Reduction in pressure ulcers & Incontinence Associated Dermatitis in Adult Intensive Care Unit

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SKIN CARE BUNDLE - SKINS

S – Surface, Every patient is nursed on a **Nimbus mattress** unless contraindicated (unstable spinal or pelvic fractures)

K – Keep moving, Every patient is moved every 4 hours, if existing pressure ulcer or blanchable redness is present patient is moved every 2 hours.

I – Incontinence Care , Every patient has got urinary catheter in situ, Barrier wipes are used for prevention and treatment with very good effect.

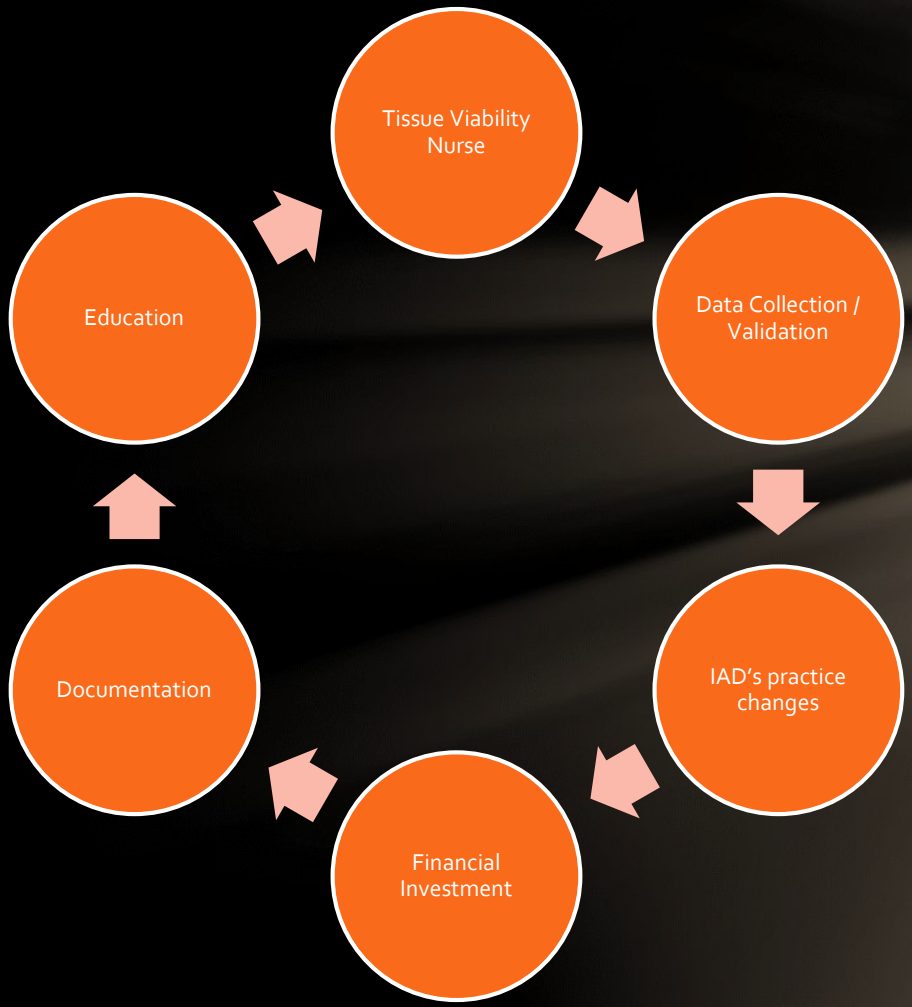
N – Nutrition, MUST score done every 12 hours and Dietician review daily

S – Skin inspection, skin is inspected every 4 hours, if existing pressure ulcer or blanchable redness is present skin is inspected every2 hours

Braden score is done on admission and then every 12 hours

Skin inspection is currently done within 6 hours of admission, however, this will change to skin inspection immediately after admission to the unit.

How we have achieved a reduction in pressure ulcer and IAD's incidences in AICU?



AICU Tissue Viability Nurse was appointed

Clinical role

- TV Ward Round and patient's reviews
- Dressing changes
- Working with surgical colleagues, etc…

Education

- Teaching at study days
- Teaching at Foundation Course
- Competency framework for our staff

Administrative Role

- Datix and data validation
- Monthly reports
- Audits, Data collection
- Stock levels and orders

Tissue Viability Ward Round

Tissue Viability Nurse works clinically with nurses and patients on a regular basis, which enhances theoretical and practical skills for nurses.

Patients with no pressure damage are assessed also and are being recommended what pressure ulcer prevention would be the best for them.

All nursing documentation regarding Pressure Ulcer Assessment & Prevention is being checked/assessed on a regular basis.

Most ICU patients will always have some kind of wound, these are assessed, redressed and documented on a wound care plan as part of the tissue viability ward round.

Validation of our data

. Made a huge difference

. All reported skin issues and pressure ulcers are assessed and validated

and Data forms corrected accordingly by the AICU Tissue Viability Nurse.

. Pressure ulcer rates dropped significantly, especially grade II PU's.

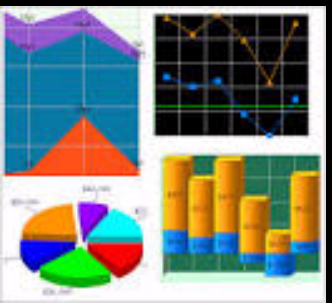
. Moisture lesions were often mistaken for grade II pressure ulcers.

. Diabetic or leg ulcers mistaken for grade III and IV pressure ulcers.

. Mucosal & Equipment related pressure ulcers and moisture damage were

reduced by investing in new equipment (Hollister ET tapes, Shield Barrier wipes).

. Close working relationship with Clinical Governance co-ordinator



Data

Month	Inherited PU's	Acquired PU's	Inherited IAD	Acquired IAD
January 2014	10 (in 6 pt's)	5	N/A	15
February 2014	5	1	N/A	13
March 2014	4	3	N/A	16
April 2014	6	2	N/A	11
May 2014	4 (in 6 pt's)	4	N/A	4
June 2014	14 (in 7pt's)	3	4	9
July 2014	8 (in 6 pt's)	4	6	11
August 2014	7 (in 7 pt's)	2	2	2
September 2014	5 (in 3pt's)	4	3	2
October 2014	9 (in 4pt's)	2	6	2
November 2014	2	2	4	1
December 2014	2	0	2	4

Pressure Ulcer and IAD date 2015 (JR)

Month	Inherited PU's	Acquired PU's	Inherited IAD	Acquired IAD
January 2015	1	2 (Shin, finger)	6	2
February 2015	12 (in 5pt's)	1 MPU (prone patient)	4	0
March 2015	9 (in 6 pt's)	1MPU	5	2
April 2015	2 (in 2 pt's)	0	6	1
May 2015	14 (in 8 pt's)	1 (heel)	4	1
June 2015	10	9	No data	No data
July 2015	4	1 (prone patient)	4	5 (sweat)
August 2015				
September 2015				
October 2015				
November 2015				
December 2015				

IAD prevention / treatment

Pre-implementation , the IAD prevalence rate was 18%. Following implementation of a standardised incontinence protocol the average monthly IAD was 8.5%. This represents an average monthly IAD reduction of 54%.

Prior to implementation, standard of care for incontinence skin care involved skin cleansing foam or water with liquid soap, paper basin bowel, cloth and barrier cream or spray for treatment only.

Post implementation , standard of care for incontinence skin care involved skin cleansing foam or water with liquid soap and all-in-one, disposable , dimethicone – infused barrier cloths.

Financial Investments and Variety of equipment

Skin Care


COMFORT
SHIELD
Skin Care and
Pressure Ulcer
Prevention Basket
Bed Space - C5


Patients Name (please print):
Date:
Gentle Wash
250g
QV
Skin Lotion
for dry skin conditions
250mL
Bath Oil
250mL


COMFORT SHIELD® BARRIER CREAM CLOTHS
DO'S
DON'T
QV

Documentation

Tissue Viability Nurse Assessment Chart 03/07/2015 18:3

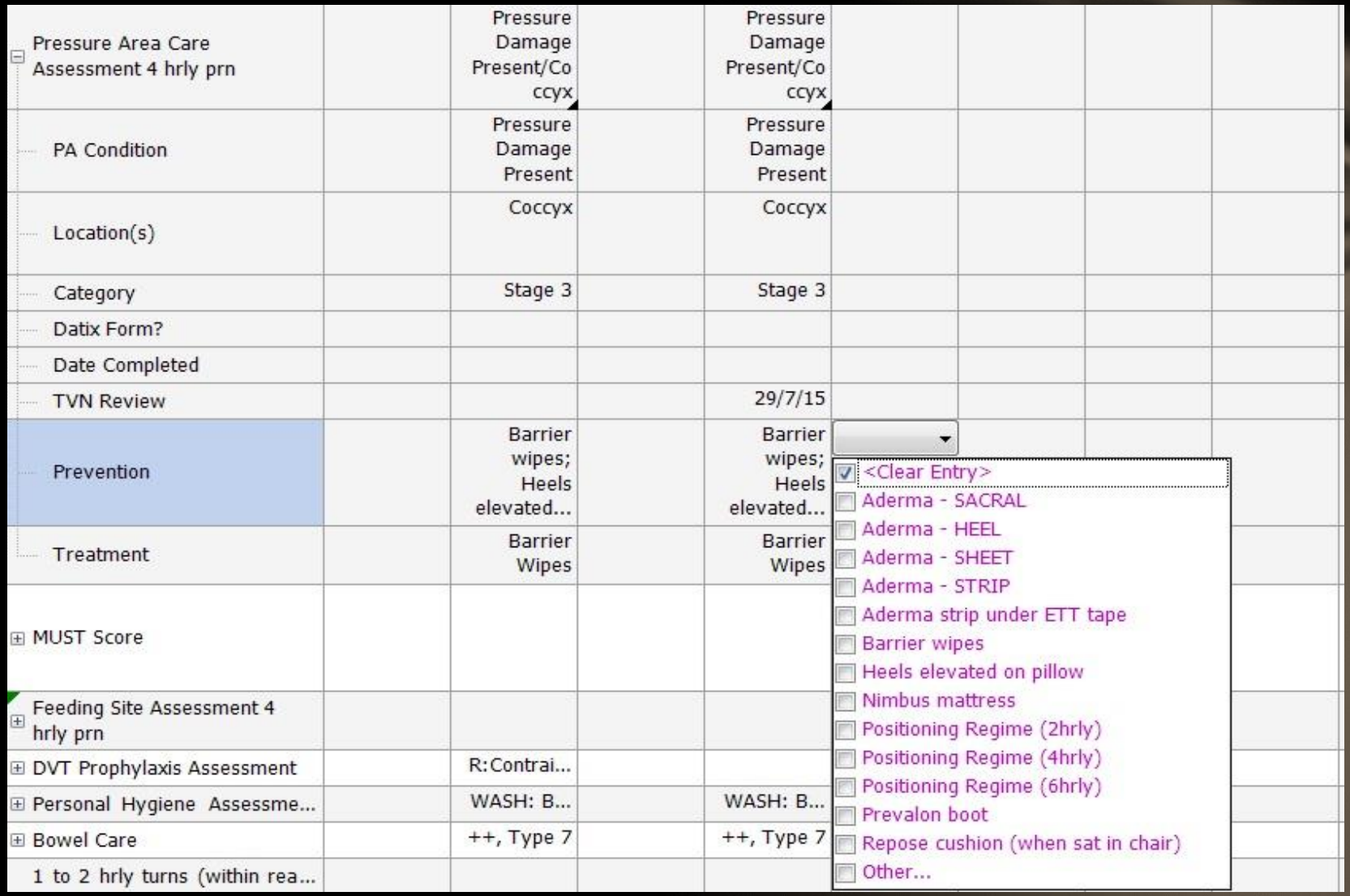
Assessment Chart	
Pressure Area Assessment	03/07 Patient admitted from community on 22/6 with grade III pressure ulcer to sacrum. Patient assessed on 03/07. Pressure Ulcer is 2.0 x 1.5 cm. No slough. Nice clean wound bed. 09/07 Sacral PU detoriated to ischaemic (purple) wound with dark edges, but not yet necrotic, also not a clear impression of SDTI. Keep documenting as a grade III , because bone, tendon not visible. Please annoted "Sacral PU detoriated to ischaemic (purple) wound with dark edges, but not yet necrotic, also not a clear impression of SDTI." Incontinence Associated Dermatitis (IAD) developed. Treat with Barrier wipes only.
Pressure Ulcer Prevention Plan	. STRICTLY 2 hourly rolls and skin inspection . Pillows between legs and under legs, we should utilize at least 5 pillows when repositioning Alice. . Alice being seen by Dietetian on regular bases . Braden score - VERY high risk due BMI 9.0 . Nursed on Nimbus mattress . Heels to be elevated on pillows at all times . Barrier wipes - leave one on her skin for Alce to sit on it due to continues diarhoea (flexiSeal failed)
Skin Assessment	Please,Use adhesive remover for any adhesive tapes or dressings. Alice is very skinny (BMI 9.0) with poor skin condition. She has developed multiple leg ulcer to both legs and feet. She has got multiple areas of skin tears and subtucaneous petechial bleeding. Due to her weight loss and poor skin condition she is very high risk of developing pressure ulcers and skin tears. 09/07 - Left heel has dry cracked skin. No pressure damage, all blanching....
Skin Care Plan	Wash gently with QV wash and apply QV cream (tube). Moisturize her legs and feet.
Tissue Viability Nurse Review	
⊞ Tissue Viability Review	05/07/2015; 07/07/2015; 08/07/2015; 09/07/2015; 13/07/2015; 17/07/2015; 22/07/2015; 27/07/2015; 29/07/2015

Documentation

Pressure Area Care Assessment 4 hrly prn	Pressure Damage Present/Coccyx		Pressure Damage Present/Coccyx						
PA Condition	Pressure Damage Present		Pressure Damage Present						
Location(s)	Coccyx		Coccyx						
Category	Stage 3		Stage 3						
Datix Form?									
Date Completed									
TVN Review			29/7/15						
Prevention	Barrier wipes; Heels elevated...		Barrier wipes; Heels elevated...						
Treatment	Barrier Wipes		Barrier Wipes						

<Clear Entry>
Blancheable Erythema of Intact/Discoloured Skin
Non-blanchable erythema of intact skin/discoloured skin
Partial thickness epidermis/dermis loss. Superficial ulcer.
Full thickness skin loss with damage/necrosis of subcut tissue
Extensive destruction, tissue necrosis or damage to muscle/bone
Moisture Lesion/Excoriation
Suspected Deep Tissue Injury 'SDTI'
Friction Injury
Other...

Documentation



Pressure Area Care Assessment 4 hrly prn		Pressure Damage Present/Coccyx		Pressure Damage Present/Coccyx				
PA Condition		Pressure Damage Present		Pressure Damage Present				
Location(s)		Coccyx		Coccyx				
Category		Stage 3		Stage 3				
Datix Form?								
Date Completed								
TVN Review				29/7/15				
Prevention		Barrier wipes; Heels elevated...		Barrier wipes; Heels elevated...				
Treatment		Barrier Wipes		Barrier Wipes				
MUST Score								
Feeding Site Assessment 4 hrly prn								
DVT Prophylaxis Assessment		R:Contrai...						
Personal Hygiene Assessme...		WASH: B...		WASH: B...				
Bowel Care		++, Type 7		++, Type 7				
1 to 2 hrly turns (within rea...								

- <Clear Entry>
- Aderma - SACRAL
- Aderma - HEEL
- Aderma - SHEET
- Aderma - STRIP
- Aderma strip under ETT tape
- Barrier wipes
- Heels elevated on pillow
- Nimbus mattress
- Positioning Regime (2hrly)
- Positioning Regime (4hrly)
- Positioning Regime (6hrly)
- Prevalon boot
- Repose cushion (when sat in chair)
- Other...

Teaching & Education

. 1:1 teaching at bedside.

. 1.0 hrs lecture at Foundation Course.

.. Tissue Viability link nurse study day.

. Tissue Viability Board and topic of the month.

. Difference between moisture lesion an PU's cards at every bed space.

. Plan for education of band 7's and ward managers.

Thank you.....