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# Turn Teams, How Do You Prevent Unit Acquired Pressure Ulcers?

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## Clinical Problem/Significance

There was a marked increase in unit acquired pressure injuries in 2014 and beginning of 2015. An action plan was formulated between 3 Tower Patient Outcomes Facilitators and Unit Shared Governance Council to develop scheduled turning teams to reduce unit acquired pressure injuries.

## Clinical Question

For hospitalized patients at risk for pressure injuries, will a dedicated turning team decrease the number of unit acquired pressure injuries?

## Evidence

The Agency for Healthcare Research and Quality (AHRQ) reported in 2008 that healthcare acquired pressure injuries doubled or tripled lengths of stay.

It is estimated that pressure injuries are associated with an excess mortality rate of 72 deaths per 1,000 and excess costs of \$17,000/case. (Agency for Healthcare Research and Quality [AHRQ], 2015)

Pressure injuries have broad physical, social, and psychological effects and significantly impact the quality of life in patients. (Gorecki et al., 2009)

Studies demonstrate that the implementation of a dedicated turning team decreases the incidence of pressure injuries. (Still et al., 2013)

## References

Available upon request.

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## Implementation

**Plan:** Develop a standardized method of turning patients at risk for pressure injuries every two hours.

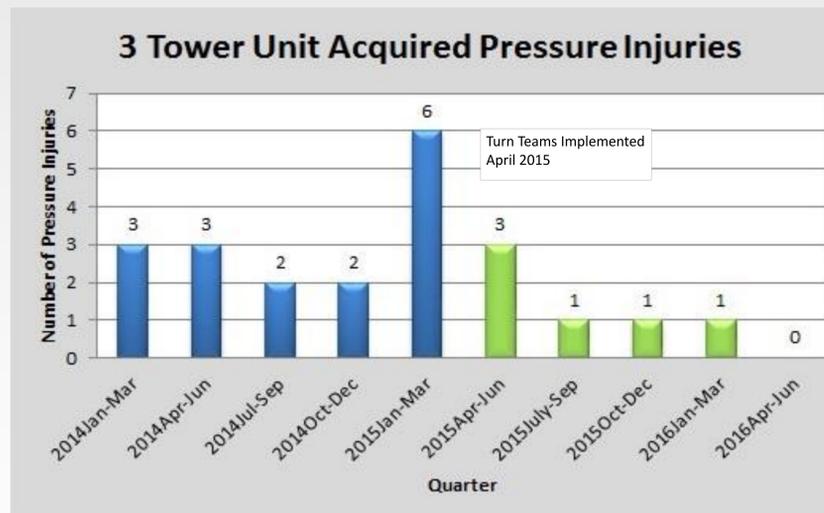
**Do:**

- Registered Nurses and Clinical Partners identify total care patients who are at risk for developing pressure injuries.
- Green Reposition Magnet is placed on the doorframe to identify those patients that need to be repositioned every two hours.
- Staff members are assigned, at the beginning of the shift, their scheduled times to turn patients.
- Unit Clerks send out reminders to reposition patients every two hours via ascom text message.
- Both team members reposition the identified total care patients and off load heels every two hours.
- Both team members circle the position the patient was turned on the rounding log and place both initials on the scheduled turn time.
- Staff education on process was completed via staff meetings, emails, and huddles.

**Check:** Daily audits completed to ensure compliance and correct process being followed.

**Act:** Turn Teams implemented as a standard of care for patients at risk for pressure injuries in 3 Tower.

## Findings



- **Average of 2-6 unit acquired pressure injuries per quarter prior to implementation.**
- **Marked decrease in unit acquired pressure injuries after implementation of Turn Teams in April 2015.**

## Sustainability

The Turn Teams have now been integrated as part of the standard nursing interventions for pressure injury prevention on 3 Tower.

The implementation of the Turn Teams on 3 Tower did not incur any incremental costs.

3 Tower has been the leader in implementing this pressure injury prevention initiative in Baptist Hospital. Multiple units within the hospital have implemented the turning teams and have had positive results.

## Implications for Practice

The implementation of the Turn Teams in 3 Tower markedly decreased the incidence of unit acquired pressure injuries. Going from an average of 2-6 unit acquired pressure injuries per quarter to 1 unit acquired pressure injury per quarter. We can conclude that this has had a positive effect in length of stay and financial implications associated with pressure injuries.

This is a simple budget neutral practice that can result in a decrease of unit acquired pressure injuries for hospitalized patients at risk for pressure injury development.

## Acknowledgments

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