Who Is Turning the Patients?
An Exploratory Descriptive Study in a Community Hospital

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Introduction

The purpose of this study was twofold:

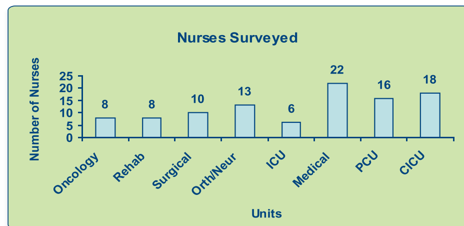
1. To assess nurses' ability to correctly identify patients at high risk for skin breakdown
2. To assess nurses' ability to reposition these patients per protocol with current resources

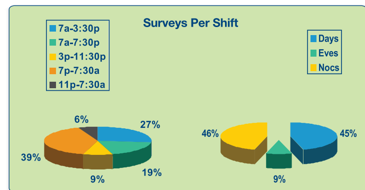
Background:

- An estimated 2.5 million persons in the U.S. are treated each year for pressure ulcers.
- It has been established that early intervention of pressure ulcers can prevent their development in those patients identified as high risk
- According to the Agency for Healthcare Research and Quality "any individual in bed who is assessed to be at risk for developing pressure ulcers should be repositioned at least every 2 hours if consistent with overall patient goals."
- At the time of our survey the pressure ulcer prevalence rate for our facility was 3.57%
- Our goal is to decrease the prevalence rate to zero
- Currently the electronic medical record used in Kootenai Medical Center has a built-in calculation of Norton scores. This is calculated at the end of every shift assessment and appears on the last screen of the assessment.

Methods:

- 101 face-to-face interviews were conducted using a scripted survey on nurses in all acute care units at Kootenai Medical Center
- Interviews were conducted on all shifts over a four day period from Monday through Thursday
- Electronic medical records were accessed to verify patients' skin risk by Norton scores



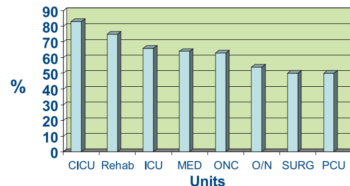


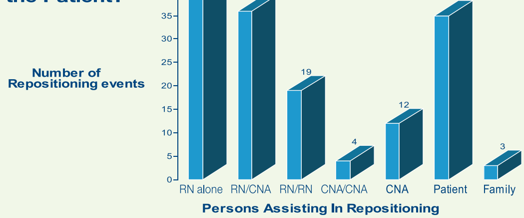
Limitations:

- Census was low so did not reach nurse sample size desired (150)
- Critical Care Units were precepting, resulting in more staff than usual
- Multiple surveyors may have been inconsistent
- Study design face-to-face – honest answers?
- 14 nurses refused to participate – were busy nurses not represented in sample?

Results:

- 28% of RNs stated that they knew the Norton score of their patients
- RNs predicted risk accurately 66% of the time
- RNs assigned incorrect risk for 116 of 348 patients (33%)
- 25% of surveyed nurses were accurate for 100% of assignment





Discussion

Reasons given for patients not being repositioned every two hours:

- Allowed to sleep (n=12)
- Off Unit (n=5)
- Patient Refused (n=4)
- Not enough Time (n=4)
- Family Refused (n=2)
- Pain (n=2)
- Not enough help (n=1)
- Patient terminal care (n=1)

Conclusion:

Do nurses have the resources they need?

- Based on results, it appears they do.
- Few said time or help were reasons they didn't reposition patients

Can nurses correctly identify patients at high risk for skin breakdown?

- Norton risk assessment scores calculated by electronic medical record is an unreliable method for communicating patient's risk for skin breakdown
- Relying on nurses' use of electronic scoring system can result in inefficient use of resources for low-risk patients and inadequate interventions for high-risk patients

Impact of Inaccurate Predictions

Wrong Predictions by RN	Number of Patients	Potential Consequences
Predicted High Risk, but Low Norton	41	Poor or inappropriate use of resources
Predicted Low Risk but High Norton	40	40 pressure ulcers
Predicted Low but Moderate Norton	4	4 pressure ulcers
Predicted High but Moderate Norton	29	No harm likely if repositioning implemented

Clinical Implications:

- Recommend changing to Braden risk assessment tool to assist nursing in focusing on factors contributing to risk for skin breakdown (i.e. incontinence, mobility, nutrition, etc.)
- Study results to be shared with unit practice councils
- Study staffing mix for better utilization of CNAs for repositioning
- Educate on managing pain, sleep, patient preferences and skin protection needs
- Strategize to improve communication of patient pressure ulcer risk

Skin and Wound Assessment Team (SWAT)

Reviewed study and made following recommendations:

- Mandatory reporting of Norton score at shift change
- Consistent use of turning clocks
- Each unit should evaluate how to identify and communicate which patients are at high risk for skin breakdown

Kootenai Medical Center