# The Pressure Is On: Skin Savers to the Rescue

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## Purpose

- High unit-acquired pressure ulcer rates and a sentinel event necessitated a practice change for an inpatient medical unit.
- A peer education plan and a skin care competency were implemented to improve skin assessment accuracy and documentation and to reduce the incidence of pressure ulcers.

## Significance

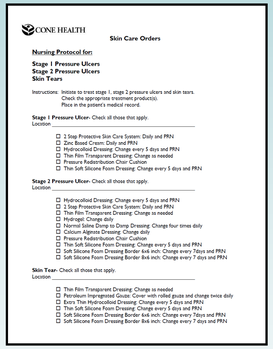
- Pressure ulcers adversely compound health care costs, length of stay, and patient satisfaction.
- Peer education empowers staff and leads to the compliance and integration of evidence-based prevention strategies into practice to deliver quality nursing care and improve patient care outcomes.

## Strategy and Implementation

- A peer education plan was developed by a unit level evidence-based practice team, called the Skin Savers, to address the identified knowledge deficit of skin and wounds.
- Utilizing a train-the-trainer method, the Skin Savers received essential education from Wound, Ostomy, Continence nurses to effectively educate their peers.
- The Skin Savers subsequently provided mandatory classes for the staff addressing wound assessment, pressure ulcer staging, prevention interventions, and the required documentation.
- Completion of the National Database of Nurse Quality Pressure Ulcer Training modules was required of all staff.
- Skin care nursing protocols were utilized for the treatment of early staged pressure ulcers and minor wounds.
- Body maps facilitated nurse technician (NT) to nurse communication of skin problems.
- Mirrors were provided to improve skin assessments.
- Skin care competencies were created to validate and document the post-education knowledge of the nurses and NTs.

## Implications for Practice

This evidence-based peer education program, inclusive of a skin care competency, proved to be effective in the prevention of pressure ulcers and can be generalized to other nursing settings in order to improve skin and wound knowledge and to diminish the incidence of pressure ulcers.



CONE HEALTH

**Skin Care Orders**

**Nursing Protocol for:**

**Stage 1 Pressure Ulcers**
**Stage 2 Pressure Ulcers**
**Skin Tears**

Instructions: Initiate to treat stage 1, stage 2 pressure ulcers and skin tears.
Check the appropriate treatment product(s).
Place in the patient's medical record.

**Stage 1 Pressure Ulcer**- Check all those that apply.
Location _____

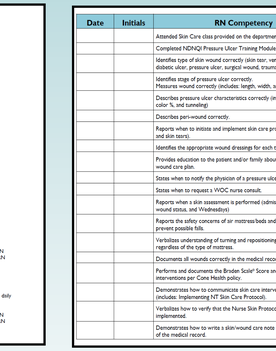
- ☐ 2 Step Protective Skin Care System: Daily and PRN
- ☐ Zinc Based Cream: Daily and PRN
- ☐ Hydrocolloid Dressing: Change every 5 days and PRN
- ☐ Thin Film Transparent Dressing: Change as needed
- ☐ Pressure Redistribution Chair Cushion
- ☐ Thin Soft Silicone Foam Dressing: Change every 5 days and PRN

**Stage 2 Pressure Ulcer**- Check all those that apply.
Location _____

- ☐ Hydrocolloid Dressing: Change every 5 days and PRN
- ☐ 2 Step Protective Skin Care System: Daily and PRN
- ☐ Thin Film Transparent Dressing: Change as needed
- ☐ Hydrogel: Change daily
- ☐ Normal Saline Damp to Damp Dressing: Change four times daily
- ☐ Calcium Alginate Dressing: Change daily
- ☐ Zinc Based Cream: Daily and PRN
- ☐ Thin Soft Silicone Foam Dressing: Change every 5 days and PRN
- ☐ Soft Silicone Foam Dressing Border 4x4 inch: Change every 7days and PRN
- ☐ Soft Silicone Foam Dressing Border 8x4 inch: Change every 7 days and PRN

**Skin Tear**- Check all those that apply.
Location _____

- ☐ Thin Film Transparent Dressing: Change as needed
- ☐ Petroleum Impregnated Gauze: Cover with rolled gauze and change twice daily
- ☐ Exact Thin Hydrocolloid Dressing: Change every 5 days and PRN
- ☐ Thin Soft Silicone Foam Dressing: Change every 5 days and PRN
- ☐ Soft Silicone Foam Dressing Border 4x4 inch: Change every 7days and PRN
- ☐ Soft Silicone Foam Dressing Border 8x4 inch: Change every 7 days and PRN



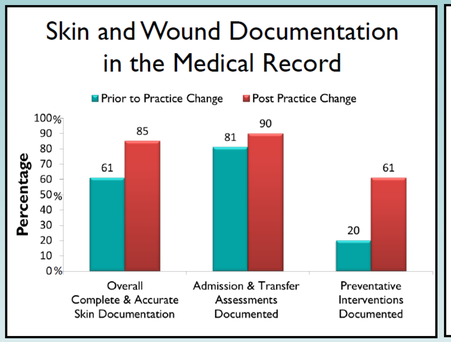
| Date | Initials | RN Competency |
|---|---|---|
| | | Attended Skin Care class provided on the department. |
| | | Completed NDNQI Pressure Ulcer Training Modules. |
| | | Identifies type of skin wound correctly (skin tear, venous ulcer, arterial ulcer, diabetic ulcer, pressure ulcer, surgical wound, traumatic injury). |
| | | Identifies stage of pressure ulcer correctly. Measures wound correctly (includes: length, width, and depth) |
| | | Describes pressure ulcer characteristics correctly (includes: odor, drainage, color %, and tunneling) |
| | | Describes peri-wound correctly. |
| | | Reports when to initiate and implement skin care protocol (Stage I, Stage II, and skin tears). |
| | | Identifies the appropriate wound dressings for each type of wound. |
| | | Provides education to the patient and/or family about his/her wound and the wound care plan. |
| | | States when to notify the physician of a pressure ulcer (>Stage II). |
| | | States when to request a WOC nurse consult. |
| | | Reports when a skin assessment is performed (admission, transfer, change in wound status, and Wednesdays) |
| | | Reports the safety concerns of air mattress beds and interventions to prevent possible falls. |
| | | Verbalizes understanding of turning and repositioning of all patients regardless of the type of mattress. |
| | | Documents all wounds correctly in the medical record. |
| | | Performs and documents the Braden Scale© Score and suggested interventions per Cone Health policy. |
| | | Demonstrates how to communicate skin care interventions with the NT (includes: Implementing NT Skin Care Protocol). |
| | | Verbalizes how to verify that the Nurse Skin Protocol has been initiated and implemented. |
| | | Demonstrates how to write a skin/wound care note in the Progress Notes of the medical record. |

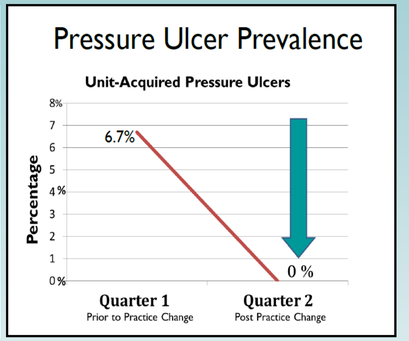
| Date | Initials | NT Competency |
|---|---|---|
| | | Attended Skin Care class provided on the department. |
| | | Identifies wounds present on the patient's skin. |
| | | States when to report skin or wound abnormalities to the nurse. |
| | | Reports when to initiate the NT Skin Protocol. |
| | | Describes when and how to document accurate, timely NT actions in the medical record. (Skin care, peri-care, bath, patient turning, etc.) |
| | | Defines skin care information that should be communicated to the next NT during shift to shift reporting. |
| | | Reports that all patients still need to be repositioned and turned regardless of type of mattress or bed. |
| | | Reports what to do when a patient refuses to be turned or repositioned (notifying the nurse immediately). |
| | | Reports safety concerns of air mattress beds and interventions to prevent possible falls. |

Skin Savers team meeting:
Discussing the evidence and developing the peer education plan

Unit-based education led by staff nurses from the Skin Savers team

## Evaluation

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## Skin Savers Evidence-Based Practice Team

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