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SORE NO MORE: The Power of a Microscope in Skin Integrity.

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Sore No More: Changing the Culture of Skin

6B, Medical-Surgical Unit
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Background:

- 34 bed medical-surgical unit reported 32 pressure ulcers acquired on the unit
- Identified population that had an increased risk of developing a pressure ulcer:
  - Poor nutrition status
  - Braden® score less then 18
  - Length of stay greater than 3 days
  - History of diabetes
  - Decreased mobility
  - Incontinence
- Over half of the acquired pressure ulcers were Stage II
- Opportunities for staff education

Review of Evidence:

- Nursing Executive Center. (2009). *Safeguarding Against Nursing Never Events Best Practices for Preventing Pressure Ulcers and Patient Falls.* The Advisory Board Company, Washington D.C.
  - Team approach was beneficial in preventing pressure ulcers
  - Practices that were beneficial include: rounding, bedside report with oncoming and off going nurses, educating the technical staff in pressure ulcer techniques, and rounding by leadership teams
  - Early interventions are key to prevent pressure ulcers
- Wurster, J. (2007). *What role can nurse leaders play in reducing the incidence of pressure sores?* Nursing Economics (25) 5, p. 267-269.
  - Six most common risk factors in pressure ulcer development: reduced mobility, nutritional status, incontinence, medications, conditions that decrease tissue oxygenation, and age

Pre-Implementation:

- Unit nursing leadership team developed a standardized tool:
  - Examine the root causes including risk factors, prevention strategies, interventions, and assessment of pressure ulcers
  - Identify and stage hospital acquired pressure ulcers correctly
  - Develop prevention strategies to implement throughout the unit

The Tool:

- Enhanced identification of patients at risk for developing a pressure ulcer
- Utilized to analyze length of stay and transfers throughout the hospital
  - Determine if these increase risk of pressure ulcer
- Led to real-time teachable moments for the staff by the leadership team

Pressure Ulcer Monitoring Tool

Post-Implementation:

- Staff report increased confidence with pressure ulcer identification and scoring
- Confidence leads to prevention

Future Implications:

- Tool Utilized for all pressure ulcers identified on the unit
  - Culture of skin awareness effectively created
- Network-wide Skin Integrity Taskforce adapted tool for use on other units
  - Piloting enhanced version of the tool in an effort to standardize practice