Under Pressure... Reduce the Pressure in Palliative Care

Katherine Hynd[1], Libby Milton[2]

[1]Charge Nurse; [2]Lead Nurse; Marie Curie Hospice Edinburgh, Scotland.

Marie Curie

Care and support through terminal illness

Background

> *"Pressure ulcers impose a significant financial burden on health care systems and negatively affect quality of life"* [1]

- This is highlighted in Healthcare Improvement Scotland Best Practice Statement – Prevention and management of pressure ulcers.[2] Pressure Ulcers (PUs) can be an indicator for quality of care.[3]
- Marie Curie (MC) recognised that PU prevention/ management was an area where practice could be improved. Within Edinburgh, we identified we wanted to reduce incidence of PUs acquired in our care and improve our management of them.

Aim

To reduce incidence of PUs acquired in our care through taking a quality improvement approach.

> *"I have learnt so much and feel more confident understanding and talking and dealing with a pressure sores." Ana (HCA IPU).*
>
> *"I now feel confident in my ability to provide high quality Pressure Area Care. I can now promote best practice for patients and staff." Fiona (HCA IPU).*

Approach

1 Leadership

- Creation of link nurse role
- Commitment by Marie Curie to support the development of link nurse
- Participation in national MC Tissue Viability working group.

2 Clinical

- Review of current risk assessment and implementation of updated assessment tool
- Low threshold of reporting all PUs acquired in our care regardless of grade
- Ensuring most appropriate equipment in place – mattress/chair cushions
- Review and development of documentation and care planning.

3 Education

- Developed teaching package for RNs and HCAs
- All staff provided with teaching – face to face sessions (in the classroom and on the ward) to allow space for group discussions and individualised learning
- Developed materials to display on the wards
- Link nurse role to offer support and guidance in practice on the ward.

4 Cultural

- Every PU acquired in our care investigated and RCA completed, with feedback to the team
- Raised profile of patients who are at risk in patient safety briefs
- Ward level team discussions regarding PU prevention and management.

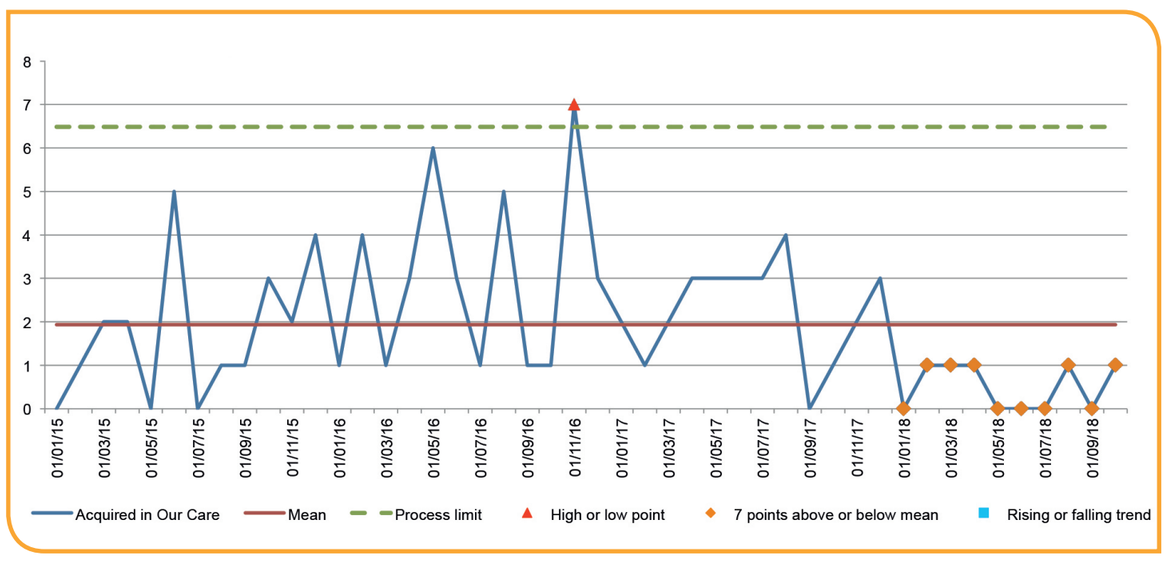

Figure 1: Pressure Ulcers acquired in our Care 2015 – 2018.

Outcome

- Incidence of PUs acquired in our care demonstrates sustained improvements, with 10 sequential months data below previous average.

Future Actions

- Recognition that there are better support systems e.g. lateral tilt mattresses available for patients to reduce the risk and incidence of pressure ulcers which have been tested and found to be acceptable and effective by patients and staff. We are now purchasing more of these for the IPU.
- Review of all PUs when a patient dies or is discharged to record changes in PU and identify healing/deterioration.
- Further development of our Risk Assessment tool is underway which will require testing and implementation once ratified.
- Ongoing staff training and development in clinical setting for current and new staff.

We care for people with complex needs who will always be at high risk of developing PUs so the battle to reduce the risk and incidence will never be over. It's our job to care and our job to reduce the risk.

REFERENCES: [1] Moore ZEH, Cowan S. Wound cleansing for pressure ulcers. [2] Healthcare Improvement Scotland. Best Practice Statement Prevention and management of pressure ulcers. 31st March 2009. [Accessed 30th Oct 2018]. Available from: http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/pressure_ulcer_best_practice.aspx. [3] Cochrane Database of Systematic Reviews. Version issued 28 March 2013; [Accessed 30th Oct 2018]. Available from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004983.pub3/full.

For further information contact: Katherine.Hynd@mariecurie.org.uk