develop a project charter. This document helps your hospital clearly define the goals, scope, timing, milestones, team roles, and responsibilities for its Pressure Injury Prevention Program. In most cases, the Leadership Team develops the project charter and gives it to the Implementation Team.

A sample project charter template is available at [https://www.ahrq.gov/sites/
default/files/wysiwyg/professionals/systems/hospital/qitoolkit/d2-projectcharter.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/d2-projectcharter.pdf). **Table 3** provides some guidelines for project charters.

Table 3. Project Charter Guidelines

| Do | Don’t |
| --- | --- |
| Give the Implementation Team guidance about what they are being asked to accomplish. | Tell the team specifically how to complete the work. |
| Make the project charter clear and concise, focusing on key elements of requested work. | Include many pages of information. |
| Keep the project charter in a location where it is available to all involved in the project so it can serve as a reference and reminder to avoid scope creep as the project progresses. | File the project charter away in a notebook or in some folder on the Team Lead’s computer. |
| Identify a consistent format for all organizational project charters to make it easier for staff to use. | Make the project charter complicated.  |
| Include which leadership and other committees will receive reports from your team and how often they will receive these reports.  |  |
| Provide guidance about the team’s decision-making authority. When appropriate, delineate the roles of those involved in making decisions about changes to be tested or made. Consider using a RACI chart (roles and responsibilities matrix) (see **Appendix A**).  | Be unclear about the team’s decision-making authority. |
| Needlessly limit the team’s ability to plan and conduct innovative small tests of change with formal approval processes. |

#### Identify Key Program Personnel

Before your hospital embarks on the Training Phase, it’s important to identify key Pressure Injury Prevention Program personnel. These may include the Implementation Team, Implementation Leaders, and QISs (or other instructors).

***Identify the Implementation Team.***Select an Implementation Team to carry out your hospital’s Pressure Injury Prevention Program. Make sure the team is both interdisciplinary and available and that someone on the team has the requisite QI skills (e.g., expertise in analyzing and interpreting data to assess performance and support improvement initiatives). To learn more about the Implementation Team, see Chapter 2 of [AHRQ’s Pressure Ulcer Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html) and [Tool 2A](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7.html#Tool2A).

***Identify the Implementation Team Leaders.***The Leadership Team that developed the charter (or other appropriate group within your facility) should determine who will lead the Implementation Team. Make sure the Implementation Team Leaders have expertise in training, mentoring, leading QI programs, managing projects, managing change, and facilitating meetings. Ensure the Implementation Team Leaders have support from an executive leader who will closely track the needs and progress of the team, address barriers, and provide resources as needed.

***Identify the QISs/Instructors.***[[2]](#footnote-2)Select the QISs or other instructors (e.g., Education Department personnel, Implementation Team Leaders, or other staff members) who will deliver the 6-hour in-person training (see **Training Curriculum** above) and provide ongoing technical assistance to the Implementation Team. These individuals will work to adopt and adapt the pressure injury prevention action plan to fit the unit or hospital.

**Note:** During the AHRQ pilot initiative (see **AHRQ’s Pressure Injury Prevention Program** above), two QISs with expertise in QI and patient safety were assigned to each hospital. The QISs delivered the in-person training, assisted the hospital Implementation Team throughout the program, and provided as-needed technical assistance. They also served as liaisons between participating hospitals and national pressure injury prevention experts.

However, there are a variety of ways to implement AHRQ’s Pressure Injury Prevention Program. It is recommended that your hospital use QISs and make the Implementation Team accountable to them. This accountability was a critical factor in the success of the pilot initiative.

Determine what responsibilities (if any) QISs will have in your hospital’s Pressure Injury Prevention Program. If you do opt to use QISs, decide whether they will be internal staff members or consultants brought in from outside.

If you opt not to use QISs, decide who will lead the in-person training. Also decide who the Implementation Team will be accountable to and what resources will be available to the Implementation Team for any needed ongoing technical assistance.

Choose the QISs/instructors with care. They should:

* Have QI training and experience.
* Be advocates of teamwork.
* Be dynamic presenters with a desire and talent to teach.
* Have strong oral communication skills.
* Hold positions that allow flexible scheduling.
* Be highly visible, accessible, and available for coaching throughout the change effort.

Pressure injury prevention success cannot be achieved through classroom training alone. As in any change effort, the introduction of a quality improvement initiative requires champions in everyday practice to reinforce, monitor, and role-model pressure injury prevention and QI principles.

#### Prepare for the In-Person Training

To ensure a successful in-person training, hospital leadership, the Implementation Leader, QISs, and instructors should prepare for it.

***Hospital Leadership’s Responsibilities.*** Hospital leadership should prepare for the in-person training as follows:

* Provide participant handouts (e.g., hard copies of the participant agenda; participant slides; tools; and hospital processes, policies, and procedures).
* Send invitations to participants.
* Assign a person to take notes on the in-person training, including opportunities for improvement participants identify. (If there are two QISs/instructors, the one who is not presenting may fill this role.)

In addition, hospital leadership should provide the following for the in-person training:

* A room large enough to accommodate all participants
* Needed audiovisual equipment, including a laptop computer, LCD projector, and screen
* One or two flip charts with stands
* Lunch for participants (or instructions to bring a bag lunch)
* Coffee/tea/water for morning and afternoon breaks

***Implementation Team Leader’s Responsibilities.*** The Implementation Team Leader, with input from other relevant staff, should prepare for the Training Phase as follows:

* Complete the following pretraining tools[[3]](#footnote-3):
* Resource Needs Assessment, [Tool 1E](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7.html#TooloneE)
* Multidisciplinary Team, [Tool 2A](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7.html#Tool2A)
* Quality Improvement Process, [Tool 2B](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7.html#Tool2B)
* Current Process Analysis, [Tool 2C](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7.html#Tool2C)
* Assessing Pressure Ulcer Policies, [Tool 2D](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7.html#Tool2D)
* Assessing Screening for Pressure Ulcer Risk, [Tool 2E](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7a.html#Tool2E)
* Assessing Pressure Ulcer Care Planning, [Tool 2F](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7a.html#Tool2F)
* Assessing Staff Education and Training, [Tool 4C](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7b.html#ToolFourC)
* Obtain the following hospital policies and procedures (to be shared during the in-person training):
* Pressure injury risk assessment
* Skin assessment
* Pressure injury prevention care plans
* Submit the completed pretraining tools, along with the hospital policies and procedures, to the QISs/instructors **at least 2 weeks** before the in-person training.
* Be prepared to discuss the policies and procedures and the completed tools during the in-person training.

***Quality Improvement Specialists’/Instructors’ Responsibilities.*** The QISs/instructors should prepare for the Training Phase as follows:

* Review, understand, and be completely familiar with [AHRQ’s Pressure Ulcer Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html).
* Review the training modules (see **Table 1**):
* Follow the guidelines for preparing for the in-person training. These are found at the beginning of each Instructor Training Guide.
* Customize the participant slides. Add your hospital’s name on the first slide. Insert images of the completed pre-training tools into the appropriate places within the slides (see Production Agenda to assist in determining where to include these tools).
* Watch the supplementary [Training webinars](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html) (see **Table 1** and **Appendix C**).
* Review the pre-training tools and policies and procedures submitted by the Implementation Team Leader (see above). Identify gaps and opportunities for improvement to discuss during the in-person training.
* Develop a production agenda (see an example from AHRQ’s pilot initiative in **Appendix D**). This is a detailed timeline for the in-person training.
* Develop a participant agenda (see an example from AHRQ’s pilot initiative in **Appendix E**). This is a less-detailed version of the Production Agenda.
* Invite/ask a senior-level hospital administrator to provide a welcome and discuss the urgency for your hospital’s Pressure Injury Prevention Program.
* Schedule the in-person training:
* The Implementation Team Leader should work with the QISs/instructors to schedule the 6-hour in-person training (see **Training Curriculum** above).Determine which staff members should participate and to what extent. Members of the Implementation Team and tentative unit champions will likely attend the entire training. Others, such as Information Technology (IT) and Education Department staff, may need to attend only the parts of the training directly relevant to their jobs.
* To prevent disruptions and scheduling problems and to maximize learning, excuse participants from all other duties during the in-person training.

During the AHRQ pilot initiative (see **AHRQ’s Pressure Injury** **Prevention Program** above), the in-person training took place in a single 1-day session. However, there are many alternatives to a 1-day training. Below are two examples:

* Deliver the five modules in two separate sessions:
* **Session 1** **–** Module 1: Understanding Why Change Is Needed, Module 2: How To Manage Change, and Module 3: Best Practices in Pressure Injury Prevention
* **Session 2** **–** Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization and Module 5: How To Measure Pressure Injury Rates and Prevention Practices
* Deliver one module per week for 5 consecutive weeks.

#### Stay in Touch

The Implementation Team and QISs/instructors should hold weekly check-in calls or meetings throughout the Pretraining Phase.

### Training Phase

The Training Phase lasts approximately 1–5 weeks. During the Training Phase, the QISs/instructors will deliver the in-person training. In addition, it is strongly recommended that participants of the in-person training view the [Training webinars](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html) during this phase (see **Training Curriculum** above).

#### Prepare for the Training Phase

To ensure a successful Training Phase, hospital leadership, the Implementation Leader, and the QISs/instructors should prepare for the Training Phase (see **Pre-Training Phase** above).

#### Complete a Draft Action Plan

One objective of the in-person training is to complete [Tool 2I: Action Plan](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7a.html#Tool2I). This draft can be fine-tuned by a core group from the Implementation Team over the following week or so and shared with the team for approval. The action plan is a living document that may change over time as it is implemented and tested.

[Tool 2I](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7a.html#Tool2I) includes the following key interventions to be identified and prioritized:

* Analyze the current state of pressure injury prevention practices in this organization.
* Identify the set of prevention practices to be used in the redesigned system.
* Assign roles and responsibilities for implementing the redesigned pressure injury prevention practices.
* Put the redesigned care processes into practice.
* Monitor pressure injury rates and practices.
* Sustain the redesigned prevention practices.

#### Stay in Touch

The Implementation Team and QISs/instructors should continue to hold weekly check-in calls or meetings during the Training Phase.

### Preimplementation Phase

The Preimplementation Phase lasts approximately 1–4 months. The purpose of the Preimplementation Phase is to prepare your hospital for a successful Implementation Phase.

#### Identify Opportunities for Improvement

The Implementation Team should start by identifying opportunities for improvement. (It may have identified some opportunities during the in-person training.) The team should follow your organization’s methodology or model for making improvements (e.g., Lean methodology, Model for Improvement).

#### Prioritize Opportunities for Improvement

Next, the Implementation Team should decide which of these opportunities for improvement to focus on. Try not to tackle everything at once. The team should focus on just a few key interventions.

To keep your prevention initiative moving forward, the Implementation Team should meet weekly during the 2 weeks after the in-person training for focused discussions on prioritizing opportunities for quality improvement. **Appendix B** tells how to prioritize these opportunities.

#### Refine the Action Plan

Once the Implementation Team has identified and prioritized opportunities for improvement, it can refine the draft action plan it created during the Training Phase. The goal is to develop an action plan within 2 weeks after the in-person training. The team may want to use [Tool 2I](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7a.html#Tool2I) or an alternate version of the action plan to address the following items:

* How to develop unit teams and how they will work with the Implementation Team
* Roles and responsibilities of each staff member and unit champions
* Standards of care and practices to be met
* Which pressure injury prevention practices go beyond a single unit and how they will be addressed
* How gaps in staff education and competency will be addressed
* Plans for rolling out new standards and practices and how they will be integrated into ongoing work processes
* Who is accountable for measuring and monitoring implementation
* How changes in performance will be assessed (both process and outcome measures)
* How the effort will be sustained

#### Collect Baseline Data

The Implementation Team should gather and review baseline pressure injury data. To learn more about measurement, see the supplementary Training webinars [*Wound Classification*](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html)and [*Measuring Pressure Ulcer Rates and Prevention Practices*](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html)and the Learning Network webinar [*Measurement*](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning).

#### Complete the Preimplementation Checklist

Before moving on to the Implementation Phase, the Implementation Team may want to use the checklist in **Table 4,** which was developed for the AHRQ pilot initiative (see **AHRQ’s Pressure Injury Prevention Program** above), to confirm that it has completed all the Preimplementation Phase activities.

Table 4. Preimplementation Checklist

| Tasks | Completion Date |
| --- | --- |
| Initial Post-Training Priorities |
| Identify pilot units |  |
| Establish various teams |  |
| Multidisciplinary |  |
| Pilot unit managers on Implementation Team |  |
| Conduct process mapping |  |
| Use pressure injury knowledge assessment |  |
| Create action plan outline  |  |
| Continue to watch webinars |  |
| Primary Preimplementation Priorities |
| Draft action plan |  |
| Prioritize list of improvement opportunities |  |
| Conduct resource needs assessment |  |
| Select improvement practices |  |
| Determine goals for improvement |  |
| Develop aim statement |  |
| Develop staff education/assessment plan |  |
| Create plans to roll out new standards/practices |  |
| Assign staff person to monitor implementation |  |
| Determine how to measure performance |  |
| Determine data collection process  |  |
| Collect/assess process measure data |  |
| Collect/assess outcome measure data |  |
| Create sustainment plan |  |
| Final Preimplementation Priorities |
| Finalize implementation action plan |  |
| Secure team buy-in |  |

#### Stay in Touch

The Implementation Team and QISs/instructors should continue to hold check-in calls or meetings. If prudent, they can decrease their meetings to every other week during the Preimplementation Phase.

### Implementation Phase

The Implementation Phase lasts approximately 8–12 months. During the Implementation Phase, the Implementation Team will implement the interventions that it prioritized in the action plan.

#### View Webinars

Team members should view any relevant supplementary [Learning Network webinars](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning) (see **Table 1** and **Appendix C**).

#### Pilot Interventions

The Implementation Team will pilot the interventions as follows:

* Choose one or two pilot units.
* Train staff on new procedures.
* Collect process and outcome measures and feedback on new procedures.
* Communicate results.
* Refine practices to address any problems.
* Start to identify which practices can be spread to other hospital units or departments.
* Assign all staff roles and responsibilities to prevent pressure injuries.
* Assign specific individuals or groups to each duty identified.
* Identify any existing pressure injury prevention experts your facility has access to, and provide staff education in collaboration with these experts.
* Determine paths of ongoing communication and reporting for pressure injury prevention processes.
* Build pressure injury prevention practices into ongoing work processes.
* Collect and analyze data to learn about pressure injury rates and causes of pressure injuries.
* Measure pressure injury prevention practices.
* Meet regularly to assess progress.
* Create a plan to implement targeted practices to other areas in the hospital.

#### Complete the Implementation Checklist

The Implementation Team may want to complete the checklist in **Table 5** and review it with the QISs/instructors. The checklist helps assess the progress of the team’s QI efforts. It’s a good idea to revisit the checklist every 2 months during the Implementation Phase.

Table 5. Managing Change During Implementation

|  | Yes | No | Comments/Description |
| --- | --- | --- | --- |
| Implementation Team  |
| Are Team Leaders and Implementation Team in place? |  |  |  |
| Does team meet biweekly to review and discuss progress? |  |  | Who attends? |
| Do Team Leaders/key staff participate in regular conference calls with QISs/instructors? |  |  | Who attends? |
| Does Unit Implementation Team meet regularly to review/discuss progress? |  |  | How often? |
| **Senior leadership** – Senior Admin Leader on Team?Does he/she visibly promote, support, and resource the project? |  |  |  |
| **Project manager –** Does he/she have adequate support to manage the project? |  |  |  |
| Specific goals set? |  |  | List goals. |
| Action Plan  |
| Updated at least every 2 months? |  |  |  |
| **Challenges** to implementing the action plan prevention practices identified at organization and unit levels? |  |  |  |
| **Strategies** for building new practices into daily routine are in place? |  |  |  |
| Processes/Support in Place To Facilitate Action Plan  |
| **Communication** – Do you have a communication plan to keep staff and the Implementation Team up to date on rates/results and progress of prevention program? |  |  | Describe plan and progress: |
| Do you have a plan to communicate rates/progress/resource needs to senior leadership? |  |  | Describe plan and progress: |
| Do you have a plan to keep other stakeholders up to date? |  |  | Describe plan and progress: |
| Do you have a plan for soliciting positive and negative feedback about the prevention strategies from staff?  |  |  | Describe feedback/what you do with feedback: |
| Do you have a plan for soliciting feedback from patients and families? |  |  | Describe feedback/what you do with feedback: |
| Do you document your efforts on this initiative for organizational history and learning? |  |  |  |
| **Education** – Did you provide staff education to support the changes being made? List topics/mechanisms used for education: |  |  |  |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| **Education:** Do you have a patient/family prevention education plan? |  |  |  |
| **Monitoring**  |
| Is a problem-solving feedback loop in place with plans to redesign practices as needed? |  |  |  |

#### Cope With Challenges

Implementation of new processes can bring various challenges. The hospitals involved in the AHRQ pilot initiative experienced a variety of barriers and worked to overcome them. **Appendix F** (Hospital Practice Insights: Challenges and Solutions) provides some of the challenges they encountered and how they coped with these challenges.

#### Stay in Touch

The Implementation Team and QISs/instructors should continue to hold check-in calls or meetings every other week.

### Sustainment Phase

The Sustainment Phase is ongoing. During the Sustainment Phase, your organization will work to make the interventions and improved outcomes normal, integrated, and mainstream—part of your hospital’s culture. This phase includes changing thoughts and attitudes as well as processes and outcomes. Sustaining an improvement means that the progress is locked in, and staff don’t revert to the old ways of doing things. To learn more about sustainment, see the supplementary training webinar [*Sustaining Pressure Ulcer Prevention Practices at Your Hospital*](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html)and the Learning Network webinar [*Sustainability*](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning).

#### Provide Leadership Support Throughout Your Pressure Injury Prevention Program

To sustain the interventions, hospital leadership must provide support from project inception through implementation and after. Hospital leadership must assess how the changes are affecting staff. Are staff making the changes as intended? If not, why not? What barriers are staff encountering, and how can management remove these barriers?

#### Communicate Clearly

Leaders and staff need to have a common vision of the change and how it will contribute to the overall goal. Make sure they understand what specific systems and processes will change (e.g., reminders or prompts in the EHR to conduct pressure injury risk assessment within a certain time) and who will carry out these actions. Communication channels created or reinforced during the Pressure Injury Prevention Program should continue throughout the Sustainment Phase.

#### Track Performance

The Implementation Team should assess the extent to which organizational structures and routines have changes and if old behaviors are resurfacing. They should evaluate performance at both an intervention level and an outcome level at least quarterly. Senior-level staff should be responsible for sustaining gains and reviewing intervention-level performance monthly in a structured reporting format (e.g., an organizational scorecard).

To learn more about measurement, see the supplementary training webinars [*Wound Classification*](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html)and [*Measuring Pressure Ulcer Rates and Prevention Practices*](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html)and the Learning Network webinar [*Measurement*](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning).

#### Celebrate Progress

The Implementation Team should reinforce desired behaviors. **Appendix F** (Hospital Practice Insights: Challenges & Solutions) suggests ways to celebrate progress.

#### Plan for Sustainment

At the end of the Implementation Phase, the Implementation Team should identify what is needed to sustain pressure injury prevention efforts, including organizational support (e.g., new staff training, existing staff refreshers, IT support for reporting performance data). It should also decide who will be responsible for sustaining ongoing pressure injury prevention efforts. In planning for sustainment, your Implementation Team may find it helpful to discuss the questions in **Table 6,** which were developed for the AHRQ pilot initiative (see **AHRQ’s Pressure Injury** **Prevention Program** above), with their QISs/instructors.

Table 6. Plan for Sustainment

| Discussion Question | Answer |
| --- | --- |
| 1. How have you generally planned for sustaining QI project elements in the past? What areas have been problematic for sustaining prevention practices (e.g., education problems in sustainment, staff turnover, poor leadership support)?
 |  |
| 1. What are you planning to do now to address these historical sustainment issues?
 |  |
| 1. What are the critical practices from your Implementation action plan that you plan to sustain?
 |  |
| 1. What are your plans to sustain these critical practices?
 |  |
| 1. What performance measures do you plan to continue collecting that will provide information for continuous quality improvement of the identified critical practices?
 |  |
| 1. What is the mechanism for reporting quality program progress and outcomes to frontline staff and up through senior leadership and the board?
 |  |
| 1. What planned interventions will you continue to work on, or what interventions do you plan to initiate, i.e., those that are not currently at the sustainment phase?
 |  |
| 1. When and how do you plan to spread your QI action plan prevention practices to other hospital units or other hospitals in your system?
 |  |

#### Stay in Touch

The Implementation Team and QISs/instructors should continue to hold check-in calls or meetings for 6 to 12 months after implementation. In addition, the Implementation Team should keep meeting regularly.

**Figure 1** shows the phases and activities of the AHRQ pilot initiative (see **AHRQ’s Pressure Injury Prevention Program** above). It illustrates how a QI program might be organized.

Figure 1. Timeline of Pressure Injury Prevention Program Activities


## Appendixes

* Appendix A: RACI Chart
* Appendix B: Prioritize Opportunities for Improvement
* Appendix C: Training and Learning Network Webinars
* Appendix D: Sample Production Agenda
* Appendix E: Sample Participant Agenda
* Appendix F: Hospital Practice Insights—Challenges and Solutions

###

### Appendix A. RACI Chart

Below is a sample of a RACI Chart. A RACI Chart is a planning tool to help establish what needs to be done and who must do it. R-A-C-I stands for the different expectations of team members. A description is provided below for the role of each category—those responsible, accountable, consulted, or informed for an activity or decision.

|  |  | Description | How Many in This Role for a Decision? |
| --- | --- | --- | --- |
| **R** | Responsible | Researches options and consequences, makes recommendations | Usually one (but sometimes more) |
| **A** | Approver | Makes the decision | One |
| **C** | Consulted | Makes recommendations | Varies (0 to many) |
| **I** | Informed | Get informed of the decision after it is made | Varies (0 to many) |

### Appendix B. Prioritize Opportunities for Improvement

It’s important to prioritize high-impact prevention strategies, as outlined in the Toolkit. Follow these steps to prioritize opportunities for improvement.

* Firm up your Implementation Team Leader, Core Team, Pressure Injury Team, and pressure injury champions for the initiative. Make sure they are all involved or represented in the prioritization process.
* Look at each idea on the brainstormed list and start to group them into categories (affinity grouping). You can use whatever categories seem to make the most sense for your group. When you review the list, categories might start to jump out at you. They might include ideas such as universal pressure injury precautions, pressure injury risk screening assessment, care planning, education, and metrics. Alternatively, you might decide to group ideas under the major categories in the pressure injury clinical pathway ([Tool 3A](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7b.html#Tool3A)).
* Once you have the ideas grouped, work to clarify each opportunity statement as needed. If someone new to your organization read the list, would he or she understand the opportunity? Remove any duplicates from the list.
* List and review each opportunity with your team.
* Prioritize which items are most important to work on. Decide on a method to use for prioritization. Below are some examples.

#### Method 1: Multi-Voting

Figure B-1. Wall Chart Displaying Votes

Multi-voting is a structured series of votes in order to narrow down your options. It involves having each person choose one-third (or other fraction) of the items.

This voting can be done in a number of ways. Think about the option that might work best for the people involved in multi-voting. In some organizations, people with more power might share their votes publicly, which could sway others’ opinions. Here are some options:

* People submit their votes privately to the person who will tally the votes.
* People share their votes publicly with the group and with the person who will tally the votes.
* People mark their choices from a list of items displayed on wall charts with an “X” or colored dot (see **Figure B-1**). This option displays results instantly. Tell people they can use all their votes for one item if that is their preference.

Once the votes are in, tally the votes.

* Eliminate items with few votes.
* If a decision is clear, stop here. Otherwise, repeat the multi-voting process with the remaining items as needed.

#### Method 2: Prioritization Matrix

Develop a prioritization matrix. List the opportunities in rows down the left side and your identified criteria across the columns.

Criteria (ideally developed by your group) might include the following:

* Resources (Are needed resources readily available?)
* Continuity (Does this support organizational goals and priorities?)
* Cost (How much cost does your organization incur each time this issue occurs or fails to occur?)
* Feasibility (Is the opportunity actionable/feasible? Are there ways to address this issue? Is there room to make meaningful improvement?)
* Integration (Is there an opportunity to build on existing work? Would this be a duplication of efforts?)
* Potential impact (Is there reason to believe that the opportunity will have a significant impact on your populations?)
* Readiness (Is there momentum to help move the issue forward? Will it be seen as important?)
* Responsiveness (Does this address a need expressed by patients, family, or staff?)
* Risk (How much of a risk does this issue pose to the well-being of patients?)
* Urgency (How soon does this issue need to be addressed?)

Decide on and define a rating scale for your criteria—typically 1 through 5 or 1 through 10. You can decide to weigh certain criteria more than others. Rate the opportunities as a group. Alternatively, have each group member rate the opportunities individually, and then discuss them as a group. The rating will be subjective and is meant to be used as a guide to stimulate discussion.

Once the matrix is completed, scores can be totaled for each opportunity. Discussion is needed to make final selections. The selections don’t need to be the items with the highest rating, although higher scores often indicate higher priority.

#### Method 3: PICK Chart

A PICK chart is a Lean Six Sigma tool used to categorize and prioritize improvement ideas. It’s sometimes called an effort/impact chart. The chart has four quadrants:

* **P**ossible idea
* **I**mplement idea
* **C**hallenge idea
* **K**ill idea

An easy way to create a PICK chart is to draw a 2 x 2 grid either on a whiteboard or a large paper flip chart. Have participants place improvement ideas (written on sticky notes) in the quadrant where they feel the idea best fits.

A PICK chart can be a helpful tool for deciding what to work on first. The ideas in the “implement” quadrant are likely a good place to start. The team can then start looking at some of the ideas in the “challenge” quadrant that are more difficult but have a high payoff. The ideas in the “possible” quadrant are not a priority to pursue, and the ideas in the “kill” quadrant should likely not be considered.

Here are some guidelines for using a PICK chart:

* Don’t let participants put their sticky notes between quadrants. They need to decide what quadrant they go in. The beauty of sticky notes is that they can always be moved as the team discusses each idea.
* Keep the PICK chart simple. Don’t subdivide each quadrant or allow participants to be strategic about the quadrant they place their sticky note in.
* If participants have trouble putting an idea in the quadrant labeled “kill,” explain that “kill” just means that the idea is hard to do and has a low payoff.

### Appendix C. Training and Learning Network Webinars

These webinars are intended to supplement the Pressure Injury Prevention Program in-person training. Participants should view these webinars **outside** of the in-person training.

#### Training Webinars

It is strongly recommended that participants view the following [Training webinars](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html) during the Training Phase.

##### Staff Roles and Training for Your Pressure Ulcer Prevention Program

* Presented by Elizabeth Ayello, Ph.D., RN, ACNS-BC, CWON, ETN, MAPWCA, FAAN
* This webinar tells how to assign staff roles and train staff for your pressure injury prevention program.

##### Conducting a Comprehensive Skin Assessment

* Presented by Karen Zulkowski, D.N.S., RN
* This webinar discusses the attributes and goals of a comprehensive skin assessment, including how to integrate the assessment into normal workflow and documentation.

##### Using Pressure Ulcer Risk Assessment Tools in Care Planning

* Presented by Elizabeth Ayello, Ph.D., RN, ACNS-BC, CWON, ETN, MAPWCA, FAAN
* This webinar discusses pressure injury risk factor assessment, tools, and care planning.

##### Wound Classification

* Presented by Karen Zulkowski, D.N.S., RN
* This webinar discusses how to assess and measure a wound.

##### Measuring Pressure Ulcer Rates and Prevention Practices

* Presented by Karen Zulkowski, D.N.S., RN
* This webinar discusses prevalence and incidence of pressure injuries and how to calculate the rates.

##### Sustaining Pressure Ulcer Prevention Practices at Your Hospital

* Presented by Dan Berlowitz, M.D., M.P.H.
* This webinar discusses sustaining pressure injury prevention practices at your hospital.

#### Learning Network Webinars

The following [Learning Network webinars](https://www.ahrq.gov/professionals/systems/hospital/pressureinjurypxtraining/trainingwebinars/index.html#Learning) are intended for use by relevant staff on an as-needed basis.

##### Risk Factors for Pressure Ulcers: Going Beyond Validated Instruments

* Presented by Elizabeth Ayello, Ph.D., RN, ACNS-BC, CWON, ETN, MAPWCA, FAAN
* This webinar reviews the importance of addressing the subscale risk factors in a risk assessment tool and incorporating the subscale assessment data into clinical patient care planning decisions.

##### The Power of Nutrition for Pressure Ulcer Prevention

* Presented by Mary D. Litchford, Ph.D., RDN, LDN
* This webinar examines the undernutrition-malnutrition continuum and the impact of inflammation on risk for skin breakdown. It describes the National Pressure Ulcer Advisory Panel (NPUAP) Clinical Practice Guidelines specific to nutrition in wound healing and examines innovative nutrition strategies useful in the prevention of pressure injuries.

##### Putting the Nutrition Guidelines Into Practice for Pressure Injury Prevention

* Presented by Mary D. Litchford, Ph.D., RDN, LDN
* This webinar discusses strategies to identify new admissions who are at risk for malnutrition and pressure injuries. The role of nutrition in reducing readmission rates is discussed and nutrition guidelines for prevention of pressure injuries are presented using a case study approach.

##### Device-Related Pressure Injury

* Presented by Karen Zulkowski, D.N.S., RN
* This webinar reviews medical device-related pressure injuries, mucosal injuries, and how they differ from regular pressure injuries. The webinar also reviews strategies for preventing device-related injuries and how to document these injuries.

##### Sustainability

* Presented by Pat Posa, RN, B.S.N., M.S.A., FAAN
* This webinar describes key elements of sustaining a prevention program successfully over time. It describes key components of sustainable change, as well as barriers to sustainability.

##### Measurement

* Presented by Karen Zulkowski, D.N.S., RN
* This webinar reviews measurement and analysis of pressure injury prevalence and incidence rates, and prevention practice processes. The webinar also includes a discussion of the importance of communicating data trends.

#### Other Resources

* IHI Sustainability and Spread How-to-Guide, available at <http://www.ihi.org/resources/Pages/Tools/HowtoGuideSustainabilitySpread.aspx>.

### Appendix D. Sample Production Agenda for the In-Person Training

**Production Agenda: Pressure Injury** **Prevention Program Training
Hospital Name**Date and Time for Training

| Time  | Min. | Content | Speaker | Tools |
| --- | --- | --- | --- | --- |
| 8:15–8:20  | 5 | **Opening Remarks**Thank you from leadership to attendees for participating in pressure injury initiative | Senior Leader  |  |
| 8:20–9:05  | 35 | **Module 1: Understanding Why Change Is Needed**WelcomeInstructions to maximize participationLogistics, breaks, cell phones, etc.ObjectivesAHRQ Toolkit approach/training | Quality Improvement Specialist (QIS)/Instructor Note: Alert the organizational leader (or other appropriate individual) to share what led the organization to begin this pressure injury prevention initiative and how senior leadership plans to support this initiative. Consider developing a project charter to kick off the project.Alert the Implementation Team Leader to be ready to present and discuss the completed *Resource Needs Assessment* (Tool 1E) in Module 1. Have the Team Leader make copies of the completed needs assessment for each participant, or use the laptop to show the completed needs assessment on the screen. |  |
| 10 | Resource needs  | Implementation Team Leader  | 1E: Resource Needs Assessment |
| 9:05–10:35  | 10 | **Module 2: How To Manage Change** Intro | QIS/Instructor Note: Discuss with the Team Leader if the hospital currently uses a quality improvement (QI) change methodology, such as Plan, Do, Study, Act (PDSA); Lean Six Sigma (LSS); or another methodology.Meet with the Team Leader(s) prior to the day of training to decide how the team will operate.Alert the Implementation Team Leaders(s) or designee(s) to be ready to present and discuss findings from Tools 2A, 2B, 2C, 2D, 2E, and 2F.Alert the Implementation Team Leader to be ready to discuss and decide who will oversee administering the *Pieper Pressure Ulcer Knowledge Test* to staff, and who will be in charge of assessing the results and folding them into planning for staff training. |  |
| 5 | Multidisciplinary Team | Implementation Team Leader  | 2A: Multidisciplinary Team |
| 5 | Quality improvement process | Implementation Team Leader  | 2B: Quality Improvement Process |
| 35 | Current process analysisSmall group exercise | QIS/Instructor All participants | 2C: Current Process Analysis |
| 15 | Assessing current pressure injury prevention policies and practices | Implementation Team Leader  | 2D: Assessing Pressure Ulcer Policies2E: Assessing Screening for Pressure Ulcer Risk2F: Assessing Pressure Ulcer Care Planning |
| 10 | Action plan | All participants | 2I: Action Plan |
| 10:35–10:50 | 15 | **Break** |  |  |
| 10:50–12:10 | 40 | **Module 3: Best Practices in Pressure Injury Prevention**IntroComprehensive skin assessment and videoRisk assessment and case study | QIS/Instructor—facilitated group discussionNote: Ask the Team Leader which pressure injury risk assessment tool the hospital uses.If the hospital is using an assessment scale other than the Braden or Norton Scale, ask the Team Leader(s) to be prepared to review the subscales of the risk assessment tool they use or plan to use. Then, consider deleting the next 5 slides on the Braden Scale and ask the Team Leader(s) to discuss how the assessment scale they are using is scored. Ask them to include an example of how to score using their risk assessment scale. | 3A: Pressure Ulcer Prevention Pathway for Acute Care3B: Elements of a Comprehensive Skin Assessment3C: Pressure Ulcer Identification Pocket Pad3D: The Braden Scale for Predicting Pressure Sore RiskMr. K Case Study3E: Norton Scale  |
| 40 | Care planningIdentifying bundle of best practicesAction plan and summary | QIS/Instructor—facilitated group discussion | 3F: Care Plan3G: Patient and Family Education Booklet2I: Action Plan |
| 12:10–12:55 | 45 | **Lunch** |  |  |
| 12:55–2:10 | 60 | **Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization**Implementation planning goalsStaff roles/unit teamCommunication/integrationEHRChange/monitor/engage staff Staff education and training Assessment of current staff education and training | QIS/Instructor Individuals who can speak on IT issuesNote: Ask the Implementation Team Leader to work with the manager of the pilot unit(s) prior to this training to identify Unit Champions for each shift on each pilot unit. Ask the Implementation Team Leader to assign a Task Force Leader to think about which staff roles will be responsible for performing the best practices tasks using Tool 4B: *Staff Roles*. Alert the Implementation Team Leader or designee to be ready to present findings from Tool 4C: *Assessing Staff Education and Training* and to lead a group planning discussion of developing an action plan for this education.Alert the Education Department representative to be present and ready to discuss Tool 2G: *Pieper Pressure Ulcer Knowledge Test* and staff training needs.Alert the information technology (IT) representative on the Implementation Team to be ready to talk about the following topics during this module: * The electronic health record (EHR) and the possibility of building pressure injury prevention into the electronic documentation system
* How to use electronic communication modalities to communicate the program’s progress and success to the rest of the hospital staff
 | 4A: Assigning Responsibilities for Using Best Practice Bundle4B: Staff Roles4C: Assessing Staff Education and Training2G: Pieper Pressure Ulcer Knowledge Test |
| 10 | Develop an education plan on best practices for staff  | QIS/Instructor—facilitated group discussion | Education plan for pressure ulcer prevention staff education and training  |
| 5 | Enhance action plan Summary | QIS/Instructor | 2I: Action Plan |
| Time  | Min. | Content | Speaker | Tools |
| 2:10–2:25 | 15 | Break  |  |  |
| 2:25–3:50 | 15 | **Module 5: How To Measure Pressure Injury Rates and Prevention Practices**Introduction  | QIS/Instructor—facilitated group discussionNote: Alert the Implementation Team Leader or designee (as well as the QI Team, if appropriate) that he/she will be leading or helping to lead a group activity to complete the *Action Plan Tool To Measure Pressure Injury Rates and Pressure Injury Prevention Practices*. |  |
| 25 | Measuring pressure injury rates  | QIS/Instructor—facilitated group discussion |  |
| 15 | Measuring key processes of care |  | 5C: Assessing Comprehensive Skin Assessment 5D: Assessing Standardized Risk Assessment5E: Assessing Care Planning |
| 30 | Creating measurement action plan and enhancing overall action plan | QIS/Instructor | Action Plan Tool To Measure *Pressure Injury Rates and Pressure Injury Prevention Practices* |
| 3:50–3:55 | 5 | **Closing**Evaluation Next steps | QIS/Instructor |  |

**Note:** Remember to review supplementary webinars.

### Appendix E. Sample Participant Agenda

**Preventing Pressure Injuries in Hospitals
Improving Quality of Care Workshop**

**Location: Insert
Date: Insert**

|  | **TOPIC** | **PRESENTER** |
| --- | --- | --- |
| 8:00 to 8:15 a.m. | Sign In |  |
| 8:15 to 8:20 a.m. | Opening Remarks | Senior Leader |
| 8:20 to 9:05 a.m. | Module 1: Understanding Why Change Is Needed  | Quality Improvement Specialist (QIS)/InstructorImplementation Team Leader |
| 9:05 to 10:35 a.m. | Module 2: How To Manage Change  | QIS/InstructorImplementation Team Leader  |
| 10:35 to 10:50 a.m. | Break |  |
| 10:50 a.m. to 12:10 p.m. | Module 3: Best Practices in Pressure Injury Prevention | QIS/InstructorImplementation Team Leader  |
| 12:10 to 12:55 p.m. | Lunch |  |
| 12:55 to 2:10 p.m. | Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization | QIS/InstructorImplementation Team Leader IT Specialist |
| 2:10 to 2:25 p.m. | Break |  |
| 2:25 to 3:50 p.m. | Module 5: How To Measure Pressure Injury Rates and Prevention Practices | QIS/InstructorImplementation Team Leader |
| 3:50 to 3:55 p.m. | Closing | QIS/InstructorImplementation Team Leader |

### Appendix F. Hospital Practice Insights: Challenges and Solutions

The hospitals involved in the 2-year AHRQ pilot initiative encountered a variety of barriers. They identified innovative and inspiring solutions to overcome these obstacles and decrease pressure injury rates. Below are brief descriptions of their challenges and solutions, along with suggestions for how to operationalize these ideas at your facility.

#### Module 1: Understanding Why Change Is Needed

Hospital: 600+ beds
Pilot Units: ICU, Vascular Surgical; 85 beds

**Challenge:** Lack of leadership buy-in or support.

**Solution:** Invite the chief executive officer (CEO) and other leaders to conduct pressure injury prevention rounds on the pilot units.

**Description:** Early in the program, the hospital CEO made rounds on the pilot unit. Three months later, the Executive Team and divisional leaders were scheduled to round on the units to check on progress and identify any gaps in the program. Leaders updated the visibility board with strategies to improve deficiencies that were noted when monitoring process measures.

The visibility board is a valuable strategy to engage unit staff with the prevention approaches being used and to follow progress of the process and outcome metrics on their unit. It also is an excellent strategy to visually show hospital leadership how the prevention program is improving care on a particular unit.

##### What You Can Do:

* Ask the CEO or other executive leadership to commit to rounding on pilot units to check on progress and identify any gaps. Leadership rounding can help demonstrate the importance of the Pressure Injury Prevention Program in reducing pressure injuries.
* Be sure to have process and outcome data available or plans to collect metrics, to discuss with the hospital leader during rounds. Rounds can be an excellent opportunity to justify resources for the prevention program.

#### Module 1: Understanding Why Change Is Needed

Hospital: 50–200 beds
Pilot Units: ICU, 6 West, 7 East; 133 beds

**Challenge:** Lack of leadership buy-in or support.

**Solution:** Present a business case and other information about pressure injury prevention to hospital leadership.

**Description:** The Implementation Team shared details about their initiative via a board report, a presentation at the quarterly board meeting, and a meeting of the Quality Committee (which includes some leaders and board members). The team made a financial case for preventing pressure injuries—a savings of close to $700,000. It was helpful to have a representative from the Finance Department on the team to put costs and outcomes together.

The charter included:

* The Pressure Injury Prevention Program and how the hospital used the AHRQ [Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html) to implement best practices.
* Critical success factors from the team’s metrics and overall goal (i.e., reduce HAPI Stage 2 and above). The team also shared metrics for the tools.
* A detailed action plan.
* Core Team members.
* Web portal for collaboration among team members.
* Approximate cost of HAPI. Using the national average of $43,000 for each >stage 2 HAPI that occurred at the organization; the team, with a member from their Finance Department, estimated costs the hospital saved by preventing >stage 2 HAPI.

As shown in Table F-1, there were 11 fewer HAPIs in the first 6 months of 2015 compared with 12 months in 2014. The 6-month cost savings were estimated at $473,000. At this same rate of prevention, there was an estimated cost savings of $946,000 for 12 months in 2015.

Table F-1. Hospital-Acquired Pressure Injuries and Costs

| January-June 2015 | January-December 2014 |
| --- | --- |
| Stage | # HAPI | ~Cost | Stage | # HAPI | ~Cost |
| Stage 1 | 0 | N/A | Stage 1 | 3 | N/A |
| Stage 2 | 6 | N/A | Stage 2 | 14 | N/A |
| Stage 3 | 4 | $172,720 | Stage 3 | 7 | $302,260 |
| Stage 4 | 0 | $0 | Stage 4 | 0 | $0 |
| Unstageable | 4 | $172,720 | Unstageable | 5 | $215,900 |
| Deep Tissue Injury | 8 | $345,440 | Deep Tissue Injury | 15 | $647,700 |
| TOTAL (> Stage 2) | 16 | $690,880 | TOTAL (> Stage 2) | 27 | $1,165,860 |

They also took the opportunity of having the board as an audience to show how information technology (IT) issues were impeding their efforts. The presentations sparked the interest of a board member who is a physician with expertise in wound care and became involved in the team’s efforts.

##### What You Can Do:

* Consider requesting assistance from the Finance Department in calculating cost-benefit ratios and savings for patient safety and quality improvement programs. Adding costs and savings can add extra incentives to patient safety and quality efforts.
* Share information with your board and other administrative leaders through multiple avenues (e.g., meetings, reports), and show them ongoing progress and improvement.
* Determine what expertise is available at your facility.

#### Module 1: Understanding Why Change Is Needed

Hospital: 400+ beds
Pilot Unit: Neuro Medical ICU (MICU); 9 beds

**Challenge:** Lack of leadership buy-in or support.

**Solution:** Discuss pressure injury prevention with leaders at regular meetings.

**Description:** At the beginning of the Pressure Injury Prevention Program, the Implementation Team added a standing monthly meeting with the chief nursing officer (CNO) to update her on the program. The program was reported to both management and C-suite staff and at every quality meeting.

In addition, the Implementation Team conducts a rapid cycle improvement meeting at their weekly management huddle. C-suite staff attend this meeting and can assist in implementing immediate action. Pressure injuries are discussed during these meetings.

Some of the pretraining tools (e.g., [Tool 1C: Leadership Support Assessment](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7.html#TooloneC), [Tool 4C: Assessing Staff Education and Training](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7b.html#ToolFourC)) highlighted a gap in education for ancillary departments. To help other staff members evaluate the care processes at the facility, C-suite staff shared the information from the AHRQ [Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html) and the pretraining tools with other units and with quality improvement committees on other topics (e.g., central line-associated bloodstream infections, hospital-associated infections, general safety).

##### What You Can Do:

* Determine how administration/C-suite can be involved in the Pressure Injury Prevention Program (e.g., monthly meetings).
* Consider rapid cycle improvement meetings for any pressure injuries.
* Consider using the AHRQ [Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html) tools for other quality improvement projects.

#### Module 1: Understanding Why Change Is Needed

Hospital: 50–200 beds
Pilot Units: ICU, 6 West, 7 East

**Challenge:** Resource support.

**Solution:** Conduct a 90-day pilot study of a device.

**Description:** Pressure Injury Prevention Program leadership conducted a trial for a floatation turning device intended to offload pressure, minimize friction and shear, manage moisture, and make it easier to turn the patient. Staff were in favor of the device, but the Value Analysis Committee could not see a true picture of benefits and costs based on the criteria used to evaluate the devices. The committee proposed a 90-day pilot study in the ICU. The Implementation Team revised the criteria to include nurse and patient satisfaction, cost of underpads, and cost of employee injury.

##### What You Can Do:

* Evaluate whether you have the appropriate criteria when reviewing devices.

#### Module 1: Understanding Why Change Is Needed

Hospital: 200–400 beds
Pilot Units: Telemetry, Med/Surg, Neuro-Medical; 56 beds

**Challenge:** Resource support.

**Solution:** Provide a calendar to help unit managers schedule skin champions’ attendance at Skin Care Team meetings.

**Description:** Due to schedule conflicts, the hospital’s skin champions were unable to participate in Skin Care Team meetings, trainings, and prevalence studies. In response to this issue, the team gave unit managers a color-coded calendar marked with these activities. Unit managers then scheduled replacements so that skin champions could participate.

##### What You Can Do:

* Coordinate with participating units.
* Create a calendar so that staffing can be adequate for both the unit and the Implementation Team.

#### Module 1: Understanding Why Change Is Needed

Hospital: 50–200 beds
Pilot Units: Telemetry, Med/Surg; 24 beds

**Challenge:** Resource support.

**Solution:** Use available evidence to assist in advocating for equipment and other resources.

**Description:** In a review of at-risk patients, the wound care ostomy nurse found that about one-third of the organization’s patients were at risk of developing a pressure injury and that the hospital needed additional equipment to prevent these injuries. A literature review was performed to determine the best devices to purchase.

##### What You Can Do:

* Implement literature searches as part of product evaluation.
* Determine the at-risk population in your facility to drive resource needs.

#### Module 2: How To Manage Change

Hospital: 200–400 beds
Pilot Units: Telemetry, Med/Surg, Neuro-Medical; 56 beds

**Challenge:** Defining roles.

**Solution:** Clarify job duties using [Tool 4B](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7b.html#ToolFourB).

**Description:** Staff nurses had expectations of the wound care nurse that were not in line with his or her job duties. For example, staff nurses thought the wound care nurse should change patient dressings. Using [Tool 4B: Staff Roles](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7b.html#ToolFourB) and the support of the Implementation Team Lead, the nurse managers clarified job duties.

To further clarify roles and outline working relationships, wound care nurses and staff nurses made a partnership agreement. The agreement led to increased collaboration between frontline nursing staff and wound care consultants during the evaluation and treatment planning process to optimize patient outcomes related to skin and wound management.

As a result, communication and work relations improved. In addition, the nurse manager of the outpatient wound care program has become more involved with the Inpatient Team, bringing enhanced skills and clinical support.

##### What You Can Do:

* Review job duties and expectations.
* Survey staff to ensure that they understand their responsibilities related to skin care and pressure injury prevention.
* Work with all staff to ensure that the skin care and pressure injury prevention activities are adequately covered.

#### Module 2: How To Manage Change

Hospital: 400+ beds
Pilot Unit: Neuro MICU; 9 beds

**Challenge:** Defining roles.

**Solution:** Set requirements for Skin Wound Analysis Team (SWAT) members.

**Description:** The Implementation Team outlined requirements for SWAT members in a document, which each SWAT member must review and sign. The requirements include providing peer-to-peer education on their units every 3 months, educating other staff members on pressure injury prevention, conducting audits, reviewing policy changes that affect skin care practices, and attending SWAT meetings. This activity clarified expectations of SWAT members.

##### What You Can Do:

* Develop a contract or commitment form for those involved in SWAT to outline expectations.

#### Module 2: How To Manage Change

Hospital: 200–400 bedsPilot Units: Medical ICU and Medicine floors; 40 beds

**Challenge:** Process analysis assessment.

**Solution:** Develop a nurse-driven protocol to facilitate timely selection and placement of appropriate support surfaces.

**Description:** The Implementation Team identified delayed placement of support surfaces for at-risk patients as a root cause of many hospital-acquired pressure injuries (HAPIs). They wanted to standardize the bed ordering process for these surfaces. To facilitate timely selection and placement of appropriate support surfaces, the hospital developed a nurse-driven protocol. The protocol includes risk factors and the patient’s body mass index (BMI). It also allows nursing to be alerted once the patient’s risk factors have been identified.

##### What You Can Do:

* Review your facility’s pressure injury prevention processes to determine areas that can be streamlined and improved.

#### Module 2: How To Manage Change

Hospital: 400+ beds
Pilot Unit: Neuro MICU; 9 beds

**Challenge:** Process analysis assessment.

**Solution:** Conduct a shadowing program to ensure SWAT is consulted when needed and orders are implemented.

**Description:** To confirm that nurses were consulting SWAT as appropriate and implementing orders, a SWAT representative, a nurse manager, and a quality representative shadowed nursing staff for 2 months. The nurse manager validated orders, and the quality representative checked charts and conducted random bedside checks. Nurses who did not follow the process were held accountable.

##### What You Can Do:

* Shadow pilot unit staff to ensure that tasks are completed correctly and in a timely manner after initial implementation.

#### Module 2: How To Manage Change

Hospital: 50–200 beds
Pilot Units: ICU, 6 West, 7 East; 133 beds

**Challenge:** Process analysis assessment to ensure at-risk patients have the right equipment.

**Solution:** Develop an algorithm for selecting and ordering beds.

**Description:** The Implementation Team compared chart documentation, wound care nurse data, and ICD 10[[4]](#footnote-4) coding to see if staff were documenting and billing appropriately for bed rental that was or should have been used on patients. The data showed that patients were not placed on the appropriate specialty bed in a timely manner and that the payer was not billed appropriately for the cost of the rental bed. Therefore, the facility was losing money.

Staff also contacted the rental bed company and analyzed data regarding the types of beds they were renting, the rental fee, and how many days they were renting the beds on average. The hospital owns specialty beds, but staff had a hard time locating them.

With input from nursing staff, the team developed a bed algorithm to address the Braden Scale score/type of patient appropriate for each type of bed and whether that bed was already in the facility or whether it required a rental. The team distributed a printed copy of the algorithm to each nursing staff member, placed it on each computer on wheels, and made it available electronically.

##### What You Can Do:

* Examine policies and procedures for ordering and procuring support surfaces and assess billing practices.
* Review policies and procedures for providing appropriate support surfaces for each at-risk patient.

#### Module 2: How To Manage Change

Hospital: Up to 50 beds
Pilot Units: Med/Surg, ICU; 37 beds

**Challenge:** Process analysis assessment for ensuring adequate supplies.

**Solution:** Stock a mobile cart with skin and wound treatment information and supplies.

**Description:** Staff found it difficult to gather all the needed supplies for pressure injury prevention and wound care. In response, the Implementation Team stocked a mobile cart with supplies for skin and wound prevention and treatment and included a binder with care plan guidelines for preventing each Braden Scale subscale deficiency. The team inventories and resupplies the cart on a weekly basis.

##### What You Can Do:

* Evaluate whether supplies are easy for staff to obtain and are consistently stocked.
* If not, determine the best method to ensure products are adequately stocked.

#### Module 2: How To Manage Change

Hospital: 50–200 beds
Pilot Units: ICU, 6 West, 7 East; 133 beds

**Challenge:** Process analysis assessment for ensuring adequate supplies.

**Solution:** Assess the supply dispensing system, and stock it with needed skin supplies.

**Description:** The Implementation Team found that skin products and their general storage location varied by unit. The team met with Central Supply to discuss the organization of the Pyxis dispensing machines and how to make all wound care products available in a logical and similar manner in all the machines. Nursing staff saw this initiative as a way to help them provide the same products on all units and access to the products.

In addition, nursing staff provided input about the products they felt were missing. Some of the unit’s Pyxis machines have been completed to date, but the machines continue to be installed. Once the Pressure Injury Prevention Program has been completed, the Pyxis units will be maintained.

##### What You Can Do:

* Conduct a process analysis of your facility’s supply dispensing system to ensure skin and wound care supplies are available for at-risk patients.

#### Module 3: Best Practices in Pressure Injury Prevention

Hospital: 200–400 beds
Pilot Unit: Telemetry; 36 beds

**Challenge:** Improving care planning.

**Solution:** Integrate care plans into the electronic health record (EHR).

**Description:** The Implementation Team worked with the IT department to integrate care plans into the EHR. When a patient scores less than a certain number in the Braden subscale, a popup appears and asks the nurse whether a care plan should be started to address the score. After the nurse begins the care plan, the EMR provides recommendations for the patient.

The care plans are also added to the nurse’s action list, which reminds the nurse to complete the care plan. A documentation screen appears when the nurse completes the action list items. A date and time stamp are provided.

##### What You Can Do:

* Determine whether your facility’s EHR can be modified.
* Determine the best ways to integrate risk assessment with the patient care plan.

#### Module 3: Best Practices in Pressure Injury Prevention

Hospital: 200–400 beds
Pilot Units: Medical ICU and Medicine floors; 40 beds

**Challenge:** Improving care planning.

**Solution:** Automatically notify the nutritionist via task list when a patient has a pressure injury.

**Description:** The facility modified its EHR to automatically notify the nutritionist for a consult via the task list when a patient has a Stage 2, 3, 4, or unstageable pressure injury. Audits found that more than 90 percent of staff had a task order sent to the nutritionist for a consult if a patient had a Stage 2 or greater pressure injury. In addition, nutrition consults became more timely: 100 percent of Stage 2 or greater HAPIs got a nutrition consult within 24 hours.

##### What You Can Do:

* Determine whether your facility’s EHR can be modified.
* Using gap analysis, determine if any areas of the pressure injury prevention process can be streamlined to make patient care easier for staff.

#### Module 3: Best Practices in Pressure Injury Prevention

Hospital: 200–400 beds
Pilot Unit: Med/Surg

**Challenge:** Improving care planning and standardizing care.

**Solution:** Take and store a photo of each wound.

**Description:** The hospital purchased new software for staff to take and store a photo of each identified pressure injury. They take the photos using a tablet. The photos are then automatically downloaded into the EHR and stored on a secure server.

##### What You Can Do:

* Determine whether the use of photo documentation in wound care is an option for your facility.
* Make sure your institution is familiar with the rules on wound photography in your State and have a policy in place to ensure patient privacy and confidentiality.

#### Module 3: Best Practices in Pressure Injury Prevention

Hospital: 600+ beds
Pilot Units: ICU, Vascular Surgical; 85 beds

**Challenge:** Improving care planning and standardizing care.

**Solution:** Develop a skin care navigator within the EHR.

**Description:** The Implementation Team worked with the informatics nurse to develop a skin care navigator within the EHR. The navigator suggests interventions and correct products based on the combined factors from the Braden Scale risk assessment. It also ensures that the CNA task list is populated from the care plan. The navigator has decreased the number of places where nurses must document skin and wound care and drives the clinical care plan.

##### What You Can Do:

* Determine whether your facility’s EHR can be modified.
* Streamline nurse documentation by developing a skin care navigator within the EHR.

#### Module 3: Best Practices in Pressure Injury Prevention

Hospital: 400+ beds
Pilot Unit: Neuro MICU; 9 beds

**Challenge:** Skin assessment barriers to practice.

**Solution:** Conduct peer audits.

**Description:** The SWAT implemented a peer-auditing program housewide. Nursing units evaluate and calculate the prevalence of pressure injuries for a different unit that provides the same level of care (e.g., ICU A reviews ICU B). This approach helps standardize and reinforce pressure injury prevention and determination of prevalence. It also provides a second opinion on each patient’s skin integrity. By reviewing a different unit, the nurse may recognize discrepancies in processes that the unit may not discover. It could be easier to see what is happening on the other units.

##### What You Can Do:

* Have similar units audit each other to reinforce desired processes and to ensure that all at-risk patients and pressure injuries are adequately captured.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Hospital: 50–200 beds
Pilot Units: Telemetry, Med/Surg; 24 beds

**Challenge:** Staff turnover.

**Solution:** Assign new nurses to help with pressure injury prevalence studies.

**Description:** It was challenging to get enough staff to participate in monthly pressure injury prevalence studies. To remedy this shortage, new nurses were assigned to help with the prevalence studies. Wound champions partnered up with and taught the new nurses how to conduct chart audits (including how to find the information they need in the chart) and product reviews. This approach helps reinforce what the new nurses have learned and ensures that there are enough staff members to perform the prevalence study.

##### What You Can Do:

* Determine how your facility can best incorporate new nurses into the Pressure Injury Prevention Program and other patient safety efforts.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Hospital: 200–400 beds
Pilot Unit: Med/Surg

**Challenge:** Staff turnover.

**Solution:** Start a new residency program for new nursing graduates.

**Description:** The hospital started a residency program for new nursing graduates with the goal of retaining new graduate nurses, getting the nurses interested early in skin care, and developing wound care champions. The program includes monthly classes, mentoring, and skin training. Residents also help with quarterly prevalence surveys and attend a 3-hour class on pressure injuries, skin integrity, and wound care.

##### What You Can Do:

* Determine creative ways to retain new nursing graduates.
* Educate new nurses on the Pressure Injury Prevention Program and other patient safety efforts.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Hospital: 400+ beds
Pilot Unit: Neuro MICU; 9 beds

**Challenge:** Staff turnover.

**Solution:** Require the units to provide SWAT representatives from all units and shifts.

**Description:** The SWAT has a representative from each unit and shift. There are also backups in case a representative is unavailable or leaves the unit. While not every SWAT representative can make it to all meetings all the time, at least one representative per unit is expected to attend the SWAT meeting. Attendance is reported to leadership to ensure the continuing participation of SWAT members.

##### What You Can Do:

* Determine the best way to form committees dedicated to enacting change.
* Ensure participation from members.
* Replace members when they leave the organization.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Various hospitals and units

**Challenge:** Staff engagement.

**Solution:** Various engagement methods.

**Description:** Participating hospitals have used a variety of methods to engage staff:

* At one hospital, a banner designed specifically for the Pressure Injury Prevention Program travels each month to a unit that is performing well.
* One hospital branded its pressure injury prevention efforts as Save Our Skin (SOS). It used a life preserver logo and passed out Life Savers® candy to communicate the program to staff.
* The corporate office of one hospital recognized the Implementation Team’s work to define roles and responsibilities. This led to increased collaboration between frontline nursing staff and wound care consultants related to evaluation and treatment planning.
* To motivate staff to attend safety fairs, participating hospitals used the following techniques: awards for entire unit attendance, mandatory attendance, and themed fairs.

##### What You Can Do:

* Tell facility personnel about your team’s pressure injury prevention efforts.
* Determine ways to increase the visibility of the Pressure Injury Prevention Program.
* Reward staff members who are doing well in pressure injury prevention.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Hospital: 200–400 beds
Pilot Units: Telemetry, Med/Surg, Neuro-Medical; 56 beds

**Challenge:** Staff engagement.

**Solution:** Provide financial support for the Pressure Injury Prevention Program.

**Description:** The hospital provides financial support for the Pressure Injury Prevention Program. Skin champions get a complimentary lunch during training every other month in recognition of their extra duties. Staff are paid if they attend the annual safety fair (which includes skin care education) during their time off. The hospital also provided funds for marketing the initial rollout of the program.

##### What You Can Do:

* Provide paid time for activities related to the Pressure Injury Prevention Program, which shows staff their work is valued and allows time to complete the program work.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Hospital: 600+ beds
Pilot Units: ICU, Vascular Surgical; 85 beds

**Challenge:** Staff engagement.

**Solution:** Hold celebrations.

**Description:** Pressure Injury Prevention Program leaders felt that small successes should be rewarded early on. One month after implementation of the program, the Implementation Team held a breakfast to celebrate the staff’s active participation. They also held a performance improvement celebration at the 7-month mark because they felt that at that time the success was sustainable.

##### What You Can Do:

* Determine what types of rewards can be shared with staff members and units that are doing great work related to the Pressure Injury Prevention Program.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Hospital: 400+ beds
Pilot Unit: Neuro MICU; 9 beds

**Challenge:** Staff education.

**Solution:** Educate SWAT members, who in turn educate unit staff.

**Description:** Educating SWAT representatives occurs through various methods. SWAT representatives receive education via an online program. Every other month, the SWAT meeting includes an educational session for the team that focuses on current pressure injury prevention strategies at the facility. SWAT representatives, in turn, provide peer-to-peer education on pressure injury prevention to staff on their unit every 3 months.

A sign-in sheet is used to record peer-to-peer education. If education of a staff member is not completed due to staff vacations or other absences, the unit SWAT representative must create an action plan to ensure that education is completed, and the staff member has an extra week to complete the education.

##### What You Can Do:

* Coordinate education for staff.
* Use the pressure injury prevention unit champions as one way to disseminate education and information about the program to staff.
* Ensure adequate followup and ownership of the education by checking that education has been conducted.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Hospital: 200–400 beds
Pilot Units: Telemetry, Med/Surg, Neuro-Medical; 56 beds

**Challenge:** Staff education.

**Solution:** Take a boot camp approach to education.

**Description:** The Implementation Team took a boot camp approach to educating skin champions and other interested staff. The education was carried out over 2 days and covered the AHRQ [Toolkit](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html), along with hospital-specific pressure injury prevention and treatment. Staff took a knowledge-assessment test before and after the training. There was a notable increase in correct answers after the training: The pretest average score on [Tool 2G: Pieper Pressure Ulcer Knowledge Test](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7a.html#Tool2G) was 69 percent; the average score on the posttest was 94 percent.

##### What You Can Do:

* Use [Tool 2G: Pieper Pressure Ulcer Knowledge Test](https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7a.html#Tool2G) to assess staff knowledge regarding pressure injury prevention, particularly before and after educational sessions.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Various hospitals and units

**Challenge:** Staff education.

**Solution:** Use newsletters to educate staff.

**Description:** Participating hospitals have used newsletters in a variety of ways to educate staff. For instance, they have used them to:

* Announce the Pressure Injury Prevention Program kickoff.
* Announce the schedule for trainings and prevalence studies.
* Give short quizzes about pressure injury prevention and treatment.
* Provide information about outcome and process measures.
* Provide information about such topics as staging and support surfaces.
* Show photos of pressure injury prevention staff (such as wound care nurses, skin champions, and Skin Care Team members).
* Showcase pressure injury data.

##### What You Can Do:

* Include Pressure Injury Prevention Program information in a newsletter.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Hospital: 400+ beds
Pilot Units: MICU, Med/Surg; 48 beds

**Challenge:** Staff education.

**Solution:** Provide pressure injury prevention education.

**Description:** The Implementation Team determined that the organization needed a coordinated educational plan and provided the following to all nurses on the pilot units:

* Case study to test proper EHR documentation
* Pressure injury prevention education targeted to different types of nurses
* Simulation with a mannequin to educate on wounds, proper head-to-toe skin assessment, and appropriate dressings
* Structured education classes for nurses related to Braden Scale scoring, associated interventions, and implementation of those interventions

After testing the education in the pilot units and making any necessary changes, the team provided the following education housewide:

* Annual Skin Fair
* Focused “arm-in-arm” training, which includes audits to ensure education is translated into action
* Online pressure injury prevention education
* Audits to identify areas that need more education
* Based on audit results, additional education (one issue per quarter), including direct staff education and rounding to provide real-time education

##### What You Can Do:

* Educate staff on new processes, implement the new processes, and then audit the processes so you can ensure they are hardwired into practice.
* Offer multiple educational opportunities for staff to learn of the new processes, which helps you reach more staff members and reinforce the processes.

#### Module 4: How To Implement the Pressure Injury Prevention Program in Your Organization

Hospital: 400+ beds
Pilot Unit: Neuro MICU; 9 beds

**Challenge:** Staff education.

**Solution:** Hold a Patient Safety Fair and provide education for all hospital staff.

**Description:** Through the evaluation of their program, the facility realized that their educational offerings focused mainly on nurses, but other staff members can be educated to recognize when patients need assistance. Therefore, the facility held a Patient Safety Fair, which all staff, regardless of their involvement in patient care, were expected to attend.

The fair included pressure injury prevention and maintenance of skin integrity. It provided information on such topics as available resources to use with patients, ways to reduce friction and shear, and other factors contributing to pressure injuries. The facility plans to hold an annual Patient Safety Fair for all employees.

In addition to the fair, the facility provided updated hospitalwide education. Attendance at the Education Fair in June 2015 was 100 percent of staff, including secretarial staff, transport staff, and ancillary departments. The Implementation Team will continue to provide updated education every 6 months.

##### What You Can Do:

* Hold a Patient Safety Fair to share information about pressure injury prevention practices and other patient safety issues with all staff.

#### Module 5: How To Measure Pressure Injury Rates and Prevention Practices

Hospital: 50–200 beds
Pilot Units: Telemetry, Med/Surg; 24 beds

**Challenge:** Inaccurate staging and coding.

**Solution:** Improve pressure injury terminology to facilitate accurate staging.

**Description:** The Implementation Team found inconsistencies in clinical documentation and staging of pressure injuries and deep tissue injuries. This inconsistency could result in revenue loss for the hospital. In addition, a review of the ICD-10 billing system showed that some pressure injuries that were listed as hospital acquired were in fact present on admission, according to the wound care nurse notes in the patient’s EHR.

The team reviewed the charts of patients with pressure injuries before discharge, and nursing worked with the Coding Department to ensure that the patient documentation and coding information matched. The team also worked closely with the coding specialists to ensure that documentation was adequate for accurate coding. Nursing now uses better terminology that facilitates accurate staging and coding.

##### What You Can Do:

* Determine whether the staging of pressure injuries is accurate.
* Coordinate between the Billing Department and the Implementation Team to ensure that nursing is providing enough information for the Billing Department to accurately code skin issues, including pressure injuries.

#### Module 5: How To Measure Pressure Injury Rates and Prevention Practices

Hospital: 50–200 beds
Pilot Units: ICU, 6 West, 7 East; 133 beds

**Challenge:** Quality improvement.

**Solution:** Showcase data.

**Description:** The facility’s quality boards are frequently updated with new information. Pressure injury data are updated quarterly, but some of the other items, such as the action plan, are updated more often. The boards are visible to staff, patients, and visitors. Nurse leaders, the Pressure Injury Prevention Program Lead, and bedside nurses are available to answer questions about the boards.

##### What You Can Do:

* Display information about the Pressure Injury Prevention Program.
* Be transparent with and update the tracking data from your prevention efforts.

#### Module 5: How To Measure Pressure Injury Rates and Prevention Practices

Hospital: 600+ beds
Pilot Units: ICU, Vascular Surgical; 85 beds

**Challenge:** Quality improvement.

**Solution:** Showcase data.

**Description:** As part of the facility’s Lean QI approach, visibility boards are posted on nursing units. These boards show trended data (such as audit results) specific to the unit for the quality indicators measured and monitored. Leaders round and update the boards with countermeasures, such as auditing using the “four eyes principle” of cross-checking.

Executive leaders visit the units and discuss results with staff. It is the unit manager’s responsibility to discuss poor scores and to close any gaps with more education, time management strategies, or whatever will help staff perform better.

A visibility board forces structure and attention to the prevention program. Each board is unit specific and showcases the process and outcome data from that patient care unit.

For each True North[[5]](#footnote-5) organizational goal, this hospital identifies the following on the unit’s visibility board:

* Unit-specific pressure injury prevention goal
* Baseline data and current process and outcome metrics
* What you are measuring and how you are measuring improvement
* How you are doing with your goals

##### What You Can Do:

* Display information about the Pressure Injury Prevention Program and the unit’s efforts.
1. In April 2016, the National Pressure Ulcer Advisory Panel (NPUAP) announced a change in terminology from “pressure ulcer” to “pressure injury,” and updated the stages of pressure injury. Therefore, this Guide uses the term “pressure injury” except in cases where an existing document uses the term “pressure ulcer.” [↑](#footnote-ref-1)
2. Some content in this section was adapted from TeamSTEPPS 2.0 Course Management Guide, retrieved July18, 2017, from <https://www.ahrq.gov/teamstepps/instructor/essentials/coursemgmt.html>. [↑](#footnote-ref-2)
3. Be sure to begin these assessments several weeks before the in-person training to allow enough time to complete them thoroughly. [↑](#footnote-ref-3)
4. ICD-10 = International Classification of Diseases, 10th Revision. [↑](#footnote-ref-4)
5. \*True North is a Lean QI term that describes the goals (i.e., compass needle visual) to take the organization from the current condition to where they want to be (ideal condition). [↑](#footnote-ref-5)