Pressure Ulcer Prevention: Implementation Strategies

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WE WILL PREVENT PRESSURE ULCERS.
KNOW THE FACTS. TAKE ACTION.

Prevention Program

Prevention Program Assessment

- Include ALL staff?
  - Nursing (licensed and caregivers)
  - Dietary
  - Therapies
  - Physicians/Nurse Practitioners

Prevention Program

Prevention Program Assessment

- Include?
  - The individual and family members
  - Housekeeping, Activities, Maintenance, etc.
    - Assist with answering call lights
    - Monitor equipment
    - Notify appropriate staff if the individual is:
      - in one position too long
      - smells of urine or feces
      - has not been given hydration, meal tray, supplements

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Prevention Program

Prevention Program Assessment

- Consider the unlicensed caregivers to drive the prevention program
  - Solicit feedback and ideas
  - Empowerment
- Consistent assignments and universal workers

Assessing Programs

- Break your pressure ulcer prevention program down into two areas:
  - Admission process
  - On-going Prevention Program
- Utilize the Quality Improvement process when assessing each program

Admission Program

- Developing a task force for skin:
  - Assess when and where your admissions are happening
  - When and who is inspecting the skin upon admission/ within 24 hours (not just to the care setting, but also to the unit)
  - When and who is identifying the risk factors within 24 hours, and

Admission Program

- Developing a task force for skin:
  - When and who is care planning/implementing the interventions within 24 hours? Reality -- not what the policy and procedure states

Admission Process

- All care settings' admission process (within the first 24 hours) should include:
  - A head to toe skin inspection by the licensed staff (ideal within 8 hours)
  - A risk assessment for the potential for skin breakdown
  - Development of a temporary plan of care
  - Communication to the caregivers

Admission Program

- Admission Process Tips
  - At a MINIMUM interventions within the first 24 hours should include:
    - Support surfaces (bed and W/C)
    - Turning & repositioning schedules
    - Incontinence care & keeping skin clean and dry
    - Heels elevated off bed
    - Dietary and therapy referrals
    - Access to topical dressings if admitted with pressure ulcers

Prevention Program Assessment

- Does your current prevention program include:
  - Ongoing Risk Assessments per care setting guidelines?
  - Ongoing skin inspections?
  - Ongoing updates to the plan of care?

Prevention Program Assessment

- Does your current prevention program include:
  - Ongoing communication and involvement with the direct caregivers?
  - How do the caregivers communicate skin concerns (verbally or written)?

Prevention Program Assessment

- Does your current prevention program include:
  - Identified interventions/products for skin risk factors such as:
    - Pressure redistribution bed surface, including access to low-air-loss and air-fluidized beds if needed
    - Wheelchair cushions
    - Heel lift devices and/or pillows

Prevention Program Assessment

- Does your current prevention program include:
  - Identified interventions/products for skin risk factors such as:
    - Barrier ointments/creams to protect from incontinence (are they accessible to the caregivers)
    - Lifting and positioning devices
    - Dietary supplements as appropriate
    - A list of interventions to consider for potential risk factors, to help develop the plan of care

Prevention Program Assessment

- Do you have effective communication systems
  - between shifts and between caregivers (last time turned & toileted at a minimum)?
  - Are interventions being communicated to the caregivers (turning schedules, heel lift, toileting, etc.)?
  - Between Units?
  - Between health care settings?

Prevention Program Assessment

- Do you have monitoring programs in place such as:
  - Monitoring turning and repositioning (sticky notes)
  - Monitoring toileting schedules
  - Assessment and confirmation that equipment is in place and functioning properly

Prevention Program Assessment

- Are you utilizing your Wound Care Nurse for prevention????
  - Monitoring that the risk assessment and skin observations are done at appropriate intervals
  - Monitoring that the plan of care reflects interventions being implemented and identified risk factors

Prevention Program Assessment

- Are you utilizing your Wound Care Nurse for prevention????
  - Do the risk assessments, physician orders, caregiver assignment sheets and MDS/RAPS match the care plan?

Other Prevention Program Tips

- Do you have monitoring programs in place such as:
  - Monitor treatment books
  - Ensure IDT is being proactive and discussing high risk individuals (immobile, losing weight and incontinent)
  - Monitor daily cares to ensure they are inspecting skin, doing proper peri-care, ROM, feeding/supplements, weights, I & O, etc.

Education

- **Ongoing Education for Prevention**
  - During initial orientation
  - At least yearly
  - Include all staff