

Zeroing the prevalence of Hospital Acquired Pressure Injury in a Women's Hospital

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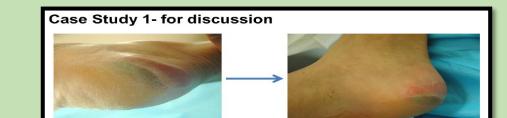
Background

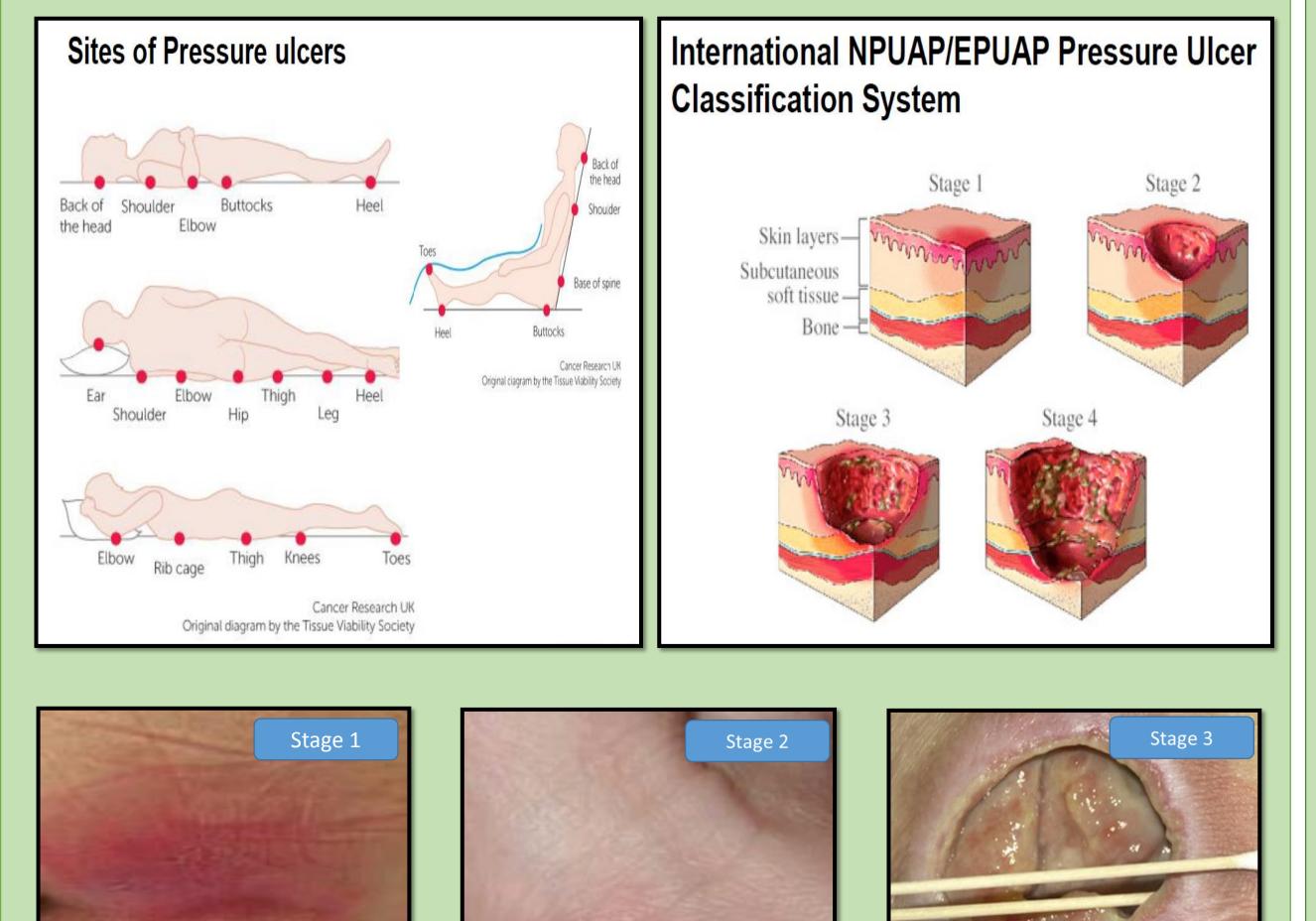
Most of the Hospital Acquired Pressure Injury (HAPI) is preventable however, some healthcare professionals are not aware that unrelieved pressure over a certain time frame can affect the integrity of the skin causing it to break. There has been an increased in observation of patients with Hospital Acquired Pressure Injury incidences arising from the time patients were in Operating Theatre to the inpatient wards. Currently there is no standard workflow on applying prophylactic pressure preventive dressing for these patients who are highly susceptible to develop pressure injury from prolong hours of surgery.

Aim(s)

To create acute awareness among nurses in a) identifying patients who may have a certain degree of immobility b) proactively target best prevention efforts to minimize risk of pressure injuries

Interventions





Phase 1

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Abdominal area
All of the above

The team brainstorms on all the activities that occur within the scope of the inpatient stay process through case discussion

Survey In-service Pressure Injuries KK Women's and Children's Hospit Knowledge Questionnaire for Nurses a. Immobility b. Inability to perceive pain c. Friction and shearing force d. All of the above Circle the BEST answe a. Gel and heated gel pao b. Pillows) Which statement(s) are true about pressure injur They are areas of localized skin and tissue damage They tend to occur at bony sites c. Foam and gel mattress d. All of the above They are caused by prolonged pressure, frictions, shearing and moisture. The patient's nutrition status affects the development of a pressure ulce. All of the above) The most susceptible sites to pressure ulcer developm Pressure injuries were reported as a cause of death True / False Factors that aggravated pressure injuries a a. Pressure and friction

e. Pressure and motified b. Pressure and motified c. Pressure, shearing and friction d. Friction, motisture, shearing e. Pressure, frictions, shearing and motisture 4) Pressure injuries risk assessment and a systematic skin inspection should be conducted for all pati Prior to admis b. Within 1 hour of admission

c. At 24 hours interval d. Every 72 hours e. Sensory impairment (such as stroke or dementia) 5) For high risk area, reassessment of pressure injury is to be performe

a. Once a day b. Every shift . Following a change in the patient's clinical condition e. All of the above

6) The Braden Scale provides a method for assessing pressure injuries risk by evaluating a. Past & current history of co-morbid conditions, sensory, activity, nutrition and fricti b. Sensory, moisture, activity, medications, nutrition and friction c. Sensory, moisture, activity, mobility, nutrition and friction nsory, moisture, psycho-social issues, mobility, nutrition and fr

7) Which of the following steps should NOT be taken to prevent pressure injury from develop a. Repositioning patients every two hours Repositioning patients every two hours
90 degree side lying position or semi recumbent positio
Limited sitting time to 2 hours per session
Assess natient's untritional status

ssage over body prominences ning patients at least every two hours while in bed

9) What are the primary risk factors for pressure ulcer development in the intraoperative pa 10) What are the Pressure reducing surfaces and positioning devices available in Operating Theatre

Please circle "True" if you think the statement is true and "False" if you think the statement is false

Donut devices or ring cushions help to prevent pressure ulcer

B) Obese patients are rarely malnourished and therefore at lower risk of developing pressure ulcer ue / False

4) A sign of that identifies the beginning of an ulcer can be an appearance of a deep open woun

Friction or shear may occur when sliding a person up in bed inte / False

6) Another way to assess patient's pressure injury risk is to use knowledge derived from your experience with othe

Erythema or redness on any patient that is non blanchable is not pressure injuries invol 5 also

Bony prominences (areas) should not have direct contact with one another nucl False.

1. Australian Wound Management Association. (2014). Pan Pacific Clinical Practice Guideline for the Preventio and Management of Pressue Injury. WA: Cambridge Publishing. Duest Bulletin Issue 5- Be a Risk Manager! Manage your patient's risk of developing Pressure Ulcer effectively. Redelings, M. D., Lee, N. E., & Sorvillo, F. (2005). Pressure ulcers: more lethal than we thought?. Advances in skin & wound care, 18(7), 367-372.

ntact skin with visible deep

Phase 2

Intact blister with deep tissue



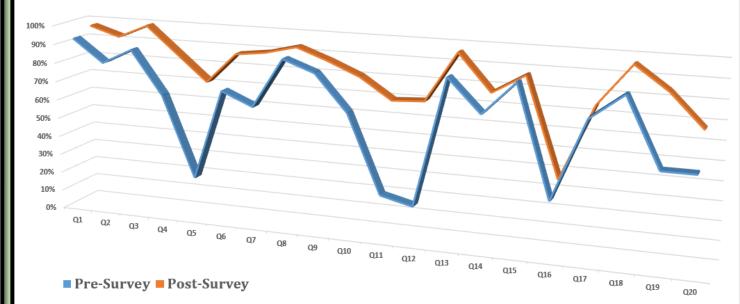
Blister by lancing.



Staff knowledge were assessed using pre and post survey questionnaires

noval of haemoserous fluid fro





Phase 3

Identify gaps between current and recommended practices and proposed a solution

Proposed Solution

Increased observation of patients with Acquired Pressure Injury incidences

Phase 4 **Staff Education**



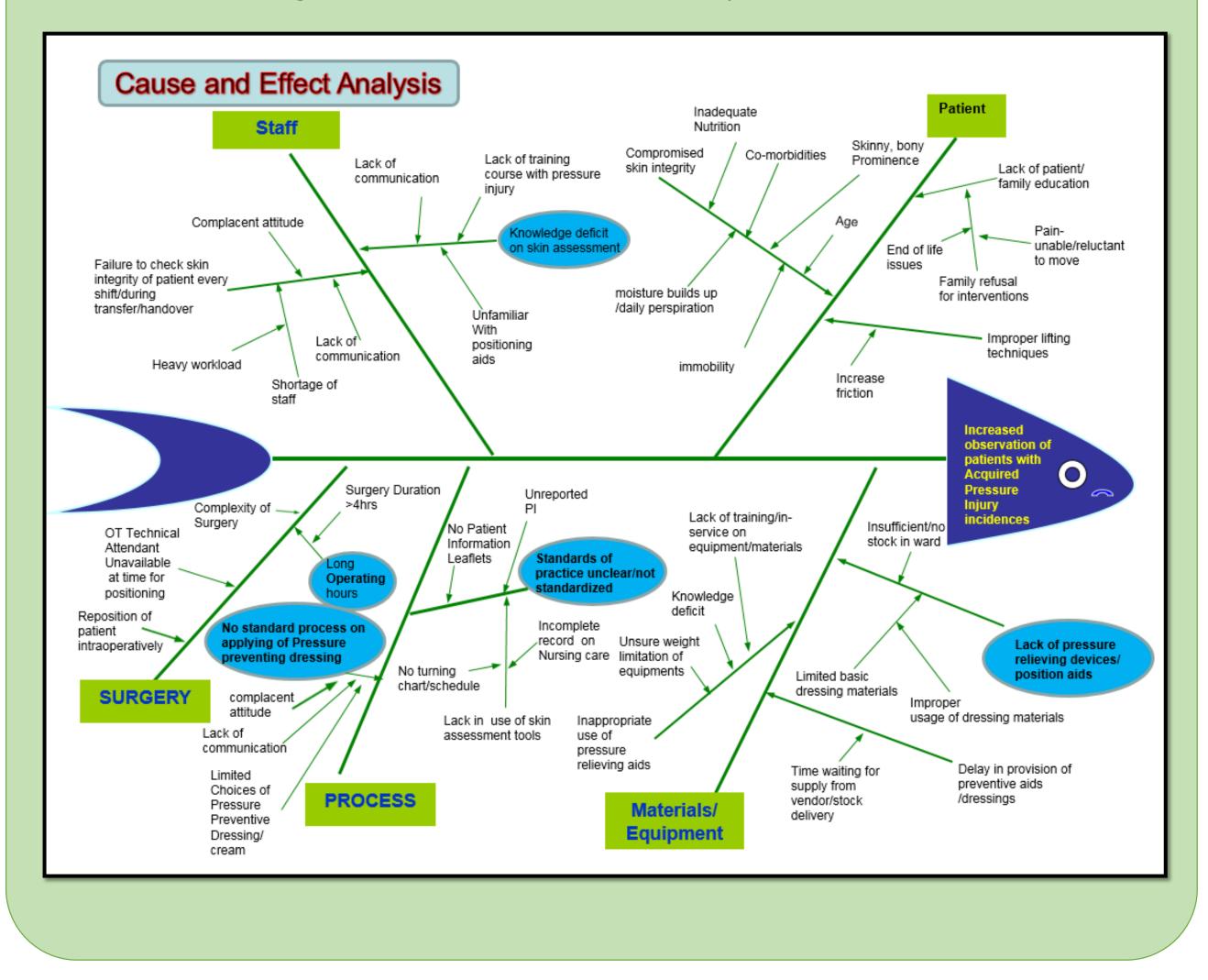






Methodology

This project was conducted using the process Improvement Project (PIP) methodology. A team was formed with representation from different departments like Plastic, Reconstructive and Aesthetic Surgery, Operating Theatre (OT), Inpatient Wards, Women Intensive Care Unit and Resources Nurses. The team were able to identify 7 main root causes using the Cause and Effect Analysis.



5 main root causes were identified

Focus group deliberates and decides to work to tackle on standard of practice which will cover some of the other root causes identified below

 Knowledge Deficit on Skin Assessment Action - conduct staff and patient / caregiver education

 Standards of practice unclear/not standardized Action - focus group intend to work on getting the standard of practice across the towers collaborating with Focus Group Representatives/Wound Nurses/Operating Theatre Nurse Managers/National Quality Improvement Team

 Lack of appropriate pressure relieving devices and position aids Action - team will work with Material Management Department and wound nurses/ Operating Theatre Nurse Managers/National Quality Improvement Team of devices required

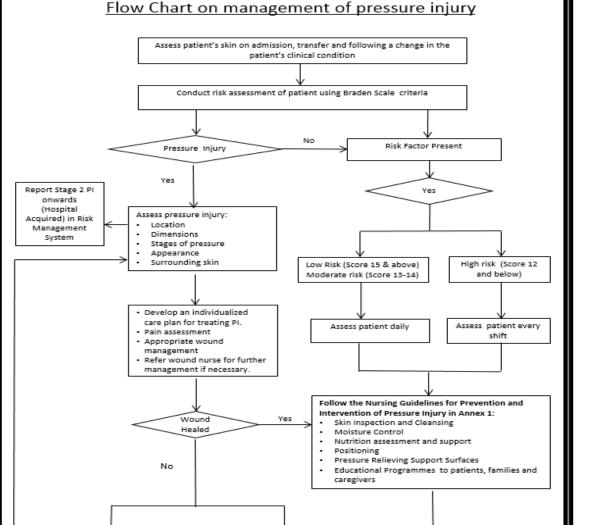
 No standard process on applying of Pressure preventing dressing materials Action - team will focus on course of action in applying preventive pressure relieving aids that appear unclear to nurses. Organize in-service talks, workshop and product demonstrations Action- collaborate with Material Management Department /Pharmacy/Wound Nurses

Long Operating hours

Action - team acknowledged time is beyond focus group's control however the processes on relieving and preventing Pressure Injury from occurring will be initiated from Operating Theatre

Phase 5

Initiatives were refined and implemented using Plan Do Study and Act (PDSA) cycle



Guidelines for Prevention and Intervention of Pressure Ulcer

. Skin Inspection and Cleansing

- Perform a systematic skin inspection at least once a day. Pay particular attention to bony prominences. Document skin status including absence of redness/intact skin in the Nursing Care Record.
- · Cleanse skin at time of soiling and at routine intervals, using lukewarm water and a
- mild cleansing agent. Avoid hot water and soaps that are drying to the skin. · Educate and encourage patients or caregivers on skin inspection.

Moisture Control

- · Minimise skin exposure to moisture due to perspiration, incontinence or wound
- Use underpads (e.g. Incontinence sheets) in cases where skin exposure to moisture cannot be controlle
- · Apply prescribed topical moisture barrier agents to areas frequently exposed to
- Apply prescribed moisturizing agent for dry skin.

Nutrition

- Assess patient's nutritional status.
- Ensure adequate dietary intake of protein and calorie maintenance
- · Consult the Doctor and Dietician in cases where dietary intake remains inadequate and interventions such as enteral or parenteral feedings should be considered

Positioning

- Do not massage over bony prominences. · Assist the patient to turn and reposition every 2 hours to relieve any prolonged pressure to the tissues unless medically contraindicated
- Offer bedpan or urinal in conjunction with turning schedules. For babies and children, change of diaper to be performed every 3 hourly.
- Document the patient's position in the electronic documentation
- Refer the patient to the physiotherapist or occupational therapist for early initiation of rehabilitation

common pressure areas and prevents flexion contracture of the hips.

· Educate patients on the importance of turning and encourage regular turning.

5. Pressure Relieving Support Surfaces

injury due to shearing forces.

 Place patients with limited mobility on pressure-reducing devices e.g. air mattress while they are in bed.

· Use the prone position if not contraindicated. This position relieves pressure at the

• Use assistive devices and proper transferring and lifting techniques to minimise skin

· Sit patient out of bed if not contraindicated by diagnosis or condition. Reposition

seated patient every hour. Place patient's feet on footstool when they do not reach the

- Raise the heels off the mattress for patients who are completely immobile.
- · Use pressure redistributing seat cushions for patients who are chair-bound.

<u>Educational Programmes</u>

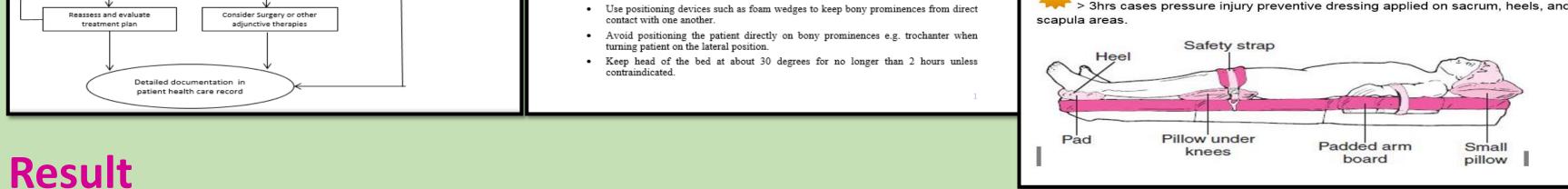
- Provide educational programmes on the prevention of pressure injuries to patients, families and caregivers
- Train family members or caregivers to continue with nursing care of the patient at home, if necessary,
- Keep patient as active as possible, encourage mobilisation.

Workflow-

OT operating tables padded with gel pad and pre warmed

Positioning devices and additional gel pads applied accordingly





With the development of the new clinical workflow, nurses are able to engage and integrate their hands-on knowledge and expertise on the management of patients identified as at risk (based on the Braden Scale). This applies seamlessly across multiple departments in the hospital which reduces the risk of HAPI and improve better patient outcomes

Conclusion

Standardising the workflows ensures the efforts of pressure injury prevention practices continues and be seamless across the multiple departments. This helps staff to take responsibility in achieving the set objectives as well as heeding the hospital's attempt to achieve "ZERO HARM".

PATIENTS AT THE HE RT OF ALL WE DO