Continuum of Care

[Working Together to Prevent the Incidence of Pressure Ulcers]

MEMPHIS COMMENTS

Question #1

How can we work together to reduce the incidence of pressure ulcers across care settings?

Answer #1

Nursing Home

- Teamwork in all care settings
- By following the minimum standards of care, pressure ulcers can be reduced significantly
- Standardized documentation across settings
- Accurate measurement from facility to facility
- Sharing information and ongoing education across care settings
- Uniformity of risk management tools
- Sharing best practices and treatment interventions across care setting
- Sharing product information
- Coming together to discuss lessons learned in treating and preventing pressure ulcers within each other's settings
- Early intervention
- Uniformity in the basic standards of care across the different care settings
- Each setting must have a multidisciplinary approach and upper management support
- Stop the "blame game" - we should all be on the same team, working together to provide the best care for our patients and residents
- Both settings should implement risk assessments upon admission
- Have annual meeting of local hospitals and nursing homes to discuss treatment protocols and lessons learned
- Individualized treatment/care plans
- Providing patient history before admitting to the facility/or hospital
- Good documentation to provide a clear picture of patient needs.
- Skin assessments prior to and upon hospital return
- Educate nursing and dietary staffs across both care settings

Hospitals

- Providing a through history and care plan to the transferring facility
- Better communications across care settings
- Making it a team approach, begin to think of other care settings as being on the same team
- Communicate risk factors from one setting to another
- Develop better MD awareness across settings. Also, begin to education MD and other professionals (i.e., therapist, dietary etc.)
- Each setting should be completing assessment upon admission and providing through documentation
- Uniformity and consistency across the care settings regarding wound terminology

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Question #2

What barriers does your facility face in preventing pressure ulcers?

Answer #2

Nursing Home

- Staff turnover
- Inefficient skin assessments
- Lack of C.N.A. education, especially regarding risk factors
- Staff cooperation between disciplines
- Spreading information and knowledge to evening/weekend shifts
- C.N.As not reporting early signs to treatment nurse
- Lack of compliance with nursing and direct care staff
- Chronic health problems with residents
- Lack of accountability facility-wide
- Staffing needs to be related to acuity of patients rather than state guidelines or facility corporate guidelines
- Lack of caring staff
- High cost special support surfaces and devices, and also treatment products
- Lack of proper equipment
- MDs are not aggressive in treating wounds
- Incontinence education
- Ratio patient/caregiver load
- Lack of staff awareness and understanding of importance of prevention
- Immobility of patients

Hospital

- Not having wound history of patient (wound healing, nutrition, appetite etc.)
- Lack of education to families
- Staff not putting prevention as a priority
- Nursing aids are not educated in prevention and treatment of pressure ulcers
- Assessments are not being done accurately. Also, need more education on treatment of pressure ulcers
- Staff turnover
- Poor documentation. Goals that are not measurable
- Lack of staff, and also inadequate staff
- Skin care is not a priority
- Decrease in staff, which leads to a longer period of time between turning schedules and ADL care
- Too much paper work, too much duplication in paper work
- Inconsistent care given by care givers

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Question #3

What lessons have you learned within your facility as you work towards reducing the incidence of pressure ulcers?

Answer #3

Nursing Home

- Continually monitor protocols and check for adherence on all shifts for all caregivers
- Float heels at all times
- Never assume, always check to make sure proper protocols are being followed
- Empower staff. Education
- Team participation will ensure that everyone is working towards the same outcome
- Recognizing change of condition, ie decline and then implementing preventive measures before pressure ulcers progress
- Prevention is much more effective and less costly than healing wounds
- Implement policy of "if you see it, report it", and then following through with the assessments and documentation
- All disciplines must work together in the prevention of pressure ulcers
- Wound rounds are very helpful
- Consistency between shifts
- Look at the entire person, not just the wound. Consider medical factors that may be the root cause of developing a wound, as well as, pressure related
- Providing staff with continuous education and awareness about pressure ulcer, will help to prevent pressure ulcers
- Following standards of care practices
- Always do skin assessment upon admission
- Comprehensive education for risk factors to care givers: incontinence, hydration, positioning, nutrition etc.
- Providing C.N.As opportunity to learn and to become more accountable
- Weekly assessments, through assessment on admission, monitoring residents with decrease in appetite, decline in condition and provide proper rotation and support system

Hospital

- Acuity level of patients
- Accessibility of equipment and supplies is key
- Nursing aids need more education
- Everyone needs to be working together
- Holistic view is key, good assessment skills and utilizing all departments
- Frequent spot checks and making wound rounds
- Properly staging and documenting wounds
- MDS need to look at patient , not just assessments to ensure accuracy in documentation
- Pressure ulcer prevention and healing will occur when staff are provided proper training
- Better communication
- Family education

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Question #4

What is the number one thing that can be done by my facility/organization to help your facility/organization to reduce the incidence of pressure ulcers?

Answer #4

Nursing Home

- Develop education materials for families and community regarding pressure ulcer prevention and risk factors that are used in each care setting
- Networking opportunities
- Developing good communication and relationships between care settings in an effort to share best practice guidelines
- Keeping in touch with one another to ensure that there is unity and consistency in standards of care given
- Standardization of tools that are used for each care setting

Hospital

- Reporting history of pressure ulcers to transferring care setting
- Share ideas that have worked with each other, and involve family and community
- Develop a competency wound checklist to include measurement performance and how to do a complete comprehensive skin assessment
- Networking