

BACKGROUND

- Hospital-acquired pressure injuries (HAPIs) are a costly and preventable patient safety issue.
- HAPIs increase morbidity, length of stay, and healthcare costs (\$10,000–\$70,000 per case).
- In the MICU, patients are at high risk due to immobility, sedation, and complex medical needs.
- Baseline audits revealed inconsistent prevention bundle use and documentation, contributing to higher HAPI rates.

PURPOSE

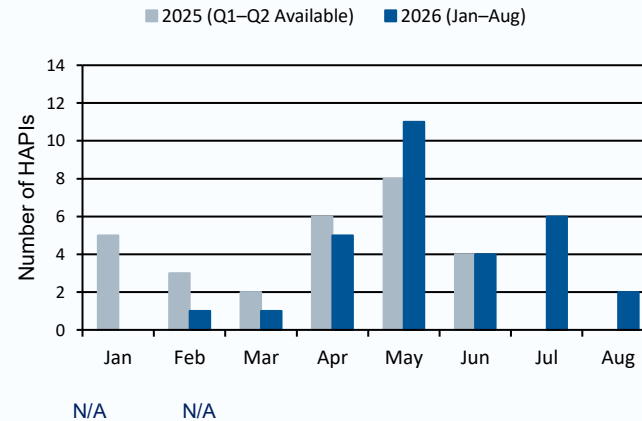
- To decrease HAPI rates in the MICU by $\geq 10\%$ within one year.
- To improve compliance with prevention bundle protocols.
- To achieve measurable cost savings through reduction in HAPI incidence.

METHODS

- Collaborated with the wound care team to strengthen HAPI prevention bundle.
- Standardized unit-based supplies for skin offloading and protection.
- Implemented daily RN-led skin checks with WOCN support.
- Educated staff via huddles, posters, and monthly feedback.
- Introduced pre-prepared WOCN pretreatment protocol for early DTI/Stage I ulcers.
- Used audits and checklists to monitor compliance.
- Collected staff feedback on barriers and facilitators.
- Adjusted education and workflow based on compliance data.
- Sustained interventions through leadership support and accountability.

MICU HAPI DATA: 2025 vs 2026

Monthly Hospital-Acquired Pressure Injuries (HAPIs)



RESULTS

- Total MICU HAPIs decreased by 12% from 34 (2025 Q1–Q2) to 30 (2026 Jan–Aug).
- 82% decrease from peak (May 2026) to August 2026.
- Compliance with prevention bundle improved based on audits and staff feedback.
- Staff engagement increased through education, huddles, and visual reminders.
- Early identification and intervention for at-risk patients improved with standardized protocols.
- Potential cost savings estimated at \$XXX,XXX based on reduced HAPI incidence.

CONCLUSIONS

- Structured quality improvement interventions can significantly reduce HAPIs in the MICU.
- Staff education and accountability are key drivers of success.
- Cost savings reinforce the sustainability of the program.
- Continued monitoring and leadership support are essential.

REFERENCES

1. Agency for Healthcare Research and Quality. (2024). Preventing pressure ulcers in hospitals: A toolkit for improving quality of care. <https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureulcer/tool/index.html>
2. Agency for Healthcare Research and Quality. (2017). Pressure injury prevention in hospitals training program. <https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressure-injury/index.html>
3. Centers for Medicare & Medicaid Services. (2026). Hospital-acquired conditions. <https://www.cms.gov/medicare/payment/hospital-acquired-conditions-hac>
4. University Medical Center of Southern Nevada. (2025–2026). MICU hospital-acquired pressure injury (HAPI) quality data [Unpublished internal quality-improvement data].

MICU HAPI SUMMARY

Time Period	2025 MICU HAPIs	2026 MICU HAPIs	% Change
Q1 (Jan–Mar)	10	2	↓ 80%
Q2 (Apr–Jun)	18	20	↑ 11%
Q3 (Jul–Aug)	N/A*	8	—
Total (Jan–Aug)	34**	30	↓ 12%

* Q3 2025 data not available at this time.

** 2025 total based on available data (Q1–Q2).

