Wounds Canada Pressure Injury Symposium:

Pressure Injury Prevention: "Synergy in Practice"

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Debra Johnston is a clinical nurse specialist certified in wound, ostomy and continence. Her practice at the University Health Network Toronto General Hospital aims to improve quality of life of patients and their families by developing and promoting quality care through best practice guideline development and providing education for patients living with wounds, ostomies and fistulae.

Leslie Heath is a certified nurse specialized in wound, ostomy and continence. Her practice focuses on providing specialized holistic assessment, prevention, treatment and management strategies for patients living with acute or chronic wounds, ostomies and fistulas. As a Clinical Nurse Specialist, she provides consultation and treatment recommendations while advocating on behalf of patients across the continuum of care.

Pressure injuries (PIs) are the third most expensive disorder in hospitals, after cancer and cardiovascular disease. The presence of a PI has been associated with a two- to four-fold increase in risk of death for critically ill patients, especially older patients in the intensive care unit (ICU). Two-thirds of all hospital-acquired pressure injuries (HAPIs) occur within the first week of the patient's stay in the ICU. Interruptions to nursing, alarm fatigue, and noise and distractions all contribute to the development of PIs in ICUs. Additional external factors include poor written documentation, poorly defined plans and care goals, poor transfer of accountability and missed or delayed initial assessments.

Risk Factors

Patients with immobility and incontinence have been found to be three-and-a-half times more likely to develop a hospital-acquired PI than those without these additional risk factors. This risk persists after controlling for immobility.

Prior to implementing changes to a PI prevention or management program, needs and gaps must be identified. This assessment must be ongoing and include feedback from frontline staff. All team members should be included, and education and resources must be readily available. There must be investment in the point of care. Staff providing the day-to-day care are the ones best positioned to see the issues, gaps and opportunities for improvement. They are also in the best position to implement education and protocol changes, such as use of new equipment.

PI Prevention Bundles

"Bundles" are the implementation of three to six mandatory interventions that are targeted toward a specific procedure or treatment. They can help standardize the language used, the specific care provided to promote best practice, and can act as a snapshot of an evidence-based guideline.

Education is key in pressure injury prevention. Education must be provided to health-care providers (HCPs) at all levels who interact with the patient. It must be multi-pronged and multi-modal. Patients and their families/care partners should receive information and training on skin and wound care, the need for frequent repositioning and when to seek medical attention. Written handouts with pictures should be given, and HCPs should speak at the patient's level of understanding and ask for the patient's and family's verbalization of understanding. It is important to regularly assess the effectiveness of education programs for both staff and patients so that the most up-to-date, relevant information is readily available.

Wherever possible, it is recommended that a nurse

specialized in wound, ostomy and continence care (NSWOC) be included in the pressure injury prevention/management team. NSWOCs can act as HCP-mentors; guides for prevention, practice and education; advocates; developers of best practice; collectors of data; and specialists in equipment and supplies.

Strong communication among members of the team can help reduce errors and improve patient and health-care provider satisfaction, as well as prevent readmission and even death. (It is important to remember that communication gaps can occur between the patient and HCPs and among HCPs.)

Programs using a bundled approach to PI prevention include the following components:

- Risk assessment
- Skin assessment
- Defined skin care regimen
- Measures to control extrinsic factors
- Nutritional education and support
- Use of appropriate support surfaces
- Patient and family education
- Clinician training
- Resources to guide staff with preventative care

These programs should be based on:

- A common outlook
- External support
- Bedside support and feedback
- Team communication
- Manager/leader communication and accountability

Litigation Related to Pressure Injuries

Primary Causes of Litigation

- Minimal to no patient/family education on the problem and the prognosis
- Unrealistic goals and prognosis
- Poor documentation of care and/or justification of selected treatment

Common types of litigations include:

- Disregarding prevention procedures
- Intentionally falsifying medical records
- Neglect or abuse
- Overmedication
- Malnutrition
- Care gaps (e.g., improper support surfaces, failure to turn and reposition, inadequate treatment, infection)

Prophylactic Dressings

A meta-analysis of 25 studies supports the use of a five-layer silicone dressing to the sacrum and coccyx as prevention against friction and shear. These dressings have been proven to combat extrinsic factors that can contribute to developing pressure injuries, including redistributing pressure and shear, reducing friction and tissue deformation, and maintaining an optimal microclimate. They are used in conjunction with regular skin assessment and use of support surfaces. While there are many prophylactic dressings available, they are not all built the same; the engineering behind the dressing is what will eventually determine healing outcomes.

REACT

Remove the source of pressure

Ensure you protect the skin

Assess and evaluate your intervention

Communicate with your team

Talk to your patient

Closing the Gap Between Planning and Implementing Prevention Strategies

The implementation of PI prevention strategies extends beyond the "doing" of a planned activity. Documentation must be balanced with patient care. Good documentation must be comprehensive, consistent, concise, chronological, continuous and reasonably complete. Success requires a shift from a solely unit-based PI management approach to a systemic, hospital-wide approach.

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