



PRESSURE ULCERS: “STUCK BETWEEN A ROCK AND A HARD PLACE”

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INTRODUCTION

Patients in an acute inpatient rehabilitation setting are at high risk for pressure ulcer development. Medical conditions and complications, immobility and functional impairments create opportunities for nurses to implement both individualized and systematic processes to prevent the development of pressure ulcers.

In the second half of 2012, Brooks identified an increase in hospital-acquired pressure ulcers. To address this problem, we 1) reviewed and revised our skin policies, 2) increased the number of Wound Care Certified nurses from two to four and 3) created a comprehensive Wound Assessment form for WCC nurses to use.

ACTIONS

1) Skin Care Protocol was revised to include Risk Assessment Scores. The score is calculated on each patient at admission and weekly. Our Revised Skin Care Protocol now includes the intervention for each score, so that nurses are empowered to implement the appropriate action according to patient need.

2) Increased the number of Wound Care Certified Nurses from two to four with one nurse working primarily on the weekend, so that our patients can be assessed/tracked by a WCC nurse seven days a week.

3) A Wound Assessment form was created to insure a reliable assessment of each wound, thereby insuring that all information is captured consistently with each assessment and is easily understood by the multi-disciplinary team caring for the patient.

The Lead WCC nurse coordinates new consults daily and assigns patients to each WCC nurse according to patient load. The assigned WCC nurse performs a comprehensive assessment and treatment recommendations are submitted for MD approval. The assigned WCC nurse tracks the assigned patient for the duration of the patient's stay; at least once a week and with any changes.

WCC nurses meet every third Friday with the Charge Nurses to discuss wound care and hospital education needs.

WOUND ASSESSMENT			
Patient Name: _____ Room #: _____		Location of Wound: _____	
Type of Wound: _____		Date of Assessment: _____	
Measurements: _____ cm length x _____ cm width x _____ cm depth			
Exudate	Wound Bed	Wound Margins	
Quantity	Color	Elevated	Attached
Scar	Red	Calloused	Noninflamed
Small	Pink	Macerated	Jagged
Moderate	White	Epiloid	
Large	Gray	Surrounding Tissue	
Obvious	Black	White	Cool
Type/Color	Yellow	Pink	Warm
Clear	Tan	White	Edematous
Blood Tinged	Brown	Red	Shiny
Vesicle		Purple	
Tan		Yellow	
Purulent		Black	
Serosanguinous		Bloody	
Serous		Slough	
Green		Necrotic	
		Fibrin	
		Eschar	
		Undermining	
		_____ cm _____ o'clock	
		_____ cm _____ o'clock	
		_____ cm _____ o'clock	
		Tunneling/Depth	
		_____ cm _____ o'clock	
Odor			
Present			
Absent			
Foul			
Musty			
Pain			
Y/N			

Recommended treatment: _____

Y/N Debridement (type) _____

Y/N Turning/repositioning (frequency) _____

Y/N Support surface as use (type) _____

Y/N Nutritional Support (type) _____

Y/N Support Intolerance Control - if no, please explain _____

Completed by: _____ Brooks Rehabilitation _____ Date: _____

F511 _____ Patient: _____

Progress Record

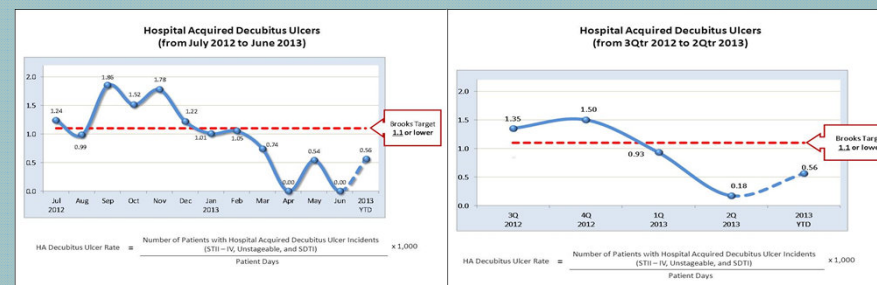
CONCLUSION

High Risk Patients are identified immediately following admission and appropriate interventions are implemented.

By using a standardized Wound Assessment form, all wounds are documented completely and consistently by any of the four WCC nurses, improving the description and documentation of each wound.

We have a WCC team of nurses who are seen as wound experts and are available to staff for education and guidance in assessment and treatment.

Since implementing these changes, our Hospital Acquired Pressure Ulcer rate has decreased significantly. Please see graph.



REFERENCES

Bergstrom N, Bennett MA, Carlson DE, et al. Treatment of Pressure Ulcers. Clinical Practice Guideline, No. 15. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 95-0652. December 1994.

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