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Development And Implementation Of A Simple Wound Care Guideline For Minor Skin Lesions: A Quality Improvement Project

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DEVELOPMENT AND IMPLEMENTATION OF A SIMPLE WOUND CARE GUIDELINE FOR MINOR SKIN LESIONS: A QUALITY IMPROVEMENT PROJECT

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Title

Development and Implementation of a Simple Wound Care Guideline for Minor Skin Lesions: A Quality Improvement Project

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Structured Abstract

Purpose: The purpose of this QI project was to use the best available evidence and expert opinion to develop and implement a simple inpatient nursing care guideline for minor skin lesions.
Participants and Setting: This wound care guideline was developed for nurses working on inpatient adult acute care units. The setting was a large community hospital in southwest Minnesota.
Approach: The guideline was validated for its clarity and appropriateness by external and internal expert wound care nurses. It was implemented through in-person unit rounding on the nursing units, distribution of badge cards with the guideline, and a required online education module about the guideline. Surveys and audits were conducted to measure changes in knowledge and skin care pre- and post-guideline implementation.
Outcomes: Wound documentation audits assessing whether patients had an appropriate treatment improved from 45% (104 out of 231) to 80% (209 out of 260). Nurses' self-rating of their knowledge about which dressings and topical treatment to use improved from 18% (16 out of 89) agreement to 57% (55 out of 96). Nurses' self-rating of their knowledge about when to change dressings and reapply topical treatments improved from 27% (24 out of 89) agreement to 65% (62 out of 96).
Implications for Practice: Although there is evidence for a variety of dressings or products to treat wounds, this QI project demonstrated increased compliance with providing appropriate care when just a few treatment options were recommended to nursing staff through a structured guideline. This guideline continues to be used at the project site and is now being implemented at affiliate hospitals.

Introduction

There is no formal guideline that delineates the types of wounds or risk factors that can be managed by the inpatient staff nurse and those wounds or conditions that require the expertise of a certified wound care nurse.[1] This can lead to mismanagement of patients' wounds. Consults

may be ordered for patients with minor skin lesions that the inpatient staff nurses could manage using a wound care guideline or protocol. There may also be missed opportunities for referrals to the wound care nurse for treatment of complex wounds.

Developing a consultation process that allows wound care nurses to focus on more complex wounds is important because it can lead to better patient care and reduce wasted time and expenses. An initial assessment and development of a plan of care by the wound care nurse takes approximately 60 minutes.[2] Consults for wounds that do not require expert workup translate into wasted time and money. An efficient consultation process, which includes a guideline for the care of minor skin lesions, also promotes fewer delays in patient care. Once the wound care consult is placed, the inpatient staff nurse has a false sense of assurance that what is best for the patient has been done. The staff nurses may or may not treat the wound while awaiting a plan of care from the wound care nurse. At some facilities, there is no evening or weekend coverage for the wound care service, and this can mean delays in treatment for several hours to a few days. This delay could be addressed by training staff nurses on how to effectively treat minor skin lesions and how to manage complex wound until the wound care nurse can develop a formal plan of care.

A scoping search of the literature reveals a plethora of case studies about inpatient nurses using care bundles or protocols to prevent pressure injuries.[3-7] These studies typically consist of the nurse completing a risk assessment, such as the Braden Scale, to identify patients at risk for developing pressure injuries and then implementing needs-specific preventative measures for these patients. These bundles and protocols were largely successful at reducing hospital-acquired pressure injuries. Accordingly, it may be reasonable to consider using an evidence-based guideline or protocol to direct nurses' management of minor skin lesions. Furthermore, one randomized-controlled trial directly supports the use of a protocol to direct care for Stage 1 pressure injuries.[8] The purpose of this study was to determine if using the appearance of non-blanching erythema (i.e. a Stage 1 pressure injury) as the indication to implement pressure injury prevention would lead to increased incidence of Stage 2, 3, and 4 pressure injuries when compared to the Braden Scale risk assessment. The results showed no real difference ($p > 0.99$) between the control group (6.7%) and the experimental group (6.8%). An implication for practice is that just as the inpatient nurse is generally considered qualified to complete the Braden Scale risk assessment on patients and initiate a pressure injury prevention protocol, the bedside nurse should also be able to care for minor skin lesions, such as Stage 1 pressure injuries, with the direction of a protocol or guideline. A certified wound care nurse does not need to get involved unless the wound deteriorates.

Finally, the implementation of a wound care guideline for minor skin lesions can ensure that best practice is being used. When researchers used the Pieper Pressure Ulcer Knowledge Tool, a validated exam, to assess the knowledge of certified wound care nurses, staff nurses, and physicians, the wound care nurses performed the best, while the physicians performed the worst.[9-11] The implication of these findings is that the wound care nurse is the expert on pressure injury prevention and care, and an evidence-based wound care guideline developed by this specialist and implemented by staff nurses may be more reliable than wound care orders placed by physicians. Furthermore, while these studies also suggest that additional education is needed for staff nurses, knowledge does not always translate into practice. A study was carried out to determine if relationships exist between the nurses' knowledge about pressure injuries and the preventive care they provided, and researchers noted a large discrepancy between what nurses knew and what interventions they implemented.[12] A wound care guideline would reduce the

amount of decision-making (and potential for errors) involved in wound management and could lead to more consistent care.

The purpose of this quality improvement project was to use the best available evidence and expert opinion to develop and implement an inpatient nursing care guideline for minor skin lesions.

Approach: Development of the Guideline

The *Inpatient Nursing Care Guideline for Minor Skin Lesions* (Figure 1) for this project was developed to simplify and standardize nursing care for skin tears, incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), Stage 1 pressure injuries, and Stage 2 pressure injuries. It was believed that the care of these wounds was inconsistent because the hospital's current clinical practice guidelines offered too many options. For instance, the guideline for skin tears listed 14 different dressings that could be used. The *Inpatient Nursing Care Guideline for Minor Skin Lesions* was drafted to align with the hospital's policies and procedures but also to limit treatments to just one or two options per type of wound. This new guideline also made it clear how often to change dressings or reapply topical treatments.

To decide which dressings or treatment would be included, the recommendations of national wound advisory panels were reviewed. The authors also considered what wound care products were readily available throughout the hospital. Brand names were used for this guideline, because they were more recognizable for the nursing staff.

Before being implemented, the guideline was validated by external and internal expert panels for clarity and appropriateness. An analysis in the literature sets the standard of 78% (0.78) affirmative responses for individual items for them to be considered relevant.[13] This ensures a level of agreement that is greater than chance. Items with greater than 78% agreement were considered validated by the expert panel, while those with less than 78% agreement were revised until the 78% standard was achieved.

External experts, or those not affiliated with the organization where this project took place, were selected based on recognition by their peers or publications as wound care experts. Experts were affiliated with the following organizations: Emory Healthcare, Cleveland Clinic, Rutgers School of Nursing, Yale New Haven Hospital, UConn Health, and UF Health Jacksonville. All external experts were nurses or nurse practitioners certified in wound care by the Wound, Ostomy and Continence Nursing Certification Board. Ultimately, six external experts responded to the invitation to be part of the panel. The results of the external expert panel can be seen in Figure 2.

Internal experts, or those affiliated with the project site, were selected based on recognition by their peers as wound care experts and were currently employed as wound care nurses or nurse practitioners. Five internal experts agreed to be part of the panel. The final results of the internal expert panel can be seen in Figure 3.

Approach: Implementation of the Guideline

Participants and Project Setting

The *Inpatient Nursing Care Guideline for Minor Skin Lesions* was developed for nurses working on the adult inpatient units, including the critical care unit, progressive care unit, and any of the medical-surgical units. The obstetrics and behavioral health units were not included in

this project. The setting for implementation of this QI project was a community hospital with 166 licensed beds in southwest Minnesota. This hospital in an affiliate of a larger, nationally-ranked academic hospital, and it shares that institution's policies, clinical practice guidelines, and electronic medical record.

Ethical Acknowledgment

This project did not require Institutional Review Board (IRB) approval as it qualified as a QI project, as opposed to human subjects research. The *Inpatient Nursing Care Guideline for Minor Skin Lesions* for this project was based on the organization's current clinical practice guidelines and was reviewed by a panel of wound care experts. Prior to implementation, the project was also given approval from the hospital's Department of Nursing and inpatient wound care nurses.

Quality Improvement Model

Lean Six Sigma methodology was used for this project. This methodology focuses on eliminating waste, defined as "anything other than the minimum amount of equipment, materials, parts, space, and workers' time, which are absolutely essential to add value to the product."[14] At the hospital where this QI project took place, it was identified that the current wound care clinical practice guidelines were possibly overly comprehensive and could be a source of waste. For instance, the practice guidelines included 14 different dressings for managing skin tears, some of which were not even available at the clinical site.

DMAIC (define, measure, analyze, improve, control), the framework for implementation of the *Inpatient Nursing Care Guideline for Minor Skin Lesions*, was also derived from Lean Six Sigma. *Define* refers to identifying the gap in the quality of a process. *Measure* includes using data to describe how the process is performing. *Analyze* involves identifying important factors causing the gap in quality. *Improve* refers to eliminating the causes of the quality gap. Lastly, *control* includes a description of the lessons learned from the project and a plan to sustain any gains.

Intervention

The intervention for this QI project was implementation of the expert-panel validated *Inpatient Nursing Care Guideline for Minor Skin Lesions*. The guideline was disseminated to nursing staff in several ways. It was emailed out to the nurses so that they could readily find a copy of the guideline. It was assigned as part of a required online education module, and all nurses completed the module within three months of it being assigned. The education module discussed both the clinical practice of caring for minor skin lesions and documentation requirements. Finally, it was distributed as a badge card along with in-person rounding to discuss the guideline and to address any questions or concerns about it. Sixty percent (157 out of 260) of the nursing staff were rounded on and received a badge card. During the last week of the implementation phase, an email was sent out to all of the nurses sharing those frequently asked questions (and their answers) from the in-person rounding.

Implementation Time

Implementation of the guideline took place over a three-month period. Pre-implementation data was collected for one month before roll-out of the guideline, and comparative outcomes data was collected for one month after the implementation phase. Data

will continue to be collected every three months as part of a plan to ensure ongoing success with this intervention.

Outcome Measurements

For this project, only quantitative data was collected. Prior to implementation of the guideline, a survey was emailed to inpatient nurses. The survey included five knowledge questions about content covered in our clinical practice guidelines and two Likert-type scale questions asking the nurses to self-evaluate their knowledge. Thirty-four percent (89 out of 260) nurses completed the survey. The results of the two self-evaluation questions can be seen in Figure 4.

Pre-implementation wound documentation audits were also performed to see if the nurses were providing appropriate care for patients with minor skin lesions. The audit tool can be seen in Figure 5. On 12 different days in the month prior to implementation, the auditor looked at the wound documentation for every patient on the inpatient units included in this QI project. If a documented wound was one of the five types included in the *Inpatient Nursing Care Guideline for Minor Skin Lesions*, that wound was included in the audit. If any nurse documented the same treatment recommended by the guideline within the past 24 hours prior to the audit, credit was given for the patient having the appropriate treatment. Credit was also given if the patient had a treatment documented that was recommended by the hospital's clinical practice guidelines or that was prescribed by a provider. For instance, if a patient had intertriginous dermatitis, and the nurse documented using InterDry®, credit was given. If, instead, the provider ordered nystatin powder and the nurse documented administering it, then credit was given. If no treatment was documented at all for 24 hours, then no credit was given.

After the guideline was rolled out, the same pre-implementation survey was emailed out to inpatient nursing staff. Thirty-seven percent (96 out of 260) of nurses completed the survey. The results of the two self-evaluation questions can be seen in Figure 6. Additionally, wound documentation audits were performed again for 12 different days during the month after implementation of the guideline.

Outcomes Analysis

Frequencies and percentages were calculated by the lead author to describe the changes in knowledge scores and treatment of minor skin lesions before education and implementation of the simple wound care guideline and post-guideline implementation.

Outcomes

Comparing the pre-implementation survey results with the post-implementation survey results showed some improvement in nurses' knowledge about the organization's clinical practice guidelines. For instance, from the pre-implementation survey, only 55% (49 out of 89) of nurses correctly identified that an indwelling Foley catheter is not recommended for management of incontinence-associated dermatitis. After roll-out, 77% (74 out of 96) of nurses answered this question correctly.

More significantly, the nurses' self-rating of their knowledge increased. From the pre-implementation survey, 18% (16 out of 89) of nurses said they "strongly agree" or "agree" that they know which dressings and topical treatments are best for minor skin lesions. For the post-

implementation survey, 57% (55 out of 96) said they "strongly agree" or "agree." Similarly, from the pre-implementation survey, 27% (24 out of 89) nurses said they "strongly agree" or "agree" that they know how often to change dressings or reapply topical treatments for minor skin lesions. For the post-implementation survey, 65% (62 out of 96) said they "strongly agree" or "agree."

The wound documentation audits also showed a significant improvement. From the pre-implementation audit, 45% (104 out of 231) of wounds had an appropriate treatment. Post-implementation, 80% (209 out of 260) had an appropriate treatment.

Discussion

Strengths and Limitations

To our knowledge, this is the first QI project to simplify and standardize the treatment options for minor skin lesions to improve compliance with providing appropriate care.

A limitation of this QI project is that the knowledge questions used in the electronic surveys were not validated. During in-person rounding, as nurses asked questions, it became clear that the knowledge questions may have been too difficult, especially with the select-all-that-apply option. However, the questions could not be changed for the post-implementation survey, so that results could be compared with the pre-implementation survey.

Another limitation is that some of the improvements noted from the wound documentation audits may have been related to better documentation and not necessarily better patient care. For instance, the electronic medical record has no dropdown option to document InterDry®, or moisture-wicking fabric. The required online education module reminded nurses to select "Other" and type "InterDry" in the comment box. It is possible that in the pre-implementation timeframe nurses were using moisture-wicking fabric without documenting its use.

Clinical Implications

The pre-implementation survey results revealed that nurses self-identified a gap in their knowledge about how to care for minor skin lesions. Since some clinical sites expect nurses to care for these wounds without a consult to a certified wound care nurse, ideally most nurses should "strongly agree" or "agree" that they know how to care for these wounds. For the hospital where this QI project took place, this was not the case until after implementation of the *Inpatient Nursing Care Guideline for Minor Skin Lesions*. This suggests that the guideline helped increase nurses' knowledge and confidence in their ability to care for these wounds.

Furthermore, the improvement in wound documentation suggests that this guideline supported translating this increased knowledge into better clinical practice. This success can be attributed to both the simplicity of the guideline and to having it be easily-accessible as a badge card for the nurses.

Finally, the low scores on the pre-implementation survey and wound documentation audit seemed to suggest that inpatient staff nurses were inadequately prepared to care for minor skin lesions. However, not all facilities, especially rural hospitals, have regular access to a certified wound care nurse to initiate a plan of care for these wounds. The improvements noted from this QI project suggest that the *Inpatient Nursing Care Guideline for Minor Skin Lesions* may be a cost-effective, easily-accessible alternative.

Lessons Learned

A key lesson learned from this QI project is that while expert clinicians will generally base their practice off of the evidence, they may also use their own experiences to form their opinions. This presented some challenges in trying to get the guideline validated.

Another lesson was that knowledge questions really need to be validated to be meaningful. Single-answer questions are also preferred to select-all-that-apply questions, as participants still seemed to select one answer, suggesting that they may not have read the question carefully.

Conclusions

Although there are many evidence-based dressings and products available to treat wounds, this project demonstrated increased compliance with providing appropriate care when just a few treatment options were recommended to nursing staff through a structured, evidence-based guideline. Quantitative data from this QI project also suggested that the *Inpatient Nursing Care Guideline for Minor Skin Lesions* improved nurses' knowledge and confidence in their ability to care for these wounds. This guideline continues to be used at the project site and is now being implemented at affiliate hospitals.

Key Points

- Implementing a guideline for bedside nurses to manage minor skin lesions can potentially reduce consults for these wounds, allowing certified wound care nurses to focus on complex wounds and to get involved in other aspects of their role.
- Comprehensive clinical practice guidelines for wound care may offer too many alternatives for bedside nurses, leading to variable clinical practice.
- There may be increased compliance with providing appropriate wound care when just a few treatment options are recommended through a structured, evidence-based guideline.

References

1. Wound Ostomy and Continence Nurses Society. *Professional Practice Manual*. 4th edition. Mount Laurel, NJ: WOCN Society; 2013.

2. Saunders, K. View from here: building and justifying a comprehensive WOC nurse team. *J Wound Ostomy and Continence Nurs*. 2016;43(4):341-345.

3. Hiser, B, Rochette, J, Philbin, S, Lowerhouse, N, Terburgh, C, Pietsch, C. Implementing a pressure ulcer prevention program and enhancing the role of the CWOCN: impact on outcomes. *Ostomy Wound Manage*. 2006;52(2):48-59.

4. Capasso, V, Collins, J, Griffith, C, et al. Outcomes of a clinical nurse specialist-initiated wound care education program: using the promoting action on research implementation in health services framework. *Clin Nurse Spec*. 2009;23(5):252-257.

5. Ahroni, JH. Developing a wound and skin care program. *J Wound Ostomy and Continence Nurs*. 2014;41(6):549-555.

6. Beinlich, N, Meehan, A. Resource nurse program: a nurse-initiated, evidence-based program to eliminate hospital-acquired pressure ulcers. *J Wound Ostomy and Continence Nurs*. 2014;41(2):136-141.

7. Anderson M, Finch Guthrie P, Kraft W, Reicks, P, Skay C, Beal AL. Universal pressure ulcer prevention bundle with WOC nurse support. *J Wound Ostomy and Continence Nurs*. 2015;42(3):217-225.

8. Vanderwee, KV, Grypdonck, M, Defloor, T. Non-blanchable erythema as an indicator for the need for pressure ulcer prevention: a randomized-controlled trial. *J Clin Nurs*. 2007;16(2):325-335.

9. Zulkowski, K, Ayello, EA, Wexler S. Certification and education: do they affect pressure ulcer knowledge in nursing? *J Nurs Adm.* 2010;40(10 Supp):S28-S32.

10. Levine JM, Ayello EA, Zulkowski KM, Fogel J. Pressure ulcer knowledge in medical residents: an opportunity for improvement. *Adv Skin Wound Care*. 2012;25(3):115-117.

11. Cox J, Roche S, Gandhi N. Critical care physicians: attitudes, beliefs, and knowledge about pressure ulcers. *Adv Skin Wound Care*. 2013;26(4):168-176.

12. Gallant, C, Morin, D, St-Germain, D, Dallaire, D. Prevention and treatment of pressure in a university hospital centre: a correlational study examining nurses' knowledge and best practice. *Int J Nurs Pract*. 2010;16(2):183-187.

13. Polit, DF, Beck, CT, Owen, SV. Is the CVI an acceptable indicator of content validity? Appraisal and recommendation. *Res Nurs Health*. 2007;30(4):459-467.

14. Ruttimann, BG. *Lean Compendium: Introduction to Modern Manufacturing Theory*. Cham, Switzerland: Springer International Publishing AG; 2018.

Figure 1

Inpatient Nursing Care for Minor Skin Lesions	
Wound Type	**Topical Treatment**
Skin Tear	• Mepilex® Border (foam) dressing Q 3 days
Incontinence-Associated Dermatitis (IAD)	• Z-Guard® Paste 2x daily & with each incontinence episode • If candidiasis ("satellite" lesions) present, also request topical antifungal Rx from provider & apply to skin under Z-Guard
Intertriginous Dermatitis (ITD)	• Cleanse skin folds daily with Remedy® No-Rinse Foam • Place InterDry® Ag moisture-wicking fabric between skin folds o Allow 2" of fabric to be exposed to air o Change Q 5 days or if soiled • If candidiasis ("satellite" lesions) present, request topical antifungal Rx from provider for areas *not* being treated by InterDry® Ag (e.g. axillary area)
Stage 1 Pressure Injury	• Mepilex® Border (foam) dressing Q 3 days • Alternatively, with urinary or fecal incontinence, use Z-Guard® Paste 2x daily & with each incontinence episode
Stage 2 Pressure Injury	• Mepilex® Border (foam) dressing Q 3 days • Alternatively, with urinary or fecal incontinence, use Z-Guard® Paste 2x daily & with each incontinence episode

Figure 2

Wound Type and Treatment Order	Ratings				Suggestions
	Clarity: Is this order clear and easy to understand?		*Appropriateness*: Is this an appropriate treatment for this type of wound?		
	Clear	Unclear	Appropriate	Inappropriate	
Skin Tear • Mepilex® Border (foam) dressing Q 3 days	6/6	0/6	5/6	1/6	
Incontinence-Associated Dermatitis (IAD) • Z-Guard® Paste 2x daily & with each incontinence episode • If candidiasis ("satellite" lesions) present, also request topical antifungal Rx from provider	5/6	1/6	5/6	1/6	

Intertriginous Dermatitis (ITD)
• Cleanse skin folds daily with Remedy® No-Rinse Foam
• Place InterDry® Ag moisture-wicking fabric between skin folds
  ○ Allow 2" of fabric to be exposed to air
  ○ Change Q 5 days or if soiled
• If candidiasis ("satellite" lesions) present, request topical antifungal Rx from provider for areas *not* being treated by InterDry® Ag (e.g. underarms)
	6/6	0/6	6/6	0/6	

Stage 1 Pressure Injury • Mepilex® Border (foam) dressing Q 3 days • Alternatively, with urinary or fecal incontinence, use Z-Guard® Paste 2x daily & with each incontinence episode	5/6	1/6	6/6	0/6	
Stage 2 Pressure Injury • Mepilex® Border (foam) dressing Q 3 days • Alternatively, with urinary or fecal incontinence, use Z-Guard® Paste 2x daily & with each incontinence episode	5/6	1/6	6/6	0/6	

Figure 3

Wound Type and Treatment Order	Ratings				Suggestions
	Clarity: Is this order clear and easy to understand?		*Appropriateness*: Is this an appropriate treatment for this type of wound?		
	Clear	Unclear	Appropriate	Inappropriate	
Skin Tear • Mepilex® Border (foam) dressing Q 3 days	5/5	0/5	4/5	1/5	
Incontinence-Associated Dermatitis (IAD) • Z-Guard® Paste 2x daily & with each incontinence episode • If candidiasis ("satellite" lesions) present, also request topical antifungal Rx from provider	4/5	1/5	4/5	1/5	

Intertriginous Dermatitis (ITD)
• Cleanse skin folds daily with Remedy® No-Rinse Foam
• Place InterDry® Ag moisture-wicking fabric between skin folds
  ○ Allow 2" of fabric to be exposed to air
  ○ Change Q 5 days or if soiled
• If candidiasis ("satellite" lesions) present, request topical antifungal Rx from provider for areas *not* being treated by InterDry® Ag (e.g. underarms)
	5/5	0/5	5/5	0/5	

Stage 1 Pressure Injury • Mepilex® Border (foam) dressing Q 3 days • Alternatively, with urinary or fecal incontinence, use Z-Guard® Paste 2x daily & with each incontinence episode	5/5	0/5	5/5	0/5	
Stage 2 Pressure Injury • Mepilex® Border (foam) dressing Q 3 days • Alternatively, with urinary or fecal incontinence, use Z-Guard® Paste 2x daily & with each incontinence episode	4/5	1/5	4/5	1/5	

Figure 4

Use the scale below to explain how much you agree or disagree with the following statement: I know which dressings and topical treatments are best for minor skin lesions, including skin tears, intertriginous dermatitis, incontinence-associated dermatitis, Stage 1 pressure injuries, and Stage 2 pressure injuries.

a.	Strongly agree	0 (0%)
b.	Agree	16 (16%)
c.	Somewhat agree	55 (55%)
d.	Neither agree nor disagree	5 (6%)
e.	Somewhat disagree	10 (11%)
f.	Disagree	2 (2%)
g.	Strongly disagree	1 (1%)

Use the scale below to explain how much you agree or disagree with the following statement: I know how often to change dressings or reapply topical treatments for minor skin lesions, including skin tears, intertriginous dermatitis, incontinence-associated dermatitis, Stage 1 pressure injuries, and Stage 2 pressure injuries.

a.	Strongly agree	3 (3%)
b.	Agree	21 (21%)
c.	Somewhat agree	44 (44%)
d.	Neither agree nor disagree	6 (6%)
e.	Somewhat disagree	11 (12%)
f.	Disagree	3 (3%)
g.	Strongly disagree	1 (1%)

Figure 5

Patient Initials/Age/Sex	Wound Type	Topical Treatment and/or Dressing	Is this the same as the treatment recommended by the guideline?	Is this an appropriate dressing per Lippincott or wound care orders?

Figure 6

Use the scale below to explain how much you agree or disagree with the following statement: I know which dressings and topical treatments are best for minor skin lesions, including skin tears, intertriginous dermatitis, incontinence-associated dermatitis, Stage 1 pressure injuries, and Stage 2 pressure injuries?

a.	Strongly agree	7 (7%)
b.	Agree	48 (50%)
c.	Somewhat agree	34 (35%)
d.	Neither agree nor disagree	3 (3%)
e.	Somewhat disagree	2 (2%)
f.	Disagree	2 (2%)
g.	Strongly disagree	0 (0%)

Use the scale below to explain how much you agree or disagree with the following statement: I know how often to change dressings or reapply topical treatments for minor skin lesions, including skin tears, intertriginous dermatitis, incontinence-associated dermatitis, Stage 1 pressure injuries, and Stage 2 pressure injuries?

a.	Strongly agree	9 (9%)
b.	Agree	53 (55%)
c.	Somewhat agree	28 (29%)
d.	Neither agree nor disagree	3 (3%)
e.	Somewhat disagree	2 (2%)
f.	Disagree	1 (1%)
g.	Strongly disagree	0 (0%)