

Report on Clinical Practice

This article focuses on the impact of the Clinical Practice component of the Pressure Ulcer Awareness Program (PUAP) Pilot in the clinical setting.

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Throughout the program's implementation, many positive clinical outcomes were realized. One of the greatest changes noted was that Stage I pressure ulcers were recognized early—before they deteriorated to become deeper areas of injury. This early recognition by various members of the health-care team, including patients and families, facilitated the prompt implementation of appropriate interventions that prevented the progression

of skin damage. Prior to the program's implementation, pressure-related injuries were often not reported until the client's skin was actually open, and interventions were not implemented until pressure ulcers progressed to Stage II or III.

In some facilities, the medical director and key physicians became involved in supporting the program. Referrals to dietitians for patients with nutritional risks increased at many sites. At one site, needs increased so dramatically that additional resources were hired. A dietitian at another site created high-protein "smoothie" supplement drinks for patients with nutritional risks identified by the Braden assessment.

As involvement of occupational therapists, physiotherapists, family and caregivers increased, creative strategies for patient positioning, transfers, and the obtaining of special devices were noted.

During the pilot, it was discovered that although the

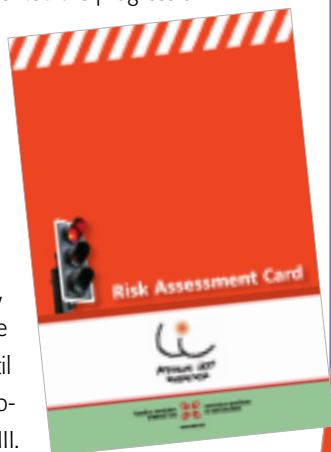
Braden Scale had been used at most sites prior to the program's introduction, a reduction in pressure-ulcer prevalence had not occurred. The Braden tool was re-introduced with a focus on the value it provides as a care-planning tool. Scores from the individual subscales were assessed to highlight factors that increased patients' risk for skin breakdown. This enabled staff to develop individualized plans of care targeted to the specific risks identified.

Targeted interventions were then recorded on colour-coded (according to risk level) Risk Action

Cards, which made it easy to identify patients' risk for skin injury on the plan of care. The interdisciplinary team conducted weekly skin-care rounds on all patients identified to be at high risk for skin breakdown as designated by the red Risk Action Cards. High-risk rounds facilitated early identifica-

tion of skin damage, ensured appropriate prompt interventions, and provided an opportunity for one-to-one education with staff, patients, and families, empowering them to take appropriate actions to prevent skin breakdown.

Throughout implementation of the program's clinical component, a few challenges were encountered. Flexible creative strategies were required to accommodate staff shortages, time constraints, limited resources, lay-off announcements, heavy workloads, frequent



interruptions, and conflicting priorities. Educational sessions were modified at some sites to accommodate staff availability. Some sessions were condensed into shorter 20- to 30-minute, interactive, small-group workshops that were delivered in meeting rooms located on the patient units. Staff attended as time permitted. High-risk skin rounds were incorporated into routine morning patient care, thus minimizing the impact on busy workloads by accommodating the nurses' schedule of care delivery.

Some sites reported difficulties in accessing resources such as physiotherapy (PT), occupational therapy (OT), prevention devices and equipment. Some physiotherapists and occupational therapists provided resources for the facilitator to utilize for the educational sessions when they were unable to participate.

The need for increased resources to prevent pressure ulcers was identified (equipment, dietitian, PT, OT, boots, surfaces, etc.). Some sites noted that patients and families became more involved in helping to reduce risk factors by assisting with repositioning and providing needed equipment and supplements.

In summary, many positive clinical outcomes resulted from this pilot project. The consistent use of the Braden Scale and high-risk skin rounds led to the early identification of pressure damage and individualized care plans targeted at specific risks. Increased involvement of the interdisciplinary team resulted in the implementation of both basic and creative strategies to reduce the risk for skin breakdown.

Also evident at most pilot sites was a positive shift in staff attitudes, awareness, and responsibilities related to pressure-ulcer prevention and the shift toward early intervention.

Some challenges to implementation included staff shortages, workloads, time constraints, frequent interruptions and conflicting priorities. These were effectively addressed through flexible and creative revisions to the timing and delivery of staff education sessions.

Overall, this program empowered the teams in each facility—including patients and their families—to change clinical practice at the bedside and to prevent pressure-ulcer occurrence. ☺