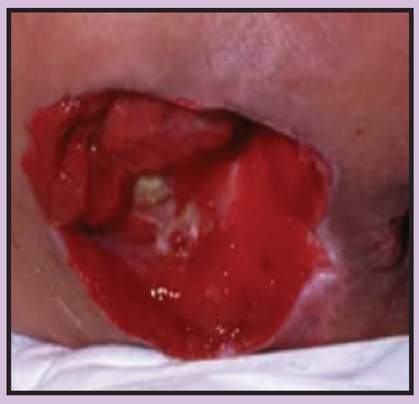
South Eastern Health and Social Care Trust



Let's Put Pressure on Prevention!

ED/MAU collaboration

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Background

- Nursing KPI's and Ministerial priority
- There is no validated pressure ulcer risk assessment tool that accurately reflects risk in the ED patient population
- Lack of documentation in ED regarding pressure ulcer prevention and pressure ulcer risk status
- Potential increase in SET pressure ulcer incidence due to lack of evidence of skin checks in ED
- Potential risk of increased facility acquired pressure ulcers due to extended ED waiting times
- Application of pressure relieving mattresses in MAU not timely as identified via pressure ulcer incidence checklists.

Aim

For all medical admissions in ED identified at High Risk of pressure damage 30% will have assessment of risk and preventative measures initiated and documented by May 2016.

Baseline Audit

QUESTION ASKED 26 records audited	ANSWER Yes or No
Was the patient at risk from a pressure ulcer?	73%
Was the SKIN bundle documentation completed?	12%
Was there any advice given on transfer of patient for a pressure relieving mattress requirement or was the patient transferred on a mattress	12%

Bespoke ED SKIN Bundle

South Eastern Health and Social Care Trust

Name:
D.O.B.:
Hospital Number:

Emergency Department
Identification of Pressure Ulcer Risk & Prevention of Pressure Damage

Pressure Ulcer development Risk Factors – Consider patients as 'AT RISK' of developing pressure ulcers if they have/are any of the following:	**Please tick if applicable to the patient**
Critically ill/loss of consciousness/orthopaedic trauma	
Limited Mobility e.g. bed bound/chair bound/use a walking aid	
Unable to feel and/or respond appropriately to discomfort from pressure e.g. due to CVA	
Previous or current pressure damage	
Significant cognitive impairment e.g. dementia	
Patient is unable to reposition themselves independently	
Patient has nutritional deficiency/hydration e.g. emaciated or obese	

There may be other factors that may indicate that a patient is 'AT RISK'. This is an aid to clinical judgement and cannot replace it.

Pressure Ulcer prevention Interventions – If the patient has any of the above risk factors please:	**Please tick if actioned**
Give advice of their 'at risk' status and the actions that they can take to prevent pressure damage (if applicable)	
Consider commencing the SKIN bundle overleaf to address: - Pressure Relief: Consider the use of the Trust Pressure Relieving/Reducing Equipment guidance flow chart if therapy bedding is considered - Nutritional needs - Skin care needs e.g. if the patient has very dry skin or is incontinent	

Review the patient's risk factors as above.

Note: It is good practice to observe the skin for pressure damage caused by medical devices (catheters, Oxygen tubing, splints, semi-rigid cervical collar and pulse oximeter probes). Consider using a prophylactic dressing for preventing medical device related pressure ulcers.

Checklist:

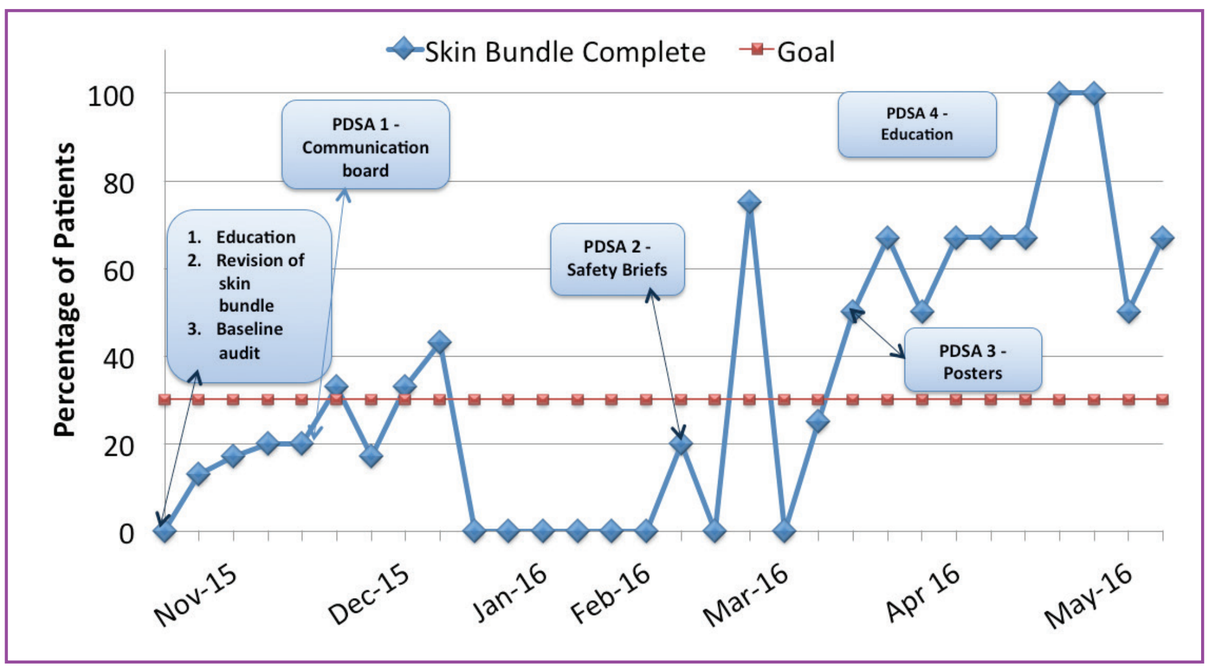
How was transfer to ward completed	Phone/Face to Face
Area of ED patient transferred from	Resus/Majors/Ambulatory Ward/Observation Ward/Other
Who completed handover	Name of staff nurse:
Who received onto ward	Name of staff nurse:

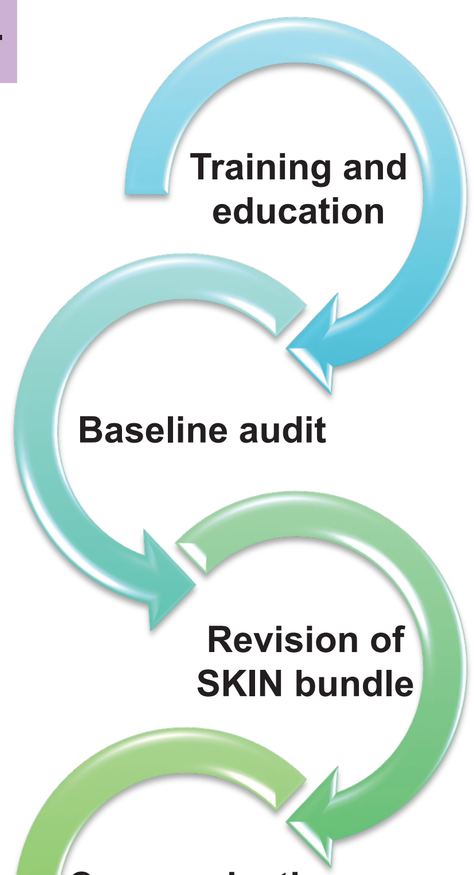
South Eastern Health and Social Care Trust — Emergency Department SKIN Bundle

Date:	Frequency of repositioning: (Number of hours)	On Trolley: 1 2 3 Other_____	In Bed: 1 2 3 Other_____	In Chair: 1 2 3 Other_____
Special Considerations: Can only lie on back – please circle if any of following apply: Spinal injury/instability, traction, limb dislocation, contractions, haemodynamically unstable, other please state_____				
Surface	Time:			
	Name:			
	Designation:			
	Current position? (Trolley/Bed/Chair)			
	Mattress insitu: State type	Y N NA Refused	Y N NA Refused	Y N NA Refused
	If applicable state mattress order no.			
The condition of the patient's skin should be recorded each time the patient is repositioned. If unable to reposition, check pressure points where possible.				
Keep Moving	Skin checked Current skin condition Key: Blanching Erythema B; Grade 1 G1; Grade 2 G2; Grade 3 G3; Grade 4 G4; Un-gradable U; Deep Tissue Injury D; Incontinence Associated Dermatitis IAD	Refused NA	Refused NA	Refused NA
		No evidence of pressure damage If unable to check skin please tick	No evidence of pressure damage If unable to check skin please tick	No evidence of pressure damage If unable to check skin please tick
		State Reason:	State Reason:	State Reason:
	Discomfort/ pain over pressure areas	Y N	Y N	Y N
	Action taken to relieve pressure			
	Report Changes	Y NA	Y NA	Y NA
Incontinence	Incontinence			
	Key: C = Continent, UI = Urine Incontinence, FI = Faecal Incontinence, DI=Double Incontinence, SRC = Self Retaining Catheter, FMS = Faecal Management System			
	Continence Management	Soap alternative; Barrier Cream; Incontinence Pad; Not applicable	Soap alternative; Barrier Cream; Incontinence Pad; Not applicable	Soap alternative; Barrier Cream; Incontinence Pad; Not applicable
	Tick if used			
	Patient left clean and dry	Y	Y	Y
Nutrition	Offered nutrition/fluids (observe fluid restrictions)	Y N NA Refused	Y N NA Refused	Y N NA Refused
	Fluid Balance Sheet update	Y NA	Y NA	Y NA
Environ	Belongings & call bell in reach	Y No Access	Y No Access	Y No Access
	Bed in low position	Y	Y	Y

Impact in ED

Significant increase in patients 'at risk' with an individualised preventative care plan

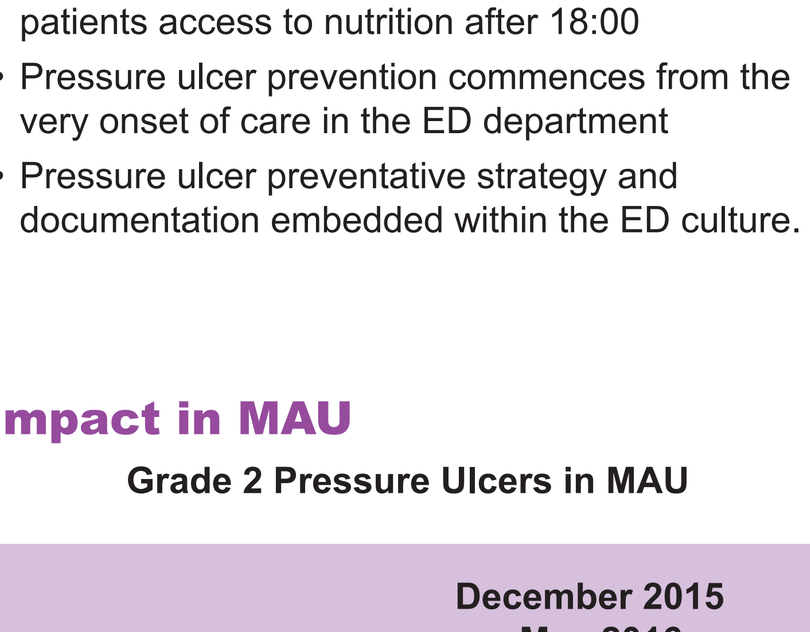




- 66% increase in the number of 'at risk' patients with an individualised preventative care plan implemented and documented in ED
- Introduction of food trolleys in ED ensuring patients access to nutrition after 18:00
- Pressure ulcer prevention commences from the very onset of care in the ED department
- Pressure ulcer preventative strategy and documentation embedded within the ED culture.

Impact in MAU

Grade 2 Pressure Ulcers in MAU



- Staff survey showed more time released for staff to provide patient care
- Improved communication between ED and MAU in relation to patient's pressure ulcer risk status and preventative measures.