

PREVENTION OF SKIN BREAKDOWN IN THE ED

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BACKGROUND

- Limited beds available on units causing overflow resulting in holding patients in the Emergency Room on stretchers
- Frequent complaints from patients regarding discomfort from long stay on stretchers
- Patients who are nonverbal/confused who do not have advocates at bedside
- Unit nurses reporting skin breakdown that Emergency nurse missed

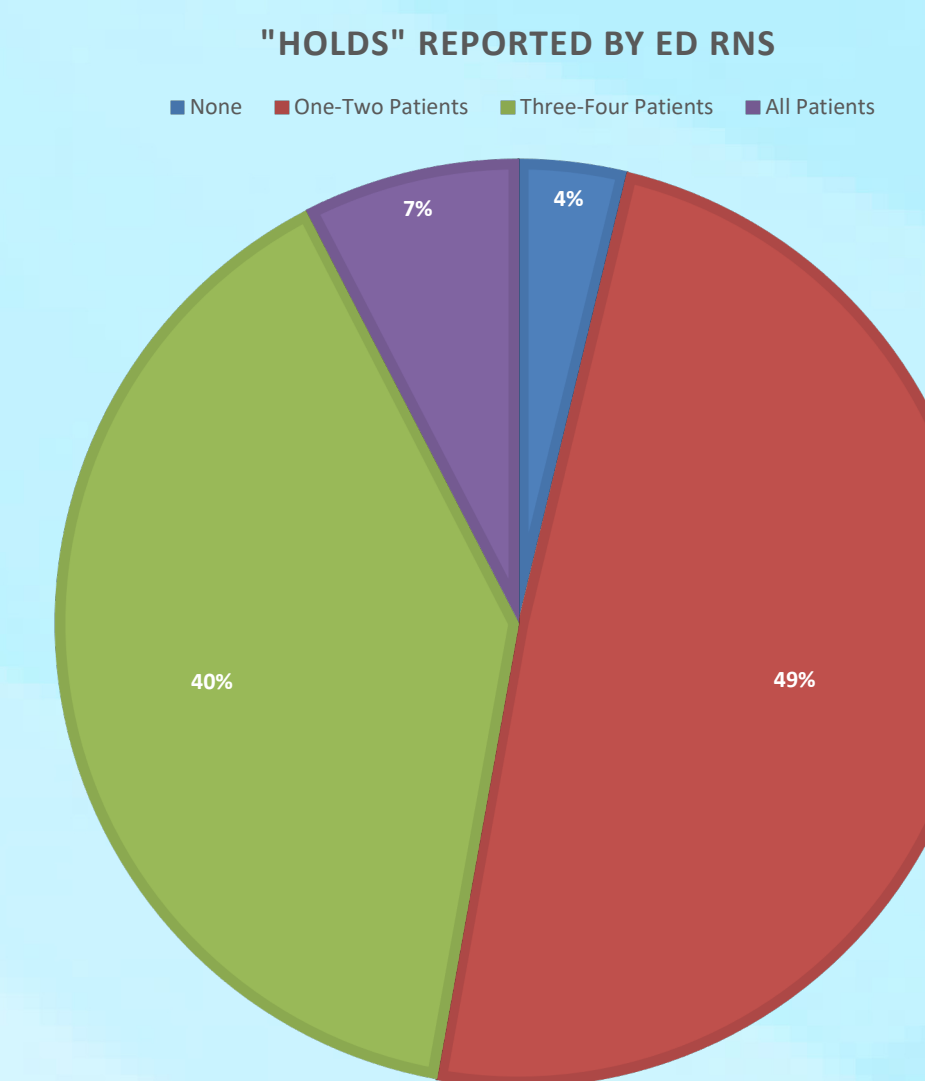
PICO

- **P:** Emergency Department Nurses
- **I:** Identify patients at high risk for skin breakdown
- **C:** Documentation of repositioning
- **O:** Impact change on documentation and interventions by ED nurses regarding skin care

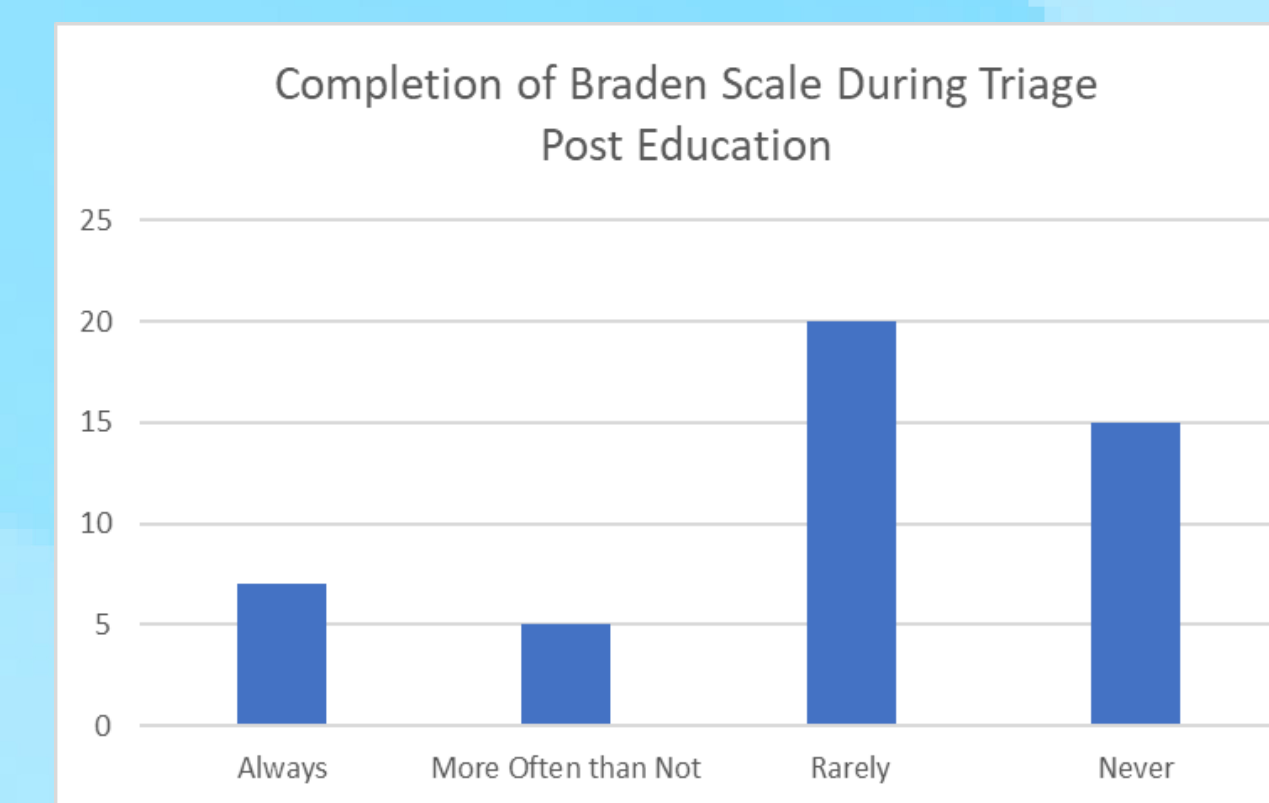
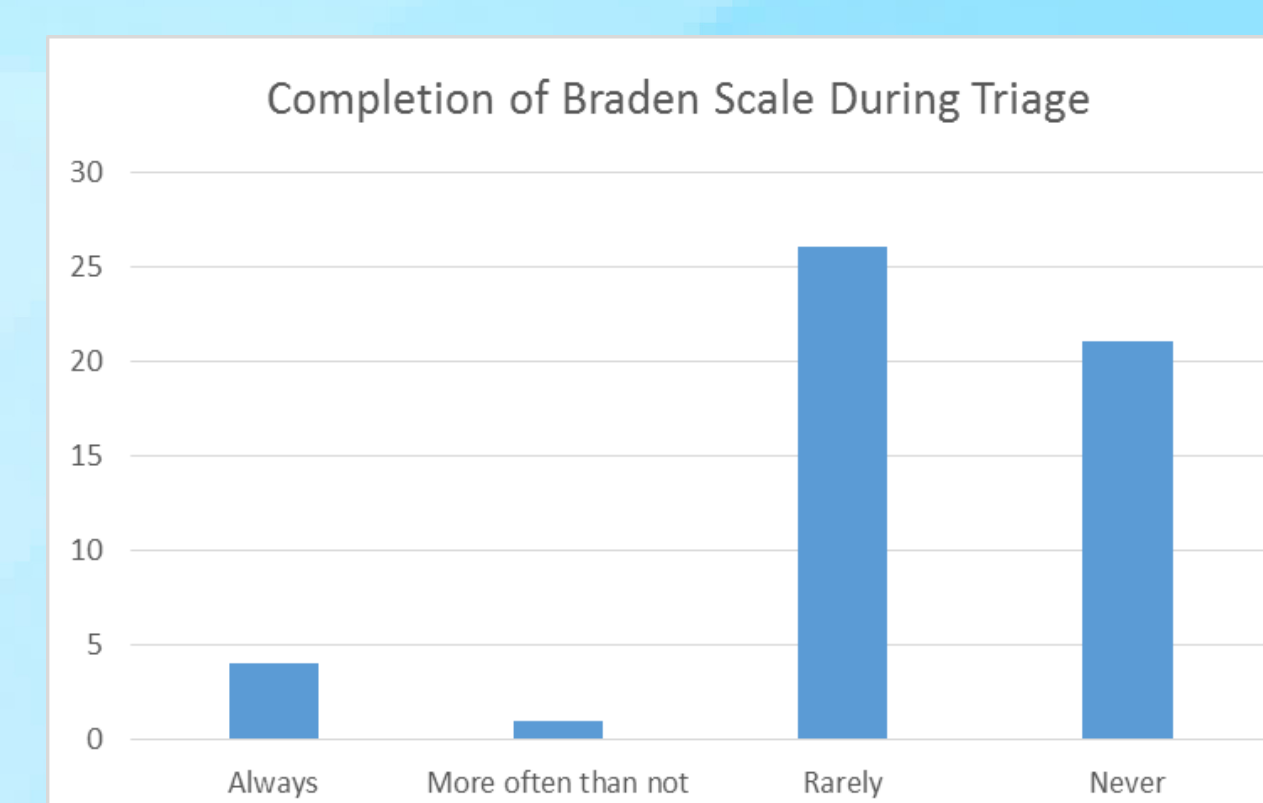
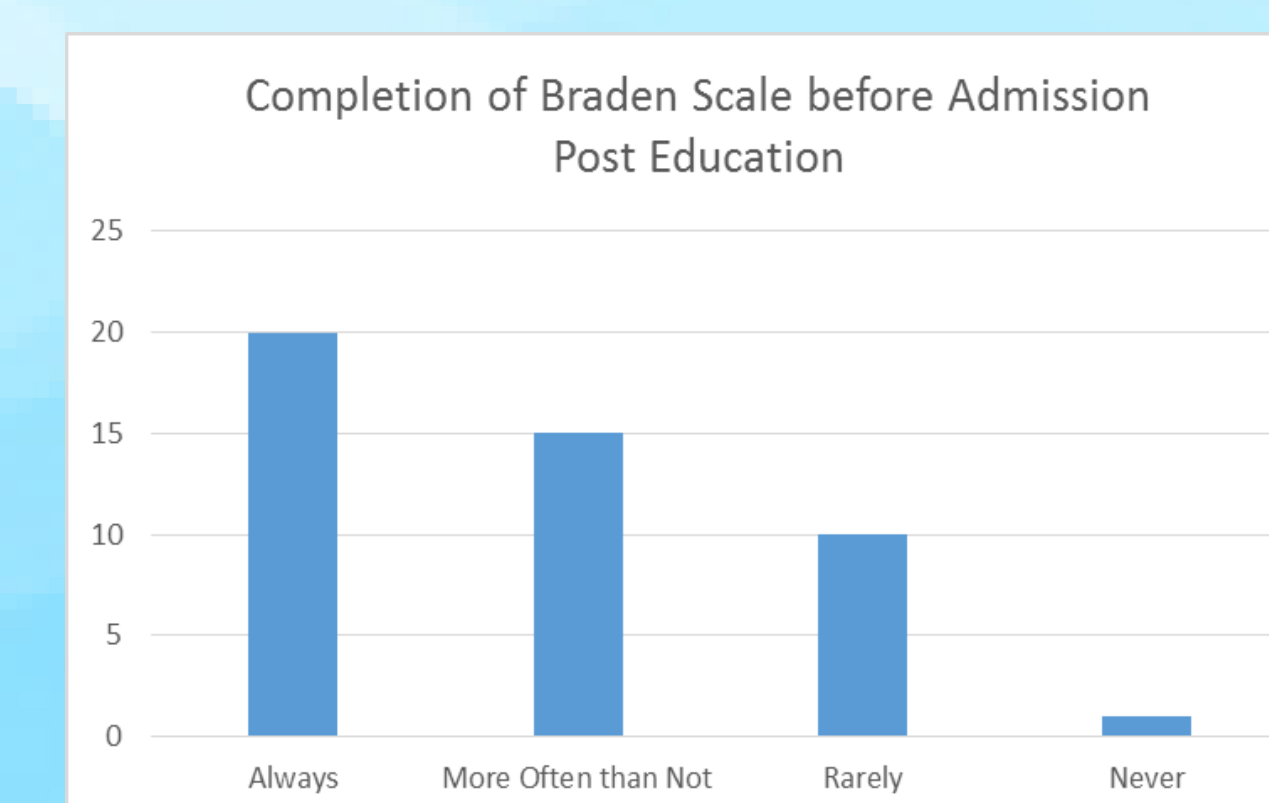
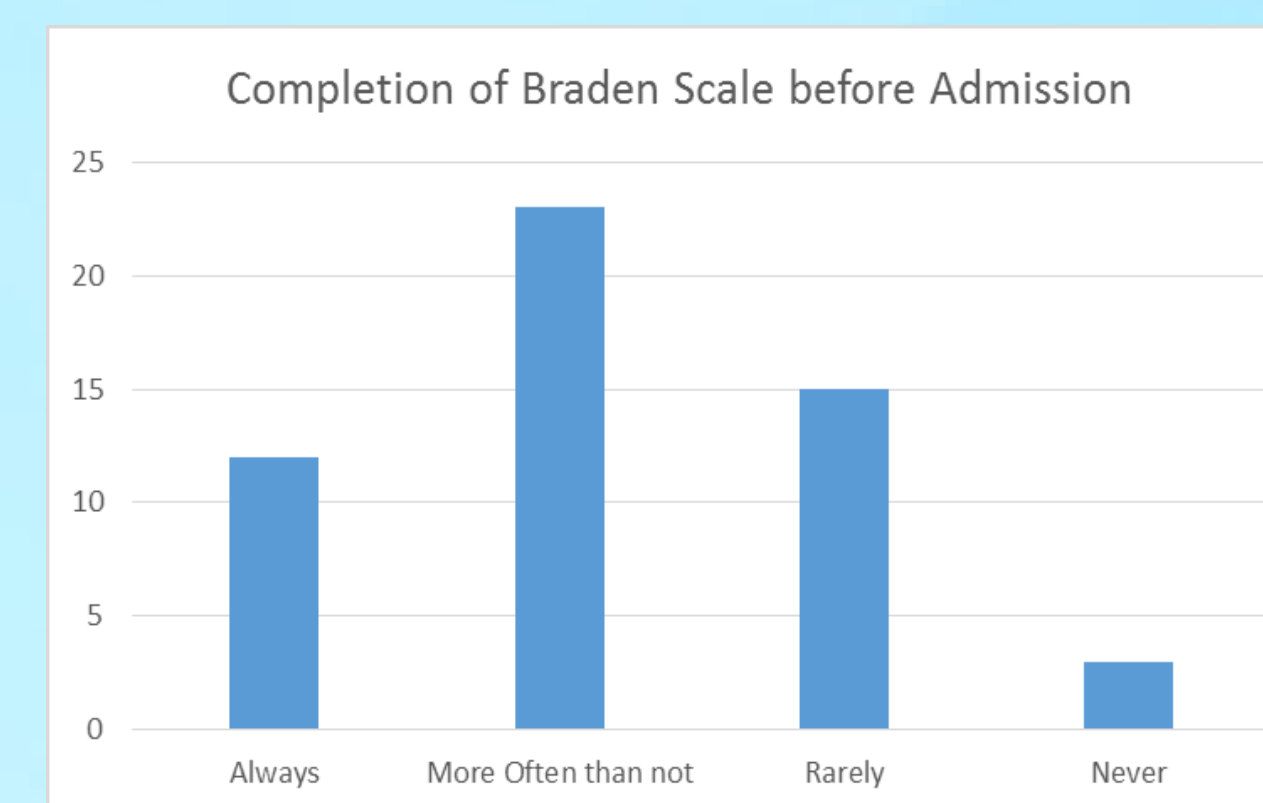
EVIDENCE

- Prevention of skin injuries or hospital acquired pressure injuries (HAPIs) is a challenge in the acute care setting.
- Risk factors in the emergency department include increased wait times, limited patient mobility, and ineffective support surfaces.
- At risk patients that were repositioned frequently resulted in reduced occurrences of skin injuries
- A pressure ulcer can develop in several hours, depending upon risk factors. Constant vigilance of skin pressure areas of at-risk patients, especially those who are immobile, older, and nutritionally compromised, requires the ED nurse to understand skin dynamics as the skin can become compromised over a very short period of time
- Implementation of comprehensive assessment of skin and education of repositioning at risk patients reduced the rate of hospital acquired pressured ulcers (HAPU)
- Future research should determine which strategies are most effective in the ED environment.

OUTCOMES



- Pre-Survey determined that 89% of ED RNs report caring for at least 1 patient who is determined a "hold"
 - Proves significance for change in practice



- **Pre-Education Survey**
 - 65% of ED RNs reported that they either "Always" or "More often than not" complete the Braden Scale Assessment before a patient is admitted to the hospital
 - More "Often than not" responses than "Always"
 - However, only 10% of ED RNS reported completing the Braden Scale Assessment "Always" or "More often than not" during a patient's triage process
- **Post-Education Survey**
 - 65% of ED RNs reported that they either "Always" or "More often than not" complete the Braden Scale Assessment before a patient is admitted to the hospital
 - Same % as pre-survey, however, more "Always" responses than "More often than not"
 - 23% of ED RNs reported they would "Always" or "More often than not" complete the Braden Scale Assessment during a patient's triage.

IMPLEMENTATION

- ED RNs provided with pre-survey to determine baseline understanding of the Braden Scale, how they most often utilize it, and skin breakdown interventions currently used by staff members
- Education was developed and distributed to ED RNs defining Braden Scale and providing common methods of skin breakdown prevention
- Post-survey was distributed to ED RNs to determine if learning had occurred

NEXT STEPS

- More evidence is needed to determine the benefit of utilizing the Braden Scale Assessment Tool during the triage process
 - Trial run
- Involve management to assist with the implementation of practice change as determined by the additional evidence to be collected

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