SUSTAINING PRESSURE ULCER PREVENTION IN CRITICAL CARE

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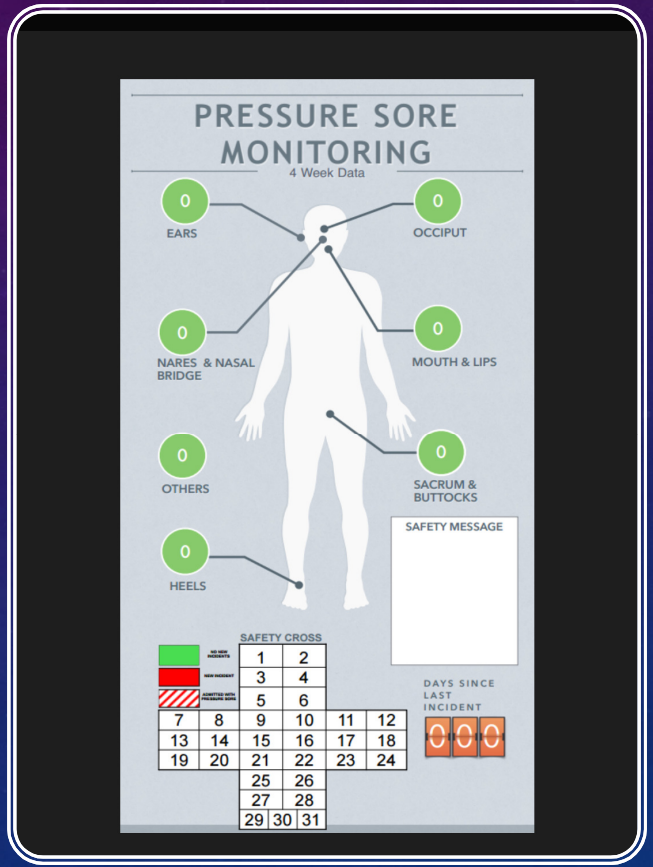
THE PRESSURE PROBLEM

- Pressure ulcers damage accounts for approximately 4% annually of NHs expenditure (1).
- Patients in critical care are much more vulnerable with between 10-41% developing ulcers (2).
- The Pressure Ulcer Group (PUG) had been initiated in the author's unit.
- In 2 years since inception, there has been great improvements in skin assessment and reporting of damage and the eradication of grade 3/4 sores.
- Following initial success however, there was an increased incidence of grade 2 sores.

PLANS FOR THE FUTURE

- Dynamic dash board, incorporating the safety cross and visual display of problem areas in real time. This will allow changes in focus immediately rather than seeing the problems retrospectively.
- Pressure mapping mattress overlay trial.
- Continued education and teaching sessions targeting smaller groups.
- Recruitment of link nurses from each team to disseminate information.
- A large recruitment drive will bring an influx of new nurses and health care assistants. Incorporating a focus on safety and pressure ulcer prevention methods, to foster ownership and responsibility from the outset. This may provide a solid base for sustainable change.



Dynamic dashboard concept

FURTHER WORK

- Identifying the issue
- Culturally changes have occurred- detection, reporting and treatment.
- However, these occurred following sore development. Unless instigated by the PUG team no further measures were taken to produce change.
- We remain poor at prevention.
- How is it possible to encourage individual staff to take ownership of the problem and maintain sustainable improvements?
- Looking to other areas where cultural changes have been achieved. What can we learn from; for example; the business sector?
- Is there a model to implement and create solid foundations for sustainable change.

REFERENCES

1. Bennett G, Dealy C, Posnett J. The Cost of pressure ulcers in the U.K. Age and Ageing 2004;33(3)230-5
2. Cooper K. Evidence based prevention of pressure ulcers in the Intensive Care unit. Critical Care Nurse 2013;33(6)

ANY QUESTIONS ?