Reducing Hospital Acquired Pressure Ulcers in an acute rehabilitation hospital

Emma Cullen Gill Tissue Viability Clinical Nurse Specialist
Clontarf Orthopaedic Hospital, Dublin, Ireland

Background

Clontarf Orthopaedic Hospital is a 160 bedded rehabilitation hospital caring for patients with a multitude of rehabilitation needs such as orthopaedic, neurological and frail, older patients. In April 2021, Clontarf Hospital commenced a quality improvement project on urinary incontinence.

Urinary Incontinence

Urinary incontinence (UI) is a common issue which affects people of all ages, however, it does become more predominant with older age. Unfortunately, it is poorly managed with limited assessments and treatment. Urinary incontinence can increase risk to patients of falls, particularly at night, moisture lesions, pressure ulcers, and social isolation.

Pressure Ulcer Statistics

The Tissue Viability Nurse (TVN) monitors, audits and documents all Hospital Acquired Pressure Ulcers (HAPU) via the Pressure Ulcer to Zero and National Information Management System (NIMS), on a monthly basis. The NIMS is forwarded to the Risk Department for further analysis. This is then collated and sent to the Health Service Executive.

March – December 2019 HAPU's = 36
Incidence rate =2.8%. * (not a full year of statistics)

Quarter 1, 2020 HAPU's = 9.
Incidence rate = 2.4%

Therefore, the aim of the quality initiative plan was to reduce Hospital Acquired Pressure Ulcers.

Aims & Objectives:

- To decrease the incidence of urinary incontinence by accurately assessing, diagnosing and managing the condition.
- To decrease prevalence and incidence of Incontinence Associated Dermatitis (IAD)/moisture lesions.
- To improve staff knowledge on urinary incontinence
- To improve quality of care.

Improvement initiative

- Visible presence of the TVN on all wards, taking referrals, reviewing patients, assessing wounds, discussing wound care plans and giving expert advice.
- Hospital Pressure Ulcer policy and SSKIN Bundle were updated and uploaded onto the public share drive system.
- Education rollout on Pressure Ulcer Prevention and Management in collaboration with Occupational Therapy department .
- Collecting and auditing metrics of pressure ulcer statistics and observing trends.
- Disseminating quarterly reports to key stake holders, which included, quality, risk and senior nursing departments.
- Offloading heel cushions were purchased and distributed to all clinical areas.
- Rental air mattresses were audited on a weekly basis, ensuring 'at risk' patients were appropriately nursed on them.
- A #stopthepressure stand was organised to highlight Pressure Ulcer awareness day in November.
- Wound Link nurses were recruited from each ward with details of roles and responsivities.

Challenges and Supports

Due to the Covid 19 pandemic within the hospital, the TVN service was severely restricted , resulting in limited patient reviews and no education. Once service resumed, education was provided with social distancing measures and restrictive numbers of participants in place.
Online webinars replaced study days and conferences

Figure A

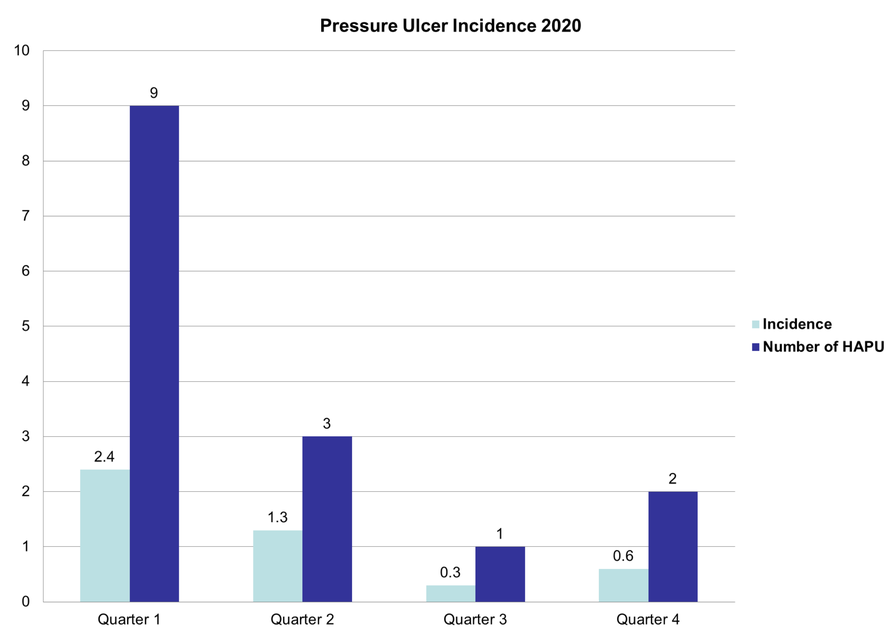
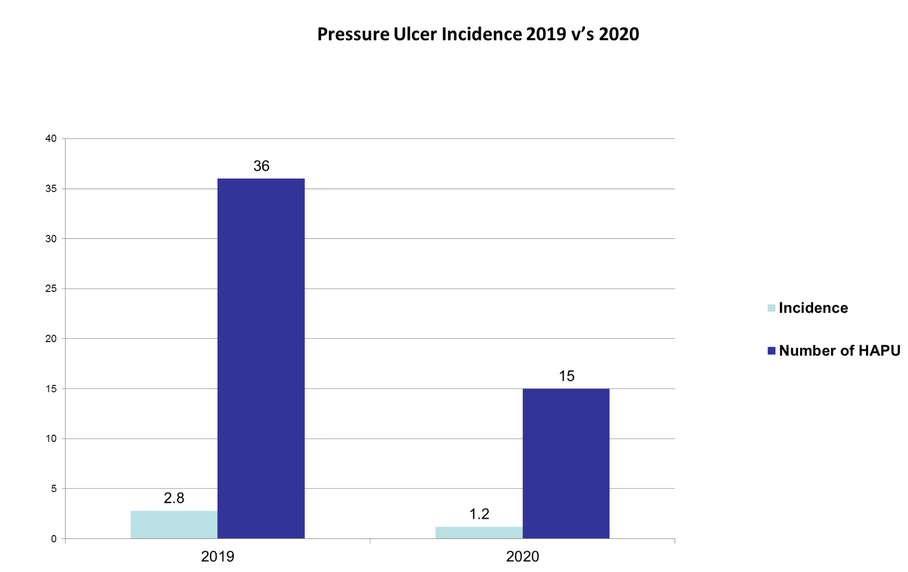


Figure B



Benefits and Outcomes

Q2-Q4 showed a steady decrease of HAPU's despite the Covid 19 pandemic occurring in the hospital at that time (Figure A).

Total HAPU's for 2020 = 15. Incidence rate =1.2%
HAPU's from 2019 to 2020 were reduced by over 50% (Figure B).

References

Gallagher, P., Barry, P., Hartigan, I., McClusky, P., O'Connor, K., O'Connor, M. (2008)
HSE National Wound Management Guideline (2018)