

Creation and Implementation of a Pressure Ulcer Prevention Bundle Has Improved Patient Outcomes

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Problem: Pressure ulcers increase patient length of stay, discomfort and nursing care hours. In 2004 and 2005, Stony Brook University Medical Center's (SBUMC), prevalence and incidence pressure ulcer rates were above the national average.

Evidence: A review of the literature provided evidenced based pressure ulcer prevention practices. This led to the development of a pressure ulcer prevention program based on the recommendations of the Wound Ostomy Continence Nurse's Society, Agency for Health Care Research and Quality, as well as experts such as Ayello and Braden.

Strategy: SBUMC developed a Pressure Ulcer Prevention Bundle that became the central focus and driving force of a pressure ulcer prevention program. The program consisted of education about prevention, improved staff communication regarding pressure ulcer rates and administrative support for compliance with the bundle elements.

Practice Change: SBUMC initiated monthly prevalence and incidence studies on all adult in-patient units as compared to previously done quarterly studies.

Evaluation: The results of the prevalence and incidence studies are trended and reviewed on a monthly basis. Units that are above the national average for prevalence or incidence are held accountable and required to complete daily pressure ulcer audits.

Results: Prevalence and incidence remains at or below the national benchmark in monthly studies and has improved patient outcomes as well as the quality of patient care.

Recommendations: Reduction of pressure ulcer rates requires education, the incorporation of evidenced based practice, improved communication, administrative support and ultimately, a culture change. Change can be slow and require constant reinforcement; however positive patient outcomes are well worth the challenge.

Bibliography:

1. Lyder C. Pressure Ulcer Prevention and Management. *The Journal of the American Medical Association*. 2003; 289(2): 223- 226.
2. Lyder C, Yu C, Stevenson D, et al. Validating the Braden Scale for the prediction of pressure ulcer risk in blacks and Latino/Hispanic elders: a pilot study. *Ostomy Wound Manage*. 1998;44(suppl3A):42S-49S.
3. Reddy M, Gill S, Rochon P. Preventing Pressure Ulcers: A Systemic Review. *The Journal of the American Medical Association*. 2006; 296(8): 974-984.
4. Whittington, K, Briones, R. National Prevalance and Incidence Study: 6-Year Sequential Acute Care Data. *Advances in Skin & Wound Care*. 2004; 17 (9):490 – 494.
5. Novation/KCI National Prevalance & Incidence Study Report. KCI USA, Inc. 2006.
6. The Agency for Health Care Research and Quality (AHRQ). The AHRQ National Guidelines Clearinghouse page. Available at: <http://guidelines.gov>
7. Ratliff CR, Bryant DE. Guideline for Prevention and Management of Pressure Ulcers. Glenview, IL: Wound, Ostomy, and Continence Nurses Society; 2003