Pressure Ulcer to Zero
PUTZ Overview

- Background to PUTZ
- OLOL Experience
  - Successes
  - Challenges
- Sustainability & Spread
A collaboration in Health Care is when MDTs come together with a common aim to improve some aspect of patient care and outcomes. It involves group based learning, practical improvement projects and shared thinking towards a common aim.

This collaboration aims to reduce the number of pressure ulcers in the Irish Healthcare system. This is done by enabling staff to put in place reliable systems which will continue to support local improvement after involvement with the collaboration.
“A pressure ulcer is defined as a localised injury to the skin and/or the underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing factors are also associated with pressure ulcers: the significance is yet to be elucidated.

(EPUAP/NPUAP/PPPIA 2014)

Both immobility and diminished activity are considered as primary risk factors.

(Bergstrom et al 1992)
Irish Prevalence Rates

- Moore & Pitman 2000
- Sheerin et al 2005
- Gallagher et al 2008
- Gethin et al, Mc Dermot -Scales et al 2009
- Moore & Cowman 2012

The mean prevalence is 16% (Moore et al 2013), varying from 4% (Mc Dermott - Scales 2009) to 37% (Sheerin et al 2005)
Irish Incidence Rates

- Moore & Pitman 2000
- Sheerin et al 2005
- Gethin et al 2005
- Gallagher et al 2008
- Obrien & Cowman 2011
- Moore et al 2011

**Mean incidence is 11%** (Moore et al 2013) **varying from 8%** (Moore & Pitman 2000) **to 14.4%** (Gallagher et al 2008)
COST – Ireland

- It is estimated that it cost €119,000 to successfully treat one patient with a grade 4 pressure ulcer – extrapolated that it would cost €250,000,000 per annum to manage pressure ulcers across all care settings in Ireland (Gethin et al. 2005)

- Comparison of pressure ulcer incidence and costs associated with repositioning older individuals in a long – term setting using 2 different repositioning regimes. The costs would be €1.5m (experimental group) and €2.10m (control group) (Moore et al 2013)
Human Cost

- **Cost to the patient** =
  Impacts negatively on HRQoL including:
  - pain, isolation, embarrassment,
  - loss of Income, psychological,
  - Impact on others, lack of knowledge etc

(Langemo 2000; Fox 2002; Franks et al 2002; Hopkins et al 2006; Gorecki et al 2009)
PUTZ Aim in DNE
2014

To reduce the number of AVOIDABLE pressure ulcers across all participating sites by 50%

Time Frame
February – September 2014
**Avoidable Pressure Ulcer**

Provider of the care did not do one of the following:

- Evaluate clinical condition & PU risk
- Plan & implement interventions consistent with pt needs & goals and recognised standards
- Monitor & evaluate the impact of interventions OR
- Revise the interventions as appropriate
Driver Diagram

Outcomes

To eliminate avoidable pressure ulcers in participating organisations by November 2012 (At least a 50% reduction from baseline)

Primary Drivers

- Local Risk Identification
- Reliable Risk Assessment
- Reliable implementation of the SSKiN bundle
- Identification, grading of pressure ulcers (site acquired/transferred in)
- Education and training

Secondary Drivers

- MDT staff, patients and families work collaboratively to understand pressure ulcer risk factors and prevent harm
- Staff understand local context and use local data to assess patient/residents at risk
- Utilise ‘At risk’ cards/systems to enable quick identification of individuals at risk
- Timely risk assessment (depends on setting) but within a maximum of four hours of admission
- Reassess at least daily or where there is a change in patients condition/needs
- Reliably Implement SSKiN prevention bundle
  - Surface: ensure patients have the right support
  - Skin inspection: regular inspection of skin
  - Keep your patients moving
  - Increased moisture/continence: Ensure patients are kept clean and dry
  - Nutrition/hydration: right diet & fluids
- Utilise local tissue viability nursing expertise
- Utilise standardised grading tool
- Utilise treatment bundle
- Initiate and maintain correct and suitable treatment
- Staff education – utilise resources
- Educate patient and family – utilise Patient/Carer leaflet
- Utilise ‘How to Guide’ for relevant tools
- Share learning across teams.
Getting Started

Local Steering Group (Managers)

**Role:** to enable the improvement teams

Implementation Group (Frontline)

**Role:** To test and champion improvements to prevent PU development in their specific ward / unit.
Plan, Do, Study, Act (PDSA) Cycle

**PLAN**
Define the objective, questions and predictions. Plan to answer the questions (who? what? where? when?)
Plan data collection to answer the questions

**DO**
Carry out the plan
Collect the data
Begin analysis of the data

**STUDY**
Complete the analysis of the data
Compare data to predictions
Summarise what was learned

**ACT**
Plan the next cycle
Decide whether the change can be implemented

Small Changes
Adopt a multidisciplinary Approach to Pressure Ulcer Prevention
- Early Pressure Ulcer Risk Assessment (within 2 hours)
- Good Compliance with Risk Assessment >95%

Risk assessment is the first step in planning pressure ulcer prevention strategies……..
….. Prevention interventions may then be planned, implemented & evaluated (Moore & Cowman 2014)

“A Pressure Ulcer risk assessment was conducted within 6 hours of admission/transfer to the unit/ward and was dated, timed and signed by the assessing staff member “…… METRICS
Hierarchy of Risk Factors (Moore et al 2011)
“Mobility & Activity limitations can be considered a necessary condition for PU development. In the absence of these conditions, other risk factors should not result in a pressure ulcer”

(NPUAP/EPUAP 2014)
Safety Cross

Prior to the learning session please complete the safety cross on your ward/home/in your team (please see the programme guide for guidance on using the Safety Cross)

Days since last PU
___ days

Data Collection System
NPUAP/EPUAP/PPPIA Classification (2014)

Category/ Stage I

Non – Blanchable Erythema

Early Recognition of Stage 1
Moisture Lesion

- A wound not above a bony prominence is unlikely to be a pressure ulcer.
- A moisture lesion may occur over a bony prominence. However, pressure and shear should be excluded as causes and moisture should be present.
- A combination of moisture and friction may cause moisture lesions in skin folds.
- A lesion that is limited to the anal cleft only and has a linear shape is not pressure ulcer and is likely to be a moisture lesion.
- Peri-anal redness / skin irritation is most likely to be a moisture lesion due to faeces.

Differentiate between Pressure Ulcer and Moisture lesion
SSKIN Care Bundle

The skin care bundle is a powerful tool as it defines and ties best practices together. The bundle also the process of preventing pressure ulcers visible to all. This helps minimise variation in practice.
SSKIN

Skin Inspection: Early inspection means early detection. Show patients and carers what to look for.

Keep your patients moving.

Incontinence/Moisture: Your patients need to be clean and dry.

Surface: Make sure your patients have the right support.

Nutrition/Hydration: Help patients have the right diet and plenty of fluids.

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MDT Education

- SSKIN Documentation
- Pressure ulcer staging
- Equipment
- Moving & Handling
- Nutrition
- Incontinence
- Patient education
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<th>Risk Assessment</th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
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Patient Education

- A patient survey indicated that patients/families felt they were given information about pressure ulcer prevention and they were aware of a care plan.
Challenges

- Merging of 2 wards due to staff deficits
- Nursing staff turnover
- Diluting of Learning
- AHP rotation
- Competing priorities
Pressure Ulcer to Zero can make a difference……Feb 2014- Oct 2014

To date 11 grade 1 pressure ulcers developed (all reversed except 1)
6 grade 2 pressure ulcers developed since admission to department

Acknowledgement of data from P Suresh
Source of Pressure Ulcers
- Medical Unit 2015

Acknowledgement of data from P Suresh
### Pressure Ulcer Prevention Care Plan

**LOUTH HOSPITAL GROUP**

**Addressograph**

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**Frequency of care delivery (circle as appropriate):** 1hrly  2hrly  3hrly  4hrly

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**Date**

**Time**

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**SURFACE**

See advice re surfaces on LKMG Guidelines on Pressure Ulcer Prevention (on T Drive).

Indicate each day if Foam □ or Pressure Relieving Mattress □ (tick)

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**Mattress appropriate & functioning correctly:**

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**Appropriate seating**

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**Foot protectors**

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**SKIN INSPECTION**

Inspect skin at boney prominence every 2 – 4 hours. Existing Pressure Ulceration Y/N (Circle), Stage & site of existing ulceration recorded in wound assessment chart Y/N (Circle)

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**Pressure areas checked**

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**New Redness**

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**State Site:**

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**KEEP MOVING**

Frequency of repositioning is determined by skin inspection. If red at least 2 hourly.

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**B**

**E**

**D**

**R Side**

**L Side**

**Back**

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**CHAIR**

Standing / Mobilising

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**INCONTINENCE**

Incontinence Related Skin Care regimen implemented Y/N (Circle), Tissue Viability Folder Y/N

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**Dry and clean**

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**Non-ster skin healthy**

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**NUTRITION**

Fluid Balance Chart / Food Chart in progress Y/N (circle and continue), Otherwise record below

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**Milk / snack taken**

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**Drink taken**

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**Supplements taken**

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**Signature**

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**Grade:**  S/N = Staff Nurse, HCA = Health Care Attendant, OT = Occupational Therapist, D = Dietician, P = Physiotherapist, S = Student, SALT

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**Audit of SSKIN carried out in July & Dec 2015**

**Good compliance recorded**

**Recommendation**

- Record frequency of care

- MDT use of SSKIN
Sustainability & Spread??
# Sustainability & Spread 2016

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NEVER EVENTS

If a ‘never event’ should occur the CEO or equivalent HS Manager is accountable for ensuring that it is immediately notified to the Q&S Division of the HSE “Stage 3 or 4 PU acquired after admission to a HC facility but excluding progression from 2 to stage 3 IF stage 2 was recognised on admission”

Tony O Brien
HSE Director General 2014
“A lot done more to do”!!