Love the Skin They're in: Development of a Comprehensive Pressure Ulcer Prevention Education Program

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Abstract

Pressure ulcers (PUs) are a serious health care problem, and it is crucial for staff to accurately assess patient's skin for evidence of PU at admission. A caring, skilled nurse focuses on prevention of hospital-acquired pressure ulcers and healing of those that already exist. Unfortunately, the expertise of many nurses prevents them from meeting this goal. In October 2012 new regulations from the Centers for Medicare and Medicaid Services (CMS) require Acute Inpatient Rehabilitation Facilities to report all acquired and worsening PUs on the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI). This presentation will review how a team of nurses came together to assess & address skin integrity and pressure ulcer prevention utilizing an on line education needs assessment of Staff Nurse's PU Knowledge. Data from the PU Knowledge assessment was used to develop a comprehensive education plan to enhance nurse's skill set to assess skin, properly identify pressure ulcer stages and manage the PU care utilizing Jean Watsons' Caring theory. The Pressure Ulcer Prevention (PUP) team adopted PU prevention measures based on Watson's Caritas process: creating a healing environment and tending to patients' basic human needs. The outcome was we enhanced the clinical practice of >200 nurses as evidenced by significantly improved post-test PU Knowledge scores, excellent care delivery, more confident assessments, and treatment of PUs in a peer-supported caring environment. Peer Mentoring Team Skin Rounds provided clinical support and ensured process change sustainability. The intensive PU education and ongoing clinical support has resulted in better quality care.

PUP Team

Team Membership:

Nurse manager from each unit – 6 campuses totaling 9 units

2 RNs from each unit – received 16 additional hrs of education

Nurse Educators/specialists, Certified Wound Ostomy Nurse

Objectives

Measure the nurses knowledge of pressure ulcer assessment and prevention

Develop an education plan to improve pressure ulcer assessment, care and documentation

Implement a sustainable process for education, peer mentoring, monitoring, and reporting

Evidence - Based Practice

*National Pressure Ulcer Advisory Panel

*Agency for Healthcare Research & Quality – Pressure Ulcer Prevention Guidelines

Process

EDUCATION NEEDS ASSESSMENT:

We administered a modified version of the Pieper Pressure Ulcer Knowledge test (1995) on line via Survey Monkey. The modified tool incorporated current PU assessment definitions. The items were reviewed by an expert panel and pilot tested. The 35 question assessment was administered to 200+ professional nurses and addressed 5 areas of competency: 2 Risk Identification Questions, 13 Standard of Care Questions, 10 Terminology Questions, 9 Physiology Knowledge Questions & 1 Wound Differentiation Question. The web-based program used allowed ease of calculating responses in a variety of formats. Results were the foundation of the educational offering.

INTENSIVE FOUR HOUR EDUCATION PROGRAM:

A 2½ hour didactic classroom lecture was developed focusing on the following:

Scope of the problem; healthcare changes related to the affordable care act and reporting of hospital acquired pressure ulcers (HAPU); anatomy & physiology of healthy skin; components of a risk, skin and wound assessment; pressure ulcer prevention strategies; wound differentiation - pressure vs other; physiology of pressure ulcer evolution; anatomical location of the major bony prominences; standards for comprehensive wound assessment – accurate pressure ulcer staging, wound measurements, wound bed characteristics & descriptors, surrounding skin assessment.

A 1½ hour skills lab assessing the nurses competency to:

Accurately stage, locate, measure, describe a variety of photographs of pressure ulcers; identify appropriate treatment choices based on wound presentation; accurately access the electronic medical record and input all information per our documentation standards. Upon completion of the four hour education all nurses were immediately retested with the Pressure Ulcer Knowledge test.

STANDARDIZATION OF CARE:

Care delivery and assessment expectations were standardized across all Moss units:

Head to toe skin inspection is performed within 24 hours of admission.

Identification of a pressure ulcer and determination of staging is performed with a peer. Upon discovery an incident report is completed.

Admission assessment documentation indicates a PU is present on admission, comprehensive wound assessment is documented in the medical record and a photograph using a standardized process is taken.

Presence of a pressure ulcer is additionally reported to the unit nurse manager and review of documentation and validation of staging is provided in a supportive manner within 24 hours of admission.

The patient is referred to be seen in weekly pressure ulcer wound rounds for the unit.

An environment for ongoing quality monitoring, hands-on educational opportunities and nurse to nurse mentoring & growth was created.

PEER MENTORING PROCESS:

Trans-disciplinary wound rounds occur weekly on each unit at a designated day and time. Team members include; wound experts, primary nursing staff, PT, OT, physician & dietician. This provides an ongoing real-time educational opportunity for continuous quality monitoring, hands-on education and nurse to nurse mentoring & growth.

A Wound Education monthly newsletter is distributed to all nursing staff highlighting specific areas of interest/concern. Another ongoing peer support mechanism to provide peer feedback and education.

Outcome

OUTCOME SUMMARY

Pre-Test	10 questions out of a total of 35 questions received a score of less than 80%
Post- Test	5 questions out of a total of 35 questions received a score of less than 80%
1 Year Post-Test	6 questions out of a total of 35 questions received a score of less than 80%

One year post-education results have allowed us to identify continued areas of growth and provided guidance for ongoing provision of modified and relevant education..Benchmark for the future is a score of 90%

Outcome

SAMPLE OF TEST QUESTIONS

- A low Braden score is associated with increased pressure ulcer risk?
- a pressure ulcer with a wound base of 50% slough and 50% red tissue with visible bone would be classified as an unstageable pressure ulcer?
- Suspected deep tissue injury (DTI) is a pressure ulcer of unknown depth because the wound bed is covered with slough or eschar?
- Tunneling is an area of tissue destruction extending under intact skin along the periphery of a wound?
- A blood blister from pressure and/or shearing of underlying tissue is classified as a deep tissue injury?
- A stage II pressure ulcer is a full thickness skin loss.
- Stage II pressure ulcers may be extremely painful due to exposure of nerve endings?
- It is important to massage bony prominences?
- A stage III pressure ulcer is a partial thickness skin loss involving the epidermis and/or dermis?
- Scattered superficially open areas with red wound bases, located on the buttocks are usually stage II pressure ulcers?

Competent clinical assessments were enhanced as evidenced by the improved 35 question post-education test scores. We have been able to sustain the education process through a variety of ongoing educational offerings.

Sustaining the Outcomes

- Wound champions identified for all units. Each person functions as a clinical resource for staff members.
- Monthly education classes provided to further increase the knowledge base of professional nurses requiring additional support.
- All new orientees are educated and attend wound rounds.
- "Wound-Ed" bulletin boards on each unit displaying wound education newsletters and additional wound information. A "Dear Wound-Ed" column is included to address the specific questions posed by direct care nurses.
- Peer-to-peer feedback given continuously. Validation of findings and evaluation of documentation provided by colleagues.
- Prevention and Staging cards for ID badges are worn by all RN staff members.
- Annual competency assessment of wound knowledge and application.
- Modification of wound education curriculum based on outcomes and continued areas of growth.

References:

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