



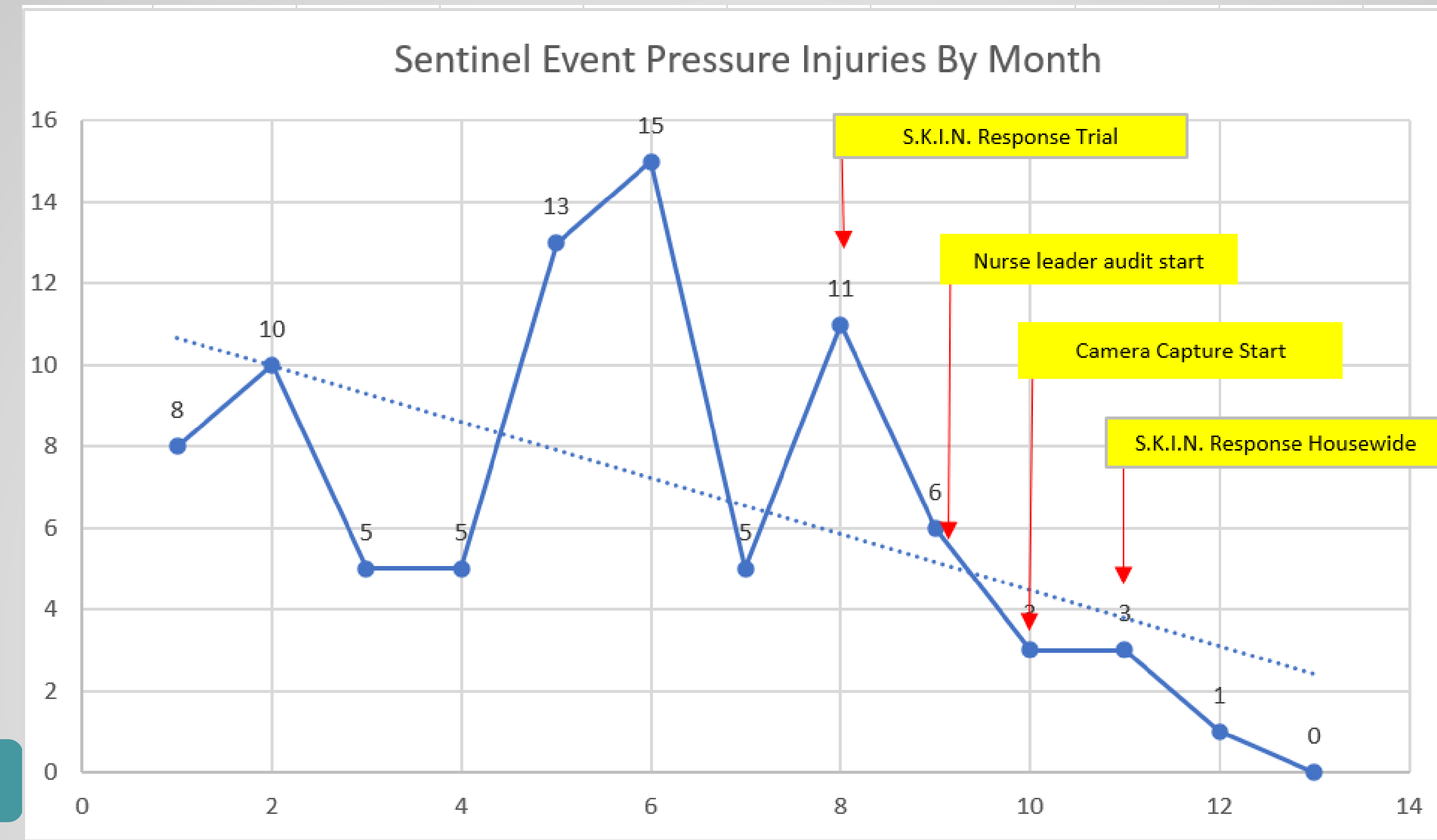
Background

- The National Quality Forum defines never events as, “any stage 3, stage 4, and unstageable pressure injury acquired after admission/presentation to a healthcare setting.”
- Hospital acquired pressure injuries (HAPIs)** are classified as ‘never events.’
- More than 2.5 million people develop pressure injuries in the United States every year and 60,000 die from complications
- HAPI rates in **the United States** have risen six percent
- Northern Light Eastern Maine Medical Center (NL EMMC) reported 100 sentinel event pressure injuries in fiscal year 2020.

Process

- Initiated by the frontline RN by dialing 0; Monday-Friday 0800-1630 for assistance with any concerns about skin, wound potential, treatment, or plan of care related to skin
- Within 20 minutes bedside nurse, Wound RN, provider, facilitator, nutrition, nurse leader, executive leader, CI will arrive at bedside.
- Assessment, interventions, treatment, and plan of care will be established at the time of the S.K.I.N. Response.
- The S.K.I.N Response (SR) may, or may not, result in a wound consult depending on individual patient need.
- Allows barriers to care to be identified and overcome in real-time to ensure optimum chance for success in skin care and pressure injury prevention
- SR facilitator will complete form and enter information into tracking software, ensure action items are assigned and completed.
- Nurse leader to continue daily follow up during nurse leader quality rounding to ensure plan of care is implemented as instructed and adjustments made as needed

Data & Timeline



S.K.I.N. Response—

A team will be with you at the bedside within 20 minutes to help you with a care plan for your patient.

S. Surface
K. Keep patients moving
I. Incontinence/moisture
N. Nutrition/Hydration

Help with skin abnormality— assistance with any concerns about skin or wound potential

Call S.K.I.N Response by dialing 0 and we will respond to you!

Hours: 8-4:30 M-F

Results

- Sentinel event pressure injury were reduced over 75% from FY 2020 to FY 2021
- Implementation of a S.K.I.N team served as the catalyst for an organization wide culture change around skin care management and pressure injury prevention
- Full support from executive leadership support, provider engagement, and the wound nurse team led to the positive results of the S.K.I.N program

Additional Considerations

- Critical care areas did not follow the same implementation timeline as medical-surgical units leading to some variation between units.
- Additional focus critical care units and device related pressure injuries requires tailored consideration

Conclusions

- Executive leadership commitment and support of the quality improvement effort was critical to its success
- Evaluation of commitment and readiness to change should occur before implementation of a S.K.I.N. Response team.
- AHRQ Pressure Injury Prevention toolkit served as the guide and resource used to drive the work from the initial phases through the control phase
- A combination of all quality improvement initiatives outlined in the graph above contributed to the success of this project.
- Implementation of a real-time, multidisciplinary, shared decision making, approach to identification, treatment, and care planning of existing skin alterations/at risk populations was a key component in the reduction of pressure injuries at NL EMMC.

References