Pressure ulcers in hospitalized patients represent a significant health care problem. Despite advances in modern technology and the array of preventative strategies available, the prevalence of pressure ulcers continues to rise. In addition to the impact on patients and families and the significant financial burden on the health care system, pressure ulcer rates are viewed by the public as an indicator of the quality of care provided.

Evidence-based guidelines for pressure ulcer prevention programs have been developed; however, their existence does not ensure quality care. While some of these programs have decreased prevalence, reduced care costs and demonstrated more effective use of resources, the development of hospital-acquired pressure ulcers has continued to rise despite increased expenditures on these prevention programs. Successful implementation of evidence-based practice needs administrative support and available resources but ultimately will only have positive outcomes if it is adopted into daily practice by the staff at the bedside.

Pressure Ulcer Prevention Protocol Intervention (PUPPI) is an evidence-based nursing initiative developed using the competencies for pressure ulcer prevention and treatment compiled by The National Pressure Ulcer Advisory Panel (NPUAP) Education Committee. These included risk assessment, skin assessment, individualized skin care programs, documentation, critical thinking and use of referrals as needed. Integration into practice in September 2004 focused on teamwork, communication and critical thinking to allow staff ownership and control for improving the quality of patient care and outcomes. Following implementation pressure ulcer prevalence was reduced by 10% and has been maintained well below national benchmark for more than a year.

References Cited:


