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Reducing the Incidence of Hospital-Acquired Pressure Ulcers by Enhancing the Role of Unit-

Based Skin Champions

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Internship: Clinical Nurse Leader

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Based Skin Champions

Clinical Leadership Theme

The theme for this project emphasizes the Clinical Nurse Leader (CNL) essential element of *Outcomes Improvement and Safety*. Of particular focus are CNL roles as Systems Analyst and Risk Anticipator, Outcomes Manager, Educator, Team Manager, and Clinician. As systems analyst and risk anticipator, the CNL participates in review of processes and evaluates the efficacy of current evidence-based pressure ulcer prevention protocols that promote patient safety and overall patient outcomes (AACN, 2007, p. 13). As outcomes manager, the CNL fulfills this competency as champion and change agent that utilizes performance measures in assessment, improvement, promotion, and delivery of high quality and evidence-based practices (AACN, 2013, p. 12).

Education is another major element of a CNL. As a leader, meaningful education is important and achieved through time spent with her peers and interdisciplinary teams in support of outcomes improvement and policy changes. This competency is further accomplished through generation and dissemination of knowledge, planning and implementation, and giving detailed presentations about the concepts and role of skin champions (AACN, 2013, p. 14). Furthermore, as a clinician, the CNL utilizes leadership skills to teach, coach, and mentor staff and other healthcare team members (AACN, 2013, p. 20). Additionally, as an advocate for patient and family, this unique partnership will effect quality outcomes that translate care that is safe, efficient, and free from harm (AACN, 2007, p. 13). Moreover, the CNL will continuously work together with other disciplines in order to address gaps in today's healthcare delivery systems for outcomes improvement and patient safety (Reid, K. B., & Dennison, P., 2011).

Global Aim Statement

Pressure ulcer is a common, serious, and significant healthcare occurrence in the frail and elderly. This complication causes pain, disfigurement, slow recovery from co-morbid conditions, and interferes with activities of daily living. And although one of the goals of Healthy People 2020 is to reduce pressure ulcer related hospitalizations among older adults (Jackson, S., 2011), studies have shown that hospital-acquired pressure ulcer (HAPU) complications have been associated with “up to 60,000 deaths each year in the United States” (AHRQ, 2014). While majority of hospital institutions worry about affordability from a business perspective, as of October 2008, the Centers for Medicare and Medicaid Services (CMS) will no longer reimburse HAPUs, which further impacts hospital budget and revenue.

The primary aim of the Skin Task Force is to reduce the incidence of hospital-acquired pressure ulcers by fifty percent by May of 2016. The goal of this quality improvement project is to enhance and empower Unit-Based Skin Champions. Their role and unit presence will foster utilization and implementation of evidence-based preventive skin care protocols, optimize consistency of practice, perform root cause analysis, conduct prevalence studies, identify barriers in care delivery, and provide expert advice to peers. Increasing their knowledge and awareness of pressure ulcer prevention strategies through training and education will support practice changes at the microsystem of care (Bergquist-Beringer, S., et al., 2009, p. 22).

Statement of the Problem

Pressure ulcer prevention has been a major nursing concern for many years. Considered a major health problem that has affected millions of adults, pressure ulcers acquired during hospitalization present grave consequences on the well-being of the patient, significant treatment and recovery delays, increase length of inpatient stays, and have become a “never” event from

the standpoint of Medicare reimbursement. Direct and indirect costs associated with treating a stage 4 pressure ulcer and their related complications could amount to \$129,248 per ulcer (Duncan, K., 2007). Concurrently, the average cost per hospital stay when a pressure ulcer is listed as a secondary diagnosis is estimated to be \$43,180. In addition to the financial costs, pressure ulcers have a major impact on an individual's physical and social function. This puts them further at risk for serious infections, and are a major source of morbidity and mortality (Saha, et al., 2013, p. 1).

Although most pressure ulcers are considered preventable, the incidence has been increasing in hospitals and health care facilities. Oftentimes, pressure ulcer prevention has been overlooked as critical to patient's safety (Moore, Z., 2013). And while patient safety remained a focus for quality improvement at this medical center, but despite a well-sustained pressure ulcer prevention strategies and protocols, the 2014 to 2015 skin prevalence studies showed a marked increase in the incidence of HAPUs (**Appendix A**). With eight verified HAPUs from January to February 2016, a comparative regional data from 2009 to 2011 showed zero HAPUs of all stages and zero HAPUs stage 2 and above (**Appendix B**). Furthermore, the Certified Wound Ostomy and Continence Nurse (CWOCN) daily referral reports showed a rapid increase in inappropriate consults. These became detrimental to CWOCN's work, especially on allocation of appropriate resources. Time became an issue and was directed towards screening referrals, instead of seeing patients, thus, further jeopardizing patient safety. Although the Intensive Care Unit (ICU) has the majority of HAPUs, unit observations revealed an increasing number of patients at high risk due to the fact that this institution has the highest older adult patient population who are sixty five years of age and above. There has also been a decline in the number of active Unit-Based Skin Champions. Those that remained in the role were either too busy, overwhelmed, and have

verbalized losing their competence, knowledge, skills, and experience. There has been an ongoing confusion on which skin care products or preventive skin care protocols to be used. Additionally, more staff articulated the need for education, updates, and training in order to be an effective skin champion.

As healthcare processes become increasingly complex, improving patient care outcomes require not only a systematic process, but also the utilization of a multimodal approach including early detection of patients at risk for developing pressure ulcers, and prompt, personalized care and treatment. Furthermore, with the proven success of a similar program in the past five years, the decision to revive the Skin Task Force and enhance the Unit-Based Skin Champion program, were identified as key drivers for change. The skin champions' presence, will foster application of existing prevention modalities, early intervention and efficient, cost effective treatment, and as mentors and experts, will ensue practice changes beginning within the microsystems of care.

Project Overview

The site for this project is a 175-bed general medical and surgical teaching hospital in a suburban area in Southern California. The microsystem in focus is the writer's medical surgical geriatric unit and ICU. Although more emphasis will be placed on these units, raising awareness on the importance of pressure ulcer prevention is critical for the whole hospital requiring a shift in focus, thereby educating and training all inpatient units' skin champions.

In the years 2014 and 2015, the hospital has been challenged with eleven and twenty HAPUs respectively. As of February 2016, eight HAPUs were identified and verified, and two of which were reportable. Of those HAPUs that were reported, one developed severe complications which resulted in increased length of stay, and several unfavorable outcomes. Although this incident was considered unavoidable due to the nature of the patient's overall condition, but the

majority of HAPUs were preventable. And despite the existence of evidence-based pressure ulcer prevention policies and protocols, inconsistencies in application and practice have been demonstrated. These inconsistencies in nursing care and practices, if not addressed, are threats to patient safety.

Pressure ulcer prevention is an important nursing role and frequently used benchmark for quality care. Enhancing and reinventing the role of Unit-Based Skin Champions are critical in promoting patient safety and overall patient outcomes. With the leadership of the Clinical Nurse Leader (CNL) student, this project will begin with the revival of the Skin Task Force. This team will be comprised of a physician champion, nurse champion (CNL student and current charge nurse), administrative skin team lead, ICU department administrator, CWOCNs, and a quality representative. Ad hoc team members will include a patient safety officer and all nursing department administrators. Inpatient units will concurrently identify their respective unit skin champions, both days and nights, and on opposite weekends. Once the skin champions are identified, a four hour education and training will follow. The planned education will be interactive and will comprise of a lecture, questions and answers section, video, quiz, and group case studies (**Appendix C – Agenda**). The lecture portion will highlight the role of the skin champion (**Appendix D**), CWOCN referral guidelines (**Appendix E**), four eyes skin assessment guidelines (**Appendix F**), Braden Scale (**Appendix G**), wound care and preventive care products, skin prevention protocols, and identification and staging of wounds and pressure ulcers (prepared by CWOCNs).

Evidence shows that staff education and training is an integral part of quality improvement and enhances a nurse's knowledge and skills. Increasing awareness on the importance of pressure ulcer prevention will foster utilization of evidence-based practice and

preventive care at the bedside. Furthermore, the skin champions will serve as unit experts and resource for pressure ulcer prevention and skin care, educate and update staff on new guidelines, perform root cause analysis, assist in identifying patients at risk, conduct prevalence studies, and identify barriers in the delivery of preventative care.

Reducing pressure ulcers can be obtained through evidence-based intervention guidelines. This has been made top priority throughout the healthcare continuum by the Institute of Healthcare Improvement's (IHI) 2006, 5 Million Lives Campaign, in which the national standardized goal has been deemed to be zero (Duncan, 2007, p. 606). Furthermore, the Joint Commission's (TJC) 2016 National Patient Safety Goals clearly states that most pressure ulcers are preventable and worsening at stage I can be halted (TJC, 2016).

Currently, the average cost per case in which pressure ulcers were listed as a secondary diagnosis at this institution, is estimated to be \$43,180 per hospital stay. With eleven and twenty HAPUs in 2014 and 2015 respectively, the total cost for treating thirty-one pressure ulcers \$1,338,580. Granting these patients are Medicare beneficiaries, this amount is the hospital's total loss from Medicare reimbursement. A 50% reduction in HAPUs would significantly impact the financial standing of this institution in the future (**Appendix H – Cost Benefit Analysis**).

Using the Collaborative Alliance for Nursing Outcomes (CALNOC) data and methodology, this institution has set target at a minimum of equal to, or below 2%, and a maximum of equal to, or below 1%, and a projected aim of zero. Using incidence data, the hospital has set 2016 targets at a 40-50% reduction from 2015, at a minimum of below 40%, and at a maximum of below 50%. And although the ultimate goal of this project is a reduction of overall HAPUs, it is also critical that clinical practice follow directives that best align evidence-based prevention interventions that promote patient safety and optimum clinical outcomes.

Rationale

In today's healthcare industry, the general public want to know if they are safe once they enter the doors of a healthcare institution. In the aftermath of the Affordable Care Act (ACA), healthcare consumers would like to know if the care they receive is of the best quality. With the advancement of technology, patients can now compare hospitals across a service area and obtain relevant information including quality care indicators such as the incidence and prevalence of hospital never events like pressure ulcers. Although regulations have changed in the way hospitals are being reimbursed by the Centers for Medicare and Medicaid Services (CMS), institutions are being required to document diagnosis such as pressure ulcers, as either present on admission, or hospital acquired. This information is also available for access by the general public. Furthermore, hospitals with the highest risk-adjusted hospital-acquired conditions (HAC) rates, will receive a penalty of 1% pay reduction for all Medicare admissions, based on a total HAC score including a HAPU measure, as mandated by the provisions of ACA (Meddings, et al., 2013, p. 505).

This project involves a change process that aligns with quality improvement to promote better patient outcomes. Although implementing change in healthcare is not always easy, reinventing, reviving practices, and raising awareness requires the motivation and involvement of staff. Using Lewin's Model of Change in the revival of the Skin Task Force and in enhancing the role of Unit-Based Skin Champions, is the tool that is necessary to implement and sustain change. This also involves the support from nursing management and clinical leadership at the point of care. An assessment of the medical surgical geriatric and intensive care units, revealed several inconsistencies in among the five P's - Purpose, Patients, Professionals, Processes, Patterns, of a microsystem that needed improvement. With the irregularities identified, this

project will streamline these care processes. And through education and training, the skin champions will integrate the best available evidence into practice beginning at each microsystem of care.

Data obtained reflecting incidence of HAPUs from 2014 to 2016 revealed a steady increase (**Appendices I & J**). An analysis of a hospital-acquired pressure ulcer unusual occurrence report showed inconsistencies in the use of prevention protocols and treatment. Random chart audits revealed variations in skin assessment between nurses, and gaps in the proper identification of wounds and staging of pressure ulcers were also identified. And despite the presence of an evidence-based skin prevention protocols, these were not utilized appropriately and consistently. Furthermore, there appears to be confusion on when to initiate prevention protocols.

Brainstorming revealed the need to further analyze the increasing incidence of HAPUs and identification of the key failures and deficiencies that lead to poor results. Using a fishbone diagram, the six major categories recognized were staff/people/skills, process, environment, equipment and/or supplies, management, and patients (**Appendix K – Fishbone Diagram**). While various contributing factors led to the increasing number of HAPUs, staff's knowledge and skills, commitment, lack of communication, high turnover, and delineation of responsibilities, were linked to irregularities defined in implementing ideal preventive measures. Barriers were also found in peer-to-peer hand-off of high risk patients. Time constraints and multiple competing priorities also played a role. Furthermore, the absence of clear guidelines from CWOCNs and Unit-Based Skin Champions on preventive interventions most nights and weekends resulted in inconsistent care.

Despite the presence of adequate improvement practices at the bedside, a successful pressure ulcer prevention program requires a multimodal approach and multidisciplinary participation. Review of organizational processes and strengths-weaknesses-opportunities-threats (SWOT) analysis revealed several key elements identified as strengths and opportunities (**Appendix L – SWOT Analysis**). The effectiveness of current pressure ulcer prevention program, high level interfaced electronic medical record (EMR), availability of educational resources and nurse leaders, as well as adequate resources and supplies are major strengths. With direct involvement and support from high-level leadership and administration, reinventing the Skin Champions is another opportunity that will create a culture that empowers nurses and team members to actively participate, collaborate, and provide the best possible care for patients to decrease preventable skin breakdown. While strengths and opportunities abound, threats and weaknesses cannot be denied. Inadequate staff representation, skill preservation, issues with staff turnover, lack of team commitment, and resistance to change were identified challenges. These were addressed by the Skin Task Force, nurse leaders, and stakeholders.

The success of a pressure ulcer prevention program will not be possible if there is no support and involvement from stakeholders and high-level leadership (**Appendix M– Stakeholder Analysis**). Their input is critical not only during the implementation phase but from inception, planning, evaluation, and all through the Plan-Do-Study-Act (PDSA) cycles. Their contribution and power have an extent to influence change. Their goals and initiatives, in alignment with the project's goals and objectives will be optimized. In partnership with the driving forces to achieve patient outcomes and meet quality benchmark, stakeholders and team members' active participation and frontline staff's involvement will be essential to the change process.

For the past five years, this hospital has reached the goal of zero HAPUs utilizing the current pressure ulcer prevention protocols and expertise of unit-based skin champions. Microsystem and hospital-wide assessments and analyses showed that in order for this project to be successful, a thorough and concise process needs to be in place. This should be driven, implemented, evaluated, and continuously monitored (**Appendix N - Process**). Commitment from staff and stakeholders to quality improvement is an essential factor to achieve success. And although the change process may be seen as an inconvenience, but the organization's readiness to make these changes were evident through the enthusiasm and energy displayed by staff and stakeholders. Empowering the skin champions through training and education will foster a community built on collaboration that will make a difference on the lives of the patients that this organization care and serve.

Methodology

Prior to project implementation, components of the Skin/HAPU Prevention Program were identified. These were: 1) Skin Care/HAPU Prevention Guidelines, Policy and Procedures; 2) Prevent the deterioration of community-acquired pressure ulcers (CAPUs) and begin wound healing; 3) Skin Care Protocols; 4) Nursing Education – Wound and Skin Care Module from NDNQI; 5) Skin Champion Classes; and 6) Physician Education Outreach. This was necessary in order to incorporate the key change concepts with actionable items as it aligns with the processes and probable outcomes. The Skin Care/HAPU Prevention Guidelines, Policy and Procedures were first reviewed by the Skin Task Force members and items that were no longer applicable were removed, and any revisions, based on current skin care products and/or technology, and documentation procedures were modified. Skin Care Protocols were subsequently reviewed where no major change were identified. The HAPU incidence data were subsequently analyzed

and gaps in the skin champion role and skin prevention interventions including documentation were identified.

Because the nature of this project is vast and long term, the team felt that enhancing the role of unit-based skin champions and front line staff through education and training will be the first and foremost step in promoting the efficient and effective utilization of evidence-based skin prevention protocols. This strategy was brought to the Nursing Advisory Council meeting and was addressed to inpatient units' department administrators. This was met with great enthusiasm and participation and all were in agreement that Skin Champion classes should begin as soon as possible.

The Skin Task Force met again and collaborated with the Staff Education and Professional Development lead personnel for resources and for continuing education. The CNL student prepared and completed the necessary forms for this matter and created the agenda for the four-hour training. After the class dates and venue were set, a flyer was created and sent out via email to all inpatient units' department administrators for posting (**Appendix O - Flyer**). A list of former skin champions and new skin champions were submitted by the department administrators to the staffing office for scheduling purposes. Three classes were booked initially, but to a big surprise, sixty-five inpatient staff registered nurses (RNs), signed up to become skin champions, necessitating an additional class.

The organization's vision demonstrated commitment to the preservation of the patient's skin integrity by supporting an evidence-based pressure ulcer prevention program. Since this program already existed and has been sustained for a few years, Lewin's Model of Change of "unfreezing," "moving," and "refreezing," will drive the force that will create action to

implement and sustain change and bring HAPUs incidence to the project's goal of at least 40% (Mitchell, G., 2013).

An assessment of the staff's current practices, inconsistencies, and failures, paved the way towards the "Unfreezing" phase. Although the current demands of healthcare has been tough for many nurses especially in an ever-changing and chaotic environment, majority of the staff felt that with an increasing incidence of HAPUs, a solution needs to be drawn to achieve the best outcome for the patients. Empowering staff through active participation was critical. Through effective communication, active listening, and discussing staff's concerns and perspectives, barriers were addressed, and an understanding was reached especially on the various uncertainties of how change will affect the staff's workflow.

The "Moving" phase began when the Skin Champion classes commenced. There was excitement and energy in the auditorium. Although there was a sense of reluctance from a few former skin champions, but with encouragement from team leaders, their confidence became apparent. It was also during this time that everyone in the room "moved" to make a difference and embraced change. As each skin champion was motivated, they began to take pride and ownership, explored alternatives, and shared valuable suggestions towards the success of the project implementation.

The "Refreezing" phase began when skin champions returned to their respective units with a fresh set of knowledge. They started to re-evaluate their own patient assignments and reviewed individual skin assessments. And while they felt confident and competent in their new role, there were various questions which required revisiting the "Unfreezing" stage. These queries were explored and barriers were re-identified and addressed. Suggestions for a biweekly skin prevention rounds was added to another set of PDSA cycle. This cycle included questions

that the skin champion will ask the staff nurse that pertains to their patients (**Appendix P – Skin Prevention Rounds Questions**).

In order to fully assess the effectiveness of the Education for Skin Champions in enhancing and reinventing their roles, an assessment of the following consistent interventions will be analyzed: 1) comprehensive skin assessment; 2) pressure ulcer risk assessment (Braden Scale); 3) position changes at least every 2 hours; 4) management of moisture; 5) appropriate use of support surfaces/pressure relieving devices; 6) peer-to-peer skin prevention rounds; 7) appropriate CWOCN consults; 8) patient and family education; 9) prompt reporting and root-cause-analysis (RCA) of suspected HAPUs; and 10) initiation of appropriate treatment and preventive protocols. A weekly Skin Champion Audit Tool was created for this purpose. Results of these weekly audits are huddled to their respective units (**Appendix Q – Audit Tool**).

With the diligence of the skin team and enthusiasm and energy of the staff and skin champions, the teamwork that is apparent will drive positive outcomes. With only one HAPU for the month of March, the increasing presence and confidence of skin champions will optimize consistency of practice at the point of care. And because Certified Nursing Assistants (CNA) are the nurses' partners, a CNA Skin Protocol will be added to their four-hour update on April 20 and April 26, 2016.

Literature Review

(P) – Population: Unit-Based Skin Champions

(I) – Intervention: Enhancing skin champions' role through implementation of comprehensive educational and training program

(C) – Comparison: Current preventive practices

(O) – Outcome: Increased knowledge empowers implementation of evidence-based

preventive skin care protocols and optimize consistency in practice for effective pressure ulcer prevention

Pressure ulcer prevention has remained a major focus in healthcare institutions nationwide. Defined as a lesion caused by damage of underlying tissue over a bony prominence from an unrelieved pressure by the Wound Ostomy and Continence Nursing Society (WOCN) (2010), it has affected millions of adults nationwide. Although pressure ulcer is preventable, the incidence continues to rise placing a large financial burden on healthcare organizations. With recent reimbursement changes set by CMS and quality standards set by regulatory and licensing bodies, organizations were driven to develop innovative ways and means to improve pressure ulcer prevention and management. Furthermore, pressure ulcer prevention is not only linked to nursing quality outcome measures, but is a Joint Commission National Patient Safety Goal (TJC, 2016).

There is a growing body of literature describing various programs, including interdisciplinary interventions, in the prevention of HAPUs. A search through CINAHL and Google Scholar highlighted major factors that were linked to the success of these programs and initiatives. Involvement of nursing leaders, development of an interdisciplinary task force, department based teams, skin champions, unlicensed assistive personnel, and frontline staff, have direct effects on the success of pressure ulcer prevention programs. In alignment with the organization's goals and objectives, their efforts have brought evidence-based implementation at the bedside.

Any organizational change is often difficult especially when it involves revisions and adjustments to a nurse's workflow (AHRQ, 2014). Understanding the organization's readiness to embrace this change is crucial as this could lead to unprecedented levels of difficulties during

project implementation (AHRQ, 2014). Talks between nurse leaders generated this sense of urgency and readiness to take on ownership and greater responsibility to initiate change. Because patient safety is of utmost importance, this has been clearly expressed in the Skin Task Force's strategic plan, and understood and demonstrated among the frontline staff that were assessed. It was also made clear, that the organization's increasing incidence of HAPUs, were related to gaps in the nurses' knowledge and expertise at the prevention level and at the initiation of prompt and appropriate treatment. A lack of knowledge leads to noncompliance in the implementation of pressure ulcer prevention protocols, which is a major precursor to the development of pressure ulcers (PUs) (Yap, T. L., & Kennerly, S. M., 2011).

Nursing plays a very important role in pressure ulcer prevention. With nursing's leadership, their knowledge, expertise, and passion for outcomes are key drivers in the development of innovative solutions. Their strength and involvement in the planning process has led to organizational transformation and application of evidence-based, sustainable, and cost-effective care processes. But lack of knowledge and inexperienced staff brought by high turnover rates can have devastating consequences. In 2014 to 2015, hospital reorganization weakened the strength of the Skin Task Force, and high staff turnover decreased the number of experienced unit-based skin champions. According to Yap, T. L., & Kennerly, S. M. (2011), lack of knowledgeable staff interferes with continuity of care and weakens the care standard as they are the ones who understand the effectiveness of pressure ulcer prevention programs (p. 109). The authors further asserted that if nurse leaders do not demonstrate commitment to programs that embrace change, the staff will not visualize this culture and will lose the motivation to share the responsibilities for improvement (p. 109). When the leader and other members of the Skin Task

Force transferred to other positions, the leadership was weakened and the staff felt unsupported with their efforts to improve quality outcomes for their patients.

Pressure ulcer prevention has been identified as a nurse-sensitive quality indicator in various healthcare settings. Studies have shown that pressure relief is linked to pressure ulcer's prevalence and incidence and compliance to prevention protocol interventions. Niederhauser, A., et al, in their literature review article proved that best practices for pressure ulcer prevention were unsuccessful when implemented individually (2012). Rather, effectiveness was achieved when these practices were bundled and implemented together as part of a comprehensive, multidisciplinary program (p. 186). The authors further asserted that support from upper leadership and active participation from frontline staff at the microsystem level created a systemic change in practice. They also explained that prevention tasks such as turning and repositioning or risk assessment, and initiating pressure reducing surfaces, were consistently implemented when these were incorporated into the staff's routine practices, such as taking vital signs or mobilizing patients (p. 186). Likewise, staff that were empowered and took ownership of project implementation have better outcomes and impacted sustainability.

Sullivan, N. & Schoelles, K. M. (2013) in a systematic review of pressure ulcer prevention as a patient safety strategy, proved that prevention protects patients from harm and reduce the costs that organization's spends in caring for them (p. 410). Likewise, the authors concluded that simplifying and standardizing prevention practices, involving interdisciplinary teams in leadership, utilizing skin champions with ongoing staff education, using audit tools, and receiving continuous feedback from staff, were core key components in process improvements and reduction of pressure ulcers (p. 410). Furthermore, the 18 studies that they reviewed in acute care settings showed that 96% of the staff were educated and trained, 96% of assessment

protocols and wound documentation were revised and developed, and quality audit tools and staff feedback were performed and obtained at 81% (p. 413). A majority of the studies that the authors also reviewed utilized interdisciplinary teams with skin champions as the major team players that drove outcomes. On the other hand, higher level leadership ensured that staff are oriented, educated, and trained, resources are provided, quality programs maintained, and results of performance were constantly communicated through committee and council meetings for analysis and assessment.

Mallah, Z., et al. (2015) affirmed in a controlled before and after study, that the effectiveness of a pressure ulcer prevention on the prevalence of hospital acquired pressure ulcers is through a multidisciplinary approach utilizing multiple intervention components of patient repositioning, nutrition and vitamin supplement to promote wound healing, support surfaces such as special mattresses or overlays that redistribute pressure, and risk assessments tools to evaluate patients at higher risk (p. 107 – 108). Implementation of these interventions were also carried out through a multimodal program comprising of the utilization of Braden scale for risk assessment, accurate staging of wounds based on the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP), and nurse champions chosen after successful completion of education and training workshop and competency evaluation, and must have at least 3 years of bedside nursing experience (p. 108). Nurse champions' education consists of how to assess patients using the Braden scale, staging pressure ulcers and how to differentiate other types of wounds, how to collect accurate data, and how to use the multiple intervention components mentioned (p. 108). Furthermore, the nurse champions' roles were clearly identified as: 1) resource persons in the application of evidence-based prevention protocols according to policy and regulatory guidelines; 2) data collection and

monitoring outcomes based on the National Database of Nursing Quality Indicators (NDNQI) as benchmark; 3) identification of flaws and patterns, strengths and weaknesses, and creation and implementation of corrective plans specific for the point of care, and performance of nurse audits to ensure compliance and adherence to standards of practice (p. 108). Subsequently, all staff nurses in this study were required to undergo the training offered through the NDNQI program.

In an article by Taggart, E., et al. (2012), the study was conducted in a 507-bed level 1 trauma center whose HAPU incidence was much higher than the organization's target of less than 4%. At 7% the organization, assigned the Memorial Ostomy Wound Service (MOWS) to develop a strategy that would heighten the performance of nurses in reducing pressure ulcers (p. 385). The strategy was to develop teams of wound care resource nurses or skin champions or unit-based champions that "could also provide expertise with wound, ostomy, and continence care" (p. 385). What this organization developed was called Wound Ostomy Continence (WOC) Unit Champions. The roles of these unit-based champions were also identified as unit resource that will assist in the management patient's skin care needs, supervise unit's approaches for improvement of patient outcomes, and act as liaison between unit members and councils (p. 386). To develop the champions' skills and expertise, an educational session was also given plus access to valuable resources to support their role. As drivers of patient outcomes, this organization's pressure ulcers dropped to their goal of 4% within the first year (p. 388).

On the other hand, Kelleher, A. D., Moorer, A., & Makic, M. F. (2012), nurses at University of Colorado Hospital's Surgical Intensive Care Unit (SICU), in Aurora, Colorado, conducted a quality improvement project to decrease HAPUs in SICU. Their program began with two nurses trained by the hospital's CWOCN to become skin champions. In coordination with the unit's Clinical Nurse Specialist (CNS), nurse manager, and CWOCN, weekly "peer-to-

peer rounds” were conducted, and during these rounds, the patient’s skin condition, Braden scale score, and preventive interventions were discussed. The effectiveness of the patient’s plan of care was also assessed especially if a pressure ulcer is identified (p. 152). The authors asserted that preventive nursing rounds by skin champions were effective in reducing the prevalence of pressure ulcers. The discussions that occur during these rounds provided a medium of mutual learning and facilitated meaningful collaboration in promoting patient-centered preventive care at the bedside (p. 156). Subsequently, the sharing of information between nurses provided a clinically significant productive learning experience and perceived as more effective compared to classroom instruction or modules offered online (p. 156). Furthermore, the authors proved that, peer-to-peer bedside preventive rounds were effective as evidenced by a consistent decline in the SICU’s prevalence rates over a 36-month period (p. 154).

Numerous literatures have acclaimed the role of unit-based skin champions in various pressure ulcer prevention initiatives and strategies. While much attention was pointed on nurses as skin champions, an article by Blankenship, J., & Denby, A. (2010), a 176-bed community hospital utilized “unlicensed assistive personnel (UAP) to champion pressure ulcer prevention (PUP) strategies” (p. 12). This quality improvement project began with a luncheon sponsored by the staff education department honoring UAPs for their hard work in patient safety and quality care. Held once monthly, this meeting provided an avenue for all UAPs across the organization to discuss concerns and issues and learn. Subsequently, the nurse educator introduced tips for pressure ulcer prevention and prompt reporting of any changes in skin condition (p. 12). Subsequently, the nurse educator informed the UAPs of preventive interventions that they can implement such as repositioning patients, off-loading heels, keeping them clean and dry, and maximizing oral intake. She also made sure that UAPs will have access to prevention products

such as heel protectors, boots, pillow, or skin care products such as non-medicated creams that they can utilize within their scope of practice (p. 12).

In collaboration with the patient's primary nurse, the open communication between the nurse and UAPs have empowered them in working together in implementing strategies for better patient outcomes. They also became proactive when they see that their patients needed additional interventions and made sure that these were known and recorded. With the hospital's electronic medical record, the nurse educator receives a report highlighting high risk patients. This report further ensures if patients are receiving optimum care. Results of this initiative was a win-win for the organization and the patients (p. 13).

The literature review revealed significant information that supports the role of the unit-based skin champions in the prevention of hospital acquired-pressure ulcers. The articles written and studies conducted all emphasized a collaborative and multidisciplinary approach geared towards multimodal intervention components, but also clearly highlighted the unique role that skin champions play. Evidence also suggests that skin champions not only promote the implementation of evidence-based pressure ulcer prevention interventions at the microsystem of care but also encouraged innovative strategies at the unit level (Bergquist-Beringer, S., Derganc, K., & Dunton, N., 2009). As unit resource, champions educate, inform, and support staff in developing personalized plan of care.

Enhancing the role of unit-based skin champions have been a successful initiative and strategy utilized by the institution benefiting this project. With a growing urgency, solid goals and objectives, and ultimate support from high leadership, former skin champions, frontline staff, and multidisciplinary Skin Task Force membership, there is still another opportunity for this

project to reinvent itself and achieve its goals. This project is on the road to reducing pressure ulcers.

Timeline

This project began around October of 2015 when the Skin Prevalence Studies revealed an increasing incidence of hospital acquired pressure ulcer (**Appendix R – Timeline**). With one CWOCN split between the inpatient, wound center, and clinic, I began to assist in screening inpatient consults and referrals. Majority of the consults were for suspected HAPUs. As a skin champion, I began to investigate the efficient implementation of preventive interventions and protocols. Several gaps and inconsistencies were discovered and any changes in the patient's skin were not promptly addressed. Similarly, patients at high risk did not receive preventive treatment promptly. Concurrently, a review of CALNOC data in comparison with data from 2009 to 2011 revealed a dramatic rise in HAPUs. It was also concerning to know that a successful pressure ulcer prevention initiative has not been fully implemented as it should. Furthermore, it was alarming to realize that patient safety has been jeopardized and increasing costs to treat HAPUs can pose a financial burden to the organization.

On November 2015, I raised this concern at the Nursing Quality and Patient Safety Council meeting. Unit representatives raise the same concern. Worried regarding the decline of active unit-based skin champions were expressed, as well as the need for re-education and training, and review of policies and procedures. The team further asserted the need to revive the Skin Task Force to re-develop and re-establish a team of skin champions. This was discussed at another meeting with CWOCNs, Definitive Observation Unit (DOU) Department Administrator, Director of Nursing, Adult Services / Nursing Quality, Patient Safety Officer, Quality Representative, and myself (Charge Nurse and CNL student). The decision to revive the Skin

Task Force was achieved, and members' responsibilities were discussed including the addition of ad hoc members and a physician champion.

In December 2015, an administrative lead for the Skin Task Force was chosen. A series of meetings followed and plans to coordinate classes and ongoing education regarding products, protocols and interventions were discussed. Root Cause Analysis (RCA's) of HAPUs were reviewed and findings were disseminated to staff. Subsequent meetings were cancelled due to the holiday season.

From January 2016 to February 2016, the Skin Task Force met almost biweekly. I was in charge of putting the class together. I collaborated with Staff Education and Professional Development for materials and resources and for Continuing Education Credits (CEU's). By first week of February 2016, the class dates, venue, agenda, flyer, speakers, power point presentations, and audio-visual (AV) equipment were set. An email was sent to all inpatient units' department administrators for skin champion selection and registration. Registration was done through the staffing office. One week into the first class scheduled for February 25th, sixty-two (62) staff nurses signed up to become skin champions. With the assistance of a travel nurse, resource materials for the class were printed, stapled, and created into booklets for distribution. A resource book for skin champions was also created and will be given to each unit after all classes are completed. While this process went on smoothly, but it took a bit of time to procure product samples and pressure ulcer staging guide from the vendor representative. It was worth the wait because the booklets contained valuable and relevant information.

February 2016 to March 2016, Education for Skin Champions classes were held on February 25, March 3, March 17, and an additional one on March 31. Fifteen to twenty attendees were in the first three classes. The classes were interactive and based on the reviews and post

program evaluation, the attendees verbalized increase in knowledge and skills to perform their role as skin champions. They expressed excitement in performing their duties and responsibilities moving forward. The information made known to them, particularly the incidence and prevalence of HAPUs, created a sense of urgency and increased awareness on the job that awaits for them. Majority expressed their willingness to participate in the Skin Prevalence Study scheduled for April 28, 2016.

Expected Results

The expected results are two-folds. The first and foremost expectation is geared towards favorable patient outcome and focused on patient safety. And while a reduction in the incidence of hospital acquired pressure ulcers is the ultimate goal, prompt identification of patients at high risk and efficient implementation of preventive measures will be more than sufficient at its beginning stages. Early recognition of skin changes and appropriate referral for early treatment is also one of the expected outcome. And because of the success of a similar program a few years ago, there is a high probability that a similar success will repeat itself and achievement of the ultimate goal of zero HAPUs will no longer be in the horizon.

The second expectation is patient and staff satisfaction. When frontline staff are empowered and took ownership for their roles, they become more effective in implementing evidence-based protocols. The discussions among their peers fosters a meaningful relationship that will directly address gaps and inconsistencies in care and practice. Because pressure ulcer prevention is a nursing quality outcomes measures, achievement of goals and objectives brings satisfaction and increase morale when the realization when their roles brought meaning and favorable outcomes to their patients.

Nursing Relevance

Much has changed in healthcare for the last few decades. While nurses are now the forerunners of healthcare's quality, safety, and performance improvements, but the delivery of safe, efficient, and quality care for patients remained a challenge (Reid, K. B., & Dennison, P., 2011). And as a Joint Commission National Patient Safety Goal, a hospital-acquired pressure ulcer has been considered a "never" event from the standpoint of Medicare reimbursement. Pressure ulcers continue to be a major complication of hospitalization nationwide. While prevention is not possible for all patients, early assessment of risk, and use of preventive measures are essential steps in quality nursing care. Although prevention has been approached at a multidisciplinary level, but viewed as a quality of care and nurse-sensitive indicator, the responsibility has been placed upon the nurses' shoulders.

Pressure ulcer treatment and management can be expensive and complex. Increased length of hospital stay combined with pain and discomfort, risk for infection, disability, morbidity and mortality, place a significant burden on patients and their families. With rising costs, hospitals face substantial burden with the treatment of HAPUs. And although prevention of pressure ulcers is seen as a nursing role, this should not be the goal of just nurses, but should be considered a priority by high leaders to support quality outcomes. Understanding the risk factors and the principles of prevention, in conjunction with prompt recognition and treatment when a pressure ulcer is identified, are key factors to a successful Pressure Ulcer Prevention Program.

The CNL student in this project took a systematic approach in pressure ulcer prevention. Utilizing essential roles and competencies as outcomes manager, educator, leader, clinician, and life-long learner, she championed process reviews and evaluation of current prevention practices.

The gaps identified have been the driving forces towards the plan, creation, implementation, and completion of an educational session and training to enhance the role of existing skin champions, and promote the role of new ones. With growing evidence of the wonders that skin champions bring to each microsystem of care that they mentor, care, and touch, there is a greater possibility that this hospital's goal of achieving zero HAPUs will be fulfilled in the near future.

Summary and Conclusion

Hospital-Acquired Pressure Ulcer (HAPU) is not only a major concern at this hospital but continues to be an alarming issue in today's healthcare systems. Often preventable, it is a significant nursing role and a frequently used benchmark for quality care. And even though pressure ulcer prevention is a fundamental intervention that is not new, is inexpensive, and affects patient safety and quality outcomes, HAPU prevalence continues to rise.

In 2014-2015, a 175-general medical-surgical hospital in Southern California was challenged with an increasing HAPU incidence (**Appendices A, I, & J**). While a review of evidence and literature indicate a variety of multicomponent initiatives that have been implemented and successful across acute hospital settings, but with a higher older adult population, the hospital sought to reduce HAPU prevalence by reviving the Skin Task Force and enhancing the role of Unit-Based Skin Champions. With a primary aim of a 40-50% reduction in HAPU incidence by May 2016, the CNL student, with strong support from nurse leaders, conducted a series of meetings and analysis of internal data and external benchmarks for comparison (**Appendix I & J**). Based on the obtained data, a sense of urgency was evident, thus the goals of the Unit-Based Skin Champion Program were identified. These were: 1) to empower staff to utilize and implement evidence-based preventive skin care protocols; 2) optimize

consistency of practice; 3) perform root cause analysis; 4) conduct prevalence studies; 5) identify barriers in care delivery; and 6) provide expert advice to peers.

Strategies to generate staff enthusiasm and increase awareness were also utilized through reports, participation, and dissemination of HAPU prevalence data at several council meetings. Although staff reception were both positive and negative, but involvement of frontline staff was deemed necessary as these interactions provided feedback, staff engagement, and a voice for concerns and issues regarding pressure ulcer prevention. After brainstorming and exploration, key failures and deficiencies that lead to poor results were identified (**Appendix K – Fishbone Diagram**). A review of organizational processes and strengths-weaknesses-opportunities-threats (SWOT) analysis revealed several key elements identified as strengths and opportunities (**Appendix L – SWOT Analysis**). It was also further recognized that fundamentals for pressure ulcer prevention exists, that needed optimization to its fullest potential.

Focused on raising awareness, increasing education, improving documentation and communication, and implementing various preventive practices, sixty-two (62) skin champions underwent training and education. During the class, questions such as: 1) What are we trying to accomplish; 2) How will we know that we need to change; 3) How will we know that change is an improvement; and 4) What changes can we make that will result in improvement, were asked by former and new Skin Champions. Although this brought a great discussion, the power point slides that showed the institution's HAPU incidence data which highlighted the years 2009-2011 and 2014-2015, stimulated real-time feedback which stimulated a healthy competition among unit skin champions as they took ownership and dedication of making a difference in the patients that they serve.

The problem need, sense of urgency, team creation, data comparison, institutional goals, current practices, items for standardization, process changes, consistency of prevention practices and protocols, and definition of the Skin Champions' roles and responsibilities were clearly discussed. After the education and training session, the Skin champions were given a pop quiz and group case studies with photos and acute care scenarios (**Appendix S – Case Studies & Appendix T - Quiz**). These also stimulated enthusiasm and engagement as the participants applied the concepts learned through scenarios. Although the course evaluation showed a few negative feedbacks, (mainly audio-visual, with a 10-minute malfunction on the first class), majority verbalized the need for this education and training. Majority also acknowledged that concepts learned have shed clarity in how they practice (**Appendix U – Course Evaluation**). There was a sense of satisfaction and eagerness to fulfill their role as skin champions.

Although this pressure ulcer prevention program was approached at a multidisciplinary level, continuous monitoring of HAPU rates, continued education through huddles, bedside mentoring, and skin prevention rounds with emphasis on at risk patients influenced positive outcomes. Furthermore, the skin champions also felt the need to educate and train Certified Nursing Assistants (CNAs), as they are important members of the team, provide as much as 21% of bedside care and therefore play an important role in providing skin care and pressure ulcer prevention, and they are the RNs' extra eyes in patient care. With this, a CNA Skin Protocol was included in the CNA Update on April 20 and 26, 2016 (**Appendix V – Agenda & Appendix W – Power Point**). Additionally, the Skin Task Force also felt that frontline staff nurses would greatly benefit from the National Database of Nursing Quality Indicators (NDNQI) Pressure Ulcer Training and thus was mandatory to all staff with a completion deadline of May 9, 2016 (**Appendix X**).

Indeed, Hospital-Acquired Pressure Ulcer (HAPU) causes considerable harm to patients and hinders functional recovery. While reviewed literature strongly suggest a multifaceted program, the Skin Champion program drove practice changes at the bedside and contributed to favorable outcomes. At its early implementation, there was a “special cause” reduction in the HAPU rate as of April 2016 (**Appendix Y**). The Skin Champions’ presence empowered staff to utilize and implement evidence-based preventive skin care protocols, optimized consistency of practice, performed root cause analysis, conducted prevalence studies, identified barriers in care delivery, and provided expert advice to peers (Bergquist-Beringer, S., et al., 2009). As of April 28, 2016, Skin Prevalence Study revealed a HAPU incidence of one (1) out of 103 participants included in the study. Although at its early stages, elements that significantly contributed to the program’s success include strong leadership, peer to peer involvement, communication, audit and feedback, simplification and standardization of pressure ulcer prevention interventions, and an emphasis on personal responsibility. And while the program’s long-term sustainability is without a doubt, a biggest concern, but with ongoing training and strong leadership support, the Skin Champions will build confidence in their roles, and will continue to drive pressure ulcer prevention best practices at the point of care, until goal of zero HAPU is reached.

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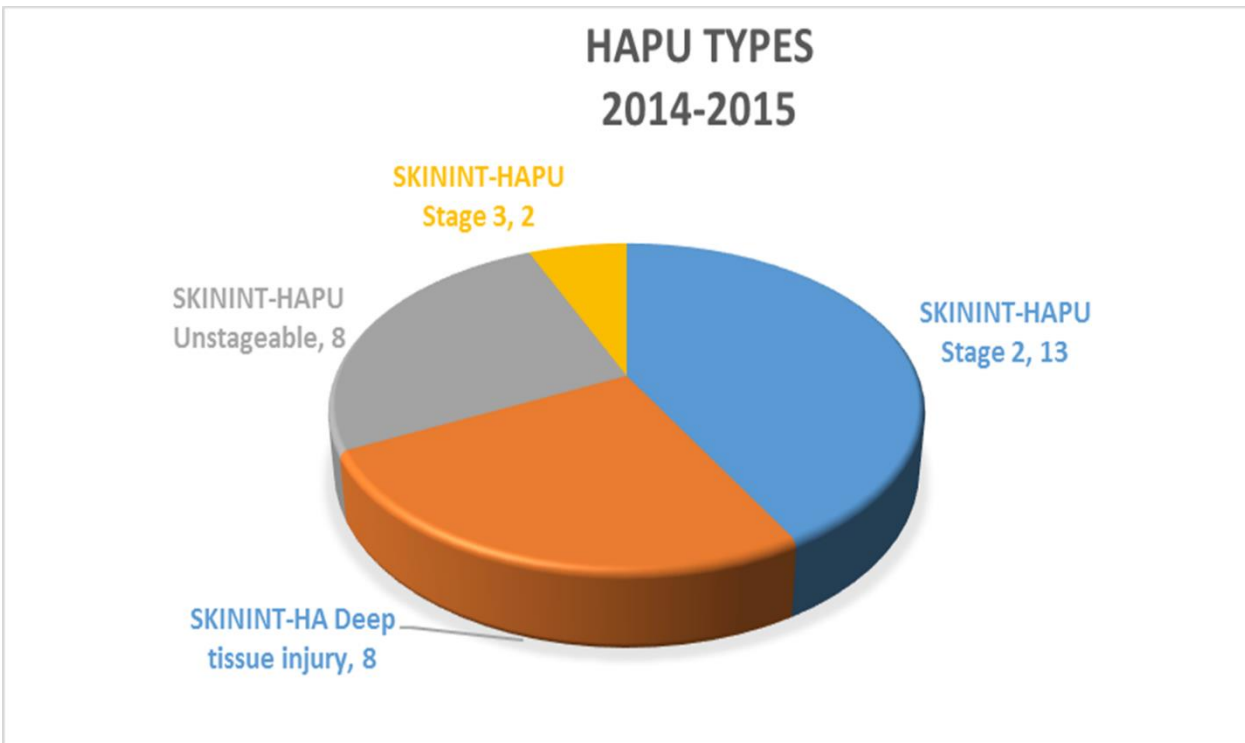
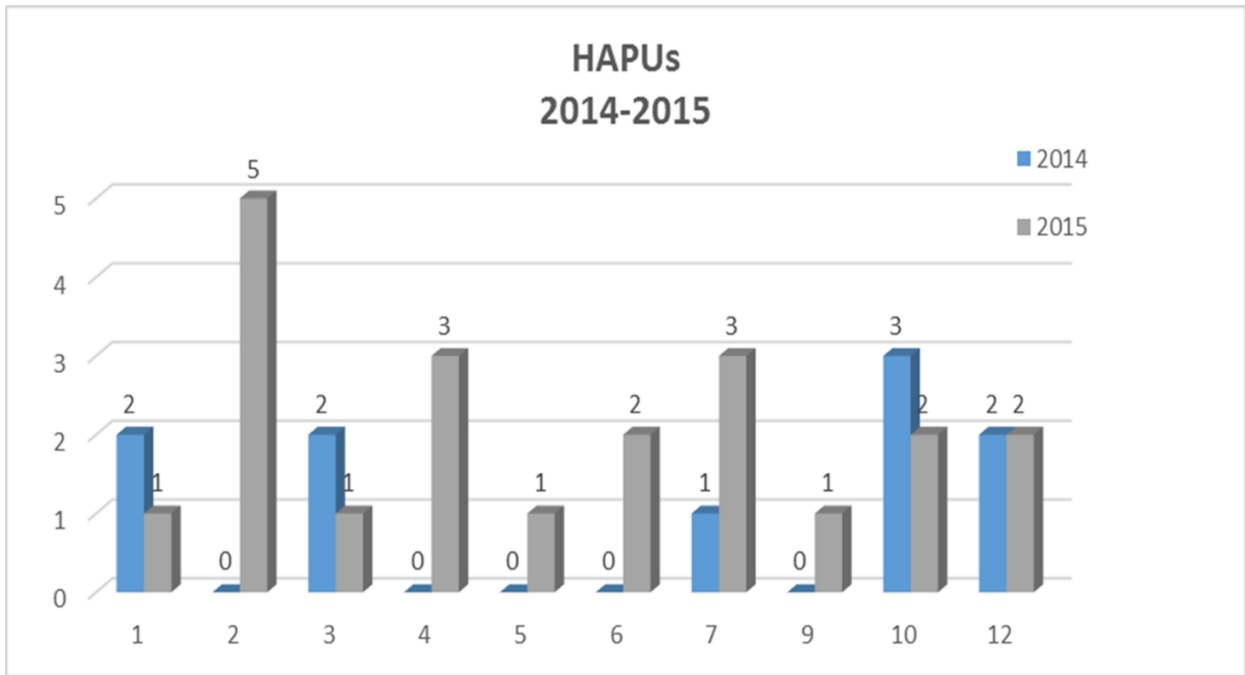
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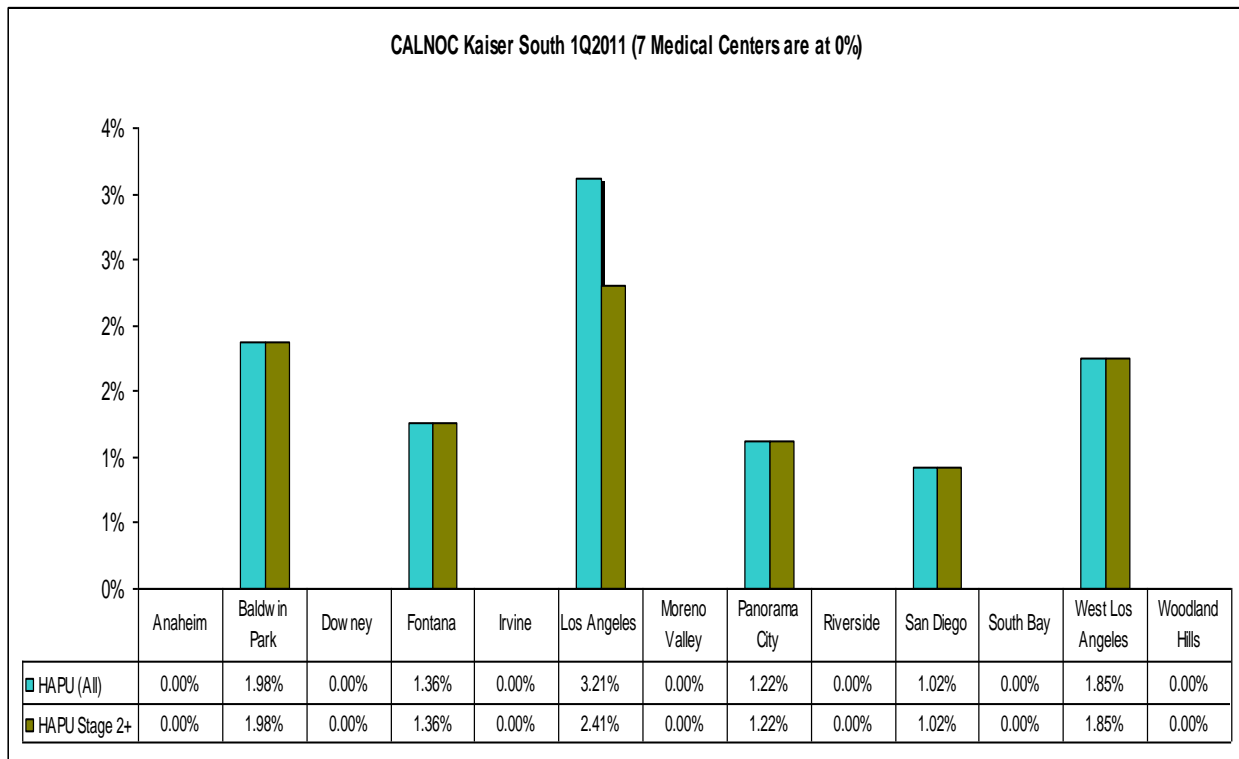
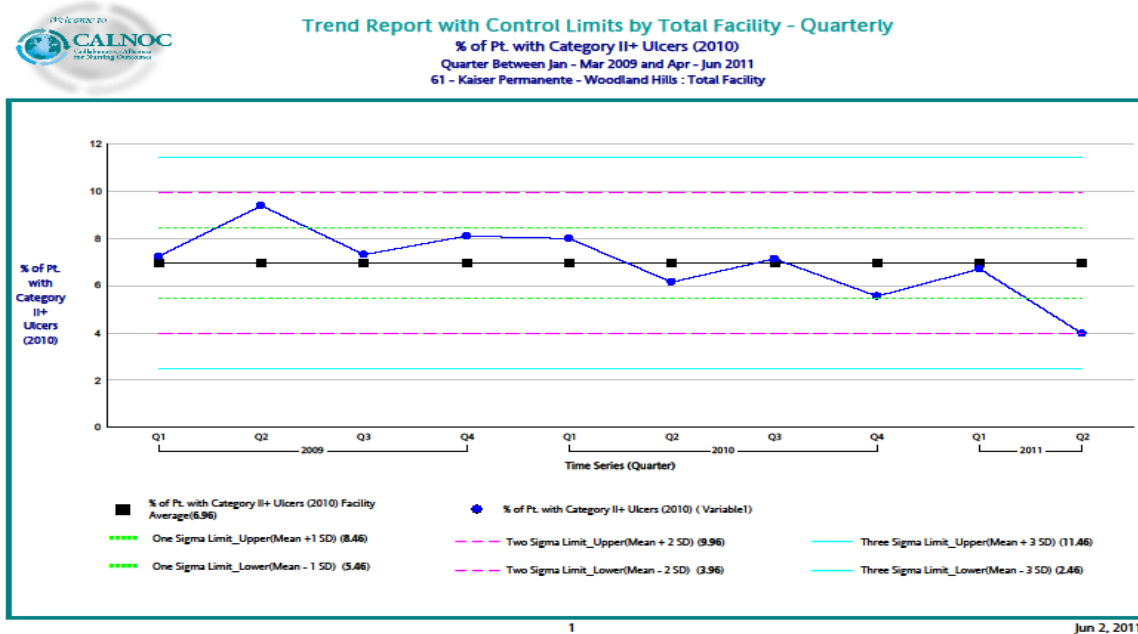
Appendix A

HAPUs 2014 – 2015



Appendix B

CALNOC Trend Report 2009 – 2011 (Pressure Ulcers Stage 2+)



Appendix C

Education for Skin Champions

February 25, March 3, 17, & 31, 2016

Agenda

Time		Topic	Speaker
0800	05 min	Registration	
0805	10 min	Welcome & Introduction (Introduce new CWOCNs)	Skin Task Force
0815	10 min	Goals & Objectives	Anne Loewenthal RN-BC
0825	10 min	Overview of Skin Champion Role	Anne Loewenthal RN-BC
0925	60 min	Staging & Treatment Differential Diagnosis HAPU vs CAPU Simple vs Complex Skin Care Protocol Critical Thinking in Action Wound Care Products	CWOCN
0935	10 min	CWOCN Referral Guidelines	Anne Loewenthal RN-BC
0945	10 min	Break	
1030	45 min	Braden Scale Overview Braden Algorithm Prevention & Early Intervention S.K.K.I.N Bundle	CWOCN
1050	20 min	4 Eyes Skin Assessment Guidelines Documentation & Picture taking	Anne Loewenthal RN-BC
1115	25 min	Quiz Case Studies Break Out in Groups	Anne Loewenthal RN-BC CWOCN All
1130	15 min	Debriefing & Discussion Understanding the Skin Champion Role	All
1145	15 min	Action Plan – Where do we go from here? (brief review of recent HAPUs)	Skin Task Force

Appendix D

Role of Skin Champions

1. Be a mentor and resource to your colleagues in the prevention of pressure ulcers in your unit
2. Recognize Stage I – II pressure ulcers and unstageable. Assist staff in identification
3. Be unit experts in pressure ulcer prevention and early detection
4. Be unit experts on proper documentation and educate and assist co-workers
5. Recognize patients at risk and assist the RN in developing patient-centered plan of care
6. Conduct a unit huddle utilizing your knowledge and expertise
7. Lead Root Cause Analysis (RCAs) on your unit
8. Promote proper use of treatments for Stage I – II pressure ulcers
9. Be available to participate in the quarterly Skin Prevalence Study
10. Be a consultant in pressure ulcer staging prior to completion of Unusual Occurrence Report (UOR)

Appendix E

**Certified Wound Ostomy & Continence Nurse (CWOCN)
Referral Guidelines for RNs**

Referral contents – Please specify

For skin/wound – Please include body site location and the specific skin issue(s).

HAPUs – CWOCN should also be paged 8 am – 4 pm M-F.

The CWOCN is to be paged for any/all “urgent” referrals Mon 8 – 4 pm

For ostomy patients – indicate type of ostomy and if new or returning

Appropriate Referrals:

- Multiple Stage 2 pressure ulcers on multiple turning surfaces
- Stage 3 & Stage 4 pressure ulcers
- Unstageable/Suspected DTIs pressure ulcers
- All HAPUs for validation before documenting as a HAPU
- Deteriorating pressure such as: advancing in stage
- Deteriorating wound(s)
- Wound VACs
- Chronic & new full thickness wounds
- New ostomates, return ostomates with equipment problems or at patient’s request
- Patients with Fistula

DO NOT place a referral for the following:

- Patient with Braden score < 18 & skin is intact (utilize Prevention Protocol)
- Stage 1, Stage 2, & DTI CAPUs
- Skin rashes that appear to be fungal
- Total body skin rashes (refer to MD)
- Diabetic foot ulcers, vascular ulcers, & infected foot ulcers (refer to MD & Podiatry)
- Incomplete order entry such as: “Check skin” or “Evaluate skin condition,” & Sacral skin breakdown” (specify location, stage, & HAPU or CAPU)
- Minor Skin Tears, Abrasions, & Bruises to Upper and Lower Extremities
- DO NOT place a referral for the following:
 - Patient with Braden score < 18 & skin is intact (utilize Prevention Protocol)
 - Stage 1, Stage 2, & DTI CAPUs
 - Skin rashes that appear to be fungal
 - Total body skin rashes (refer to MD)
 - Diabetic foot ulcers, vascular ulcers, & infected foot ulcers (refer to MD & Podiatry)
 - Incomplete order entry such as: “Check skin” or “Evaluate skin condition,” & Sacral skin breakdown” (specify location, stage, & HAPU or CAPU)
 - Minor Skin Tears, Abrasions, & Bruises to Upper and Lower Extremities

**** Incomplete order entry i.e. ‘Check skin’ or ‘Evaluate skin condition’**

Appendix F

4 Eyes Skin Assessment Guidelines

The following are the steps to follow for “4 Eyes Skin Assessment”

- 1) Upon any admission to the floor via transfers, direct admit, EPRP, ER admission, or clinic, the primary nurse will buddy with the Charge Nurse or Skin Champion to fully assess the patient’s skin condition at the time of arrival to the unit
- 2) Upon transfer from ICU to all units, the primary ICU RN will accompany the patient to fully complete 4 eyes skin assessment hand-off together with the receiving nurse on all the units the patient is transferred to
- 3) Upon discharge to Skilled Nursing Facility from the unit, the primary RN will fully assess the patient’s skin condition with the Charge Nurse or Skin Champion
- 4) Once the 4 eyes assessment is complete, the primary nurse will document the findings in the Integumentary Section of the Doc Flowsheet under “pressure ulcer” and will “free text” the name of the nurse who assisted in the skin condition assessment or document in the multidisciplinary notes
- 5) If ANY pressure ulcer dressing was changed greater than 24 hours from the time of transfer, please remove the dressing and assess skin condition, and follow the documentation guidelines
- 6) If the dressing is intact and was changed within 24 hours or less of transfer, leave dressing intact
- 7) If upon transfer the two nurses from the receiving unit (non ICU transfer) discover a new HAPU or a worsened CAPU/HAPU, the transferring unit’s primary nurse will go to the receiving unit to assess the wound
- 8) Any time a nosocomial wound is discovered, the nurse must document it as a wound until it is verified as a pressure ulcer by the CWOCN

Appendix G

Braden Scale

Braden Risk Assessment Scale

NOTE: Bed and chairbound individuals or those with impaired ability to reposition should be assessed upon admission for their risk of developing pressure ulcers. Patients with established pressure ulcers should be reassessed periodically.

Patient Name: _____ Room Number: _____ Date: _____

Sensory Perception	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment	Indicate Appropriate Numbers Below
Ability to respond meaningfully to pressure-related discomfort	Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	
Moisture	1. Constantly Moist	2. Very Moist	3. Occasionally Moist	4. Rarely Moist	
Degree to which skin is exposed to moisture	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Skin is often, but not always, moist. Linen must be changed at least once a shift.	Skin is occasionally moist, requiring an extra linen change approximately once a day.	Skin is usually dry. Linen only requires changing at routine intervals.	
Activity	1. Bedfast	2. Chairfast	3. Walks Occasionally	4. Walks Frequently	
Degree of physical activity	Confined to bed.	Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	
Mobility	1. Completely Immobile	2. Very Limited	3. Slightly Limited	4. No Limitations	
Ability to change and control body position	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Makes frequent, though slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.	
Nutrition	1. Very Poor	2. Probably Inadequate	3. Adequate	4. Excellent	
Usual food intake pattern	Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or I.V.'s for more than 5 days.	Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	
Friction and Shear	1. Problem	2. Potential Problem	3. No Apparent Problem		
	Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		
NOTE: Patients with a total score of 18 or less are considered to be at risk of developing pressure ulcers.					Total Score: _____

Appendix H

Cost Benefit Analysis

	2014	2015	2016	Total
Cost of Stage II or Stage IV HAPU as a secondary diagnosis per hospital stay	\$43,180/incident \$474,980 estimated costs of treatment for 11 HAPUs	\$43,180/incident \$863,600 estimated costs of treatment for 20 HAPUs	\$43,180/incident \$345,440 estimated costs of treatment for 8 HAPUs	\$43,180/incident \$1,684,020 estimated costs of treatment for a total of 39 HAPUS
Cost of training 62 Unit-Based Skin Champions for a 4 hour training at an estimated base hourly rate of \$55/hour				\$13,640 estimated cost for training which is already allocated to the unit's indirect hours budget
Net savings if HAPUs are prevented or decreased to the minimum goal of 40%	If 5 HAPUs would have been prevented this year, \$259,060 would have been saved	If 8 HAPUs would have been prevented this year, \$518,160 would have been saved	If 3 HAPUs would have been prevented at the beginning of this year, \$215,900 would have been saved	\$993,120 would have been saved if 40% of the HAPU incidence rates would have been prevented for two and a quarter years

The estimated costs are just rough estimates and may not necessarily reflect the actual costs, plus or minus the costs of complications or potential complications that the patient had or may occur

The cost of RN training is a rough estimate based on the current hourly RN rate for Southern California. RN rates may vary based on years of experience, longevity, specialty, position, and certification

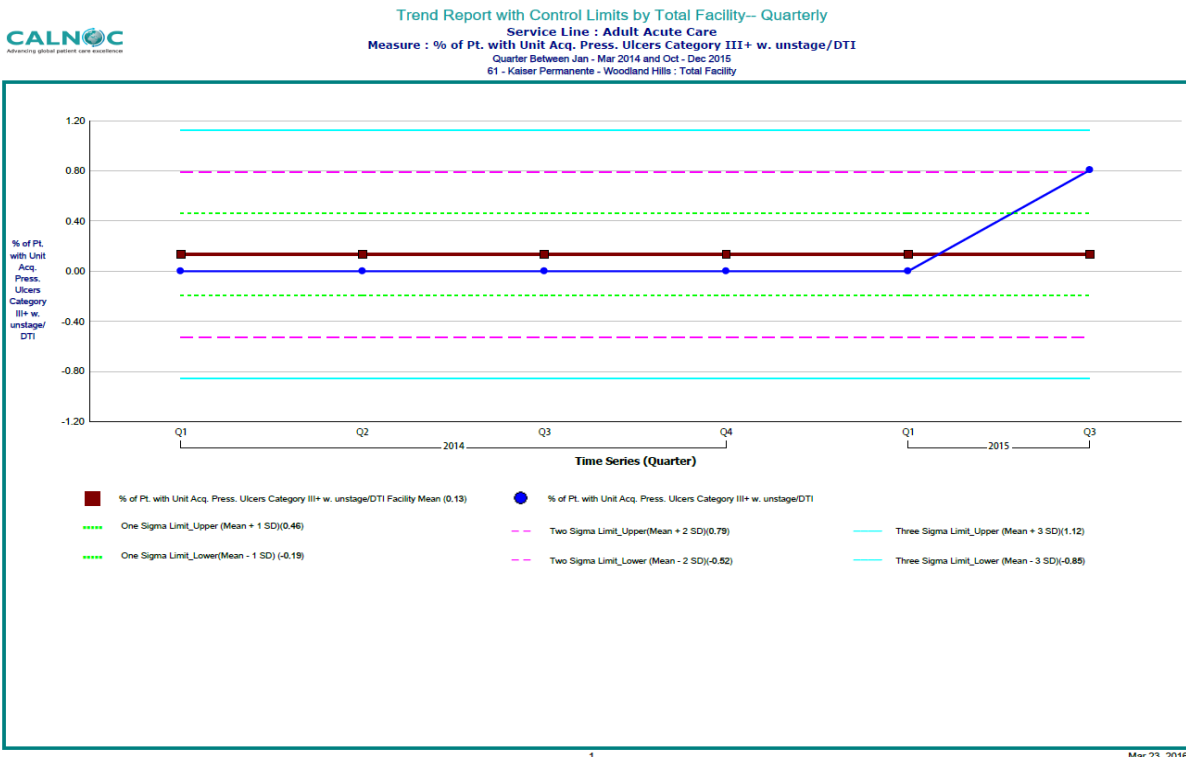
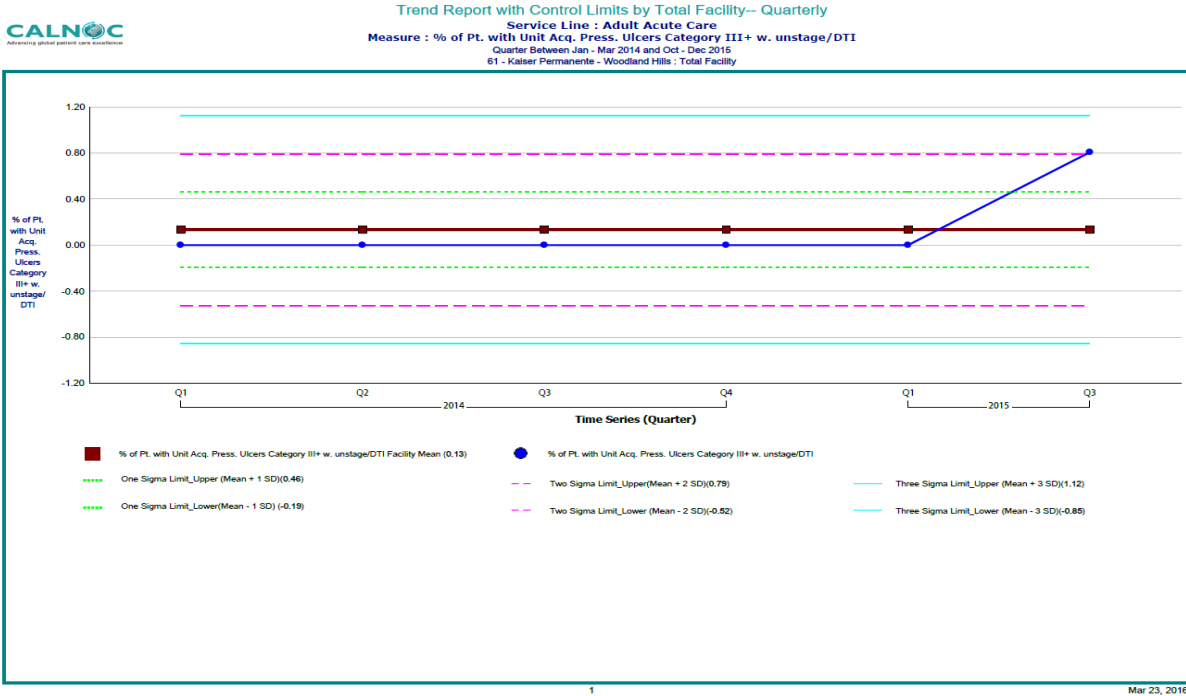
Appendix I

HAPUs by Inpatient Units 2014 - 2016

11 HAPUs were reported in 2014		Unstageable and HAPUs 3 and greater are reported to CDPH.	
Month	(All) ▾	HAPU Type ▾	Count of Incident Date
Year	2014 ▾	⊕ SKININT-HAPU Stage 2	17
		⊕ SKININT-HA Deep tissue injury	10
Department ▾	Count of Incident Date	⊕ SKININT-HAPU Unstageable	9
WOD - 2S ICU/CCU	6	⊕ SKININT-HAPU Stage 3	2
WOD - 5N Med Surg	2	⊕ SKININT-HAPU Stage 1	1
WOD - 4E Med Surg/Oncology	2	Grand Total	39
WOD - 2N Definitive Observation Unit	1		
Grand Total	11		
20 HAPUs were reported in 2015		There were 3 UORs with device related HAPUs; unstageable, Stage	
Month	(All) ▾	Year	2014 ▾
Year	2015 ▾		
20 HAPUs were reported in 2015		Contributing Factors ▾	Count of Incident Date
Department ▾	Count of Incident Date	SKININT-Device related	3
WOD - 2S ICU/CCU	13	Grand Total	3
WOD - 2N Definitive Observation Unit	3		
WOD - 4S Med Surg	2		
WOD - 5N Med Surg	1		
WOD - 3S Womens Unit	1		
Grand Total	20		
8 HAPUs were reported in 2016			
Month	(All) ▾		
Year	2016 ▾		
Department ▾	Count of Incident Date		
WOD - 2S ICU/CCU	4		
WOD - 5N Med Surg	1		
WOD - 4W Telemetry	1		
WOD - 2N Definitive Observation Unit	1		
WOD - 4S Med Surg	1		
Grand Total	8		

Appendix J

CALNOC Trend Report 2014 – 2015



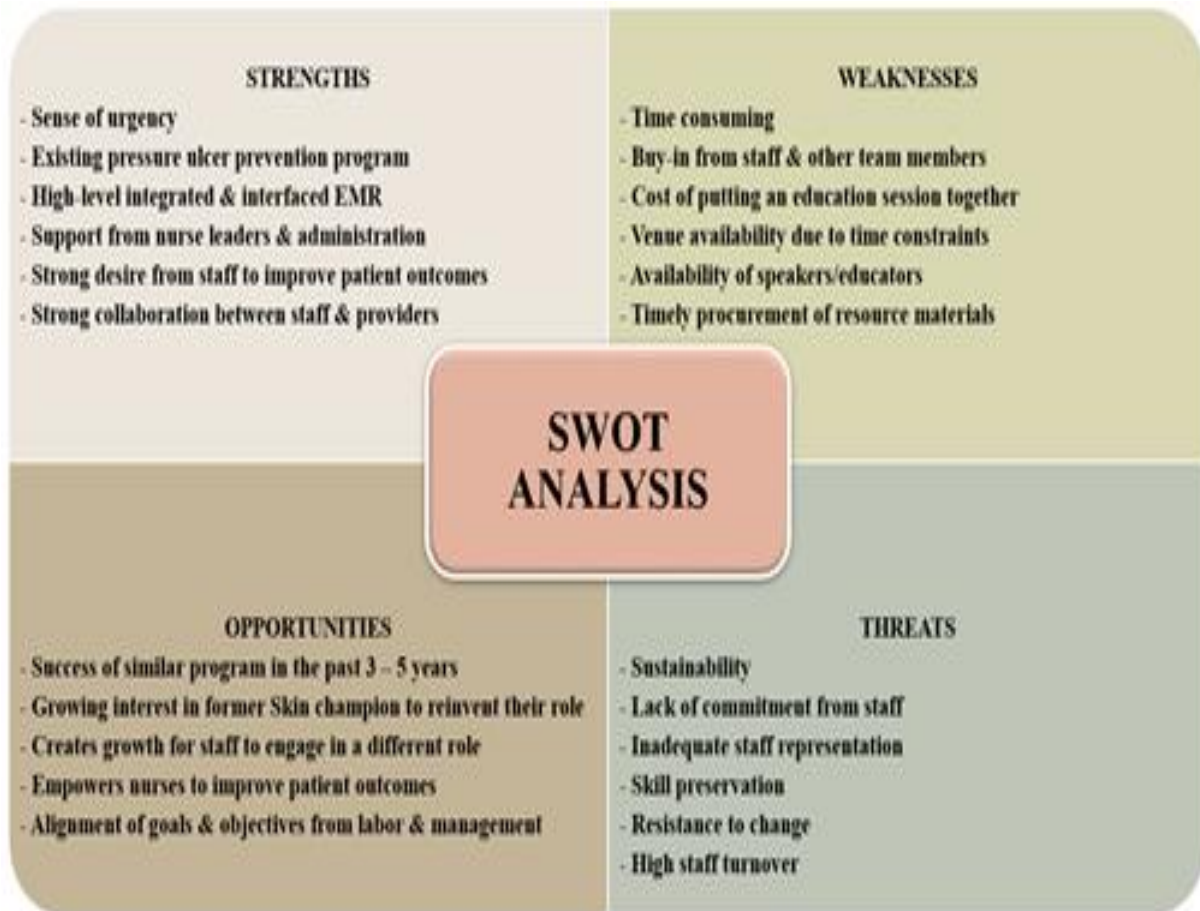
Appendix K

Root Cause Analysis Fishbone Diagram



Appendix L

Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis



Appendix M

Stakeholder Analysis

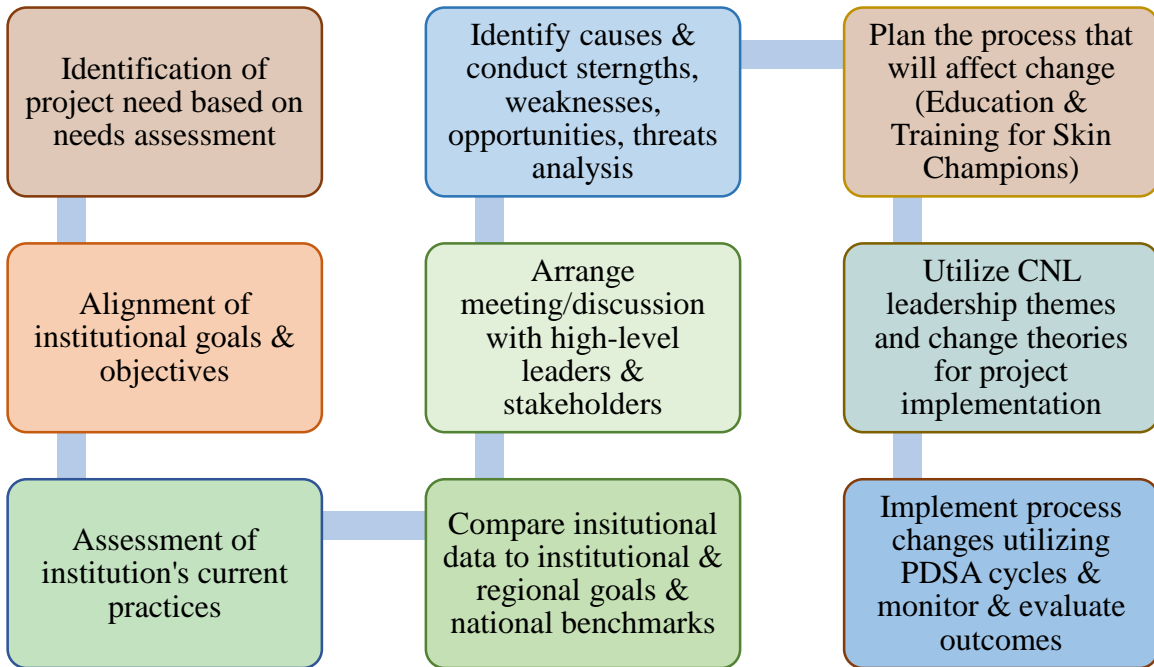
Structure/Stakeholder	Role/Process	Outcomes	Impact
Hospital Executive Leadership Support	Nursing and medical care that supports delivery of high quality, safe patient care	High quality and safe patient care	High
Skin Task Force	<p>In charge of Skin Care/HAPU/CAPU Guidelines, Protocols, and initial and ongoing Skin Champion and staff classes (products, updates, interventions)</p> <p>Coordinate education and training for nurses and physicians</p> <p>Review HAPU RCAs and disseminate results</p> <p>Conducts and participates in monthly meetings</p>	<p>Care practices are evidence-based</p> <p>Increased patient, family, nursing, physician satisfaction</p> <p>100% of nursing staff adhering to skin prevention protocols</p>	High
Unit-Based Skin Champions	<p>Frontline clinical expert/resource/mentor that assists with assessment, intervention, and appropriate consultation to CWOCN</p> <p>Disseminates information regarding RCAs practices, documentation, findings</p> <p>Peer-to-peer review on assessment, documentation, interventions</p> <p>Participates in CALNOC quarterly prevalence study</p>	<p>(62) Skin Champions will complete Education for Skin Champion Class and Training</p> <p>Appropriately assess, prevent, document, and escalate concerns related to skin issues</p> <p>Provides peer review and evaluation of Skin care practices implemented and align with</p>	High

		individualized patient plan of care	
Staff Nurses	<p>Coordinate skin care with Skin Champion and escalate with physician and CWOCN when appropriate</p> <p>Follows policy and procedures and standard protocols for prevention, treatment, and proper documentation and weekly trending</p> <p>Uses SBAR communication during end of shift report</p> <p>Perform thorough skin assessment upon patient admission with a skin champion</p> <p>Braden Scale Assessment Manage Skin moisture Assess nutrition & hydration</p>		High
CWOCN	<p>Provide treatment recommendations for HAPUs, complex wounds, patient's with multiple CAPUs</p> <p>Collaborates with physician and nursing for skin/wound concerns</p>	<p>Prevent skin breakdown/reverse further deterioration of wounds</p> <p>Real time appropriate skin interventions</p> <p>Help to maintain staff competency</p>	High
Physician Champion	Collaborates with Skin Task Force	Provides skin care interventions per hospital policy and procedures and per protocol	High

	<p>Communicates with medical staff regarding Skin Prevention Intervention</p> <p>Partners with Skin Task Force and CWOCNs to refresh/reinforce education to medical staff</p>		
Physician/Hospitalist	<p>Assess and provide medical intervention for any skin concerns</p> <p>Consults with CWOCNs for HAPUs stage III and above and CAPUs when needed</p>	Provides skin care interventions per hospital policy and procedures and per protocol	High
Department Administrators	Promote staff accountability in skin care protocols	Communicates pertinent information to staff	High
Patient Safety Officer	Communicates to Skin Task Force regulatory standards or concerns		Medium
Quality Representative	<p>Communicates to Skin Task Force pertinent quality concerns</p> <p>Responsible for CALNOC data</p>	Leads Skin Quarterly Skin Prevalence Studies	Medium

Appendix N

Process Map



Appendix O

Flyer

**It's time to MOVE
.....on Pressure Ulcer Prevention**



**Skin Champion Class dates:
February 25, March 3, 17, & 31, 2016
Time: 0800 am 'til 1200 noon
Meeting place: 2/25 → 4 West Conference Room
3/03 → Auditorium B
3/17 → Auditorium B
3/31 → Auditorium B**



**It's your TURN
..... to prevent pressure ulcers**

**Classes are limited to 15 attendees per session
Skin Champions need to attend one class**

Appendix P

Skin Prevention Rounds Questionnaire

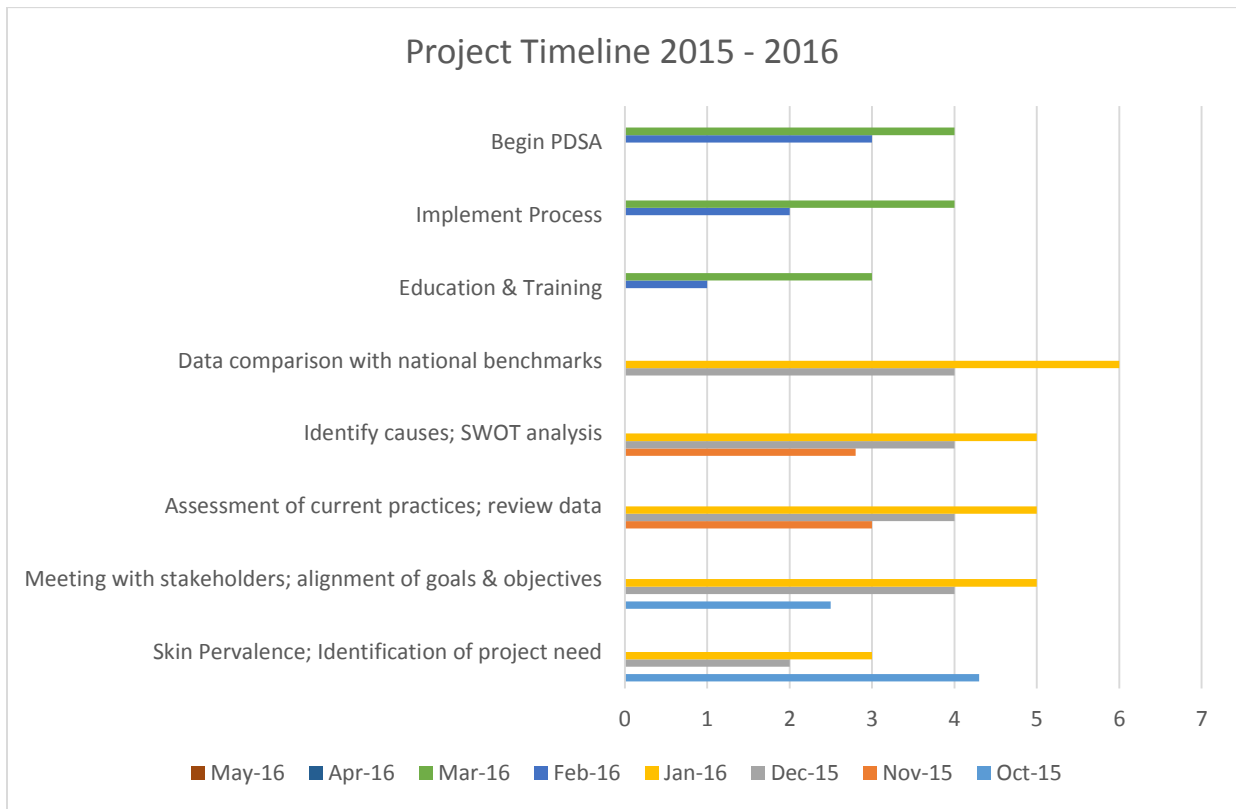
Date: _____ **Unit:** _____ **Skin Champion:** _____

Patient's Name/Room No.	What is the Patient's Current Braden Score?	Is the patient on any pressure relieving support surface? Y/N If Yes, What kind?	Is there a pressure ulcer prevention plan of care initiated? Y/N If No, Why?	Is the patient at risk for pressure ulcer? Y/N Are there any existing skin issues? If Yes, has treatment been initiated? If Not, Why?

The questions do not intend to intimidate, but rather a way to collaborate, mentor, and learn from each other and to escalate appropriate and effective plan of care

Appendix R

Gantt Chart Reflecting Timeline



Appendix S

Acute Care Scenario A

Mrs. R., a female patient is being admitted to your unit from the Emergency department. You find her fairly alert with a repeat blood sugar of 300 mg/dl. During your initial assessment you learn that Mrs. R. lives home alone, but she has recently been diagnosed with depression. Her normal eating habits are poor.

Her history includes a hip replacement and urinary incontinence. Her mobility is limited and therefore she uses a wheelchair and walker at home. She reports frequent episodes of urinary “urgency” resulting in accidents and the recent need to wear a protective pad. When you examine her skin you notice that she has several small, open reddened areas on her coccyx.

1. What is her Braden risk assessment score?
2. State a problem for her plan of care
3. Describe the wound on the initial evaluation.
4. What referrals will you make for this client to other disciplines available?
5. What recommendations would be appropriate for her skin care (include prevention modalities?)
6. Photos? Yes / No...
7. Unusual occurrence (Midas)? Yes / No ...

Appendix S (Cont'd)

Acute Care Scenario B

Mrs. J. was admitted on the night shift. You are the day nurse. In report, you are told that Mrs. J. is a very frail woman in her late 80s who is short of breath. The night nurse also tells you that Mrs. J. has an abrasion on her coccyx, and her heels are red. She needs to sit up to breathe.

In your rounds, you assess Mrs. J. and give her a Braden score of 14 (moderate risk). You note that she is on a standard accumax mattress and is sitting upright in bed with oxygen in place. You roll her over and find that what the night nurse has called an abrasion on her coccyx is really a stage III pressure ulcer. Her heels have stage I erythema.

1. Is she at risk for pressure ulcer?
2. State a problem for her plan of care
3. Describe the wound on the initial evaluation.
4. What referrals will you make for this client to other disciplines available?
5. What recommendations would be appropriate for her skin care (include prevention modalities?)
6. Photos? Yes / No...
7. Unusual occurrence (Midas)? Yes / No ...

Appendix S (Cont'd)

Acute Care Scenario C

Mrs. Jones is 85 years old, and is admitted with a right hip fracture. She had been down on the floor at home overnight. She lives alone and tried to rush to the bathroom and slipped and fell. It is expected that she will need a total hip prosthesis. She states that she eats well, but it is noted that she is under weight for her size (5'7" tall and 95 pounds.) She reports that she has a history of Crohn's disease and at times has diarrhea, "sometimes it leads out by itself." Her current medication is Prednisone 10 mg QD to control her Crohn's disease. She denies the use of any other medications. She is allergic to sulfa.

On initial evaluation of her skin, she has an area of non-blanchable erythema over her left buttock measuring 6cm. The skin around this area and the area itself is indurated to a total of 9cm. Her skin is very dry over her body, especially her feet and heels.

1. What is her Braden risk assessment score?
2. State a problem for her plan of care
3. Describe the wound on the initial evaluation.
4. What referrals will you make for this client to other disciplines available?
5. What recommendations would be appropriate for her skin care (include prevention modalities?)
6. Photos? Yes / No...
7. Unusual occurrence (Midas)? Yes / No ...

Appendix T

Pop Quiz on Braden Scale**The Case of Mr. AB**

- 75-year-old male with Non-Hodgkins lymphoma, Alert and oriented
- Height 5'9", Weight 160 lbs.

Spends most of the day in bed. Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Occasionally slides down to foot of bed, requiring some assistance to move back to the top.

- Able to walk a short distance to the chair with assistance
- Incontinent of stool
- Continent of urine – uses urinal as needed
- Skin occasionally moist from incontinence
- Admitting Orders:
 - Tube feeding formula 400cc q 4 hours per PEG
 - Dietician consult for tube feeding recommendations
 - Up in chair daily

Test Question

Using the Braden Scale, what is Mr. A.B.'s sensory perception score?

- A. 1 (Completely Limited)
- B. 2 (Very Limited)
- C. 3 (Slightly Limited)
- D. 4 (No Impairment)

Using the Braden Scale, what is Mr. A.B.'s moisture score?

- A. 1 (Constantly Moist)
- B. 2 (Very Moist)
- C. 3 (Occasionally Moist)
- D. 4 (Rarely Moist)

Appendix T (Cont'd)

Pop Quiz on Braden Scale (cont'd)

Using the Braden Scale, what is Mr. A.B.'s activity score?

- A. 1 (Bedfast)
- B. 2 (Chairfast)
- C. 3 (Walks Occasionally)
- D. 4 (Walks Frequently)

Using the Braden Scale, what is Mr. A.B.'s mobility score?

- A. 1 (Completely Immobile)
- B. 2 (Very Limited)
- C. 3 (Slightly Limited)
- D. 4 (No Limitations)

Using the Braden Scale, what is Mr. A.B.'s nutrition score?

- A. 1 (Very Poor)
- B. 2 (Probably Inadequate)
- C. 3 (Adequate)
- D. 4 (Excellent)

Using the Braden Scale, what is Mr. A.B.'s friction and shear score?

- A. 1 (Problem)
- B. 2 (Potential Problem)
- C. 3 (No Apparent Problem)

Appendix U

Education for Skin Champions Course Evaluation

Education for Skin Champions Course Evaluation	Highly Agree	Agree	Neutral	Disagree	Highly Disagree
1. This course met the stated objectives	5	4	3	2	1
2. The information provided in this course is applicable to my work	5	4	3	2	1
3. The speakers were well knowledgeable of the subject matter	5	4	3	2	1
4. The course was delivered in a well-organized manner	5	4	3	2	1
5. I was provided the opportunity to ask questions and discuss issues	5	4	3	2	1
6. Overall, I will be able to provide more appropriate nursing care to the patient population based on what I learned from this course	5	4	3	2	1
7. The learning environment was conducive to my learning experience (room, space, lighting, acoustics, audiovisuals, etc.)	5	4	3	2	1

Please rate the following speakers:

	5	4	3	2	1
*Speaker A BSN, RN					
*Speaker B BSN, RN, CWOCN					
*Anne Loewenthal BSN, RN-BC					
*Speaker D RN, BS, CWOCN					
*Speaker E RN, CWOCN					

Additional Comments:

For the privacy of the speakers other than the CNL student whose name is reflected, they are referred to as speakers A-E in this paper

Appendix V

Certified Nursing Assistants Update Agenda

CNA UPDATE 2016

AGENDA

April 20 & 26, 2016

08:00 – 12:00

08:00 08:45

Sign-in

Restraints, Falls, and Delirium.

Speaker A, GNP-C, MSN, RN and Speaker B, BSN, RN

08:45 – 09:15

Skills station; restraints and bed alarms.

09:15 – 09:30

Break

09:30 – 10:30

CNA Skin Protocol and HAPU Prevention

Speaker C, BSN, RN, CCRN

Anne Loewenthal BSN, RN-BC

Speaker D, MSN, RN-BS, PHN

10:30- 11:00

Sara Steady/Mobility

Speaker E, Account Executive; Getinge Group

1100-11:30

Skills Station with Hospital Bed, Hospital Chair, and Sara Steady

11:30 – 11:45

Message from the Chief Nurse Executive

Speaker F, MN, RN

11:45 – 12:00

Closing and Evaluations

For the privacy of the speakers other than the CNL student whose name is reflected, they are referred to as speakers A-F in this paper

Appendix V (cont'd)

Certified Nursing Assistants Update Agenda

CNA UPDATE 2016

AGENDA

April 20 & 26, 2016

13:00 – 17:00

13:00 – 13:45

Sign-in

Sara Steady/Mobility

Speaker A, Account Executive; Getinge Group

13:45 – 14:15

Skills station; Hospital Beds, Hospital Chair and Sara Steady

14:15 – 14:30

Break

14:30 – 15:30

CNA Skin Protocol and HAPU Prevention

Speaker B, BSN, RN, CCRN

Anne Loewenthal BSN, RN-BC

Speaker C, MSN, RN-BS, PHN

15:30- 16:00

Restraints, Falls, and Delirium.

Speaker D, GNP-C, MSN, RN and Speaker E, BSN, RN

1600-16:30

Skills Station with Hospital Bed Alarms, and Restraints

16:30 – 16:45

Message from the Chief Nurse Executive

Speaker F, MN, RN

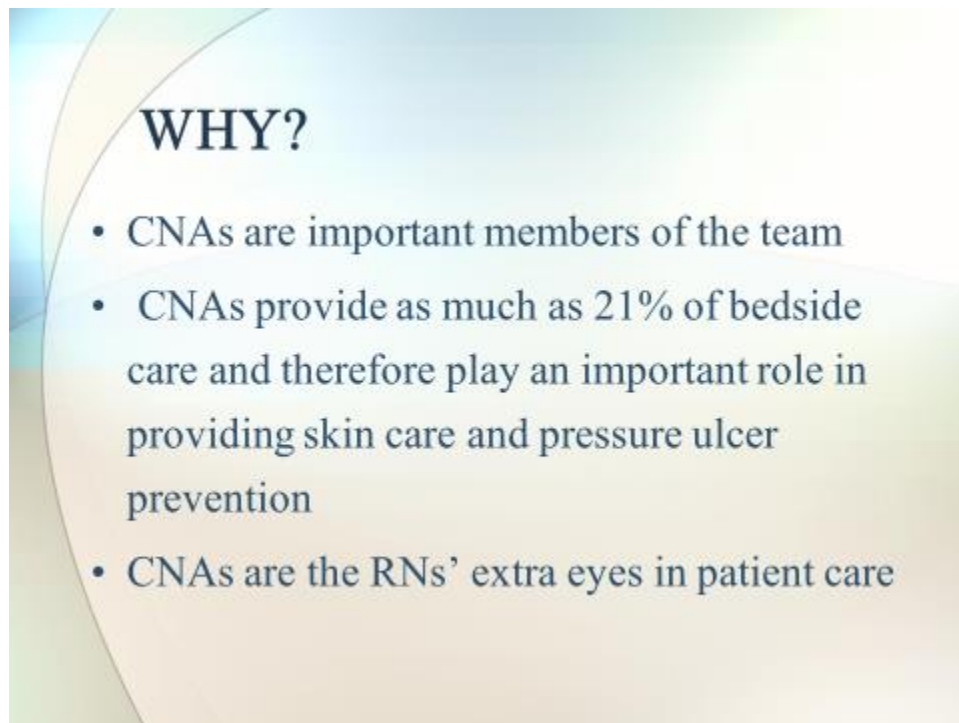
16:45 – 1700

Closing and Evaluations

For the privacy of the speakers other than the CNL student whose name is reflected, they are referred to as speakers A-F in this paper

Appendix W

CNA Skin Protocol Power Point Presentation



Appendix W (cont'd)

CNA Skin Protocol Power Point Presentation (cont'd)

Roles and Responsibilities

- At the beginning of your shift, obtain report that include patient's condition, risk for skin breakdown, nutrition, allergies if food related, hydration, incontinence and toileting needs
- Be able to identify those items that make your patient at risk such as:
 - incontinence
 - decrease in mobility
 - poor hygiene
 - decrease oral intake – solids and liquids

Roles and Responsibilities – cont'd

- On your initial rounds, check patient's skin and pay close attention to the following items:
 - mobility/position
 - all tubing and equipment are clear and away from patient's skin
 - monitor and encourage oral intake and notify nurse if with poor oral intake
- Follow DIAPER APPROPRIATE GUIDELINES
- Document Mobility/Activity and SKIN Bundle under:
 - Keep turning/Repositioning at least every 2 hours

Appendix W (cont'd)

CNA Skin Protocol Power Point Presentation (cont'd)

Roles and Responsibilities – cont'd

- Discuss with RN to add SKIN RISK to CARE Board with appropriate interventions
- If patient refuses to turn or reposition every 2 hours, notify RN
- Monitor patient's dietary intake and document
- Make sure that patient's dentures and glasses are present to facilitate proper oral intake. Assist when necessary
- When washing patient's skin, use disposable washcloth (gentle to skin) instead of washcloth (rough to skin)
- Use bedside care foam and apply moisture barrier cream as needed for protection

Roles and Responsibilities – cont'd

- Make sure the environment is clean and tidy
- Do not bring more linens than what you need in the patient's room. Check patient's room for what is there before bringing in more
- Turn the patient upon rounds and document the actual position change at least every 2 hours
- Make sure bed linen is not wrinkled under patient
- Make sure there is a draw sheet in place for all patients and only 1 Geri pad for each incontinent patient. **DO NOT PUT DOUBLE PADS**

Appendix W (cont'd)

CNA Skin Protocol Power Point Presentation (cont'd)

Roles and Responsibilities – cont'd

- If patient is on a special bed such as the Envision overlay mattress, please do not use Geri Pads as this is not appropriate
- Use the light blue pads as these are appropriate and breathable but needs to be changed as soon as possible when wet or soiled
- When replacing the prevalon boots, please make sure that if patient has sequential device, use the appropriate holes to secure them and free from patient's skin

When to Notify the Nurse?



Appendix W (cont'd)

CNA Skin Protocol Power Point Presentation (cont'd)

- Any unusual appearances noticed on any part of the skin
- Any skin changes
- If the patient refuses to turn
- If the patient refuses to eat
- If the patient has no appetite or poor oral intake
- If the patient complains of pain or if anything hurts to touch
- If the patient asks for a diaper
- If the patient is incontinent (stool and was sent for C-diff)
- If the CNA needs to change the bed several times during his/her shift
- Any irritation to bony areas

DIAPERS – To Use or Not To Use ... That is the Question

Let us be DIAPER Appropriate When is it OK to use a diaper?

- When an incontinent patient is ambulatory
- When an incontinent patient is sitting in a chair
- When an incontinent patient travels to another department

Appendix W (cont'd)

CNA Skin Protocol Power Point Presentation (cont'd)

WHY NOT DIAPERS?

- Diapers have a tendency to be left on for too long
- Unaware of what lies beneath
- Diapers promote heat, moisture, pressure, and digestive enzymes that eat away at your skin
- The elastic bands on diapers can cause pressure ulcers
- Diapers can cause skin irritation
- In males who are incontinent, use a condom catheter instead but make sure it is the appropriate size so as not to impede circulation

Questions?



Appendix X

National Database and Nursing Quality Indicators (NDNQI) Pressure Ulcer Training Flyer

Targeted group: RNs' **excluding the Unit Skin Champions**

Due: May 9, 2016

RN's will be paid 2 hours of Training after completion



This Training Program Offers Multiple Paths for Completion.

<https://members.nursingquality.org/NDNQIPressureUlcerTraining/>

1
OPTION

Option 1 - Certificate of Successful Completion
with 2 Contact Hours

Option 1 requires successful completion of all 4 modules and tests in one session. Module 4 must be completed last. **Contact hours can be earned only once with this version of the Pressure Ulcer Training.** Proof of completion also can be printed for employer.

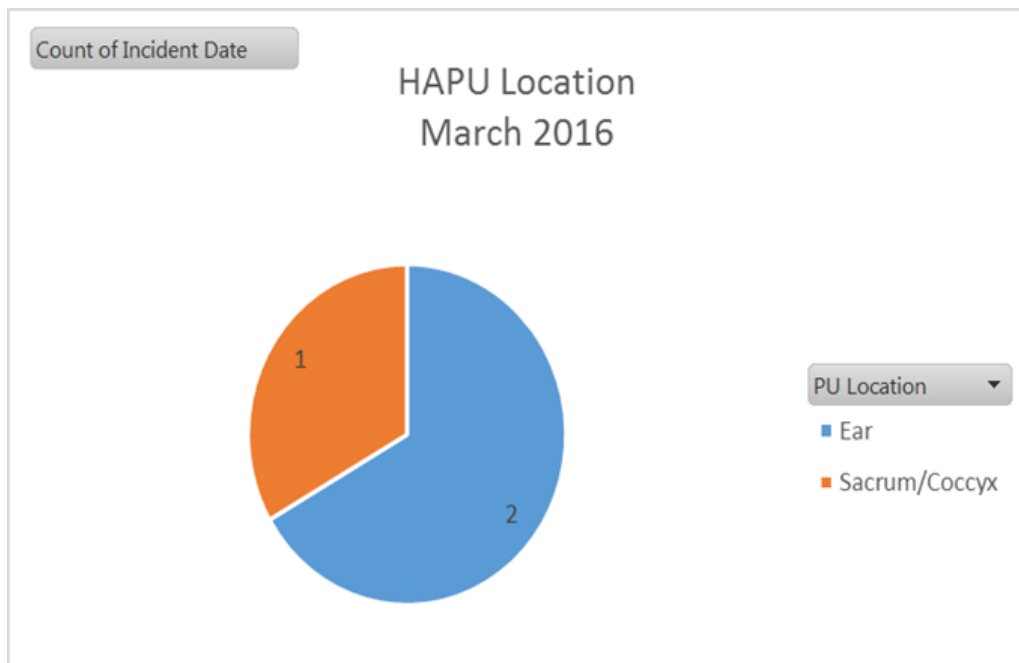
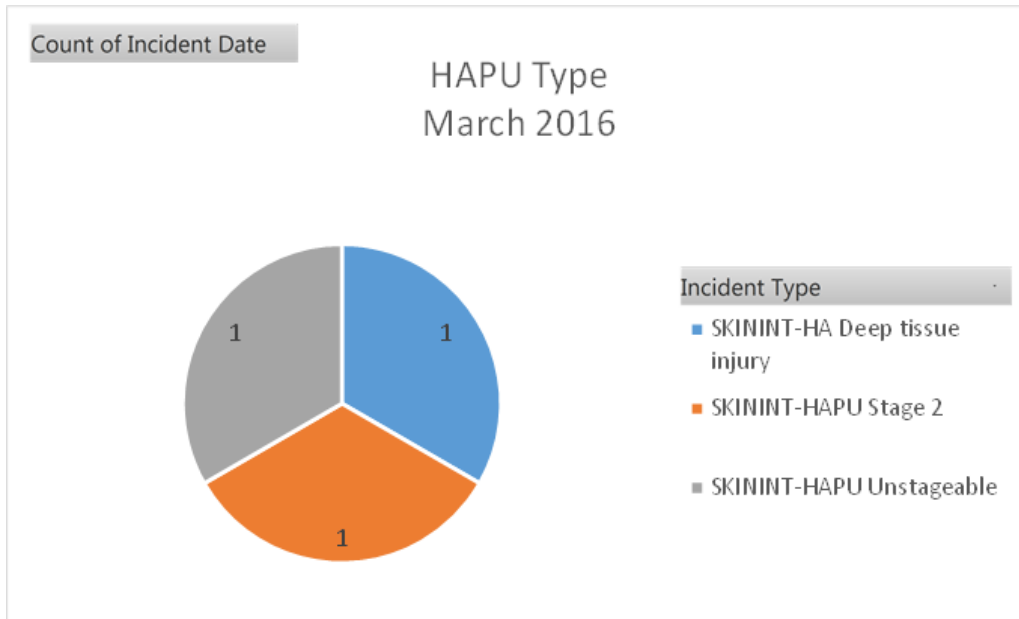
2
OPTION

Option 2 - Proof of Completion, No Contact Hours

Option 2 allows completion of modules in one or more sessions. Proof of completion can be printed for employer. Need to complete all the 4 modules.

Appendix Y

HAPUs UOR Report March – April 2016



Appendix Y (cont'd)

HAPUs UOR Report March – April 2016 (cont'd)

HAPUs UOR Report							
March 1st to April 24th, 2016							
Department	Count of Incident Date						
WOD - 2S ICU/CCU	3						
Grand Total	3						
Incident Tye	Count of Incident Date						
SKININT-HA Deep tissue injury	1						
SKININT-HAPU Stage 2	1						
SKININT-HAPU Unstageable	1						
Grand Total	3						
HAPU Location	Count of Incident Date						
Ear	2						
Sacrum/Coccyx	1						
Grand Total	3						

Appendix Z

Education for Skin Champions Power Point Presentation

Part 1

Education for Skin Champions

Anne Loewenthal, RN-BC



Why?

- Pressure ulcers acquired during hospitalization present grave consequences on the well-being of the patient, significant treatment and recovery delays, increase length and cost of inpatient stays, and have become a “never” event from the standpoint of Medicare reimbursement.

Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation

Part 1 (cont'd)

➤ **Nosocomial pressure ulcers (PUs)**

- Est. 12% acute care population

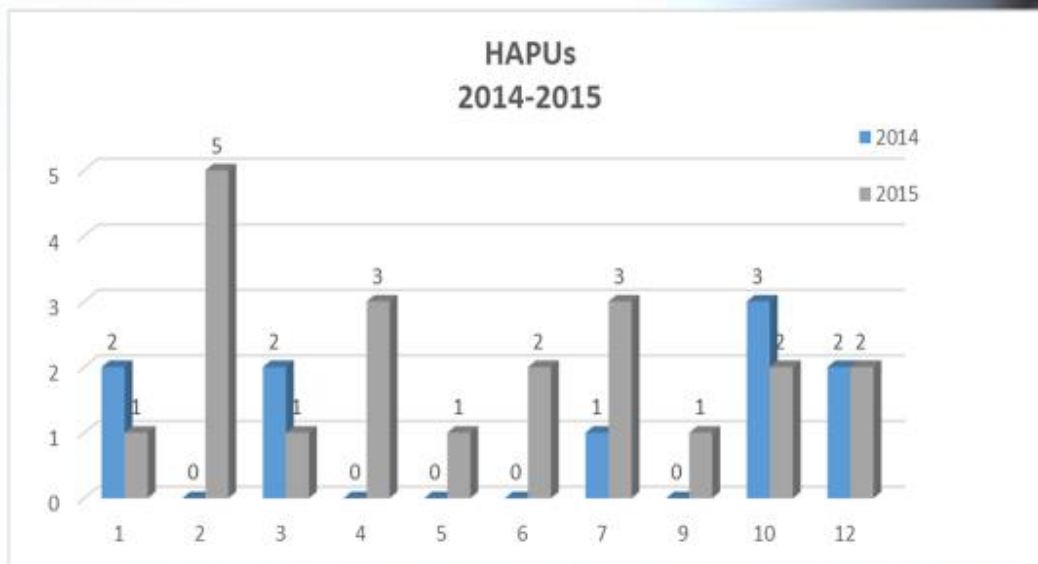
➤ **Direct costs**

- Range from \$500 to \$40,000 per PUr
- CMS will not reimburse for “preventable” PUrs

➤ **Staff nurse involvement will:**

- Raise awareness
- Directly influence improved outcomes

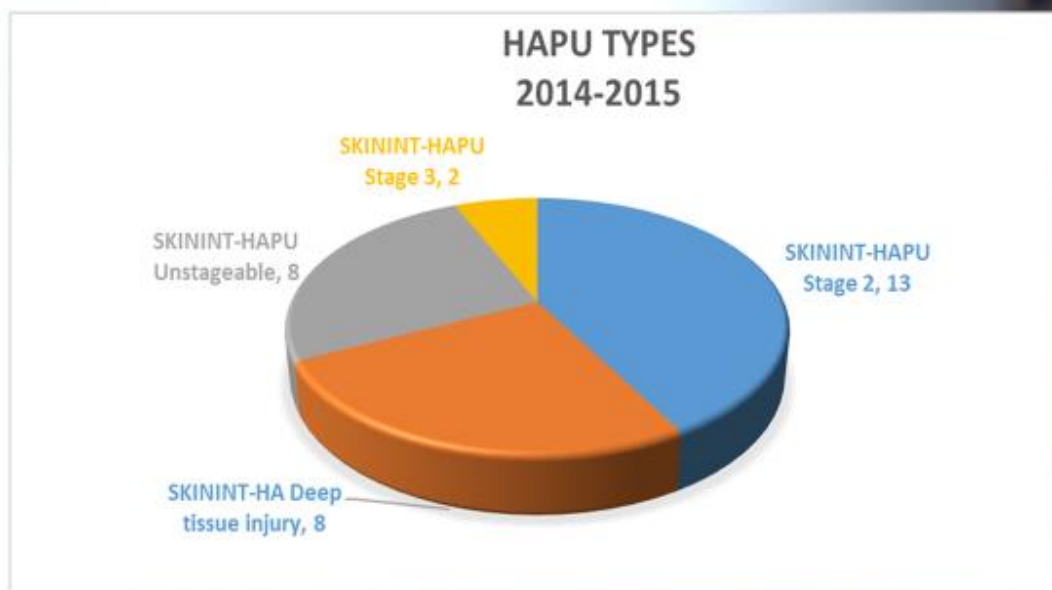
(Stoelting, et al., 2007)



Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation

Part 1 (cont'd)



Goals & Objectives

- Demonstrate knowledge of the clinical importance of pressure ulcer prevention and wound assessment.
- Decrease the incidence of hospital acquired pressure ulcer
- Accurately identify patients at risk of developing a pressure ulcer in the inpatient setting
- Identify classification and etiology of at least four (4) types of wounds including pressure ulcers

Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation**Part 1 (cont'd)****Goals & Objectives (cont'd)**

- Identify appropriate terminology to be used in assessing skin changes
- Discuss appropriate method of wound documentation
- Describe the objectives of wound care treatments
- Determine appropriate resources and the referral process
- Increase the use and implementation of pressure ulcer prevention plans

Goals & Objectives (cont'd)

- Identify appropriate terminology to be used in assessing skin changes
- Discuss appropriate method of wound documentation
- Describe the objectives of wound care treatments
- Determine appropriate resources and the referral process
- Increase the use and implementation of pressure ulcer prevention plans

Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation

Part 1 (cont'd)

Skin Champion Role

- Mentor & resource
- Assists staff in identification
- Unit experts
- Recognize at risk patients
- Develop plan of care
- Conducts huddle
- Leads Unit RCAs
- Participate in Skin Prevalence Study



Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation**Part 1 (cont'd)****CWOCN Referral Guidelines****Referral contents – Please specify**

- For skin/wound – Please include body site location and the specific skin issue(s).
- HAPUs – WOCN should also be paged 8 am – 4 pm M-F.
- The WOCN is to be paged for any/all “urgent” referrals Mon 8 – 4 pm
- For ostomy patients – indicate type of ostomy and if new or returning

Appropriate Referrals:

- Multiple Stage 2 pressure ulcers on multiple turning surfaces
- Stage 3 & Stage 4 pressure ulcers
- Unstageable/Suspected DTIs pressure ulcers
- All HAPUs for validation before documenting as a HAPU
- Deteriorating pressure such as: advancing in stage
- Wound VACs
- Chronic & new full thickness wounds
- New ostomates, return ostomates with equipment problems or at patient's request
- Patients with fistulas

Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation**Part 1 (cont'd)****DO NOT place a referral for the following:**

- Patient with Braden score < 18 & skin is intact (utilize Prevention Protocol)
- Stage 1, Stage 2 CAPUs
- Skin rashes that appear to be fungal
- Total body skin rashes (refer to MD)
- Diabetic foot ulcers, vascular ulcers, & infected foot ulcers (refer to MD & Podiatry)
- Incomplete order entry such as: “Check skin” or “Evaluate skin condition,” & Sacral skin breakdown” (specify location, stage, & HAPU or CAPU)
- Minor Skin Tears, Abrasions, & Bruises to Upper and Lower Extremities

- Previous admission with HAPU
- Patients readmitted within 24 – 48 hours for the same wound problem
- Open sores on the toes
- Evaluate for rental beds (may call to discuss options)
- Multiple skin breakdown on lower extremities
- Mild excoriation to buttocks which is responding to treatment
- Cellulitis without wounds (refer to MD)

**** Incomplete order entry i.e. ‘Check skin’ or ‘Evaluate skin condition’**

Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation

Part 1 (cont'd)

4 Eyes Skin Assessment Guidelines



STEPS to FOLLOW:

- 1. Upon any admission to the floor via transfers, direct admit, EPRP, ER admission, or clinic, the primary nurse will buddy with the Charge Nurse or Skin Champion to fully assess the patient's skin condition at the time of arrival to the unit
- 2. Upon transfer from ICU to all units, the primary ICU RN will accompany the patient to fully complete 4 eyes skin assessment hand-off together with the receiving nurse on all the units the patient is transferred to
- 3. Upon discharge to Skilled Nursing Facility from the unit, the primary RN will fully assess the patient's skin condition with the Charge Nurse or Skin Champion
- 4. Once the 4 eyes assessment is complete, the primary nurse will document the findings in the Integumentary Section of the Doc Flowsheet under "pressure ulcer" and will "free text" the name of the nurse who assisted in the skin condition assessment or document in the multidisciplinary notes

Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation**Part 1 (cont'd)**

- 5. If ANY pressure ulcer dressing was changed greater than 24 hours from the time of transfer, please remove the dressing and assess skin condition, and follow the documentation guidelines
- 6. If the dressing is intact and was changed within 24 hours or less of transfer, please remove the dressing and assess skin condition, and follow the documentation guidelines
- 7. If upon transfer the two nurses from the receiving unit (non ICU transfer) discover a new HAPU or a worsened CAPU/HAPU, the transferring unit's primary nurse will go to the receiving unit to assess the wound
- 8. Any time a nosocomial wound is discovered, the nurse must document it as a wound until it is verified as a pressure ulcer by the CWOCN

Documentation & Photographing Wounds

Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation**Part 1 (cont'd)****Purpose:**

- To obtain visual ongoing documentation of pressure ulcers/wounds that a patient may be admitted with or acquired while in the hospital. This will provide a permanent visual record of a patient's healing progress or declining status with regard to all wounds treated by hospital staff.

Policy Statement:

- The Nursing staff will photograph any pressure ulcer or wound requiring treatment by hospital staff on admission to the unit and prior to discharge from the hospital. Photographs may additionally be taken to document wound healing or deterioration on a regular basis during the patient's hospitalization.

- Photographs taken by nursing staff do not require a separate consent
- Photographs are confidential and immediately needs to be placed in the patient's medical record

Procedure:

- Gather all supplies – camera, measuring guide, cotton tipped applicator (to measure depth and undermining), dressing supplies
- Introduce yourself, ensure privacy, and explain purpose of photography
- Attach, align measuring guide and use permanent marker to label with required elements such as the date and location of the wound.
- Hold camera steady and take picture.

Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation

Part 1 (cont'd)



Case Studies



Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation

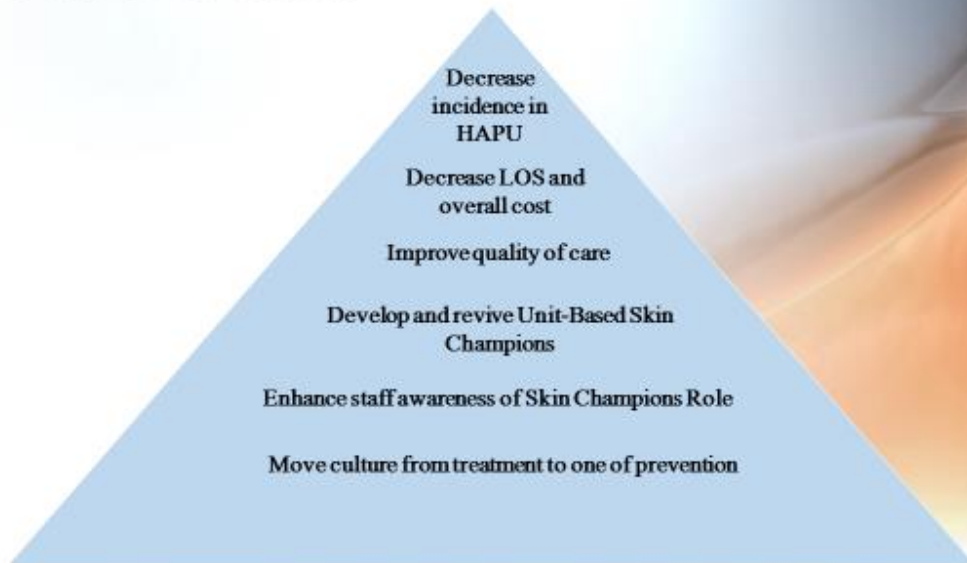
Part 1 (cont'd)

Understanding the Skin Champion Role

Where do we go from here?



Outcome Goals



Appendix Z (cont'd)

Education for Skin Champions Power Point Presentation

Part 1 (cont'd)

“Never underestimate the power of a small group of dedicated people changing the world. Indeed, it's the only thing that ever has.”

Margaret Mead

