Patient Safety | *Call to Action*

Road Map to a Comprehensive Skin Safety Program

Minnesota Hospital Association

Road Map to a Comprehensive Skin Safety Program

SAFE SKIN *based on the ICSI Skin Safety Protocol, Adverse Health Event Learnings and WOCN Clinical Practice Guidelines.*

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INFRASTRUCTURE

	Skin Safety Component	Specific Action(s)	SAFE SKIN Audit Questions
S	SKIN SAFETY COORDINATION AND TEAM APPROACH	1) Coordinates skin safety efforts.	1a) The facility has an interdisciplinary team involved in implementing the pressure ulcer prevention program with representation from across the facility. 1b) The pressure ulcer prevention program plan is reviewed by the team and updated periodically throughout the year. 1c) Department specific policies are in place to address their unique role in preventing pressure ulcers. 1d) The facility has a designated coordinator(s) for the skin safety program. 1e) The coordinator(s) has dedicated time to serve in this coordination function. 1f) The program has at least one team member with a background/education/certification in wound care.
		2) Promotes skin safety representation/champions throughout the facility	Skin champions/team members/liasons with clear roles and expectations have been designated from: 2a- Each relevant inpatient area, Emergency 2k) Department, Operating Room, Radiology, Respiratory Therapy, Dietary, Physician/provider, Certified Nursing Assistant staff, Physical Therapy/ Occupational Therapy, Risk Management/PI/QI, Nursing Administration/Senior Leadership.
		3) Promotes system wide communication	3a) There is a process in place to communicate patient's pressure ulcer risk and skin integrity status during structured hand-offs across departments. 3b) There is a process in place to communicate patient's pressure ulcer risk and skin integrity status during transitions of care between care settings. 3c) Pressure ulcer cases are routinely shared through patient stories/lived experiences, as well as through data.
A	ACCURATE AND CONCURRENT REPORTING	1) Data Collection—Tracks all stages of nosocomial pressure ulcers for early detection and causative factors.	1a) The facility has a concurrent reporting process (such as occurrence reporting) in place to collect all stages of nosocomial pressure ulcers. 1b) There is a process in place to audit the reliability of the reporting process on a regular basis through incidence studies/surveys
		2) Data Analysis—Measures/evaluates effectiveness of skin safety efforts.	2a) A process is in place for the skin safety team to review and analyze reported pressure ulcers and RCA findings on a regular basis for learnings and improvement opportunities. 2b) A process is in place to track and analyze data regarding incontinence associated dermatitis (e.g. collect during P & I studies).
		3) Promotes system-wide learning and transparency.	3a) Nosocomial pressure ulcer data and learnings are shared at least quarterly: i) within units ii) across units iii) across departments iv) with leadership

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F	FACILITY EXPECTATIONS AND STAFF EDUCATION	1) Communicates expectations of staff and provides related education for pressure ulcer prevention.	1a) Expectations and supporting competency based education has been incorporated into new employee orientation for nurses, nursing assistants and other clinical staff (e.g. roles identified under S 2a-i) 1b) Staff pressure ulcer prevention competence is re-evaluated on an annual basis. 1c) The Just Culture model is applied when staff is observed not following facility expectations for appropriate skin inspection and patient re-positioning. Skin inspection education includes the following strategies as a means of early identification of pressure related skin damage: 1d) Approaching the patient for skin inspection. 1e) Performing a thorough skin inspection (including under devices). 1f) Opportunities for performing skin inspection during other scheduled assessments and care activities. 1g) Considerations for darkly pigmented skin. 1h) Pressure ulcer prevention education incorporates strategies for preventing device related pressure ulcers and includes: focused inspection under and near devices, pressure redistribution, appropriate stabilization, and protection from moisture/friction/shear. 1i) Pressure ulcer prevention education includes strategies that link specific interventions to minimize or eliminate individual risk factors. 1j) The facility has a process in place for real time dialogue, barrier identification and education related to pressure ulcer prevention (e.g. daily huddles, weekly skin rounds, interdisciplinary rounding).
		2) Incorporates the use of recommendations and best practice guidelines.	The facility expects that best practice protocols/recommendations (e.g. MHA guidance documents, ICSI protocol, NPUAP recommendations) are used as resources for: 2a) Updating policies and procedures. 2b) Updating education materials and methods. 2c) Developing action plans for perioperative and device related pressure ulcers. **MHA Respiratory Devices Recommendations and Guidance** 2d) The facility has performed a gap analysis of current policies and procedures against the MHA respiratory guidance document. 2e) An implementation plan has been developed to address relevant gaps. 2f) The plan to address relevant gaps has been implemented to achieve at least 90% of the recommended practices.

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F *continued*	FACILITY EXPECTATIONS AND STAFF EDUCATION	3) Pressure ulcer prevention and treatment products are readily available.	**MHA Cervical Collars Recommendations and Guidance** 2g) The facility has performed a gap analysis of current policies and procedures against the MHA cervical collar guidance document. 2h) An implementation plan has been developed to address relevant gaps. 2i) The plan to address relevant gaps has been implemented to achieve at least 90% of the recommended practices. **MHA OR Recommendations and Guidance** 2j) The facility has performed a gap analysis of current policies and procedures against the MHA OR guidance document. 2k) An implementation plan has been developed to address relevant gaps. 2l) The plan to address relevant gaps has been implemented to achieve at least 90% of the recommended practices. **Anti-embolism Stockings (AES)** The facility has an anti-embolism stocking practice in place which addresses: 2m) Indication and contraindications to use 2n) Alternatives to AES 2o) When to discontinue AES 2p) Correct fitting 2q) Skin inspection care 2s) Patient/family education. 2t) Minimize use of thigh-high AES 3a) The facility has assessed access to pressure ulcer prevention and treatment products. 3b) Pressure ulcer products are organized in a common location that is readily accessible to staff. 3c) A process is in place to inventory products and ensure appropriate supplies are available to staff.
E	EDUCATION OF PATIENTS AND FAMILIES	Educates patients and families so that informed decisions can be made and mutual goals can be established.	1a) Patient/family education tools are disseminated for skin safety to patients at risk for pressure ulcers. 1b) The facility requires, AND has a designated place to document, skin safety education and patient/family response. 1c) Patient/family education tools incorporate the prevention of device related pressure ulcers (e.g. anti-embolism stockings, cervical collars, respiratory devices). 1d) Patient/family education tools incorporate the importance of at least daily skin inspection. 1e) Patient/family education tools incorporate the importance of proper nutrition in prevention of pressure ulcers. 1f) Patients at-risk for pressure ulcers due to nutritional risk factors are educated on the importance of nutrition as it relates to pressure ulcer prevention prior to discharge.

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S	SKIN INSPECTION AND RISK ASSESSMENT	1) Performs and documents regular pressure ulcer risk assessment. 2) Performs and documents a complete skin inspection at least daily including around and under medical devices. 3) Removes devices such as stockings and splints for accurate skin inspection. 4) Repositions devices such as tubes and stabilizers for accurate skin inspection. 5) Communicates pressure ulcer risk and skin integrity issues. 6) Risk assessment findings are linked to specific interventions.	1a) The facility requires, AND has a designated place to document, the Braden/Braden Q (pediatric) pressure ulcer risk assessment upon admission and daily or as indicated by care setting (e.g. acute care versus long-term acute care). 2a) The facility requires, AND has a designated place to document, complete skin inspection on admission (ideally within 6 hours) and at least daily. 2b) Pressure ulcer documentation is readily accessible to all relevant clinical disciplines. 3a) The facility requires, AND has a designated place to document, the removal of devices for skin inspection (e.g. anti-embolism stockings, cervical collars, splints and respiratory equipment). 4a) The facility requires, AND has a designated place to document, tube site inspection with site cares (i.e. NG-tubes, G-tubes, trachs, ETTs and catheters). 5a) The facility requires, AND has a process for communication of, pressure ulcer risk and existing pressure ulcers to the perioperative/ peri-procedural staff. 5b) The facility requires, AND has a process in place for, the perioperative/peri-procedural staff to assess the patient's surgical risk factors for pressure ulcer development. 6a) The facility requires, AND has a place to document, specific pressure ulcer preventive interventions to address individualized risk factors. 6b) Staff and resources are accessible 24/7 for trouble-shooting on complex patients at high risk for pressure ulcer development. 6c) Bedside nurses have been educated on the availability of 24/7 staff/resources.
K	KEEP PRESSURE OFF — MINIMIZE PRESSURE, FRICTION, SHEAR	Identifies and addresses deficits in sensory perception, mobility, and activity as defined by the Braden scale through: 1) Repositioning Q2 hours or per patient pressure ulcer risk.	1a) The facility requires repositioning Q2 hours or per patient pressure ulcer risk. 1b) Responsibility for positioning and repositioning patients is assigned and well-defined. 1c) The facility has a designated place in the medical record to document the occurrence of repositioning, which includes time of reposition and actual position. 1d) Adherence with repositioning is visually monitored by unit leadership. 1e) When regular repositioning is medically contraindicated, physician written confirmation and daily reassessment and documentation is required. 1f) When regular repositioning is medically contraindicated, hourly micro-shifts/off-loads is required (e.g. less than 15 degree shifts, heel and sacral off-loads). 1g) When patients decline or refuse repositioning, documentation of informed refusal and reason for refusal is required.

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K *continued*	KEEP PRESSURE OFF — MINIMIZE PRESSURE, FRICTION, SHEAR		1h) Patient refusal and/or underlying barriers to repositioning is re-evaluated and patient is re-educated at least daily on the importance of repositioning. 1i) When patients are not able to be adequately and routinely repositioned the facility requires immediate and on-going evaluation for an advanced support surface with features and components such as low air loss, viscous fluid, air fluids, or alternating pressure.
		2) Evaluates and uses appropriate support surfaces (mattresses, chair cushions, OR, transport, and procedure surfaces).	2a) The facility requires pressure redistribution surfaces for patients with Braden Score ≤ 18. 2b) The facility has support surface/off-loading decision-making tools that are accessible to the staff. 2c) The surface off-loading algorithm indentifies advanced support surfaces with features and components such as low air loss, viscous fluid, air fluids, or alternating pressure for patients that are not adequately repositioned. 2d) A process is in place to have an advanced support surface readily available so that patients with anticipated medical contraindications to repositioning can be initially placed on an appropriate surface. 2e) Support surfaces are evaluated across the organization for appropriate pressure redistribution properties (e.g. OR beds, chair cushions, transport carts, radiology tables, emergency department gurneys). 2f) A plan/process is in place for replacement or supplementation of surfaces that do not provide adequate pressure redistribution for patients at risk.
		3) Off-loads /floats of the heels	3a) The facility requires off-loading/floating of heels anytime patients have deficits in sensation, perfusion or mobility throughout the continuum of care (e.g. sedation, neuropathy, PVD). 3b) Facility has a designated place for documentation of off-loading/floating of heels throughout the continuum of care.
		4) Protects skin during lateral patient transfers.	4a) The facility has a standard process to identify each patient's mobility status. 4b) There is a system in place to alert all staff to the patient's mobility status. 4c) The facility has implemented a plan to utilize appropriate staff and equipment for transfers and/or repositioning tasks as indicated by patient mobility status. *Note: Refer to section F for audit questions related to devices.*

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I	INCONTINENCE/ MOISTURE SKIN PROTECTION	1) Addresses and minimizes the effects of incontinence.	1a) The facility requires the use of cleansers specifically designed for the perineal area for patients with incontinence. 1b) The facility requires the use and documentation of moisture barriers for patients with incontinence. 1c) Perineal cleansers and barriers are readily accessible for incontinent patients. 1d) The formulary for perineal products is user friendly and standardized. 1e) Staff have been educated on use of formulary for perineal products. 1f) Facility evaluates the effectiveness/quality of incontinence product selection to wick moisture away from the skin (e.g. diapers, briefs, pads). 1g) Fecal and urinary incontinence devices are FDA approved. 1h) Facility has a process in place to limit use of briefs and diapers when patients are in bed (as appropriate per age and condition). 1i) Facility has a process in place for scheduled toileting for incontinent patients (e.g. hourly rounding, toileting prior to end of shift).
		2) Addresses and minimizes the effects of excess moisture.	2a) Facility has a process in place that identifies interventions to minimize the effects of excess moisture not related to incontinence. (e.g. drooling, wound drainage, diaphoresis).
N	NUTRITION IS OPTIMIZED	1) Identifies patients with nutritional risks.	1a) Nursing nutritional risk screening is completed within 24 hours of patient admission (ideally within 8-12 hours of admission). 1b) Facility does not recommend pre-albumin and albumin levels as independent markers of nutritional status and should not be used in isolation as a trigger for a nutritional consult.
		2) Consultation for patients identified with nutritional risk factors.	2a) If the patient is at nutrition risk, a process is in place to request a nutrition consult within 24 hours of admission. 2b) A nutritional consult is also requested for patients assessed to be at-risk for pressure ulcers. (i.e. Braden Score ≤ 18 AND a nutrition subscale of 2 or less). 2c) The facility's policy and process for nutritional consults indicate a timeframe for completing the consult after a request is received.
		3) Appropriate nutritional interventions are put in place to reduce pressure ulcer risk.	3a) A process is in place for nursing to offer additional nourishment to patient as appropriate until patient can be seen by dietitian (e.g. 6 small meals, snacks as appropriate). 3b) A process is in place for dietitian or prescribing provider to order nutritional supplements as needed (e.g. Boost, Ensure, multi-vitamins) 3c) The facility requires documentation, AND has a designated place to document, consumption of supplements. 3d) The facility requires documentation, AND has a designated place to document, consumption of meals/snacks.


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