

PRESSURE ULCER PREVENTION IN THE EMERGENCY CARE CENTRE: A BELT AND BRACES APPROACH.

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Introduction.

A review of practice in the emergency care centre (ECC) of a University Hospital revealed that patients at risk of skin pressure injury are often nursed on trolleys for long periods of time. Repositioning is difficult on the ECC trolleys and heels are particularly prone to high pressure gradients. Nursing staff are often extremely busy in the department leaving skin inspection and care to the nursing assistant. Audits and root cause analysis investigation following incidents of pressure ulceration identified that while compliance with pressure ulcer risk assessment was high, preventative strategies were often neglected.

Method

Senior nurses responsible for education and quality within the ECC met with the Tissue Viability Nurse to review the systems in place to prevent skin pressure injuries in the department. Areas were identified to improve compliance with Trust guidelines and a standard operating procedure (SOP) was developed to support decisions around the selection of appropriate pressure relieving surfaces. Patient repositioning and independent movement on a trolley can be severely restricted and so the Tissue Viability team worked in collaboration with an industry partner (Direct Healthcare Services) to develop a hybrid foam/alternating pressure trolley mattress, and heel off-loading supported by an inflatable boot (Repose®) was agreed to be the standard practice for patients nursed on trolleys.


Results


A pair of Inflatable boots were assigned to each ECC trolley and this was included in the trolley preparation check list, however it has proved challenging to retain the boots in the department once the patient moves to a ward area and this has highlighted a cost pressure. It would be an advantage if the inflatable boots were available in different colours for identification purposes. The hybrid trolley mattress evaluated well both in the department and in other areas where patients are nursed on trolleys for prolonged periods of time. Clinical and portering Staff found the mattress easy to use and patients reported increased comfort. Where patients subsequently developed pressure ulcers during the in-patient episode, root cause analysis investigations identified good practice in the ECC where the SOP was initiated, and the overall incidence of hospital acquired pressure ulceration in the Trust has significantly decreased.

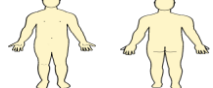
**EMERGENCY CARE CENTRE
SKIN INSPECTION AND PRESSURE ULCER RISK ASSESSMENT**

NAME:
Unit No:
NHS no:
sex:
Date:

Date: _____ Time: _____ completed by (P/N/N/T): _____ Designation: _____







Identify skin lesions on the body map using numbers below

Pressure ulcer + grade	1	Trauma wound	5
Leg ulcer	2	Incontinence dermatitis	6
Burn	3	malignancy	7
Skin tear	4	other	8

Notes:

DATE:

Anderson Pressure Ulcer Risk Assessment Tool.

Tick relevant factors
Score of 2 or more = at risk

Absolute Score (Score 2 for each)	Relative score (score 1 for each)																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Not conscious</td><td></td></tr> <tr><td>Orthopaedic trauma/surgery (major)</td><td></td></tr> <tr><td>Tetraplegic/paralysis</td><td></td></tr> <tr><td>Having difficulty or wont move</td><td></td></tr> <tr><td>Rehydration necessary</td><td></td></tr> </table>	Not conscious		Orthopaedic trauma/surgery (major)		Tetraplegic/paralysis		Having difficulty or wont move		Rehydration necessary		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Limbs mobility restricted</td><td></td></tr> <tr><td>Incontinent</td><td></td></tr> <tr><td>Nutritionally deficient/emaciated/obese</td><td></td></tr> <tr><td>Discoloured over bony prominences</td><td></td></tr> <tr><td>Seventy years or more</td><td></td></tr> </table>	Limbs mobility restricted		Incontinent		Nutritionally deficient/emaciated/obese		Discoloured over bony prominences		Seventy years or more	
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Total risk score

High risk patient management plan

Surface/heel protection	
Keep moving:	
Incontinence management	
Nutrition: IVI, NMB, diet	

University Hospital of North Staffordshire Tissue Viability Department SEPTEMBER 2012 DRAFT DOCUMENT



Discussion.

Time is a valuable and scarce commodity in the ECC and while comprehensive risk assessment is important to inform decision making, it should not override preventative actions. A concise risk assessment tool 'The Anderson Tool' is currently under evaluation in the department identifying those at risk of skin injury as they move through the centre. It is hoped that with appropriate support the nursing assistant will be able to complete a concise risk assessment tool, and that this will release time for improved risk management.