

[OP154] PRESSURE ULCER PREVENTION: DO PATIENTS RETAIN INFORMATION?

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Free Paper Session: Pressure Ulcer 3

Aim: Pressure ulceration is a key indicator of care quality. All patients are involved in care planning and provided with information on pressure ulcer prevention (PUP). This study aims to assess the effectiveness of this information.

Method: A structured interview was undertaken to assess current “patient education” and to provide staff with the opportunity to give patients further information. 50 high risk consented patients were interviewed, 9 patients undergoing repeat assessment the following day to assess retention and understanding.

Results / Discussion: Despite PUP information only 38 of 50 patients knew what a pressure ulcer was. 26 patients recognised that pressure ulcers could occur at several body sites. Only 3 knew that staff had a PUP risk assessment tool. 33 patients recognised that they were having regular skin assessment and knew why, in addition 9 patients knew to report skin soreness. 29 patients were aware that the nurses had told them that they were at risk of developing a pressure ulcer and 38 patients recognised that poor mobility was a risk factor and understood the need for repositioning. Despite all patients being on a profiling bed with a minimum of a high density foam mattress 16 felt that they were not provided with pressure relieving equipment, 4 of these were on a powered mattress. Re-questioning of the sub-group of 9 patients showed an improvement in understanding.

Conclusion: Patients understanding is incomplete. Even with additional information some patients still do not understand why and how pressure ulcers occur. This small survey indicates that we should revisit this aspect of care and work to raise public awareness of their role in PUP.

[OP155] PRESSURE INJURY MANAGEMENT: CREATING A BETTER FIT WITHIN HEALTH CARE

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Free Paper Session: Pressure Ulcer 3

Aim: Pressure Injury (PI) is a multifactorial issue which presents many challenges in all health service settings. With complex chronic care needs increasing, attention to management of longer term PI needs is necessary. This research project explored current practice across a range of Australian health service settings.

Method: A mix of qualitative methods (case studies, group discussions and in-depth interviews) was used to explore current practice. Three closely related research phases were undertaken. All data were analysed using a thematic analysis approach.

Results / Discussion: Participants discussed health system, clinician and client behaviour at length. The data suggested that participants were not convinced that general approaches to PI are meeting the needs of all clients and services. Key issues relating to workforce development included skill-mix and organisation of services, along with education and training. Consideration of the key issues at the system, client and service levels of the Australian health care system, suggested that longer term PI needs may be best met by supporting team-based approaches within primary health care. As most participants believed that increasing client and support care involvement in PI care was essential to meet increasing demands for these services, health professionals and their clients would thus benefit from the former being taught how to effectively educate the latter as partners in their care.

Conclusion: An educational model with potential application in PI management is described. The proposed model and its accompanying supports may assist health services to enhance continuity of care, as well as access to PI services, through the up-skilling of clinicians to impart information to lay-persons.

[OP156] PRIORITIES FOR PRESSURE ULCER PREVENTION: MIXED METHODS ANALYSIS OF PATIENT SAFETY INCIDENTS REPORTS FROM PRIMARY CARE IN ENGLAND AND WALES (2003-2013)

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Free Paper Session: Pressure Ulcer 3

Background: Pressure ulcers (PUs) are a key indicator of care quality. Patient safety incident report systems contain descriptions of incidents written by frontline healthcare professionals when any untoward event resulted in, or could have resulted in, harm to a patient. They contain information to model the context, sequence of events, contributory factors, and outcome of incidents.

Aim: To identify concepts and content of a change model for safer, higher quality care to prevent PUs in primary care using incident report data.

Method: PU-related safety incident reports represent over 1 in 20 primary care reports (15933/ 255,000) received by the National Reporting and Learning System in England and Wales (2003-2013). A multi-axial coding framework (incident descriptors, contributory factors, harm outcomes) was applied to a random sample of 400 PU-related reports. Frequency distribution and cross-tabulation analyses were used to explore relationships between variables. Thematic analysis of reports provided insights about contextual issues. Subject matter experts reviewed analyses to identify recommendations for practice.

Results: A large number of patients were transferred from secondary to primary care settings with pressure ulcers. Factors that contribute to PU-related harm, include:

1. Poor communication with health care professionals in primary care;
2. Inappropriate equipment and support to prevent and treat pressure ulcers in the community; and,
3. Unsafe practices by healthcare professionals in the community.

A grounded logic model was created comprising recommendations for practice improvement.

Conclusion: The patient safety incident reports highlight areas to improve PU prevention and management via changes in education, policy and practice.

[OP157] THE IMPLEMENTATION OF A STRATEGIC PLAN FOR THE ELIMINATION OF AVOIDABLE PRESSURE ULCERS ACROSS AN UK ACUTE & PRIMARY CARE ORGANISATION

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Free Paper Session: Pressure Ulcer 3

Aim: To implement a strategic plan to eliminate avoidable pressure ulcers across an Acute trust with 900 beds, Care homes with 2000 beds and a Primary Care Organisation (PCO) with a population of 620,000 over a six month period.

Method: An initial review of the current educational plan, clinical guidance and support resources were reviewed and a baseline clinician survey was undertaken to obtain details of current practice.

The development of the approach included:

- Strategic education plan
- Agreed Risk assessment tool and education
- Agreed use of SSKIN care bundle
- Agreed skin assessment tool, development of SIM (Skin integrity Model) and implementation
- Agreed adapted categorization of pressure ulcers
- Turning and re-positioning clocks
- The development of a Moisture of Pressure ulcer differentiation Tool
- Wound management formulary
- Agreed plans for the prevention and management of pressure ulcers
- Agreed Serious incident process
- Agreed equipment selection flow chart
- EPUAP Stop the pressure day events
- The development of new clinical guidelines
- Public awareness campaign

Results / Discussion: The Acute trust has eliminated all category 4 pressure ulcers developing and has seen a reduction in category 2 and 3 pressure ulcers.

The care home has reduced the prevalence of pressure ulcers to 4.2%.

The PCO has a reduction in the number of reported pressure ulcers for 8 months consecutively.

Conclusion: The strategic plan has been implemented successfully and has contributed to increased clinical and financial outcomes.

[OP158] EXPERIENCE OF PARTNERSHIP WORKING - IMPLEMENTING SOFT HEEL CASTING

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Free Paper Session: Pressure Ulcer 3

Aim: Current research has suggested that 43% of all hospital acquired grade 3-4 ulcers may be preventable. Using the Scottish Patient Safety Programme, quality improvement methodologies this study aimed to measure the impact of introducing soft heel casting as preventative device. Both quantities and qualities data was gathered for analysis.

Method: A partnership steering group including tissue viability, podiatry and orthotics was established to design and develop an implementation plan. Clinical effectiveness developed a tool to capture cost effectiveness, usability and compliance, patient and staff user experience. Using data from 2013-14, 2 test of change sites were selected for pilot. 40 multi-disciplinary staff were trained in the application of soft heel casting and a system of competency and clinical governance was used to maintain reliability during the study.

Results / Discussion: Full analysis is due in late December 14. Early preliminary findings have found that implementing soft heel casting in wards has raised awareness with staff of the impact of early detection of pressure and the accurate recording of vulnerable tissues. Staff have a clear referral pathway and previous patient waiting times for an offloading device have greatly reduced. Patient experience is positive as this device can be worn with patients own footwear and compliance.

Conclusion: To support the further use of soft heel casting a guideline, web-based teaching DVD, patient information leaflet and referral pathways have been developed and approved.