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Organizational Strategies to Implement Hospital Pressure Ulcer Prevention Programs: Findings from a National Survey

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Abstract

Aim—To describe the presence and operationalization of organizational strategies to support implementation of pressure ulcer prevention programs across acute care hospitals in a large, integrated healthcare system.

Background—Comprehensive pressure ulcer programs include nursing interventions such as use of a risk assessment tool and organizational strategies such as policies and performance monitoring to embed these interventions into routine care. The current literature provides little detail about strategies used to implement pressure ulcer prevention programs.

Methods—Data were collected by an email survey to all Chief Nursing Officers in Veterans Health Administration acute care hospitals. Descriptive and bivariate statistics were used to summarize survey responses and evaluate relationships between some variables.

Results—Organizational strategies that support pressure ulcer prevention program implementation (policy, committee, staff education, wound care specialists, and use of performance data) were reported at high levels. Considerable variations were noted in how these strategies were operationalized within individual hospitals.

Conclusion—Organizational strategies to support implementation of pressure ulcer preventive programs are often not optimally operationalized to achieve consistent, sustainable performance.

Implications for Nursing Management—The results of this study highlight the role and influence of nurse leaders on pressure ulcer prevention program implementation.

AIMS

The Veterans Health Administration (VHA) is the largest integrated health care system in the United States providing inpatient, outpatient, and long term care to over 8.5 million Veterans. In 2011, the Secretary of Veterans Affairs initiated an aspirational goal of zero hospital acquired pressure ulcers (HAPU) in the VHA. As a result, there has been a groundswell of initiatives to improve pressure ulcer prevention. The VHA Handbook 1180.02 Prevention of Pressure Ulcers (2011) was released to support this goal and is the primary source for guidance on standardization of pressure ulcer prevention programs within VHA. This Handbook provides guidance on implementation including prescribing key responsibilities for leaders and clinicians, and outlining necessary elements for pressure ulcer prevention programs. In addition, VHA began public reporting of pressure ulcer data as part of the ASPIRE initiative (<http://www.hospitalcompare.va.gov/aspire/index.asp>).

Current literature provides limited detail about how hospitals implement pressure ulcer prevention programs. This study is the first to describe the presence and operationalization of organizational strategies to support implementation of pressure ulcer prevention programs across acute care hospitals in one large, integrated healthcare system.

BACKGROUND

Pressure ulcers are a major patient safety concern for hospitals; they are common, costly, and generally preventable (Russo et al. 2008; Reed et al. 2011; Gorecki et al. 2009; Braga et al. 2013; Shreve et al 2010). Deemed a “never event”, health systems in the United States have set goals to eliminate HAPU, and U.S. policy and reimbursement changes have led to an increased emphasis on pressure ulcer prevention as a target for improvement (Department of Health and Human Services 2014; National Quality Forum 2011). A substantial body of evidence documenting the positive effects of multicomponent pressure ulcer prevention programs on patient outcomes exists (Niederhauser et al. 2012; Sullivan and Schoelles 2013; Soban 2011). One report listed multicomponent interventions to reduce pressure ulcers among the top ten patient safety strategies strongly encouraged for immediate adoption (Shekelle et al. 2013).

Comprehensive pressure ulcer programs include both nursing interventions that have some evidence of decreasing pressure ulcers (e.g., use of a risk assessment tool, conduct of skin assessments, and regular repositioning of patients) and organizational strategies to embed these interventions into routine care (Table 1). Historically, guidance on pressure ulcer prevention has focused on nursing interventions. Increasingly, organizational strategies that support implementation of nursing interventions such as establishing an interprofessional committee and monitoring performance data are reflected in expert guidance on pressure ulcer prevention programs (Table 2) (AHRQ 2011; IHI 2011; National Pressure Ulcer Advisory Panel 2014; VHA 2011). Other program strategies such as policies, wound care specialists, and performance improvement activities are less consistently included in this

guidance. These variations may be due in part to a limited understanding of the organizational factors that support or inhibit patient safety program implementation (Shekelle et al. 2011). Most studies examining prevention programs and implementation of multicomponent pressure ulcer prevention strategies report on single hospitals or nursing units within single hospitals and provide limited detail about individual program elements and how the intervention worked (Niederhauser et al. 2012; Sullivan and Schoelles 2013; Soban et al 2011). Findings from our six-site, qualitative case study of pressure ulcer prevention programs in VHA acute care hospitals noted a high degree of organizational change in pressure ulcer programs and considerable variations in the operationalization of organizational strategies to support implementation of pressure ulcer prevention programs (Soban et al. 2016). These findings highlighted the need to build the evidence-base to understand how organizations support the delivery of care to prevent adverse events such as HAPU and led to the conduct of a national survey of VHA pressure ulcer prevention programs.

Guided by the *Organizational Transformation Framework* (Van Deusen Lukas et al. 2007), this study describes the presence and operationalization of organizational strategies to support implementation of pressure ulcer prevention programs across acute care hospitals in one large, integrated healthcare system.

METHODS

Study Design and Participants

A cross-sectional, key informant national survey was conducted by email to assess how pressure ulcer prevention programs are organized across all VHA acute care hospitals.

The survey was directed to the Associate Director for Patient Care Services (ADPCS)/Chief Nurse Executive (CNE) at all VHA acute care hospitals which were defined as hospitals where acute medical/surgical care is delivered. Due to the decentralized nature of pressure ulcer prevention programs, respondents were permitted to request assistance in completion of the survey from staff in positions more directly involved in planning and overseeing pressure ulcer prevention activities such as wound care specialists. ADPCS/CNEs were identified from a distribution list located in the VHA Central Office and publicly available sources such as facility websites.

Survey Development

Survey development was guided by the *Framework for Organizational Transformation* (Van Deusen Lukas et al. 2007). This framework describes five key elements necessary for sustained organizational change: (1) *impetus to transform* (external pressure to change); (2) *leadership support* (provision of guidance, resources, oversight and accountability for change); (3) *integration* to bridge organizational boundaries (the ability to obtain cooperation from other departments; ability to obtain resources); (4) *alignment* from top to bottom (consistency of organization-wide goals with resource allocation; shared understanding of purposes and goals); and (5) *improvement activities* (targeted microsystem improvements that engage staff across disciplines and levels of the organization). These

elements, when linked to the organization's management and work processes, act together to successfully spread and sustain changes.

Organizational strategies for pressure ulcer program implementation drew upon multiple sources including: findings from a six-site qualitative research study (Soban et al. 2016), the VHA Handbook 1180.02 (VHA 2011), the AHRQ publication Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care (2011), and a systematic review of the literature on hospital quality improvement interventions for pressure ulcer prevention (Soban et al. 2011).

Survey development was an iterative process that included convening an advisory group of stakeholders representing VHA nursing leaders, wound care specialists, frontline nurses, and a non-VHA expert on pressure ulcer measurement and education. This group engaged in a day-long discussion that resulted in a list of organizational strategies that support implementation of pressure ulcer prevention programs and important, measurable features of each strategy. From this list, we identified strategies that function at the hospital-level about which a Nurse Executive or their designee would have first-hand knowledge. Using this list, in consultation with a survey expert, two investigators (LMS, RSM) drafted questions for each strategy and created an initial draft of the survey. This draft was reviewed by members of our advisory group and revisions were incorporated. Next, the survey was pre-tested among a sample of four respondents who independently completed the survey and provided feedback through a discussion of each question with investigators. Survey finalization involved priority-setting to limit length and review to assure representation of constructs from the *Framework for Organizational Transformation* (Van Deusen Lukas et al. 2007). Table 3 shows examples of survey items by construct. A final list of survey topics and measures can be found in the Appendix. This study was approved by the VHA Greater Los Angeles Institutional Review Board.

Data Collection

An email endorsing the survey was sent from the Acting Chief Nursing Officer, VA Office of Nursing Services (ONS) to all ADPCS/CNE's. Subsequently, leaders were invited to participate via an email sent from the study PI which included the survey (in clickable PDF format) and a Fact Sheet. Survey participation was not mandatory, but key informants were contacted up to six times via email and/or phone calls. Informants were considered non-responders after six contacts were made--three email communication and three phone calls. Surveys were in the field for 6 months (May 2014–December 2014). Surveys were sent to 124 nurse leaders; four sites were deemed ineligible because they did not deliver acute care. The final population was 120 hospitals.

Supplemental Data

Internally-collected clinical performance data from the VA Nursing Outcomes Database were used to describe the annual rates of hospital acquired pressure ulcers on medical/surgical units. These data are collected directly from nurses' documentation using two nationally-standardized templates specific to skin and pressure ulcer prevention which are embedded in the electronic health record. Internally-available administrative data from the

VHA Support Service Center (VSSC) were used to describe hospital size as measured by the number of hospital operating beds.

Statistical Analysis

Descriptive statistics were used to summarize survey responses. T-tests and chi square tests of association were used to evaluate relationships between some variables. All data were analyzed using STATA 13 (2013).

RESULTS

The survey achieved 97% response rate (N=116/120). Hospital size, measured by the number of operating beds, ranged from 15 to 383 with a mean of 136 operating beds. For the year October 1, 2013 to September 31, 2014, the aggregated mean HAPU rate for acute care hospital medical/surgical units was 1.02% (range 0–3.1%) Organizational strategies that support pressure ulcer prevention program implementation (policy, oversight committee, wound care specialist, staff education, performance data, and performance improvement activities) were reported at high levels. Considerable variations were noted in the operationalization of these strategies (Table 4). These variations are described below.

Pressure Ulcer Prevention Committee

Nearly all hospitals (98.3%) indicated the presence of a committee to oversee pressure ulcer prevention activities. Two-thirds (67.3%) of hospitals indicated their committee was in place for four or more years. Most committees (64.0%) reported meeting at least four times within the last six months.

Senior leader (defined as senior physician, nurse, or administrator) support for and involvement in pressure ulcer prevention committees varied. Senior leaders were most commonly reported as engaging in the review of performance data and advocating for pressure ulcer prevention at executive level meetings (85.7% and 80.7% respectively). In contrast, assuring protected time for committee members to attend meetings and attending the committee meeting were less frequently reported (36.8 % and 26.3%).

The most frequently reported disciplines regularly participating in committee meetings were clinicians including frontline nurses (88.6%), dietitians (88.6%), providers (physician, physician assistant, nurse practitioner) (85.1%), and physical/occupational therapists (73.7%). The least frequently reported regular committee members were patient safety officers (17.5%), representatives from facilities management (29.0%), and quality improvement specialists (41.2%). In hospitals where senior leadership assured representation of key stakeholders, quality improvement staff (χ^2 (1, N=114) = 5.22, $p < .05$), and patient safety officers (χ^2 (1, N=114) = 4.03; $p < .05$) were significantly more likely to be reported as regularly attending committee meetings.

Wound Care Specialists

The number of Full Time Equivalent employees (FTEs) allocated to wound care specialist positions per 100 hospital operating beds varied considerably across hospitals (Mean=2.5;

SD=1.7; Range: 0–9.8). On average, small hospitals (1–99 operating beds) had higher wound care specialist staffing rates compared to large hospitals (≥100 operating beds) (3.5 and 1.8, respectively) ($t=6.0704$, $df=114$, $p<0.001$).

Performance Monitoring

The VA Nursing Outcomes Database (VANOD) was the most commonly reported data source used to monitor performance (94.0%). High rates of the collection and use of local prevalence data (71.7%) were also reported. Use of National Database of Nursing Quality Indicators (NDNQI) data was reported by 51.4% of respondents. Perceptions of the value of data varied by source: of the participants who used VANOD data, 41.9% rated them as extremely valuable, and 43.2% of those who used data from prevalence studies rated them as extremely valuable. Of the participants who reported using NDNQI data, only 25.0% rated them as extremely valuable.

Staff Education

Most informants (78.3%) reported making changes to enhance the content of their education program in the last year. Most hospitals (96.6%) reported offering pressure ulcer-specific education to existing RN/LVN/LPN staff within the last year. Education for other nursing staff (health techs and nursing assistants) was reported by 78.5% of the hospitals; and education for non-nursing clinical staff (physicians, dietitians, physical and occupational therapists) was reported by 54.3% of the hospitals. Online modules were the most commonly reported educational strategy for RN/LVN/LPN education (84.8%) relative to annual skills day (67.0%), simulation with models (64.3%), and formal lectures (61.6%). The most commonly reported content of the staff training were pressure ulcer prevention strategies (96.4%), pressure ulcer staging (92.9%), and the conduct skin and pressure ulcer risk assessments (86.6%). Care planning and patient education were reported by 72.1% and 73.6% of the facilities respectively. Nearly one-third of the respondents (33.1%) reported that time for RN/LPN/LVN staff to complete training was unavailable or barely sufficient.

Improvement activities

Most respondents (91.4%) indicated they had conducted at least one performance improvement activity specific to pressure ulcer prevention within the last three years. Adoption of a skin bundle (a small, core set of related, evidence-based practices used to achieve consistent performance of pressure ulcer preventive care) was reported by 38.6% of respondents. Use of a second nurse verifier to assure accurate documentation of pressure ulcers among newly admitted patients was reported by 27.6% of respondents.

CONCLUSIONS

This paper reports on the presence and operationalization of organizational strategies to implement pressure ulcer prevention programs across acute care hospitals in a federal integrated health care system in the United States. All hospitals had an impetus to change and develop stronger prevention programs because of a national goal of zero HAPU and public reporting of pressure ulcer outcomes. All hospitals were provided with the same guidance for establishing pressure ulcer prevention programs, but details regarding how the

programs were operationalized were left to the discretion of each hospital. For example, details on how to provide staff education and the topics covered were left up to each hospital.

Overall, organizational strategies to support pressure ulcer prevention programs appear to be nominally in place across all acute care hospitals in the VHA system. However, we identified a high degree of variation with respect to how these strategies were operationalized. Prior qualitative research on VHA acute care hospitals revealed patterns between operationalization of organizational strategies to support implementation of pressure ulcer prevention programs and pressure ulcer prevalence rates (high versus low) (Soban et al., 2016). Understanding the nature and extent of variations in program implementation is critical to advancing the improvement and sustainability of pressure ulcer prevention initiatives both inside and outside of the VHA system. In addition, the use of a common theory or conceptual model is central to advancing the science of patient safety (Shekelle et al. 2011). In an effort to place our findings in the context of a theory, our discussion is organized according to the elements of the *Framework for Organizational Transformation* (Van Deusen Lukas et al. 2007), the theoretical foundation of this study.

Alignment

Alignment between policies, processes, and appropriate resource allocation support achievement of organization-wide goals (Van Deusen Lukas et al. 2007).

Prevention of pressure ulcer prevention requires nursing staff to have a high level of skill and knowledge. Staff education is a strategy to achieve alignment between hospital policies, nursing actions, and safety goals. We found that staff education for pressure ulcer prevention appeared to be a focus of intense change across the VHA system: the majority of respondents indicated making changes to their education offering within the last year. Respondents indicated that education was offered within the last year at high rates for RN/LPN/LVN staff, as well as for nursing support staff (health techs). However, the majority of respondents indicated that there was insufficient time for RN/LVN/LPN staff to attend/complete training for pressure ulcer prevention. This may speak to a lack of alignment between resources for professional development and organizational goals for HAPU reduction.

Collection and monitoring of performance data is another important strategy to achieve alignment between program features and performance goals. Our findings indicate little variation across hospitals in the collection and monitoring of pressure ulcer performance data. VANOD data were reported to be used by the majority of respondents who also reported these data to be moderately to extremely valuable. Similarly, locally collected prevalence data were reported to be used by a majority of respondents and perceived to be moderately to extremely valuable. The substantial investment VHA made in VANOD, combined with public reporting of these data, appears to have yielded high levels of attention to pressure ulcer performance data.

Integration

Integration is necessary to bridge organizational boundaries between departments so a system can sustain change (Van Deusen Lukas et al. 2007).

Wound care specialists and interprofessional committees are examples of integration strategies for pressure ulcer prevention programs.

Consistent with the guidance in the VHA Handbook, nearly all hospitals reported some allocation of time for a wound care specialist. However, there was a high degree of variation in the staffing levels of wound care specialists across hospitals. These variations indicate different levels of investment in wound care specialists. To date, there is no evidence regarding optimal staffing levels of wound care specialists. Wound care specialist staffing levels and their relationship to nursing processes of care and patient outcomes for pressure ulcers is an important area for future research.

Pressure ulcer prevention committees also serve to promote integration across organizational boundaries. Representation of staff from across disciplines and departments is a measure of a committee's potential to achieve integration. The VHA Handbook describes the committee as the key group that plans, implements, and monitors the program over time. We found a high degree of variation in committee membership. Regular participants on pressure ulcer prevention committees were primarily clinical staff, such as nurses, dietitians, and physicians, with notably less participation by staff from quality, safety, and facilities management departments. Limited involvement of non-clinical representatives may indicate the lack of a systems approach and integration for pressure ulcer prevention within the organization. Committees also varied with respect to meeting frequency. Although most respondents reported a committee that met close to monthly, more than one-third of the respondents reported their committee meetings occurred less frequently, which may indicate a less active committee. The success of a pressure ulcer prevention program could be limited if the committee is not meeting on a regular basis or is not actively engaged in the prescribed responsibilities.

Leadership Support

Leadership support at all levels of the organization is critical for organizational transformation. Leadership support includes provision of guidance and oversight for change, provision of resources to support change, and administering accountability processes to ensure change (Van Deusen Lukas et al. 2007). As described above, the influence of leadership is implicit in the operationalization of strategies that serve to align and integrate the pressure ulcer program, for example, assuring resources for professional development and determining levels of wound care staffing.

Our survey included a series of questions specific to senior leader engagement in the pressure ulcer oversight committee. We found the majority of hospitals reported having a member of their senior leadership team who engaged in committee activities by data monitoring and advocacy for pressure ulcer prevention at executive level meetings. In contrast, a minority of hospitals reported that a member of their senior leadership team played an active role in assuring representation of diverse stakeholders on their pressure

ulcer committee and assuring that committee members have time away from clinical duties to attend committee meetings. Clarke et al. (2005) found that ongoing and consistent support from administrators was critical to guideline implementation. Variations in leadership engagement in the committees in this study may reflect lower prioritization and commitment to pressure ulcer prevention programs.

Improvement Activities

Improvement activities are important mechanisms for organizational change as they improve operations, engage staff, and build momentum for future change (Van Deusen Lukas et al. 2007). Although participants reported high levels of improvement activities specific to pressure ulcer prevention across hospitals within the last three years, the adoption of two specific improvement activities, the use of skin bundle and second nurse verification of pressure ulcers, were low. The low rate of adoption of a skin care bundle was surprising given that pressure ulcer prevention was a system priority. VHA actively promoted adoption of a skin care bundle through a variety of mechanisms including informational video conferences and sponsorship of Breakthrough Collaboratives on HAPU. Rates of adoption of a second nurse verifier were even lower than those for skin bundles. One possible explanation for the lag in adoption of improvement activities is that the VHA is not dependent on reimbursement from third party insurers that are financially penalizing other facilities in the United States for HAPU. Another explanation may be that much of the internal focus of the organizational change in VHA pressure ulcer prevention programs was directed at changes in education programs with less emphasis on implementing changes in processes and systems of care. Education is a necessary but insufficient component of pressure ulcer prevention strategies.

In summary, our findings indicate that, although hospitals are using implementation strategies to support pressure ulcer preventive care, these strategies are often not optimally operationalized to achieve consistent, sustainable performance. Although some of variations in operationalization may be appropriate to meet the contextual differences in organizations, poor uptake of evidence-based skin bundles indicates opportunities for more focused efforts to reduce HAPU. These findings also highlight the importance of considering not only the presence or absence of organizational strategies to support pressure ulcer prevention but how these elements relate to each other, including the extent to which leadership support is evident across the strategies. A future study will examine the relationship between implementation strategies and pressure ulcer performance.

IMPLICATIONS FOR NURSING MANAGEMENT

Nurse leaders have a key role in operationalizing patient safety initiatives such as pressure ulcer prevention (Ryan et al., 2015). Prior studies examining the relationship between nursing leadership and pressure ulcer outcomes have shown mixed results (Wong et al., 2013). The results of this study highlight the role and influence of nurse leaders on pressure ulcer program implementation. Our findings point to three areas that nurse leaders seeking to strengthen their pressure ulcer prevention programs should consider: (1) assuring alignment through education; (2) improving integration of pressure ulcer prevention through

committees/improvement teams; and (3) use of improvement activities to achieve performance goals.

Pressure ulcer prevention is complex requires high levels of diligence, skill, and contributions from all team members. Nursing and non-nursing leaders should examine their educational offerings and consider expanding pressure ulcer prevention education beyond RN/LPN/LVN staff to nursing assistants/health techs and physicians, physical therapy and respiratory therapy. In addition, and equally important, leaders must consider training time in workload calculations so that staff are assured time away from clinical assignments to participate in educational offerings.

Pressure ulcer prevention committees and quality improvement teams are important strategies for achieving integration of pressure ulcer programs across an organization. Development of collaborative partnerships with other disciplines and departments to better align and integrate efforts to improve care is an important first step for achieving integration. In addition, nurse leaders can strengthen their programs by examining committee/improvement team composition and facilitating broad representation. Both clinical (nursing and non-nursing) representation and non-clinical representation from patient safety, quality improvement, and facilities management are important stakeholders in pressure ulcer prevention. Assuring broad committee representation will leverage existing organizational expertise and facilitates a systems approach to program planning and implementation. Again, nursing and non-nursing leaders must advocate for time away from clinical assignments to allow staff to participate in committee meetings.

Improvement initiatives not only streamline work processes, but are also useful for engaging staff. Continuous improvement activities informed by performance data facilitate attainment and sustainment of organizational goals. In addition, actively engaging physicians and administrators in organizational initiatives such as pressure ulcer prevention program implementation can foster organizational improvements in patient safety. Finally, nurse leaders should consider the adoption of widely recognized improvement strategies such as skin bundles (Coyer et al, 2015; AHRQ, 2011; IHI 2011).

One of the biggest challenges for busy nurse leaders is the competing demands to eliminate other patient safety concerns such as hospital acquired infections and falls. There is an opportunity for nurse leaders to move beyond implementing programs focused on singular patient safety issues. Creating and implementing processes and systems of care that encompass multiple patient safety concerns could better support frontline staff efforts to meet the holistic needs of their patients. This will promote development of a culture of safety that prevents all types of hospital acquired conditions.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Components of Comprehensive Pressure Ulcer Prevention Programs

COMPONENTS
Nursing Interventions
• Skin Assessment and Pressure Ulcer Risk Assessment
• Develop and implement plan of care
• Documentation of care
Implementation Strategies
• Policy
• Committee or Quality Improvement team
• Wound care specialist
• Wound care champions
• Data collection and monitoring
• Staff education
• Documentation systems
• Improvement activities

Table 2

Comparison of Implementation Strategies to Support Pressure Ulcer Prevention Programs

Implementation Strategy	NPUAP ¹	AHRQ ²	VHA ³	IHI ⁴
Policy	Yes	Yes	Yes	No
Committee or Quality Improvement Team	Yes	Yes	Yes	Yes
Wound Care Specialists or Wound Care Team	No	Yes	Yes	No
Collection and Monitoring of Performance Data	Yes	Yes	Yes	Yes
Staff Education	Yes	Yes	Yes	Yes
Documentation Systems	Yes	Yes	Yes	Yes
Improvement Activities	Yes	Yes	No	Yes

¹ National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. (2014). Prevention and Treatment of Pressure Ulcers: Quick Reference Guide.

² Agency for Healthcare Research and Quality (AHRQ). (2011). Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care. Rockville, MD: U.S. Department of Health and Human Services.

³ Veterans Health Administration. (2011). VHA Handbook 1180.02 Prevention of Pressure Ulcers.

⁴ Institute for Healthcare Improvement (IHI). (2011). How-to Guide: Prevent Pressure Ulcers. Cambridge, MA: Institute for Healthcare Improvement.

Examples of Survey Items by Constructs From the Framework for Organizational Transformation

Table 3

Construct	Question
Leadership Support	Does your facility have a written policy governing pressure ulcer prevention? Does a member of your facility's senior leadership team (i.e., a senior nursing, medical or administrative leader) do any of the following in relation to your pressure ulcer prevention committee? (Check all that apply): • Receives Committee minutes • Provides feedback based on meeting minutes and reports • Attends the Committee meeting • Regularly (at least quarterly) reviews reports on performance data • Assures representation of key stakeholders on the Committee • Assures protected time for the members who are clinical staff to meetings • Serves as advocate for pressure ulcer prevention at executive level meetings
Alignment	In your facility, to what extent are the following resources sufficiently available to support nursing staff education specific to pressure ulcer prevention: a. Online training resources b. Evidence-based educational materials to use for on-site staff education c. Simulation equipment for hands-on staff education d. Personnel with appropriate expertise to conduct staff education e. Staff time to attend/complete training Below is a list of data sources that your facility's wound care specialists or others may use to monitor pressure ulcer prevention performance. For each data source, indicate if it has been used within the last 12 months. a. VANOD Daily Skin Report b. VANOD Monthly Skin Report c. National Database of Nursing Quality Indicators (NDNQI) data d. Data from prevalence studies conducted by your facility
Integration	How many full time equivalent employees (FTEs) at your facility are allocated to wound care specialist positions (i.e., positions dedicated fully to wound and skin care management)? Below are some systems/processes to assure accurate documentation of hospital acquired and community acquired pressure ulcers. For each of the following, indicate if this system or process is currently used in your acute care facility: a. Second nurse verifier for skin assessment of all new admissions b. Wound care specialist performs initial inspections on all new admissions

Construct	Question
	c. Wound care specialist verifies the presence of a pressure ulcer prior to documentation of new pressure ulcer d. Wound care specialist reviews VANOD Daily Skin Report to assure that identification and documentation of pressure ulcers are accurate For each discipline/position below, please indicate whether or not a person representing that discipline/position participates in your pressure ulcer prevention committee meetings on a regular basis: a. Nurse administrator b. Nursing unit leadership (e.g., nurse manager) c. Nursing unit frontline staff (e.g., RN, LPN/LVN or CNA) d. Certified Wound Care Specialist e. Provider (e.g., MD, PA, NP, Podiatrist) f. Physical Therapy/Occupational Therapy g. Dietitian/Nutritionist h. Pharmacist i. Social Worker j. Representative from facilities management/supplies k. Patient Safety Officer l. Other
Improvement Activities	Has your hospital initiated any projects/activities within the last 3 years to improve the quality of pressure ulcer preventive care in the acute care setting? Skin bundles are a small, core set or “bundle” of related, evidence-based practices used to achieve consistent performance of pressure ulcer preventive care. Has your pressure ulcer prevention committee considered the adoption of a skin care “bundle”?

Table 4

Elements of Pressure Ulcer Prevention Programs, VHA Acute Care Hospitals (n=116 except where indicated)

	n (%)	Mean (SD)	Range
Hospital Characteristics			
Size: number of hospital operating beds		135.5 (88.7)	15–383
Hospital HAPU Rate [Oct 2013–Sep 2014]		1.0 (0.6)	0–3.1
Policy for Pressure Ulcer Prevention			
Policy in place	115 (99.1)		
Pressure Ulcer Prevention Committee			
Committee in place	114 (98.3)		
Committee focus (n=114)			
Exclusively on pressure ulcer prevention	30 (26.3)		
Pressure ulcer prevention and wound treatment	78 (68.4)		
Other type of committee	6 (5.2)		
Committee age (n=113)			
<1 year	5 (4.4)		
1–3 years	32 (28.3)		
4 years	76 (67.3)		
Meeting frequency (during last 6 months) (n=114)			
Once	7 (6.1)		
2–3 times	34 (29.8)		
4–6 times	56 (49.1)		
>6 times	17 (14.9)		
Disciplines participating in committee (n=114)			
Wound Care Specialist	110 (96.5)		
Nursing frontline staff (e.g., RN, LVN/LPN or CNA)	101 (88.6)		
Dietitian/Nutritionist	101 (88.6)		
Provider (e.g., MD, PA, NP, Podiatrists)	97 (85.1)		
Physical/Occupational therapy	84 (73.7)		
Nursing unit leadership (e.g., nurse manager)	84 (73.7)		
Pharmacist	78 (68.4)		
Nurse administrator	52 (45.6)		
Quality Improvement representative	47 (41.2)		
Social worker	37 (32.5)		
Facilities management representative	33 (29.0)		
Patient Safety Officer	20 (17.5)		
Senior leader^J engagement/support of committee			
Regularly (at least quarterly) reviews performance data (n=112)	96 (85.7)		
Serves as advocate for prevention at executive level meetings (n=114)	92 (80.7)		
Receives committee minutes (n=114)	81 (71.1)		
Provides feedback based on meeting minutes and reports (n=114)	69 (60.5)		
Assures representation of key stakeholders on the committee (n=114)	51 (44.7)		

	n (%)	Mean (SD)	Range
Assures protected time for clinical staff to attend meetings (n=114)	42 (36.8)		
Attends the committee meetings (n=114)	30 (26.3)		
Wound Care Specialist (WCS)			
Full time equivalent (FTEs) per 100 hospital operating beds		2.5 (1.7)	0–9.8
Setting to which WCS assigned			
Exclusively to acute care setting	14 (12.1)		
Multiple settings (e.g., acute care setting and other settings)	97 (83.6)		
No WCS or WCS spends no time (or almost no time) in acute care setting	5 (4.3)		
Staff Education on Pressure Ulcer Prevention			
Changes to enhance staff education within the last 1 year (n=115)	90 (78.3)		
Education provided to RN/LVN/LPN	112 (96.6)		
Education provided to other nursing staff (e.g., health techs, CNAs)	91 (78.5)		
Education provided to non-nursing clinical staff (e.g., MD, dieticians)	63 (54.3)		
Time available to attend/complete staff education (n=115)			
Completely sufficient	9 (7.8)		
Mostly sufficient	24 (20.9)		
Somewhat sufficient	44 (38.3)		
Barely sufficient	34 (29.6)		
Unavailable	4 (3.5)		
Performance Data			
Data source used to monitor pressure ulcer prevention performance			
VA Nursing Outcomes Data (VANOD)	109 (94.0)		
National Database of Nursing Quality Indicators (NDNQI) (n=111)	57 (51.4)		
Data from prevalence studies (n=113)	81 (71.7)		
Perceived value of data source among users of that source			
VANOD (n=105)			
Extremely valuable	44 (41.9)		
Moderately valuable	52 (49.5)		
Little or no value	9 (8.6)		
NDNQI (n=56)			
Extremely valuable	14 (25.0)		
Moderately valuable	33 (58.9)		
Little or no value	9 (16.1)		
Data from prevalence studies (n=81)			
Extremely valuable	35 (43.2)		
Moderately valuable	35 (43.2)		
Little or no value	11 (13.6)		
Performance Improvement Activities Specific to Pressure Ulcer Prevention²			
Conducted 1 activity	106 (91.4)		
Number of activities		4.2 (4.1)	1–30
Adoption of skin bundle (n=114)	44 (38.6)		
Second nurse verifier for skin assessment on all new admissions	32 (27.6)		

¹ Senior leader defined as a senior nursing, medical or administrative leader

² Activities conducted within last 3 years

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