Providence

Decreasing Pressure Ulcers in Skilled Nursing Facilities (D-PUS SNF)

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Background

- Over 60,000 people die annually from pressure ulcer (PU) complications
- Residents in SNFs nationwide are at 9.2% rate for PUs , and the project site had a rate of 25.7%
- The Braden Scale assessment was not always conducted timely, nor drove care plan interventions
- Interventions were not based on evidence

Purpose

- To test effectiveness of education and new policy on timely implementation of evidence-based practice skin assessments and interventions

Acknowledgments

Angela Saathoff
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Methods

- 8- week quality improvement project
  Educated staff on new policies:
  - Completing Braden Scale Assessments
  - Multidisciplinary care planning meetings
  - Implementation of targeted skin interventions
- At-risk Braden score residents included

Results

- PU incidence before to after project reduced (Fig. 2).
- High compliance with new policy observed (Fig. 1)
- Chi-square tests comparing proportion implementing process measures on time versus not on time for eligible residents were insignificant (data not shown).

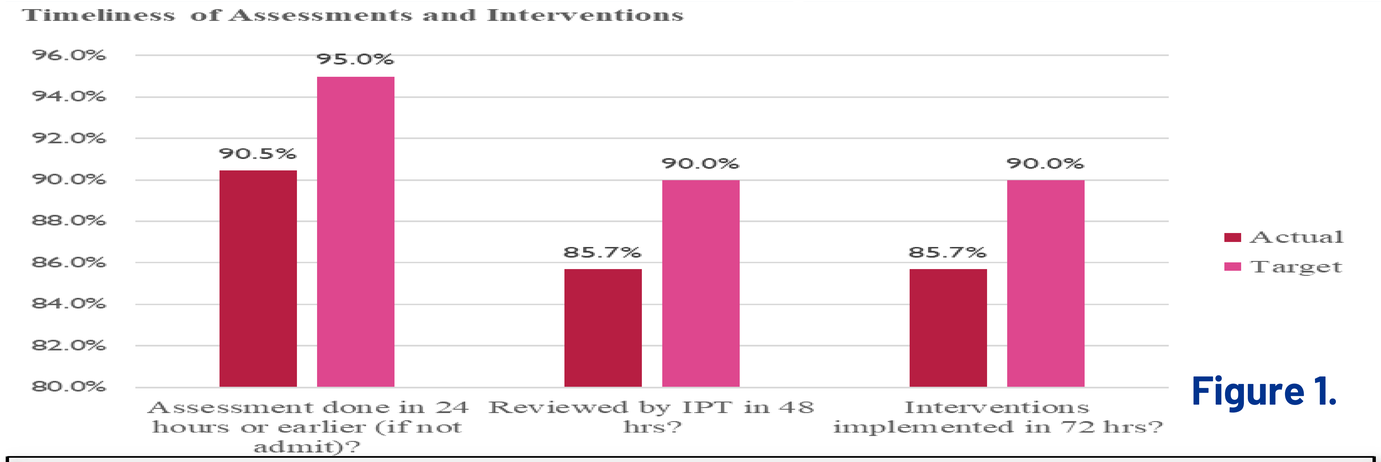

Figure 1.

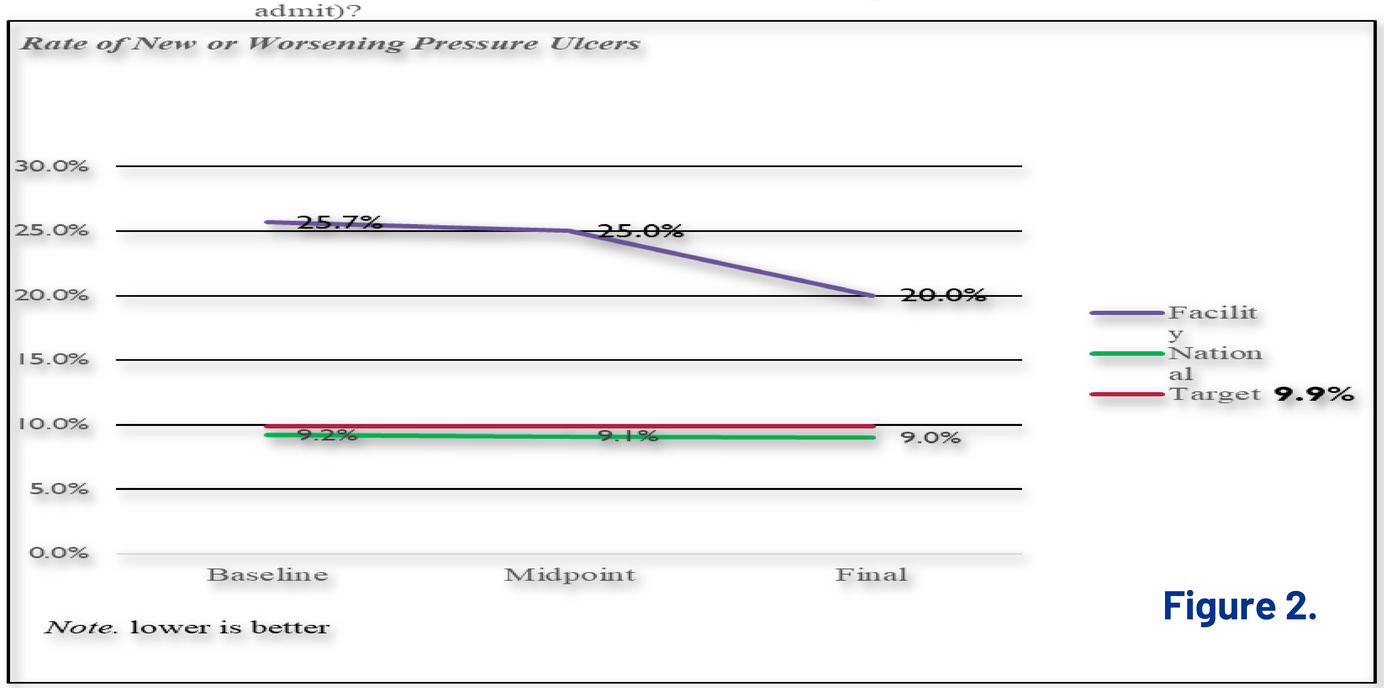

Figure 2.

Discussion

- High compliance with new skin policy and reduction in PU at the facility.
- Staff completed all three process measures equally across eligible residents.

Implications for Practice

- Using Braden subcategory scores in partnership with the interdisciplinary team informs best skin protection interventions.
- Nurses in any setting could advocate for this skin protection approach.

References available upon request