

[EP389] MEASURING ANOTHER ORGANISATIONS CONTRIBUTION TO PREVALENCE DATA: IS THIS A USEFUL TOOL IN SERVICE IMPROVEMENT?

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Thursday, May 14, 2015

E-poster Session: Pressure Ulcer 2

Aim: To analyse the prevalence of community acquired pressure ulcers when detected in the acute hospital setting.

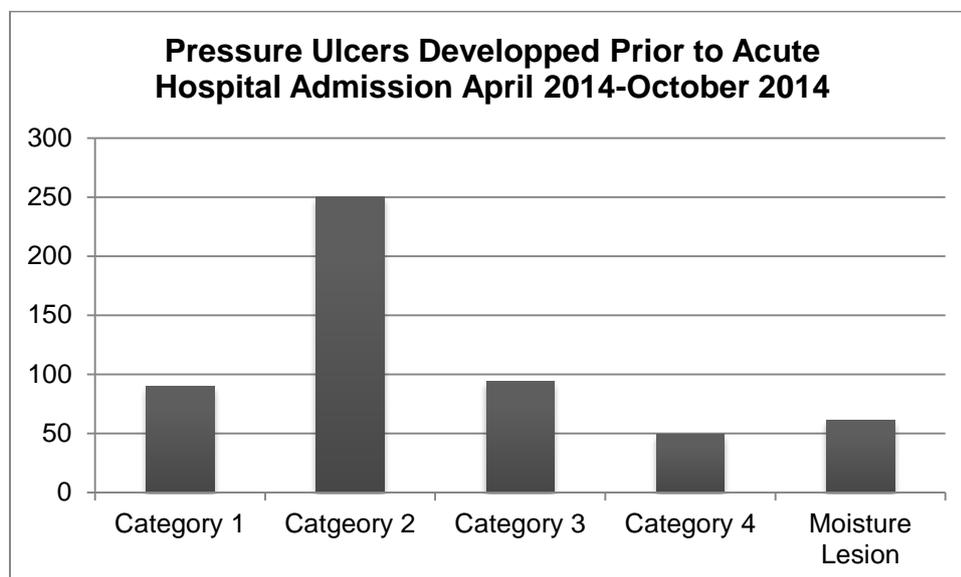
Method: A 6 month retrospective audit of incident reporting notation to include:

Where the patient was admitted from (i.e. home, care home, other hospital)

Whether the patient received any community based health or social care service (i.e. community nurse visits, home care)

Prevalence of pressure ulcer by EPUAP category

Results / Discussion: 544 community acquired pressure ulcer incidents were reported during this period.



41% of records did not indicate where the patient was admitted from and 51% did not indicate whether the patient had any health or social care input prior to admission.

Health organisations throughout the UK are required to report both incidence and prevalence. However, reporting prevalence is meaningless in terms of service improvement and patient safety if the whole health service does not work hard to understand the role that different health service partners play in pressure ulcer development. Improvements are difficult to measure based on

prevalence data and incidence may be much more useful. However, incidence does not recognise the cumulative impact that different service providers may have on a patients risk. To date there is little incentive to spend significant time on cross validation and robust processes for validation.

Conclusion: Organisations must cooperate to understand how and why individuals develop pressure ulcers. This will help individual providers of health and social care to better work together to deliver improvements in their part of the patient pathway.

[EP390] PRESSURE ULCERS PREVALENCE IN AN ITALIAN TERTIARY CARE HOSPITAL

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E-poster Session: Pressure Ulcer 2

Aim: The objective of this study was to determine the prevalence of pressure ulcers in a tertiary public hospital in north-eastern Italy.

Method: A point prevalence observational study was conducted on a single day. All the hospitalized patients were checked by the nursing staff. The data was gathered through a custom form that was compiled for every patient.

Results: 625 patients with a mean age of 72 years were surveyed: 146 pressure ulcers were found in 88 patients (14,1%). 56 patients (9%) had ulcers of grades 2-4. 81,8% of patients with pressure ulcers had a Norton score of 13 or lower, but only 54,3% of all patients with such a score had a pressure-relieving support surface for pressure sore prevention. The most affected locations were the sacrum (52,1%) and the heels (22,6%). 44,3% of lesions had developed during the hospitalization, but the real percentage could be as high as 70,5% if all the pressure ulcers of patients transferred from other departments were hospital-acquired.

Discussion: Our results were similar to other studies that reported a prevalence of pressure ulcers between 12 and 33% and better than a large European study in 2007 that had a prevalence of 18,1% for all grades and 10,5% for grades 2-4.

Conclusion: The prevalence of pressure ulcers in our hospital compared favourably with other studies. Mattresses for the prevention of pressure ulcers were used in a sub-optimal way.

[EP391] PRESSURE ULCER PREVENTION IN LONG-TERM ELDERLY CARE – THE BRADEN SCALE AND NURSING DOCUMENTATION

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E-poster Session: Pressure Ulcer 2

Aim: The aim is to analyze the use of the Braden Scale for Predicting Pressure Ulcer Risk and to analyze nursing documentation based on the results of the risk assessment.

Method: There are 1117 residents in long-term care units (nursing home, sheltered housing services with 24 hour assistance and long-term institutionalized care). The data consists of the residents' nursing documents during January, February and March in year 2012. The sample was 123 residents' nursing documents, which is 12,5 % of all the residents. The data was analyzed using descriptive methods such as frequencies and percents.

Results / Discussion: 42 % of the residents had no risk for pressure ulcer. One fourth of them had mild risk, 12 % had moderate risk and 10 % of the residents had high risk for pressure ulcers. Only two residents had severe risk. The data was missing 10 % of the residents. The most often documented nursing needs were skin integrity impairment risk (n = 33, 55 %) and skin integrity alteration (27 %). The need was missing of six documents although the residents had risk for pressure ulcers. The most often (66 %) documented aim of the care was to achieve skin integrity. The most often documented nursing interventions were skin care (n = 41), observing the skin (n = 37), repositioning (n = 23) and using of alternating-pressure mattresses (n = 22).

Conclusion: The results showed the need education to assess the pressure ulcer risk and the documentation.

[EP392] IS PRESSURE ULCER DIAGNOSIS AND GRADING ACCURATE AND ARE 95% AVOIDABLE? THE SCOTTISH EXPERIENCE

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Thursday, May 14, 2015

E-poster Session: Pressure Ulcer 2

Aim: Investigation into pressure damage occurring in a large Scottish Health Board to identify the following:

Accuracy of pressure ulcer diagnosis

Accuracy of grading

If pressure damage was avoidable or not

Method: Over a six month period all patients with grade 2, 3 or 4 healthcare acquired pressure damage were referred to the Tissue Viability Nurse Specialist (TVN). The patient was assessed by TVN to determine if the pressure ulcer diagnosis and grading was accurate. A review of care by the clinical team and the TVN was undertaken using a standardised investigation tool to determine if the pressure damage was avoidable or not and results compared. To ensure consistency in assessment by the TVN, the TVNs underwent an inter-rater reliability exercise.

Results / Discussion: For nearly three decades there has been a perception that 95% of pressure damage was avoidable in a health care setting. However recently Downie et al (2013) challenged this perception and suggested that around 40% of damage is avoidable. In addition to this, there is emerging evidence internationally that pressure ulcer diagnosis and grading amongst clinicians is poor.

Initial results concur with current literature findings that around 40% of pressure damage may be avoidable and that pressure ulcer grading and diagnosis needs to be improved in some clinical areas.

Conclusion: Clinicians need guidance and support to ensure accuracy of pressure ulcer diagnosis and grading and that 95% of health care acquired pressure damage being avoidable is a gross over estimate.

[EP393] THE USE OF HEEL PROTECTORS IN THE PREVENTION, TREATMENT AND MANAGEMENT OF PRESSURE ULCERS

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E-poster Session: Pressure Ulcer 2

Aim: Pressure ulcers are a persistent problem in hospitalised patients in the United Kingdom and Europe, which are common, costly and represent tremendous pain and suffering for many patients*. Despite having a greater understanding of pressure ulcer aetiology and the development of increasingly sophisticated pressure relieving equipment, recent prevalence in acute care settings is cited as approximately 10%. The reduction of pressure and shear forces on the heel is of concern as 18.2-24.2% of pressure ulcers occur at this anatomical location (Black, 2013*).

A pressure ulcer is described as a localised injury to the skin and or underlying tissue, usually over a bony prominence, resulting from sustained pressure (including pressure associated with shear)*.

Method: A retrospective analysis on the incidence of heel pressure ulcers compared to the usage of heel protectors over a twelve-month period.

Results / Discussion: The analysis suggests that there is a correlation between the occurrence and development of heel pressure ulcers and the use of heel protectors.

Conclusion: A heel protector is a useful tool in the prevention, management and treatment of heel pressure ulcers. Heels should be free-floating of the surface of the mattress and free from all pressure. This can be achieved by elevating the lower leg and calf from the mattress by placing a pillow under the lower legs, or by using heel protectors or suspension devices that float the heel*. This will allow the pressure to be spread along the lower leg and keep the heels free of pressure.

*EPUAP, 2014

**[EP394] INCIDENCE OF PRESSURE ULCERS AND SKIN TEARS IN PATIENTS OF INTENSIVE CARE UNIT
CARDIOPNEUMOLOGIC.**

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Thursday, May 14, 2015

E-poster Session: Pressure Ulcer 2

Aim: This study aimed to identify and analyze the rate of incidence of pressure ulcers and skin tears and the risk factors for its development in patients in the Intensive Care Unit (ICU) Cardiopneumologic.

Method: This study is a prospective cohort which data collection occurred during the months of November 2013 to February 2014, with censorship of a week, with 370 patients. For data analysis were used univariate analyzes and the Classification And Regression Tree (CART).

Results / Discussion: Overall incidences of 10,80%, 7,02% and 2,16% respectively for pressure ulcers, skin tears and both lesions simultaneously were found in critically ill patients. Different risk factors were found, depending on the type of injury, and length of stay in ICU less than 9,5 days old and less than 42,5 years common for pressure ulcers and concurrent injuries. Besides these, the white race; Use of support surfaces and the number of invasive devices in entry; and use of blood transfusion were observed factors respectively for pressure ulcers, skin tears and simultaneous injuries

Conclusion: The study therefore contributes to the knowledge regarding the epidemiology of these types of injuries, recommending that replication of their methods, especially for lesions friction in acute inpatients and critics, alone or in combination with pressure ulcers. On the other hand, by favoring a greater understanding of these lesions panorama critical cardiopneumologics patients, the results will may facilitate the planning of specific preventive care for these clients.

[EP395] EFFICIENT MANAGEMENT OF CONTINUOUS EVALUATION OF A “STATIC AIR SURFACE FOR PRESSURE ULCERS PREVENTION” (SASPUP)

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E-poster Session: Pressure Ulcer 2

Objective: Getting to know if the obtained data from the RCCT Tested in 5 Health Departments from the Valencian Community can be extrapolated to other geographical areas.

Method: Controlled, Randomized and Multicentered Clinical Trial.

Based on the obtained data from the RCCT, we intend to maintain a continuous assessment of the SASPUP in several geographical areas in an international level, whilst using a standardized work methodology and online data gathering.

Researchers:

They must have commitment on following the standardized work methodology.

They must keep actualizing the databases monthly.

Requirements for the joining to the project: Acceptance of the RCCT by the local ethics committee.

Studied Subjects: Any patient classified as “Moderated and High Risk” in the researcher’s health work environment, who meet the inclusion criteria.

Results / Discussion: The presented data are provisional, due to 2 of the Health Departments which were expected to participate did not initiate the study.

Patients included in the study						
Hospital's Environment	High Risk		Moderated risk		General total	
	n	%	n	%	N	%
Primary Health Care			6	100,0	6	8,3
Hospital's Service	6	66,7	3	33,3	9	12,5
Home Health Care	8	100,0			8	11,1
Special Hospital Services	30	61,2	19	38,8	49	68,1

Total	44	61,1	28	38,9	72	100,0
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Out of the total of patients included, 37 (51,4%) are the intervention group. Being aware of the difficulties for reaching a high number of patients, we are committed to continue with the RCCT for giving a higher validity to the results and comparing it with other hospital communities.