Mobility Matters!

Preventing Hospital Acquired Pressure Ulcers Utilizing Best Evidence

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Purpose

Development of a clinical skills integration program using a nurse-driven evidence-based protocol to guide clinical associate's care

Goal

Sustain improved patient outcomes through the formation of a plan of care to prevent and/or manage pressure ulcers

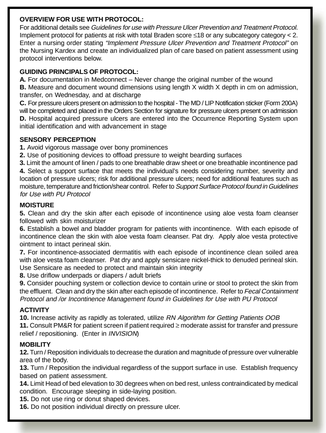
Background/Significance

Hospital acquired pressure ulcers (HAPU) higher than benchmark

- Nursing Protocol developed based on best evidence and involved participation of nurse associates and CWOCN Nurse Specialist
- Piloted and evaluated on one medical and one surgical unit
- Operationalized protocol through Mobility Matters program utilizing case studies

Methods/Implementation

- Evidence Based Protocol
- Mobility Matters applied case-based education specific to pressure ulcer assessment, prevention, and treatment
- Pressure Ulcer PI Committee
- Wound Resource Nurse concept
- Train the Trainer
- Corporate committee systemness
- Occurrence Reporting System – standard reporting
- Root-cause analysis of reporatable HAPU
- Unit specific action planning
- Small tests of change
  - Turning rounds
  - Moisture control/Underpad usage
  - Visual cues
  - Leader and associate rounding
- Process and outcome data monitoring



OVERVIEW FOR USE WITH PROTOCOL:
For additional details see *Guidelines for use with Pressure Ulcer Prevention and Treatment Protocol*. Implement protocol for patients at risk with total Braden score ≤18 or any subcategory category < 2. Enter a nursing order stating *"Implement Pressure Ulcer Prevention and Treatment Protocol"* on the Nursing Kardex and create an individualized plan of care based on patient assessment using protocol interventions below.

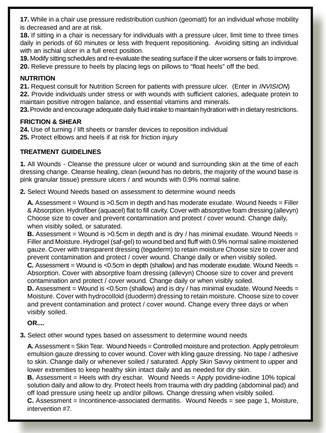
GUIDING PRINCIPALS OF PROTOCOL:
A. For documentation in Medconnect – Never change the original number of the wound
B. Measure and document wound dimensions using length X width X depth in cm on admission, transfer, on Wednesday, and at discharge
C. For pressure ulcers present on admission to the hospital - The MD / LIP Notification sticker (Form 200A) will be completed and placed in the Orders Section for signature for pressure ulcers present on admission
D. Hospital acquired pressure ulcers are entered into the Occurrence Reporting System upon initial identification and with advancement in stage

SENSORY PERCEPTION
1. Avoid vigorous massage over bony prominences
2. Use of positioning devices to offload pressure to weight bearding surfaces.
3. Limit the amount of linen / pads to one breathable draw sheet or one breathable incontinence pad
4. Select a support surface that meets the individual's needs considering number, severity and location of pressure ulcers; risk for additional pressure ulcers; need for additional features such as moisture, temperature and friction/shear control. Refer to *Support Surface Protocol found in Guidelines for Use with PU Protocol*

MOISTURE
5. Clean and dry the skin after each episode of incontinence using aloe vesta foam cleanser followed with skin moisturizer
6. Establish a bowel and bladder program for patients with incontinence. With each episode of incontinence clean the skin with aloe vesta foam cleanser. Pat dry. Apply aloe vesta protective ointment to intact perineal skin.
7. For incontinence-associated dermatitis with each episode of incontinence clean soiled area with aloe vesta foam cleanser. Pat dry and apply semiclare nickel-thick to denuded perineal skin. Use Sensicare as needed to protect and maintain skin integrity
8. Use driflow underpads or diapers / adult briefs
9. Consider pouching system or collection device to contain urine or stool to protect the skin from the effluent. Clean and dry the skin after each episode of incontinence. Refer to *Fecal Containment Protocol and /or Incontinence Management found in Guidelines for Use with PU Protocol*

ACTIVITY
10. Increase activity as rapidly as tolerated, utilize *RN Algorithm for Getting Patients OOB*
11. Consult PM&R for patient screen if patient required ≥ moderate assist for transfer and pressure relief / repositioning. (Enter in *INVISION*)

MOBILITY
12. Turn / Reposition individuals to decrease the duration and magnitude of pressure over vulnerable area of the body.
13. Turn / Reposition the individual regardless of the support surface in use. Establish frequency based on patient assessment.
14. Limit Head of bed elevation to 30 degrees when on bed rest, unless contraindicated by medical condition. Encourage sleeping in side-laying position.
15. Do not use ring or donut shaped devices.
16. Do not position individual directly on pressure ulcer.



17. While in a chair use pressure redistribution cushion (geomatt) for an individual whose mobility is decreased and are at risk.
18. If sitting in a chair is necessary for individuals with a pressure ulcer, limit time to three times daily in periods of 60 minutes or less with frequent repositioning. Avoiding sitting an individual with an ischial ulcer in a full erect position.
19. Modify sitting schedules and re-evaluate the seating surface if the ulcer worsens or fails to improve.
20. Relieve pressure to heels by placing legs on pillows to "float heels" off the bed.

NUTRITION
21. Request consult for Nutrition Screen for patients with pressure ulcer. (Enter in *INVISION*)
22. Provide individuals under stress or with wounds with sufficient calories, adequate protein to maintain positive nitrogen balance, and essential vitamins and minerals.
23. Provide and encourage adequate daily fluid intake to maintain hydration with in dietary restrictions.

FRICTION & SHEAR
24. Use of turning / lift sheets or transfer devices to reposition individual
25. Protect elbows and heels if at risk for friction injury

TREATMENT GUIDELINES

1. All Wounds - Cleanse the pressure ulcer or wound and surrounding skin at the time of each dressing change. Cleanse healing, clean (wound has no debris, the majority of the wound base is pink granular tissue) pressure ulcers / and wounds with 0.9% normal saline.

2. Select Wound Needs based on assessment to determine wound needs

A. Assessment = Wound is >0.5cm in depth and has moderate exudate. Wound Needs = Filler & Absorption. Hydrofiber (aquacel) flat to fill cavity. Cover with absorptive foam dressing (allevyn) Choose size to cover and prevent contamination and protect / cover wound. Change daily, when visibly soiled, or saturated.
B. Assessment = Wound is >0.5cm in depth and is dry / has minimal exudate. Wound Needs = Filler and Moisture. Hydrogel (saf-gel) to wound bed and fluff with 0.9% normal saline moistened gauze. Cover with transparent dressing (tegaderm) to retain moisture Choose size to cover and prevent contamination and protect / cover wound. Change daily or when visibly soiled.
C. Assessment = Wound is <0.5cm in depth (shallow) and has moderate exudate. Wound Needs = Absorption. Cover with absorptive foam dressing (allevyn) Choose size to cover and prevent contamination and protect / cover wound. Change daily or when visibly soiled.
D. Assessment = Wound is <0.5cm (shallow) and is dry / has minimal exudate. Wound Needs = Moisture. Cover with hydrocolloid (duoderm) dressing to retain moisture. Choose size to cover and prevent contamination and protect / cover wound. Change every three days or when visibly soiled.

OR....

3. Select other wound types based on assessment to determine wound needs

A. Assessment = Skin Tear. Wound Needs = Controlled moisture and protection. Apply petroleum emulsion gauze dressing to cover wound. Cover with kling gauze dressing. No tape / adhesive to skin. Change daily or whenever soiled / saturated. Apply Skin Savvy ointment to upper and lower extremities to keep healthy skin intact daily and as needed for dry skin.
B. Assessment = Heels with dry eschar. Wound Needs = Apply povidine-iodine 10% topical solution daily and allow to dry. Protect heels from trauma with dry padding (abdominal pad) and off load pressure using heelz up and/or pillows. Change dressing when visibly soiled.
C. Assessment = Incontinence-associated dermatitis. Wound Needs = see page 1, Moisture, intervention #7.

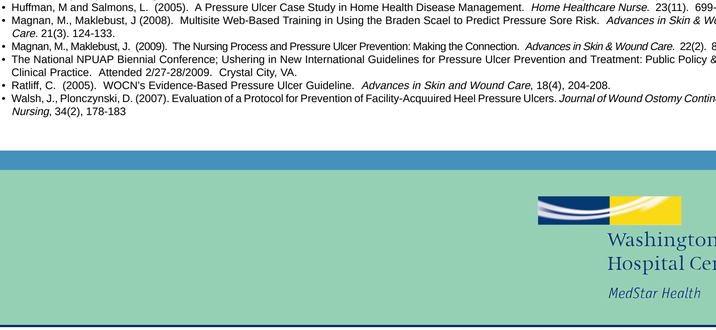
Pressure Ulcer Prevention and Treatment Protocol

Results/Evaluation

NDNQI data

- Educational program continues in phases through Q2CY11
- Validation process continues

Washington Hospital Center Hospital Acquired Pressure Ulcer



Conclusions/Implications for Nursing Practice

Use of Pressure Ulcer Prevention and Treatment Protocol

- Standardizes equipment and supplies
- Readily accessible resource to develop plan of care
- Ease of application use
- Provides point-of-care associates evidence based decision making tools

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