Pressure Ulcer Prevention: Implementation Strategies

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Pathway Health Services
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
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