Implementation Strategies for a Pressure Ulcer Program

Jeri Lundgren, RN, CWS, CWCN
Pathway Health Services

Resident and Patient Safety Learning Collaborative, Session #1
March 26, 2009

Objectives

- Describe practical strategies for implementing a pressure ulcer prevention and treatment program
- Discuss practical monitoring programs that can be used to evaluate and ensure your pressure ulcer program is on track and stays on track
- Identify pressure ulcer resources to keep your facility up-to-date with pressure ulcer prevention and treatment strategies

Assessing Programs

- Break down your pressure ulcer programs into three areas:
  - Admission Process
  - Prevention Program
  - Treatment Program
- Utilize the Quality Improvement process when assessing each program
- Ensure communication systems are in place

Assessing Programs

- Identify skin integrity champions, both licensed staff and nursing assistants
- Prioritize which areas within each program are in the most need
  - Turning and repositioning
  - Implementation of cares and interventions
  - Assessment
  - Documentation

Assessing Programs

- Pressure Ulcer Program Assessment
  - Include ALL staff?
    - Nursing (licensed and nursing assistants)
    - Dietary
    - Therapies
    - Physicians/Nurse Practitioners

Assessing Programs

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

Assessing Programs

- Prevention Program Assessment
  - Nursing assistants to drive the prevention program
    - Solicit feedback and ideas
    - Empowerment
  - Consistent assignments and universal workers

Assessing Programs

- Tracking Pressure Ulcer Trends
  - Quality Indicators
  - Prevalence and Incidence
- What is done with the information ???

Admission Process

Assessing the Admission Process

Admission Program

- Admission Process Assessment
  - Assess when your admissions happen
  - How are risk factors being identified and are appropriate interventions being put into place within the first 24 hours?
  - A skin inspection must be done—the sooner the better

Admission Process

- Admission to units within the Hospital
  - Skin checks when admitted to the unit
    - From ED, Surgery, ICU, etc.
  - Ensure Risk Assessment is conducted and is accurate

Admission Program

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

Assessing the Process

Assessing the Prevention Program

Prevention Program

- Prevention Program Assessment
  - Do you have effective communication systems:
    - Between shifts and between nursing assistants (last time turned and toileted at a minimum)?
    - That communicate interventions to the nursing assistant (turning schedules, heel lift, toileting, etc.)?
    - In the hospital between units?

Prevention Program

- Risk Assessment

The overall goal of the risk assessment is to ensure that individualized interventions are attempted to stabilize, reduce, or remove the underlying risk factors

Prevention Program

- Risk Assessment
- Long Term Care F314 states:
- “Many clinicians recommend using a standardized pressure ulcer risk assessment tool to assess a resident’s pressure ulcer risks
    - Upon admission
    - Weekly for the first four weeks after admission
    - Quarterly,
    - Or whenever there is a change in cognition or functional ability”

Prevention Program

- In long term care, a skin inspection should be conducted:
  - Upon Admission
  - Daily by the nursing assistants
  - Weekly by licensed staff
  - Upon a planned discharge

Prevention Program

- In acute care risk assessment upon:
  - Admission
  - Daily thereafter

Prevention Program

- In acute care, a skin inspection should be conducted:
  - Upon admission
  - Upon admission to the unit
  - Daily
  - Upon discharge

Risk Assessment Tools

- Use a recognized risk assessment tool such as the Braden Scale or Norton
- Use the tool consistently
- Regardless of the overall score of the risk assessment, assess each individual risk factor
- No risk assessment tool is a comprehensive risk assessment
- Incorporate the risk assessment and RAPS into the plan of care

Risk Assessment Tools BRADEN SCALE

- Mobility
- Activity
- Sensory perception
- Moisture
- Friction and shear
- Nutrition

*Note: Using the Braden scale requires obtaining permission at www.bradenscale.com or 402-551-8636

Prevention Program

- Risk Assessment Tips:
- Have a separate risk assessment tool that breaks down the score of the standardize tool (Braden/Norton) and have added risk factors that are not covered by the risk assessment tool
- Have identified interventions for correlating risk factors
- On admission, designate on the treatment sheet the initial risk assessment and then the following 4 weeks (in long term care only)
- In acute care, a trigger to complete a Braden/skin assessment daily

Prevention Interventions

- Access to pressure redistribution beds
  - Foam/gel -- Low Air-loss -- Air fluidized
  - In acute care, ensure each unit has appropriate surface for the risk level of patients (ED, ICU, Surgery, Ortho, etc.)
- Access to wheelchair cushions
  - Foam --Gel --Air
- Not a substitute for turning schedules
- Heels may be especially vulnerable even on low air loss beds

Prevention Interventions that Should be Available

- Turning and repositioning that is individualized for both lying and sitting
- In long term care in Minnesota, you must have an assessment that shows you assessed appropriate turning intervals (tissue tolerance) for:
  - Non-mobile residents
  - Upon admission, re-admission, annually and change of condition
  - In BOTH the lying and sitting position

Prevention Interventions that Should be Available

- Dietary Referral with access to:
  - Protein supplements
  - Multi-vitamins (extra Zinc and Vitamin C is only necessary if the resident has that specific mineral/vitamin depletion)
  - Hydration program (small amount of fluids over a long period of time)

Prevention Interventions that Should be Available

- Incontinence and Toileting Programs
  - Barrier ointments and creams available at all times
  - Individualized toileting plans
  - Catheters in long term care can only be used when a stage III or IV pressure ulcer can not be protected from the urine, and the wound is not showing progress. Must be discontinued once managed or healed

Prevention Interventions that Should be Available

- Pillows, body pillows, and/or foam wedges to assist with repositioning
- Heel lift devices - recommend foam heel lift boots, if working with therapy may need boots with plastic/metal heels (AFO, Prafo)

Other Prevention Program Tips

- Prevention Program continued:
  - Monitor that the risk and skin assessment are done at appropriate intervals
  - Monitor that the plan of care reflects interventions being implemented
  - Monitor that products are being utilized appropriately (i.e., wheelchair cushions, bed surfaces, devices, etc.)

Other Prevention Program Tips

- Prevention Program continued:
  - On-going monitoring of turning and repositioning (sticky notes)
  - Monitor treatment books
  - Ensure IDT is being proactive and discussing high risk residents (immobile and incontinent)
  - Monitor that the documentation is consistent (physician orders, MDS/RAPS, care plan, and nursing assistant assignment sheets)

Assessing Programs

Assessing the Treatment Program

Treatment Program

- Treatment Program Assessment
  - Do you have a system in place to ensure a new risk assessment gets done
  - Do you have a system in place to notify the physician and family/designee of the development of a wound; if no, progress in 2 weeks or when it declines
  - Do you have a system in place to initiate documentation of the wounds progress
  - Trigger to up-date the care plan and nursing assistants
  - Trigger to notify the wound nurse

Treatment Program

- Treatment Program Assessment:
  - Do you have interventions and products in place when a wound develops
    - Moisture dressings (i.e., hydrogels, hydrocolloids, and transparent films)
    - Absorptive dressings (i.e., foams and calcium alginates)
    - Enzymatic debriders (usually prescription)
    - Access to adjunctive therapies (i.e., V.A.C., Infrared, E-Stim, Ultrasound, etc.)
    - Support surfaces
    - Air, gel, or foam wheelchair cushions
    - Dietary supplementation

Treatment Program

- Treatment Program Tips
  - Monitor ALL nurses changing dressings and wound assessments
  - Monitor treatment records and documentation records
  - Monitor physician and nurse practitioner orders, diagnosis, and progress notes when appropriate
  - Ensure IDT is actively discussing/identifying wounds not showing progress

Pressure Ulcer Assessment

- Do your nurses know how to identify the etiology of the ulcer (pressure verses vascular)
- Do your nurses know how to stage pressure ulcers utilizing the new NPAUP staging system
  - Purpose of staging is for consistent communication of depth of tissue destruction
  - Once staged, the ulcer should not be back-staged, rather the wound should be described in terms of size, shape, color, drainage, and odor using one of the wound assessment measures (www.npuap.com)
  - To accurately complete the MDS, follow instructions provided

Pressure Ulcer Assessment

- Documentation of refusal of cares should include:
  - Discussion of resident's condition
  - Treatment options
  - Expected outcomes
  - Consequences of refusing treatment (pressure ulcer development, sepsis, and even death)
  - Offer relevant alternatives
  - Recommend showing residents/families pictures of pressure ulcers

Pressure Ulcer Assessment

- Documentation of individual's refusal of care and treatment in care plan
  - Document date of discussion in care plan and put resident's request in care plan
  - Review quarterly, with re-admission and with change of condition

Educational Programs

- Recommend conducting educational programs in this order:
  - Prevention
  - Assessment and Documentation
  - Treatment Modalities
  - Lower Extremity Ulcers
- Conduct bedside follow up after educational programs
- Conduct education on orientation and periodically throughout the year

Resources

- Available Resources and Web Sites:
  - www.wocn.org (Wound, Ostomy and Continence Nurse Society)
  - Available Guidelines:
    - Prevention and Management of Pressure Ulcers
    - Management of Wounds in Patients with Lower-Extremity Arterial Disease
    - Management of Wounds in Patients with Lower-Extremity Neuropathic Disease
    - Management of Wounds in Patients with Lower-Extremity Venous Disease

Resources

- Available Resources and Web Sites:
  - www.aawm.org (American Academy of Wound Management) Has list of certified wound care specialists
  - www.npuap.org (National Pressure Ulcer Advisory Panel)
  - www.woundsource.com Great source for wound care products and companies/vendors

Questions?

Jeri Lundgren, RN, CWS, CWCN

Pathway Health Services, Inc.

☎ Cell: 612-805-9703

jeri.lundgren@pathwayhealth.com

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

www.stratishealth.org