

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 than 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



Post-Implementation:

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



Not a permanent part of the patient record

Affix patient identification baby label here

PRESSURE ULCER MONITORING

PLEASE COMPLETE THE FOLLOWING FORM IN PENCIL, DO NOT PHOTOCOPIY

- Reason for monitoring:
 - Skin Rounds
 - Root Cause Analysis
- Braden score:
 - 5-9
 - 10-12
 - 13-14
 - 15-18
 - 19-21
- Was the score calculated accurately? Yes No
- Was the score completed daily? Yes No
- Does staff feel that the patient is at risk? Yes No
- Risk Factors:

<input type="checkbox"/> Albumin < 3.0 in past 30 days	<input type="checkbox"/> Immobilizing device
<input type="checkbox"/> The albumin < 3.0 in last 72 hours	<input type="checkbox"/> Hemodialysis/peritoneal dialysis
<input type="checkbox"/> Hypotension	<input type="checkbox"/> Braden < 18
<input type="checkbox"/> Dehydration	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Fragile skin	<input type="checkbox"/> Chemically altered mental status (alcohol/drugs)
<input type="checkbox"/> Obesity	<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Bedbound/bedfast	<input type="checkbox"/> Edema
<input type="checkbox"/> Diabetes/hyperglycemia	<input type="checkbox"/> Neurology
<input type="checkbox"/> Unstable spine/fracture	<input type="checkbox"/> Poor Nutrition
<input type="checkbox"/> Enteral Feeding/TPN	<input type="checkbox"/> Previous pressure ulcer
<input type="checkbox"/> Multiple system failure	<input type="checkbox"/> LOS > 3 days
<input type="checkbox"/> Contracted	<input type="checkbox"/> Surgery w/ last 72 hours
<input type="checkbox"/> Length of bedrest time is > 2 hrs	<input type="checkbox"/> ICU transfer at some point during admission
- Interventions in place:

<input type="checkbox"/> Turn/reposition Q2 hrs	<input type="checkbox"/> ET/PT/Wound consult placed
<input type="checkbox"/> Pressure redistribution	<input type="checkbox"/> Nutritional support
<input type="checkbox"/> Positioning devices/protocols	<input type="checkbox"/> Cleanse wounds
<input type="checkbox"/> Other:	<input type="checkbox"/> Elevate heels
- Overall Paper:

Overall Paper	Stage	Promote ulcer location	Was the observed pressure ulcer healed or improved?	Why and the ICU was documented for the ulcer?
<input type="radio"/> Ulcer 1	<input type="radio"/> Stage 1 <input type="radio"/> Stage 2 <input type="radio"/> Stage 3 <input type="radio"/> Stage 4 <input type="radio"/> Unstageable	<input type="radio"/> Sacrum <input type="radio"/> Spine <input type="radio"/> Nose <input type="radio"/> Ear <input type="radio"/> Hip	<input type="radio"/> Head <input type="radio"/> Heel <input type="radio"/> Penis <input type="radio"/> Unable to determine	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unable to determine
<input type="radio"/> Ulcer 2	<input type="radio"/> Stage 1 <input type="radio"/> Stage 2 <input type="radio"/> Stage 3 <input type="radio"/> Stage 4 <input type="radio"/> Unstageable	<input type="radio"/> Sacrum <input type="radio"/> Spine <input type="radio"/> Nose <input type="radio"/> Ear <input type="radio"/> Hip	<input type="radio"/> Head <input type="radio"/> Heel <input type="radio"/> Penis <input type="radio"/> Unable to determine	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unable to determine

Pressure Ulcer Monitoring Tool

- Documentation of pressure ulcer appearance correct? Yes No
- Pressure ulcer is correctly staged? Yes No
- Care plan is individualized? Yes No
- Staff products correctly utilized by recommendation of ET or according to algorithm? Yes No
- Wound consult requested? Yes No
- Patient stayed on the following units (type):

<input type="checkbox"/> ICP	<input type="checkbox"/> TA	<input type="checkbox"/> ED-17	<input type="checkbox"/> PCU	<input type="checkbox"/> ST-M
<input type="checkbox"/> SK	<input type="checkbox"/> TRP	<input type="checkbox"/> ED-CC	<input type="checkbox"/> PNI	<input type="checkbox"/> GI-M
<input type="checkbox"/> SB	<input type="checkbox"/> TC	<input type="checkbox"/> PCU	<input type="checkbox"/> SSI	<input type="checkbox"/> TE-M
<input type="checkbox"/> IC	<input type="checkbox"/> ACU	<input type="checkbox"/> MNU	<input type="checkbox"/> TNU	<input type="checkbox"/> TI-M
<input type="checkbox"/> SK	<input type="checkbox"/> BH12	<input type="checkbox"/> NS-KU	<input type="checkbox"/> THRU	<input type="checkbox"/> ED-M
<input type="checkbox"/> SB	<input type="checkbox"/> RB-BS	<input type="checkbox"/> OBT	<input type="checkbox"/> TSI	<input type="checkbox"/> RCM-M
<input type="checkbox"/> IC	<input type="checkbox"/> Dialis	<input type="checkbox"/> OR	<input type="checkbox"/> TTU	<input type="checkbox"/> RCM-M
<input type="checkbox"/> AK	<input type="checkbox"/> IAU	<input type="checkbox"/> PACU	<input type="checkbox"/> EEM	
- Length of time for ET to complete the consult:
 - 0-12 hrs
 - 13-48 hrs
 - 49-72 hrs
 - 73 hrs - 7 days
 - 8-21 days
 - > 2 wks
- Why was the ET consult delayed, if greater than 24 hours?
- Area requiring an action plan:

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