An Inpatient Rehabilitation Facility's Interdisciplinary Approach to Preventing Pressure Ulcers

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Abstract

Purpose: Prevention of pressure ulcers is an ongoing challenge for all health care facilities. Facility-acquired pressure ulcers lead to poor clinical and economical outcomes. Due to the guideline changes impacting reimbursement for preventing skin breakdown from Centers for Medicare Services and the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) criteria, pressure ulcer prevention remains imperative. The purpose of developing a pressure ulcer prevention protocol on our inpatient rehabilitation unit was to ensure compliance with a repositioning schedule. As the ptorocl was initiated, barriers to following it were discovered and addressed.

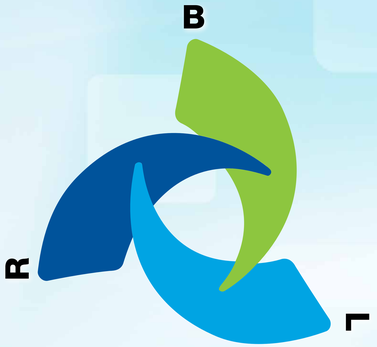
Background: The U.S. Agency for Health Care Policy and Research confirms that patients identified at risk for skin breakdown are to be repositioned every two hours, but a lack of time (Strand & Lindgren, 2010) and lack of knowledge act as barriers to following the guidelines (AHRQ, 2015).

Actions: A newly-opened IRF established an interdisciplinary skin team (consisting of PT, OT, nursing) that outlined a turning and repositioning protocol. A magnetized and laminated "LVHN Logo Sign," (Lehigh Valley Health Network), is used as a visual reminder to staff to regularly reposition high risk patients and is placed on the outer door frame of the patient's room. The team also established weekly monitoring of pressure ulcer healing or degradation via Telewound pictures that are uploaded to the electronic documentation system, where they are shared with all members of the interdisciplinary team and the wound ostomy nurses. To ensure compliance and appropriate use of the "LVHN Logo Sign", skin audits reviewed electronic documentation of patient repositioning.

Outcomes: An interdisciplinary approach is vital in providing optimal skin care for patients in rehabilitation facilities. This poster shows data collected from quarterly audits and quality outcomes and it addresses overcoming barriers to implementing a process change.

BRADEN SCALE FOR PREDICTING PRESSURE ULCER RISK				
SENSORY PERCEPTION	(1) Completely limited	(2) Very Limited	(3) Slightly limited	(4) No Impairment
MOISTURE	(1) Constantly Moist	(2) Very Moist	(3) Occasionally Moist	(4) Rarely Moist
ACTIVITY	(1) Bedfast	(2) Chairfast	(3) Walks Occasionally	(4) Walks Frequently
MOBILITY	(1) Completely Immobile	(2) Very Limited	(3) Slightly Limited	(4) No Limitation
NUTRITION	(1) Very Poor	(2) Probably Inadequate	(3) Adequate	(4) Excellent
FRICTION & SHEAR	(1) Problem	(2) Potential Problem	(3) No Apparent Problem	

Assess and choose 1 option for each category, add up the total numbers.
If the total is <18, the patient is at risk of developing a pressure ulcer.



The Research:

- Patients at risk for skin breakdown need to be turned and repositioned frequently.
- Friction and shearing forces play a role by increasing surface temperature and humidity.
- Immobility and advanced age also put a patient at increased risk.

Barriers:

- A gap between guidelines/protocols and practice exists.
- Time restraints and staffing issues are frequently sited as barriers to following EBP.
- Education needs remain
- Lack of communication between skin committee and staff regarding documentation expections.
- Lack of staff understanding/knowledge of the benefits of frequent repositioning.
- Lack of communication between RNs and TPs.
- Resistance to change
- Patient refusal (careful documentation of this and attempts to educate patient must be recorded in the EMR).

LVHN Logo Sign Protocol:

- Braden score completed q12h
- If Braden <or = 18, and cannot turn/reposition self, magnetic "LVHN Logo Sign" applied to patient's door frame = high risk for skin breakdown.

The LVHN Logo Sign:

- Prompts all clinical staff to assist pressure-relieving over bony prominences
- Promotes interdisciplinary communication regarding transfers, mobility, distance.

Positioning:

- Patient in bed-position 30° on lateral side lying with positioning devices/pillows. Avoid rubbing bony prominences
- Patient OOB in chair/recliner/wheelchair- remind patient to shift position Q15 min if able to reposition self.
- If unable to reposition or is chair-bound- assist patient Q1H.
- No patient should be OOB sitting longer than 2 hours per one sitting.

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