Implementation Guide to Prevention of Hospital Acquired Pressure Ulcers (HAPU)

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Hospital-Acquired Pressure Ulcer Prevention Overview

Background:
- Pressure ulcers can cause harm to patients, causing pain, infections and extended lengths of stay.
- Hospital-acquired pressure ulcers in the United States were estimated to cost $2.2 – $3.6 billion/year in 1999. In addition, significant personal burdens such as a decrease in quality of life, psychological and social implications occur.
- Prevalence of Stage II or greater pressure ulcers in the acute care setting range from 8.7% to 14.1% and incident rates range from 5% to 9% in the same setting.

Suggested AIMs:
- Reduce the prevalence of hospital acquired Stage II or greater pressure ulcers by 50% by December 31, 2013.
- Reduce the incidence of significant hospital acquired Stage III-IV pressure ulcers by 50% by December 31, 2013.

Potential Measures:

**Outcome:**  Percent of patients with at least one Stage II or greater hospital acquired (not present on admission) pressure ulcer on the day of the prevalence study

Patients with significant (Stages III & IV) hospital acquired pressure ulcers - (rate per 1,000 discharges)

**Process:**  Skin assessment documented within 4 hours of admission and daily thereafter

Pressure ulcer risk assessment completed within 24 hours of admission and daily thereafter

Compliance with prevention interventions for patients at risk for skin breakdown

<table>
<thead>
<tr>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
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| Conduct Skin / Risk Assessment & Reassessment | ✓ Use a head-to-toe skin and risk assessment as soon as possible, within 4 hours upon admission to the hospital.  
✓ Utilize a validated standard tool for the skin and risk assessment.  
✓ The risk and skin assessment should be age appropriate. Pediatric versus adult.  
✓ Skin Assessment and reassessment of risk daily or more frequently for high-risk patients. |
| Manage Moisture | ✓ Keep the patient dry and moisturize the skin only if necessary.  
✓ When necessary, use under-pads that wick moisture away from skin and provide a quick-drying surface.  
✓ Set specific time frames to remind staff to reposition, offer toileting often, PO fluids, reassess for wet skin, e.g. P’s – Pain/Potty/Position/Pressure.  
✓ Keep supplies handy at the bedside in the event the patient is incontinent. |
| Optimize Hydration and Nutrition | ✓ Give patients preferences to encourage hydration and nutrition.  
✓ Provide at risk patients with a different color water container so all staff and families will know to encourage hydration.  
✓ Provide nutritional supplements if not contraindicated  
✓ Consult a registered dietician if the patient is at a high risk.  
✓ Assess weight status, food and fluid intake, hydration status and laboratory data. |
| Minimize Pressure | ✓ Turn and reposition patients every two hours using visual or musical cues, bells and alarms at the nurses’ station.  
✓ Use special beds, mattresses, pillows and blankets to redistribute the potential pressure areas.  
✓ Use the NPUAP guidelines for alignment.  
✓ Use lifting devices to prevent shearing or friction. |

Making Changes:
- This intervention is in the Collaborative with Reducing Pressure Ulcers and VTEs (PIVOT Collaborative). National meetings, webinars, monthly coaching calls, change packages and other tools will augment state association activities.

Key Resources:
- AHRQ Toolkit - Preventing Pressure Ulcers in Hospitals: [http://www.ahrq.gov/research/ltc/pressureulcertoolkit/](http://www.ahrq.gov/research/ltc/pressureulcertoolkit/)
- IHI How to Guide Reducing Pressure Ulcers
**AIM:** Reduce the prevalence of hospital acquired Stage II or greater Hospital Acquired Pressure Ulcers (HAPU) by 50% by 12/31/13

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<th>Secondary Drivers</th>
<th>Change Ideas</th>
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| Conduct Skin / Risk Assessment & Reassessment | • Adopt a head-to-toe skin and risk assessment tool | ✓ Utilize a validated standard tool for the skin and risk assessment.  
✓ Assess skin and risk within four hours of admission.  
✓ Assess skin at least daily and during routine assessment.  
✓ The risk and skin assessment should be age appropriate. Pediatric versus adult.  
✓ Visual cues should be available to ensure the completion of the assessment.  
✓ Use multiple methods to visually identify patients at risk. Use visual cues in the patient’s room, door, or front of the medical record, etc.  
✓ Reassess risk for HAPU at a minimum daily. Develop documentation tools to prompt daily skin inspections.  
✓ Develop an individualized plan of care to reduce the risks of pressure ulcers.  
✓ Use cameras to photograph and document present-on-admission skin issues.  
✓ Conduct nurse-to-nurse shift reports at bedside to include skin assessment with two sets of eyes (to improve accuracy of skin assessment and documentation). |

| Manage Moisture | • Keep skin dry and hydrated. Sequence implementation by drug class | ✓ Use topical agents that hydrate the skin and form a moisture barrier to reduce skin damage.  
✓ Set specific time frames or create reminder systems to reposition; offer toileting often, PO fluids, reassess for wet skin. e.g. 3 P’s – Pain/Potty/Position-Pressure  
✓ Involve licensed and unlicensed staff such as nurse aids in every hour rounding/3 P’s  
✓ Consider Stage I pressure ulcer as a “vital sign.”  
✓ Use under-pads that wick moisture away from skin and provide a quick-drying surface.  
✓ Keep supplies readily available at the bedside in the event the patient is incontinent.  
✓ Develop a skin-care cart with supplies and a guide for how to manage skin issues according to degree.  
✓ Combine routine activities, such as a protocol or guideline.  
✓ Identify a staff nurse for each unit as a skin care resource.  
✓ Avoid using a thick paste as a cleansing/moisture barrier (staff tend to clean the paste when stool is present resulting in skin injury as the paste is not easily removed).  
✓ **ANTICOAGULANTS:** Use protocol to discontinue or restart warfarin perioperatively. |
### Primary Drivers

<table>
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<tr>
<th>Optimize Hydration and Nutrition</th>
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<td>• Assess weight, nutrition and hydration status</td>
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### Secondary Drivers

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<th>Minimize Pressure</th>
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| • Turn and reposition patients every two hours.  
• Develop and institute early mobility/ambulation protocols |

### Change Ideas

- Give patients food/liquid preferences to enhance hydration and nutrition.
- Provide nutritional supplements if not contraindicated.
- Create an automatic registered dietician consult if the patient is at high risk.
- Assess weight, food and fluid intake and laboratory data.
- Provide at risk patients with a different color water container so all staff and families will know to encourage hydration.
- Assist the patient with meals and encourage snacks.
- Offer water to the patient when rounding for the 3 “P’s”. Pain/Potty/Position

- Use visual or musical cues, e.g. a turning clock, bells, and alarms, at the nurse’s station as a reminder to turn and reposition the patient.
- Use visual cues at the bed side to turn the patient, e.g. a turning clock or white board that has the time for the next turn.
- Establish ‘rules’ for which side patients should be on at certain times (e.g. even hours on right side, odd hours on left side).
- Ensure pressure-reducing equipment is available at all times. (pillows, beds, heel protectors, foam wedges for positioning, etc.)
- Use device that elevates the heel and prevents external rotation.
- Use special beds, mattresses, pillows and blankets to redistribute the potential pressure areas.
- Use the NPUAP\(^1\) guidelines for organizational alignment.
- Use breathable glide sheets that can stay in place.
- Use lifting devices to prevent shearing or friction.
- Use ceiling lifts to encourage mobility and movement while preventing work-related injuries.
- Limit layers of linen to no more than three (greater than four has been shown to be an independent risk factor for HAPU).

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Prevention of Hospital Acquired Pressure Ulcers (HAPU)

Between one and three million people in the US develop a HAPU every year (1998). More than 2.5 million patients in U.S. acute-care facilities suffer from pressure ulcers and 60,000 die from pressure ulcer complications each year (2009). Hospital acquired pressure ulcers reduce overall quality of life due to pain, treatments and increased length of institutional stay, and may also contribute to premature mortality in some patients. Interventions that may help prevent pressure ulcers or to treat them once they occur lead to reduction of cost of HAPU care and improve the quality of life for those affected.

Suggested AIMs

Before the implementation of the improvement work starts, the team must have a goal at which to aim. An AIM statement for HAPU reduction efforts could include one of the following:

- Reduce the prevalence of Stage II or greater Hospital Acquired Pressure Ulcers (HAPU) by 50% by December 31, 2013
- Reduce the incidence of significant hospital acquired Stage III-IV pressure ulcers by 50% by December 31, 2013

Conduct Skin / Risk Assessment & Reassessment

Preventing pressure ulcers must start with assessing a patient’s skin and a patient’s risk for pressure ulcers. This assessment must be done upon admission and then at least daily during a patient’s stay. Risks for pressure ulcers include age, immobility, incontinence, inadequate nutrition and hydration, sensor deficiency, device related pressure, multiple co-morbidities, and circulatory abnormalities.

Secondary Driver: Adopt a head-to-toe skin and risk assessment tool

In order to adequately assess a patient’s skin and risk, the use of an accurate tool will allow the care team to implement timely prevention strategies for that patient.

Change Ideas: Skin Assessment Strategies

- Utilize a validated standard tool for the skin and risk assessment. The most widely used is the Braden Scale; however, there are others that may assist: Norton, Gosnell, Knoll, and Waterlow Scale.
- Assess skin and risk within four hours of admission.
- Assess skin at least daily and during routine assessment.
- The risk and skin assessment should be age appropriate. Pediatric versus adult.
- Visual cues should be available to ensure the completion of the assessment.
- Use multiple methods to visually identify patients at risk. Use visual cues in the patient’s room, on the door, or on the front of the medical record, etc.
- Reassess risk for HAPU daily at a minimum. Develop documentation tools to prompt daily skin inspections. In acutely ill hospitalized patients, patient status and skin condition can change rapidly.
- Develop an individualized plan of care to reduce the risks of pressure ulcers.
- Use cameras to photograph and document present-on-admission skin issues.
- Conduct nurse-to-nurse shift reports at bedside to include skin assessment with two sets of eyes to improve accuracy of skin assessment and documentation.

Suggested Process Measure

Monthly audit for percentage of skin and risk assessment compliance on admission
Monthly audit for percentage of daily reassessment compliance

“Hardwiring” Skin / Risk assessment and reassessment as part of improvement plan:

Hardwiring methods include incorporating skin and risk assessment in the admission assessment process and as part of the routine assessment process. The skin and risk assessment tool should be part of that documentation.
Another hardwiring method is to create and implement an admissions checklist to be used with each admission to help ensure that all elements including skin and risk assessment are completed.

**Manage Moisture**

Dry and optimally moisturized skin has a lower risk of developing pressure ulcers.\(^8\)

**Secondary Driver: Keep skin dry and hydrated**

Part of the prevention measures of HAPU should include methods to limit skin’s exposure to moisture from sources such as incontinence, drainage from wounds, or perspiration. Some methods to control the effects of moisture on the skin include the use of under pads that wick away moisture and present a dry surface to skin.\(^9\)

Topical agents are available that provide both a moisture barrier and moisturize the skin.\(^10\)

**Change Ideas: Reliable Moisture Management**

- Use topical agents that hydrate the skin and form a moisture barrier to reduce skin damage.
- Set specific time frames or create reminder systems to reposition, offer toileting often, PO fluids, reassess for wet skin, e.g. 3 P’s – Pain/Potty/Position-Pressure
- Involve licensed and unlicensed staff such as nurse aids in every hour rounding/3 P’s.
- Consider Stage I pressure ulcer as a “vital sign.”
- Use under-pads that wick moisture away from skin and provide a quick-drying surface.
- Keep supplies readily available at the bedside in the event the patient is incontinent.\(^11\)
- Develop a skin-care cart with supplies and a guide for how to manage skin issues according to degree.
- Combine routine activities, such as a protocol or guideline.
- Identify a staff nurse for each unit as a skin care resource.
- Avoid using a thick paste as a cleansing/moisture barrier (staff tend to use the paste when stool is present resulting in skin injury as the paste is not easily removed.)

**Suggested Process Measure**

- Audit compliance with hourly rounding and 3P’s through random spot checks
- Random spot checks for percent of rooms with supplies available for incontinent patients

“**Hardwiring**” Moisture Management as part of improvement plan:

Making skin care and HAPU prevention part of the everyday practice and duties of staff is a reliable hardwiring tactic. Design a process for periodic activities completed by nursing staff such as hourly rounding, repositioning, assessing for wet skin, applying barrier agents, offering toileting opportunity and oral fluids such as water. By combining routine activities performed by both licensed and non-licensed nursing staff into a protocol, staff can complete multiple tasks while in the room every two hours and document all interventions at once.\(^12\)

**Optimize Hydration and Nutrition**

Nutrition and hydration status affects skin condition and risk for pressure ulcer. It has been found that patients who have nutritional deficits may be twice as likely to develop skin breakdown\(^13\). Risk assessment for pressure ulcer development should include review of a patient’s nutrition and hydration status.

**Secondary Driver: Assess weight, nutrition and hydration status**

Patients who are found to have nutritional intake and hydration deficits frequently have muscle mass loss and weight loss. This loss makes bones more prominent and makes patient’s mobility difficult. Poor nutrition and hydration may cause edema and reduced blood flow to the skin which in turn causes ischemic damage, which all contribute to skin breakdown.\(^14,15,16\)

**Change Ideas: Strengthen Metabolic Status**

- Give patients food/liquid preferences to enhance hydration and nutrition.
- Provide nutritional supplements if not contraindicated.
Create an automatic registered dietician consult if the patient is assessed as high risk.

Consider standardized process to draw a prealbumin level in high risk patients or for high risk and medical conditions.

Assess weight, food and fluid intake and laboratory data.

Provide at risk patients with a different color water container so all staff and families will know to encourage hydration.

Assist the patient with meals and encourage snacks.

Offer water to the patient when rounding for the 3 "P’s:” Pain/Potty/Position.

**Suggested Process Measure**

- Monthly audit of percentage of high risk patients receiving full pressure ulcer preventative care (daily skin assessment, moisture management, nutrition and hydration optimization, repositioning, use of pressure-redistribution surfaces)\(^\text{17}\)

"Hardwiring" Hydration and Nutrition Optimization as part of improvement plan

To hardwire hydration and nutrition, make the process of assessing patient’s nutrition and hydration status as routine as possible, such as part of admission assessment and daily assessment of risk.

Once a patient is assessed at high risk for pressure ulcer, a system should be in place to create an automatic registered dietician consult.

**Minimize Pressure**

Minimizing the amount of pressure on bony prominences will help to reduce the possibility of skin breakdown. By repositioning and utilizing pressure-redistribution surfaces, pressure on the skin will be redistributed\(^\text{18,19}\). This is especially important - critical for patients with limited mobility as they are at high risk for developing pressure ulcers.\(^\text{20}\)

**Secondary Driver: Turn and reposition patients every two hours**

Turning and repositioning a patient helps to redistribute pressure on skin surface. This helps to maintain circulation to tissue in areas at risk for pressure ulcers.\(^\text{21}\) So, why every two hours? The literature does not provide clear guidelines for turning frequency; however, it is known that one-and-one-half to two hours in a single position is the maximum amount of time recommended for patients who have normal circulatory function.\(^\text{22}\)

**Change Ideas: Methods to Reduce Pressure**

- Repositioning, use of pressure-redistribution surfaces.\(^\text{23}\)
- Use visual or musical cues, e.g. a turning clock, bells, and alarms, at the nurses’ station as a reminder to turn and reposition the patient.\(^\text{24}\)
- Use visual clues at the bed side to turn the patient, e.g. a turning clock or white board that has the time for the next turn.
- Establish ‘rules’ for which side should be down at certain items (e.g. even hours on the right side, odd hours on the left side.)
- Ensure pressure-reducing equipment is available at all times (pillows, beds, heel protectors, foam wedges for positioning, etc.)
- Use device that elevates the heel and prevents external rotation.
- Use special beds, mattresses, pillows and blankets to redistribute the potential pressure areas.\(^\text{25}\)
- Operating room tables should have special overlay mattresses.\(^\text{26, 27}\)
- Use the NPUAP guidelines for organizational alignment.\(^\text{28}\)
- Use breathable glide sheets that can stay in place.
- Use lifting devices to prevent shearing or friction.
- Use ceiling lifts to encourage mobility and movement while preventing work-related injuries.
Limit layers of linen to no more than three (greater than four has been shown to be an independent risk factor for HAPU.)

**Suggested Process Measure**
- Monthly audit of percentage of high risk patients receiving full pressure ulcer preventative care (daily skin assessment, moisture management, nutrition and hydration optimization)

**Secondary Driver: Develop and institute early mobility/ambulation protocols**
Reduced mobility is a risk factor for the development of pressure ulcers. Putting a process into place that assesses a patient’s mobility and generates recommendations for physical therapy referral will enable staff to safely mobilize patients. Nurse driven mobility protocols have been demonstrated to be effective in reducing immobility related complications and reducing length of stay.\(^{29,30}\)

**“Hardwiring” Minimizing Pressure as part of improvement plan**

Hardwiring pressure minimizing strategies are similar to the other hardwiring strategies stated earlier. Making the process as routine as possible will help to ensure that all aspects of HAPU prevention are addressed reliably in every patient, every day. Make HAPU prevention a part of the everyday process of patient care. Design a process for skin and risk assessment, interventions such as repositioning, managing moisture, use of barrier agents, offering toileting and oral fluids, nutrition and hydration assessment and mobility assessment that will be utilized with every patient. A protocol will also identify those patients at high risk who require greater interventions such as registered dietician and physical therapy consults, and items such as pressure relieving surfaces.

**Potential Barriers**
- Recognize that for many physicians this will be a change in their practice.
  - Although pressure ulcers are a “nursing sensitive condition,” physician participation can support improvement activities, build momentum and help address medical staff concerns.
  - Traditionally, any consults to other clinicians was a function of the physician, not an intra-dependent function with non-physician staff. Include lead physicians in the improvement team. Select these leads to work as champions to dialogue with physician colleagues and accelerate adoption.
  - Order sets and protocols may be seen by some physicians as “cookbook” medicine. It is actually “best recipe” medicine that uses what is known in the literature to provide the best opportunity for patients based on their individual needs to receive the care that will reduce their risk for HAPU.
- These processes may be new territory for many physicians, nurses, physical therapists, and registered dieticians. Nurses may be concerned that they may make a mistake, that they are not adequately trained to follow the policy, or that the medical staff will not be receptive and may become angry. Education of all parties, both about the risk of delayed intervention coupled with the efficacy of immediate intervention, will help mitigate this.

**Using administrative leadership sponsorship to help remove or mitigate barriers:**
- A management executive sponsor, recognizing the value of preventing HAPU to the patients and organization, can help brainstorm solutions to what may appear to be added work, or provide resources to mitigate that additional work. An executive sponsor can also help to see the “big picture” on how this may impact organization-wide, and champions through requests for workflow change or supplies. Executive sponsors can help educate, lead, and provide solutions to staffing barriers.
- A respected physician is crucial to accomplishing the goal of organization-wide adoption of best practices.
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protocols. The unit that you decide to first trial this change should be in an area where the initiative is supported by a respected physician leader. You can work on this intervention without a physician champion, but it will be slower.

- Senior physician, senior nursing, and senior pharmacy management will be critical to the success of new innovations like we have discussed in the section. These may be perceived as something punitive (timeliness audits), something new and unfamiliar (consult a pharmacist?) or additional work (cover the floors too?)
- Start with one unit and refine the process until it is a reliable process and has demonstrated some success in HAPU reduction and no harm. You may need to start with just one physician champion to use protocols and refine.
- It is important to start with the one early adopter nursing area who can help lead and then recruit early adopter champions from other units.

This is not just a change in practice but may also be a change in culture:

- This may very well require a change in culture, particularly physician culture. The physicians will be asked to trade their traditional way of considering interventions solely on their preference for a more standardized and effective approach. This may appear to be both a loss of control as well as irresponsible to give up that control.
- Nurses and physical therapists will also experience change in that this may be the first time they would have to collaborate to such a degree. Some may be uncomfortable with the notion of staff-driven protocol intra-dependent with physicians. Education and involvement of staff in the development of the protocols may help to mitigate.
- Protocols can be scary to physicians who are not used to them. This will be a change in how they work. Physicians learn from peers. Most physicians will follow their respected peers before they will follow “expert advice.”
- This is an example of an innovation that will require small tests of change and planned spread driven by success. The ideal end result is the development of team-based care where each member of the team (physician, nurse, respiratory therapist) contributes to better and safer patient care.

Tips on How to Use the Model for Improvement

- Choice of test and intervention for HAPU reduction:
  - As highlighted above, there are many potential interventions for HAPU reduction. Where do you start? The team should ask themselves: “What is the greatest need at our facility?” Start with what will get you your biggest bang.
    - Is it skin risk assessment implementation needed?
    - Is it handoff communication between nurse on patient information such as risk and risk mitigation interventions needed/implemented?
    - Is a process redesign needed to improve skin risk assessment findings, causing appropriate interventions, e.g. specialty mattress?
    - Is it a need to focus on low costs interventions first such as implementing every two-hour turning?
  - Do not wait for the new beds to arrive or the new sheets to arrive to implement prevention strategies. Do small tests of change with what you have now and then work with the new technology later. New technology is not required for simple strategies such as turning patients or optimizing nutrition or improving handoff communications.
- Implementing a skin risk assessment tool
Step 1: Plan – Which skin risk assessment tool to use?
   - Choose an established evidenced-based practice tool such as the Braden Skin Risk Assessment Tool. Mentioned above are such tools. Choose one or two tools to test and have staff choose which one works best.

Step 2: Do – Keep scale of test small. Start first with one nurse, one shift. Only need to test with a few more nurses (two or three of varying experience level – competent to expert) and a few patients as compared to a sample of 200.

Step 3: Study – Evaluate use and effectiveness. Which tool is easy to use and gives assessment findings that can be incorporated into the care plan?

Step 4: Act – Skin risk assessment documentation flow sheets may need to go through several “tweaks” before ready to use on a wide scale.
   - Know when to stop a test. If the test results show the change is not leading to improvement, then stop the test.

Implementing Nursing Protocol to turn every two hours

Step 1: Plan – Decide which unit and shift to do the small tests of change. They should be nurses who are willing to do the trials. Is there a unit known for being early adopters? Have you identified nurse champions who are willing to try changes first?

Step 2: Do – Testing nursing protocol to turn patients at least every two hours.
   - Start simple – one unit, one shift, one process.

Step 3: Study - Staff huddle at the end of shift to evaluate the results of the process.
   - Ask themselves questions such as, “What worked well?” “What did not work well?” and “What do we need to change for the next test?”
   - Huddles are short and fast – everyone stands, preferably with a beverage in hand.

Step 4: Act – Do not wait for the next committee meeting to implement learning. Test the day on the same unit, with the same staff. Repeat until process seems to be working and then spread to another shift.
Appendix I: Educational Poster

Protect Your Patient’s SKIN

Tissue injury can be more than skin deep

HEALTHCARE THAT IS SAFE
Delivering Clinically Excellent Care
Appendix II: Clipboard reminder for patients at risk of pressure ulcers

SKIN RISK ALERT

SKIN BUNDLE INTERVENTIONS IN EFFECT

SURFACE:
- Be sure patient is on correct type of mattress.
- Do not use multiple layers of linen under patient.
- Keep linens free of wrinkles.
- Be sure patient is not lying on tubing, telephones or call bells.

KEEP TURNING:
- Reposition patient at least every two hours when in bed.
- "Self" is not acceptable for documenting repositioning.
- Document the actual position the patient is observed in.
- Shift patient's weight at least every hour if up in chair.
- Use a chair pad when patient is in a chair.

INCONTINENCE:
- Offer toileting assistance every 2 hours.
- If incontinent, give perineal care every 2 hours and as needed for stool incontinence.
- Apply a moisture barrier after incontinence care.
- If not incontinent, apply moisture barrier every 8 hours.
- Avoid diapers unless needed for containing excessive amounts of stool, patient is ambulatory and incontinent or saturates linens with most urinary incontinence episodes or patient requests diaper.

NUTRITION:
- If patient has a nutritional deficit or is high risk for a nutritional deficit, order a nutrition consult. Look at what the patient has been taking in for nutrition and also look at albumin levels.
- Consider recent weight loss as well.
- Consider hydration status.
- Carry out nutrition orders and record supplement and meal intake.

Assess skin every 8 hours. Document breakdown description on Skin Flow Sheet daily.

Document all of your interventions

Not a permanent part of the medical record
References

21 Clark M. Repositioning to prevent pressure sores what is the evidence? Nurs Stand. 1998;13:56-64.