

# No Pressure On You! Eliminating Pressure Ulcers In The ICU

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## Purpose

Patients in the intensive care unit are at high risk for developing skin breakdown and pressure ulcers secondary to immobility, poor perfusion, inadequate nutrition, edema, and other factors associated with disease states. This project presents results from one hospital setting of the implementation of the Minnesota Hospital Association Safe Skin initiative. The goals were to: reduce the incidence of nosocomial pressure ulcers, heighten awareness of the importance of skin integrity and risk assessments and eliminate reportable pressure ulcers in the intensive care unit.

## Background

Pressure ulcer occurrence has long been recognized as a physical, emotional and economic burden to patients. However, with the recent changes in reimbursement and regulatory policies, this patient safety problem has also become a quality and economic burden for health care settings. For example, all inpatient nosocomial full-thickness pressure ulcers in the State of Minnesota must now be reported to the Minnesota Department of Health thereby becoming public knowledge.

The Minnesota Hospital Association sponsors a best practice **Safe Skin** project for pressure ulcer prevention. **Safe Skin** is a comprehensive skin safety program utilizing clinical wound, ostomy, continence guidelines, the Institute for Clinical Systems Improvement (ICSI) Skin Protocol and lessons learned from adverse health events.

In July 2010, the ICU at Park Nicollet Methodist Hospital rolled out a three tiered skin initiative in addition to its current program which uses best practice for skin inspection, risk assessment and pressure ulcer prevention. Three tools were developed in this facility to implement this initiative:

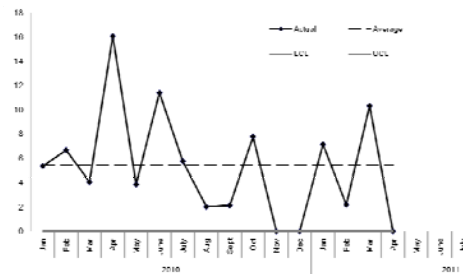
□ **Skin Integrity Assessment Tool** Documentation of skin inspection and body diagram were double-checked by another RN for all new patients admitted and transferred into the ICU.

□ **Bedside RN Skin Report Tool** This tool documents the completion of Skin Integrity Assessment Tool (body diagram), skin assessment and staging of pressure injuries, device related skin injury, high risk factors, interventions and protocols utilized. The tool remained at the bedside and was coupled with the Skin Integrity Assessment Tool concise reporting.

□ **Charge RN Skin Tracking Tool** Used to track ICU patients at risk for skin alteration or existing skin issues and to serve as a trigger during wound ostomy rounds.

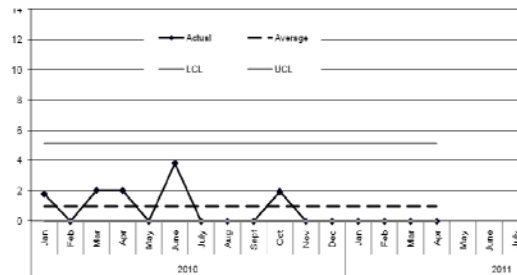


The **X-MR CHARTS BELOW** depict the **rate of pressure ulcer incidence** per 1,000 patient days. The average rate of pressure ulcers, based on past facility data, is represented by the dotted line. The gray lines represent the upper control limit and the lower control limit. These act as guidelines for the hospital. A rate outside of the upper or lower control limit would prompt further investigation, as it is outside of the norm based on the facility's past data. The goal of Park Nicollet is to achieve rates that are average or below average, in order to continue to improve practice and promote skin safety. \*Additional education sessions to support the skin initiative were provided to all ICU in November 2010. This education included hands-on wound assessment and documentation, discussion about recent nosocomial pressure ulcers and pressure ulcer prevention interventions.



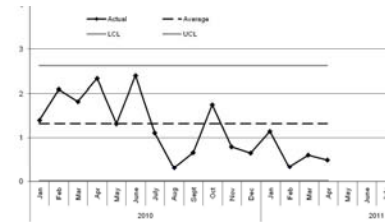
### ICU > Stage I

An increase in pressure ulcer rate prompted the ICU Skin Initiative, which began in July 2010. After the initiative began, the incidence of pressure ulcers reduced significantly. Additional education was provided in November, which contributed to another drop in pressure ulcer rate. The incidence increased in March, but was still lesser than prior to the Skin Initiative. As of May 27, 2011, the ICU has had zero pressure ulcers in both April and May.

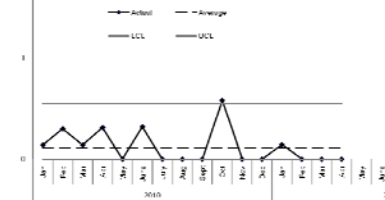


### ICU Reportable

Reportable pressure ulcers are stage 3, 4, and unstageable pressure ulcers that, if nosocomial, must be reported to the Minnesota Department of Health. This data then becomes public knowledge. Since the beginning of the ICU Skin Initiative, the ICU has had only 1 reportable pressure ulcer. Since October 2010, the ICU has had zero reportable pressure ulcers.



**Hospital-wide > Stage I**  
The successes of the ICU Skin Initiative were shared hospital-wide and created momentum throughout the entire hospital. Since the beginning of the ICU Skin Initiative, the incidence of pressure ulcers hospital-wide had reduced dramatically. Aside from October 2010, all data points are below the mean (dotted line). The pressure ulcer rate continues to trend downward.



**Hospital-wide Reportable**  
The incidence of reportable pressure ulcers also reduced hospital-wide after the ICU Skin Initiative began. Since October of 2010, the hospital has only had 1 reportable pressure ulcer.

**Summary:** The ICU Skin Initiative has dramatically impacted patient care in the ICU and created momentum throughout the entire hospital. Since October 2010, the hospital has had only 1 reportable pressure ulcer. The ICU has had zero. Hospital wide, nosocomial pressure ulcers greater than stage I have reduced by 66.4% when comparing the months of January through April 2010 to 2011. The ICU continues to utilize all of the three skin tools as part of standard practice today. The ICU Skin Initiative reduced pressure ulcer incidence and brought awareness and enthusiasm to skin safety in both the ICU and throughout the entire hospital.

## References:

- Salcido, R., and Popescu, A. (2009). Pressure ulcers and wound care. Retrieved on September 22<sup>nd</sup> 2010 from medicine: 2009 <http://emedicine.medicapedia.com/article/31934-overview>.
- Minnesota Hospital Association. (2007). Road map to a comprehensive skin safety program. Retrieved September 22<sup>nd</sup> 2010 from <http://www.mnhospitals.org/inci/data/tools/SafeSkin-Toolkit/roadmap.pdf>

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