Effective Utilization of Nurse Assistants for Skin Inspection and Rapid Response Resulting in Improved Staff Communication and Patient Outcomes

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Overview

The rate of nosocomial (hospital-acquired) pressure ulcers was reduced from 18.00% to 5.88% through skin inspection and rapid response by nurse assistants, as well as timely utilization of a skin cleansing and moisturizing protocol which included a unique point-of-use skin monitoring and communication tool.

Aim

To improve skin inspection and rapid response by nurse assistants to decrease the occurrence of hospital-acquired pressure ulcers by 10%. This aim supports the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO's) National Patient Safety Goal #2 "to improve the effectiveness of communication among caregivers."

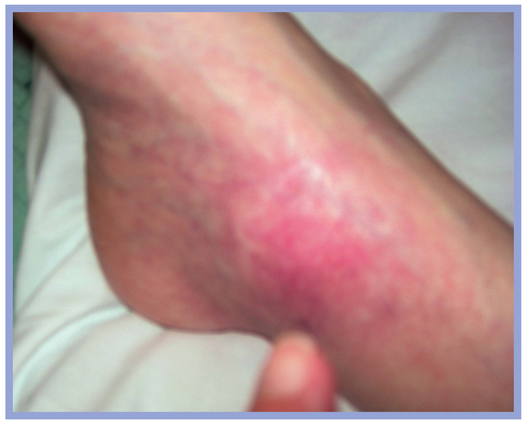
Measures

Bellin Hospital established a Skin Check Team and dual nurse assistant and licensed nurse educational programs on skin inspection/assessment. These Skin Check Programs implemented a skin monitoring tool (Comfort Bath® Skin Check™ Guide, Sage Products Inc., Cary IL) and how to use it appropriately—including frequency of use and the recording, communication and follow-up of skin observations. The skin monitoring tool is a peel-and-stick guide enabling non-licensed personnel to monitor and report a patient's skin condition during bathing. An audit tool was utilized for data collection and analysis was performed weekly on records of both new skin events and ongoing skin events. Quarterly reports were evaluated on the number of pressure ulcers. The hospital's program incorporated a complete, step-by-step plan which included staff responsibilities as well as unique incentives to promote compliance.

Changes

Improvement in the number of pressure ulcers was measured, along with cost factors and staff satisfaction with the program. A skin cleansing protocol—coupled with skin observation, recording, communication and follow-up—was implemented during the study period.

- Conducted a pre- and post-intervention study to assess a new skin care product and program that reduced costs, decreased nursing time, and with the skin inspection tool, affected the risk of developing hospital-acquired pressure ulcers.
- Used patient bath as the best time to identify skin breakdown issues.
- Utilized a skin monitoring label to improve staff awareness of the need for rapid skin inspection and enhanced communication.
- Discussed skin observations at each unit meeting to improve the level of staff communication.



Skin Check Program: A Step-By-Step Approach

A. Role of Non-Licensed Personnel

For each patient that the nursing assistant cares for during a shift, a visual observation of the patient's skin surfaces is performed during bathing time. The Skin Check label is removed from the bath package and completed, circling any areas of concern (e.g., pressure ulcers, skin tears, incontinence-associated dermatitis, etc.) on the human body diagram. Each label is handed to the nurse caring for that patient in a timely manner.

B. Role of the RN

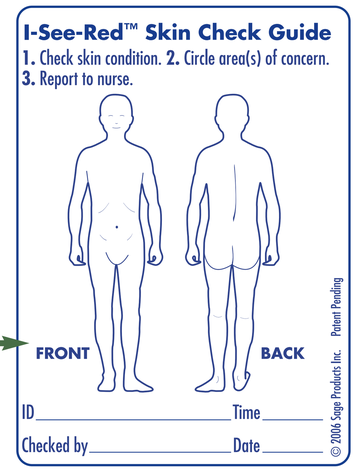
The nurse receives the Skin Check labels from each of the nursing assistants working with her patients and reviews the labels for skin integrity concerns. She also communicates directly with the nursing assistants and patients regarding any areas of concern. The label is not a permanent part of the patient record. Labels are returned to a Skin Check tin where they become eligible for a monthly drawing for a gift certificate or other small recognition incentive.

C. If a Skin Issue is Observed (see photo above)

i. The Skin Check labels are handed directly to the nurses caring for each patient.

ii. Communication occurs prn throughout the shift between nurses and nursing assistants, regarding Skin Check and many other patient concerns. The label serves as an excellent physical reminder to perform a skin inspection. Skin Check is also listed on the nursing assistant job checklist used by each nursing assistant on every shift.

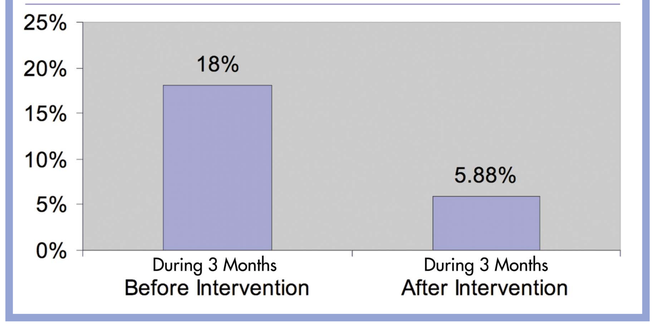
iii. Follow-up regarding a skin integrity issue with a patient becomes the responsibility of the nurse. She may apply a treatment, or involve the physician or wound nurse as appropriate. Treatment measures may be as simple as frequent turning of a patient, heel protectors or a chair pad, or increasing ambulation. Many of these measures continue to involve care provided by the nursing assistant as well as the nurse. Continued communication and collaboration is required by hospital staff to achieve the best possible patient outcome.



Results

- During the three months prior to the intervention, 18.00% of patients had pressure ulcers classified as stage I or greater. After three months of intervention with the Skin Check program, 5.88% of patients had pressure ulcers classified as stage I or greater.
- The estimated range of cost savings resulting from the decrease in pressure ulcers is $10,000 to $150,000 (Young ZE, Evans A, Davis J. JONA. 2003 Jul/Aug: 33: 380-3).
- Staff satisfaction surveys demonstrated increased satisfaction with skin cleansing products implemented during the intervention. This was due to ease of use and the unique program that improved communication and pressure ulcer rates during that time.

Figure 1: Percentage of Patients with Stage I or Greater Pressure Ulcers



Lessons Learned

- Pressure ulcers have been identified as having a statistically significant relationship to nursing care, i.e., the development of pressure ulcers is a nursing-sensitive patient outcome (Cho S, Ketefian S, Barkauskas V, Smith D. Nurs Res. 2003;52(2):71–79). However, the number of nurses available to provide patient care is declining, even as patient acuity increases. Empowering both non-licensed and licensed personnel to recognize and rapidly respond to skin issues helps achieve the patient safety goals set forth by JCAHO, as well as the guidelines for infection control established by the Centers for Disease Control and Prevention (CDC).
- Patient outcomes are enhanced with education of non-licensed and licensed nursing staff on risk factors associated with skin injury.
- There is a need for rapid and frequent inspection of skin integrity and bathing with a monitoring tool facilitates this activity.
- Skin monitoring tools can enhance communication between non-licensed and licensed nursing staff, and serve as a reminder to perform skin inspection during specified periods (eg, bathing time).
- Regular communication with staff concerning skin observations can lead to improved clinical and economic outcomes.
- Frequent auditing of skin injury observations and interventions can improve clinical and economic outcomes.
- Staff satisfaction levels are enhanced with the use of skin cleansing products and programs that improve skin integrity and are easy to use.

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