Reálné zkušenosti v prevenci dekubitů ve Velké Británii

Irena Pukiová
Sestra specialistka pro léčbu rány
Jenotka intenzivní péče / ARO
Univerzitní nemocnice Oxford

Práce sestry specialistky pro léčbu rány na jednotce intenzivní péče

Klinická práce

- vizita a dokumentace u pacientů
- převazy na lůžku;
- převazy na operačním sále (VAC);
- komunikace a vizita nemocného s dalšími týmy (trauma, plastika);
- kontrola dodržování plánu péče (investigace);
- zavádění a průběžný monitoring změn v praxi;
- vyšetření a dokumentace u pacientů před propuštěním z jednotky intenzivní péče.

Edukace personálu

- přednášení na FC kurzu;
- dohled nad sestrami při převazech;
- publikace vzdělávacích materiálů nebo kazuistik v rámci oddělení;
- zajištění kompetence personálu ;
- organizace studijních dní a materiálů k výuce;
- management pěti ‘’link nurses’’.

Kancelářská práce

- SKINS audit;
- měsíční hlášení;
- kontrola dodržování plánu péče a dokomuntace (investigace);
- investigace a validace všech hlášených dekubitů (Datix system);
- ISR a SIRI Forum a s nimi spojené vyšetřování dekubitů;
- posouzení a zavádění všech ošetřovatelských změn do praxe;
- vytváření procesů nebo podílení se na vytváření procesů v rámci celé nemocnice nebo UK;
- účast a vedení schůzí v rámci nemocnice;
- příprava materiálů na konference.

Aktivní prevence dekubitů

Pressure Area Care in Adult Intensive Care Unit

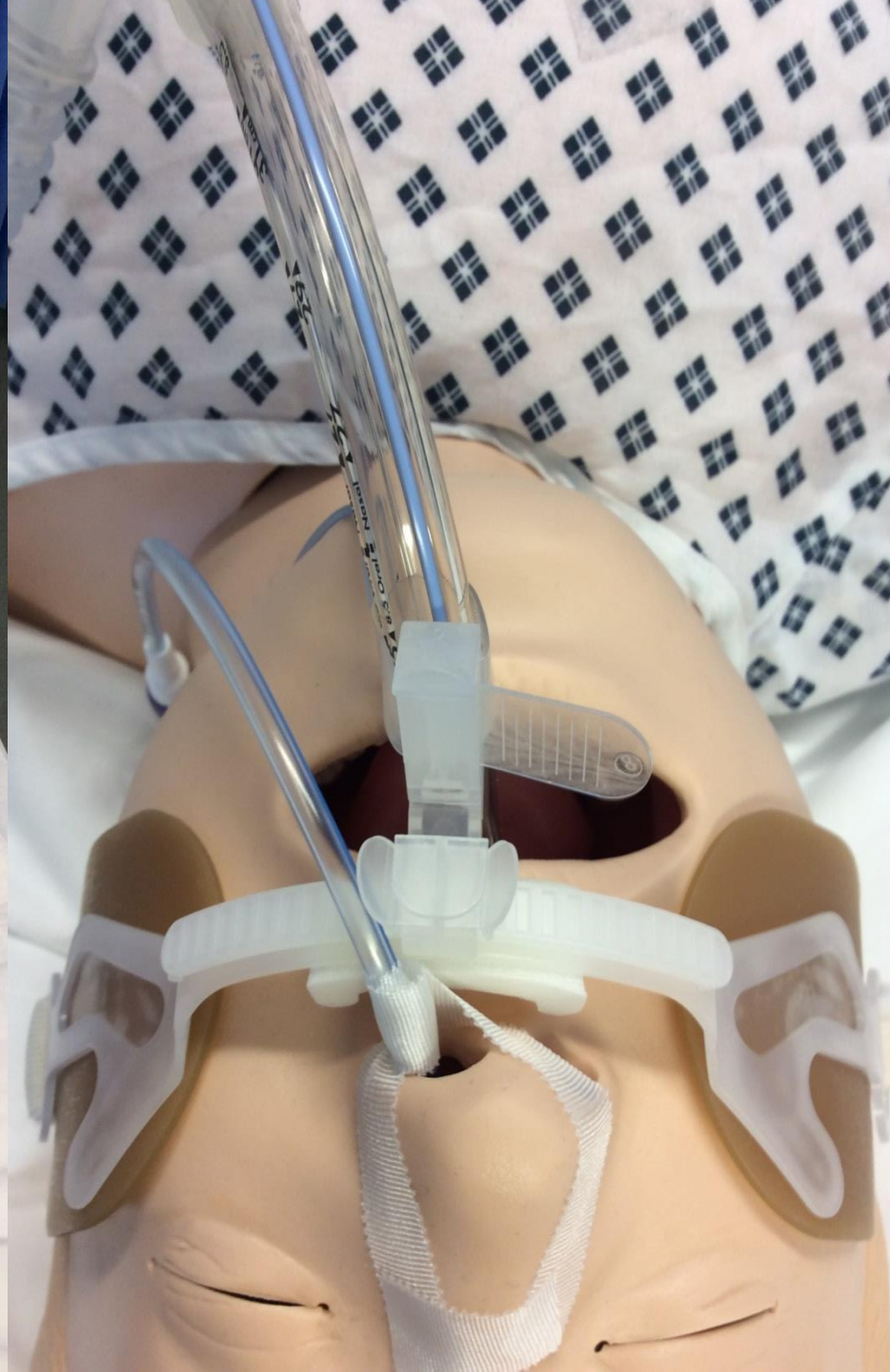
Care for patients with no pressure damage

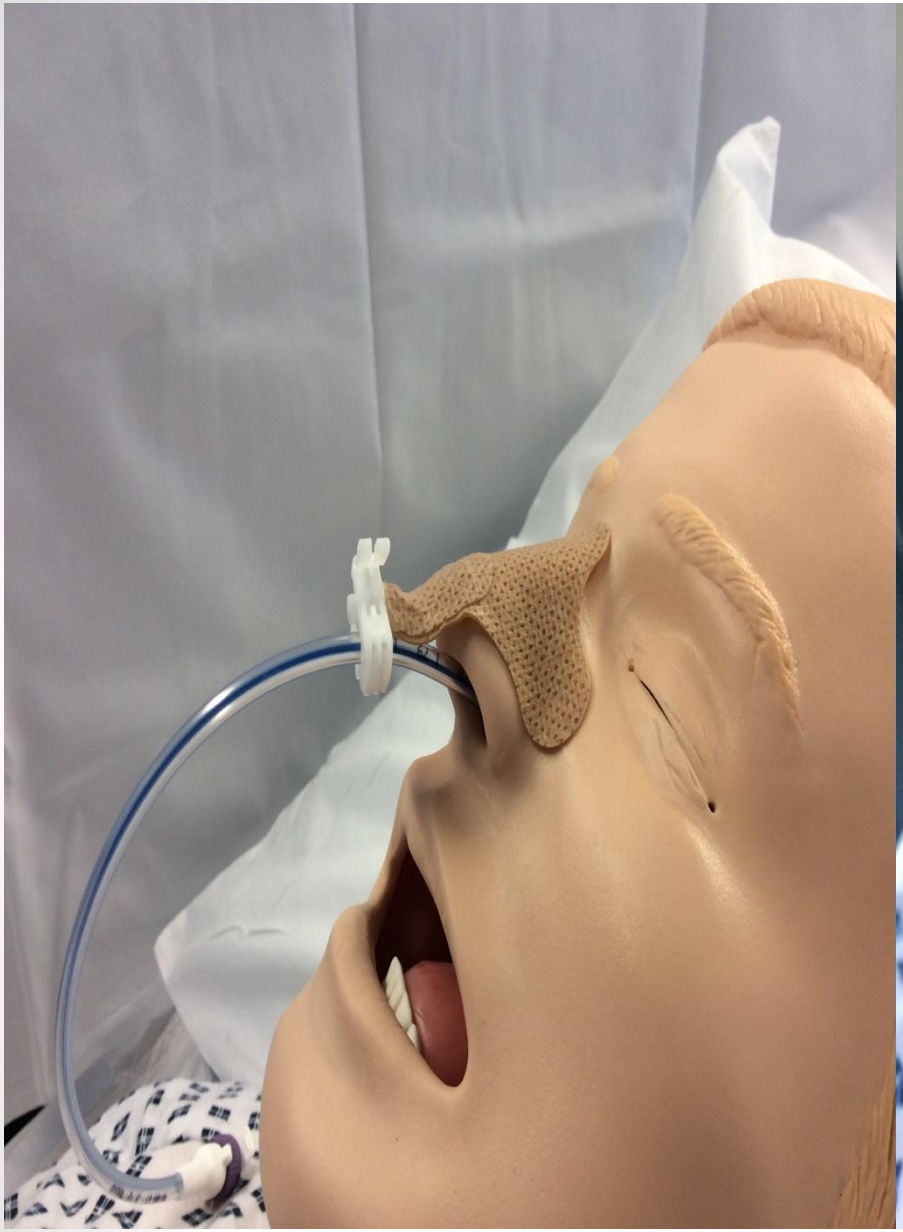
Care for patients with a pressure damage

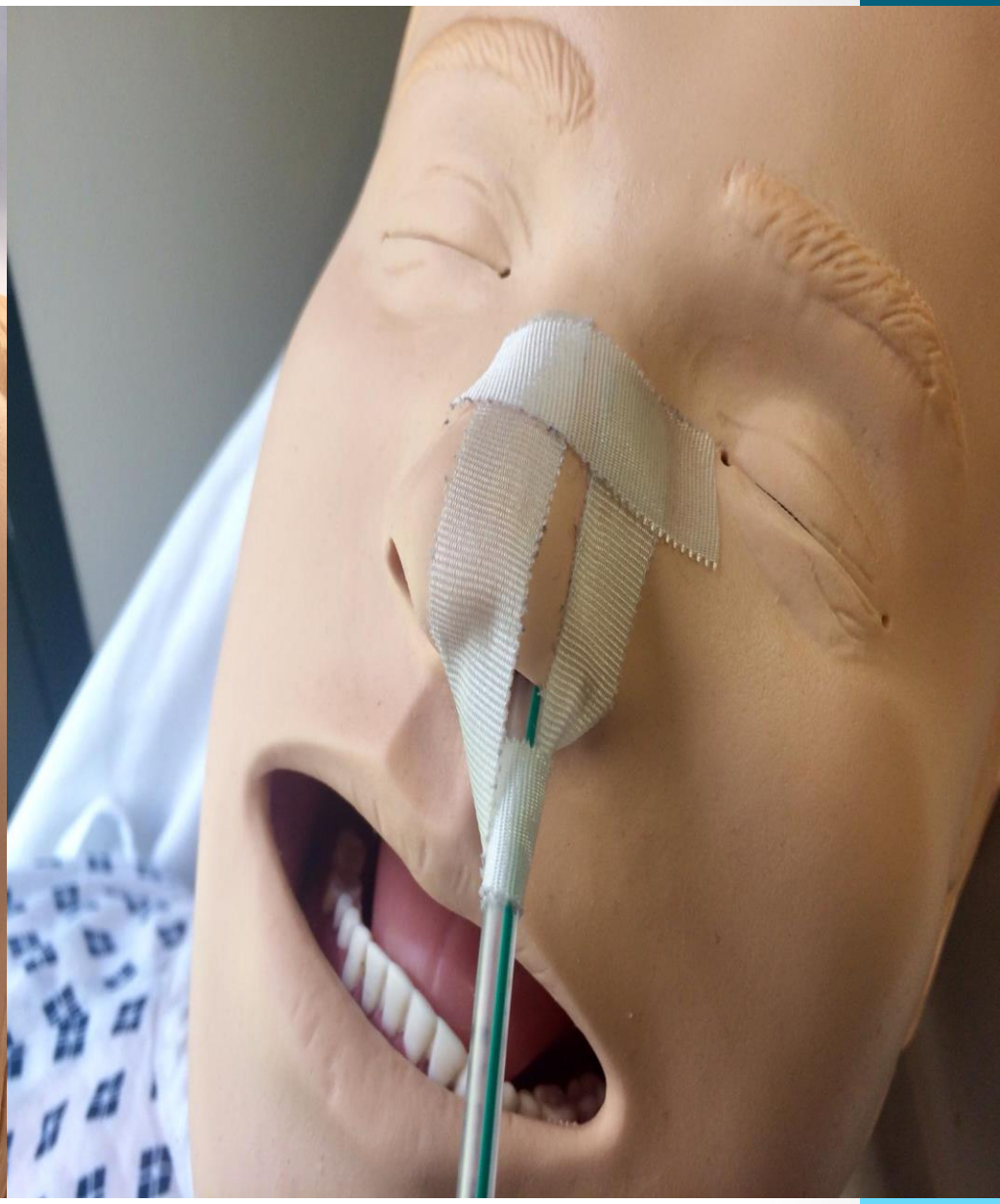
If the patient is admitted with or develops pressure ulcer **(starts from blanchaeble redness)** , frequency of repositioning and skin inspection must be changed to 2 hourly.
Any deviation from repositioning schedule needs to be clearly documented on CareVue under pressure area care with reason why it could not have been done according required schedule.
If decision not to roll a patient frequently is made by a consultant on duty this needs to be clearly documented in medical notes with date when this will be reviewed.

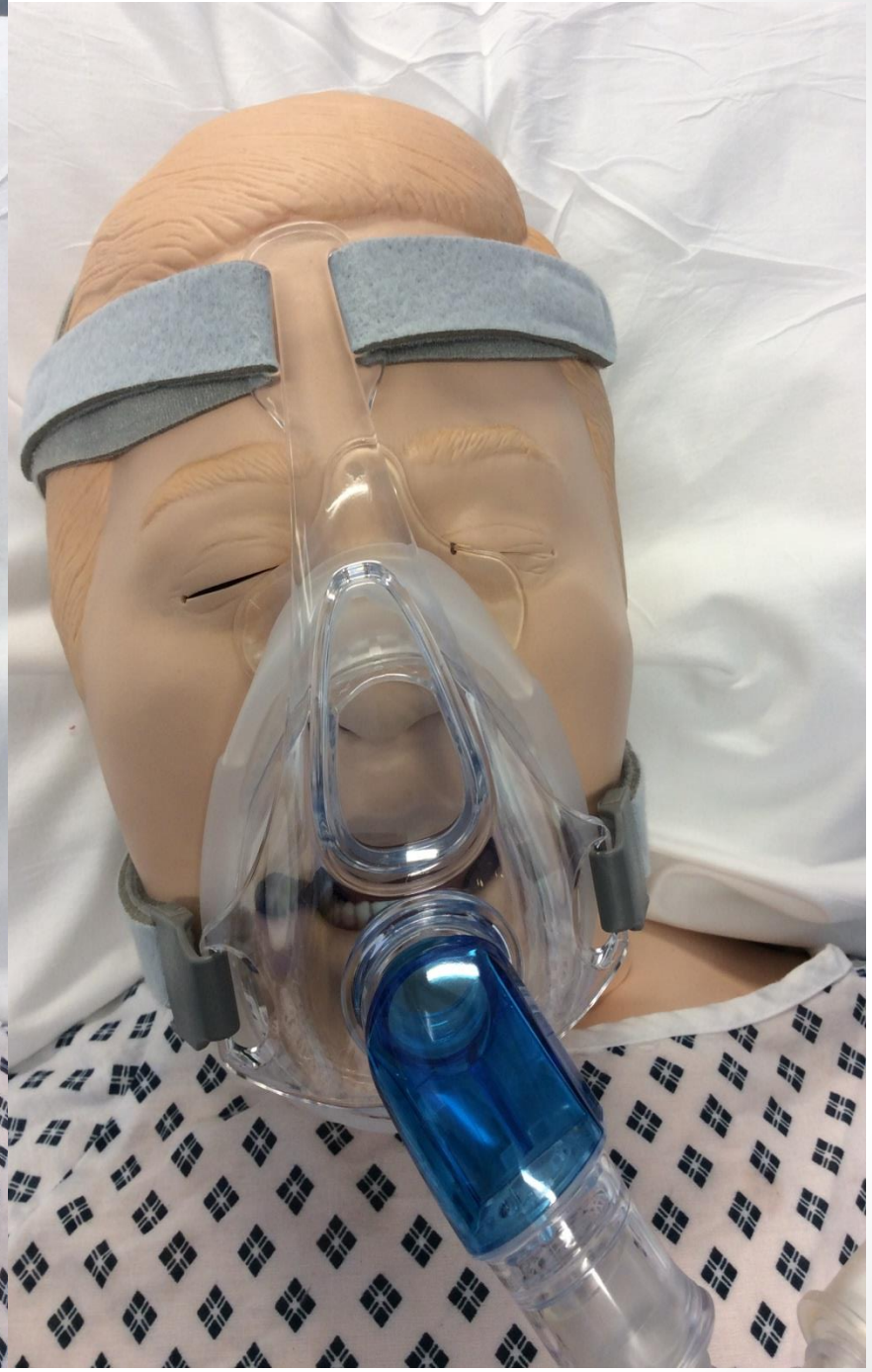
Pressure Area Care in Adult Intensive Care Unit/Irena Pukiova-AICU TVN/ April 2016/Vol.1

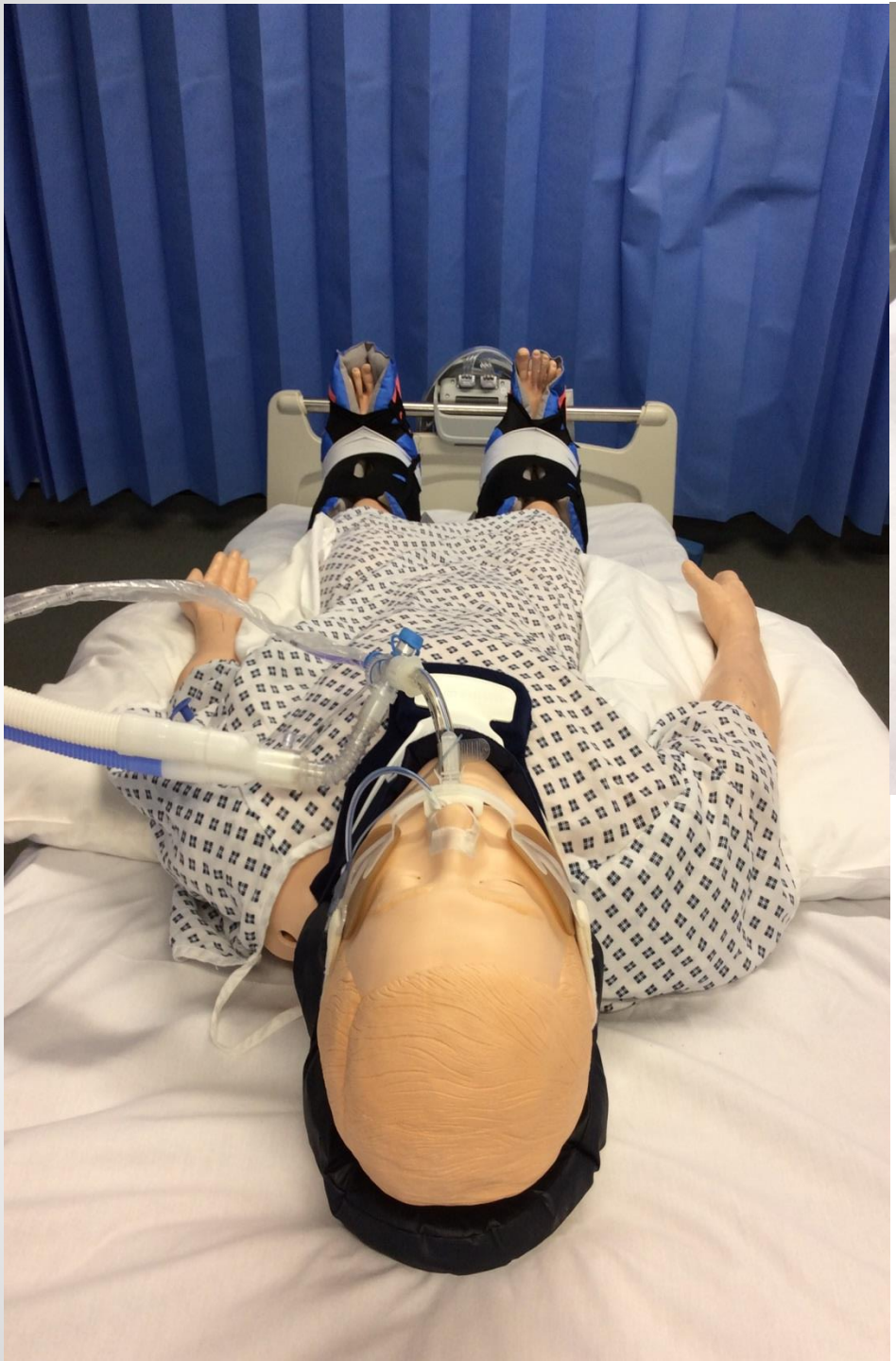
Pomůcky k prevenci dekubitů

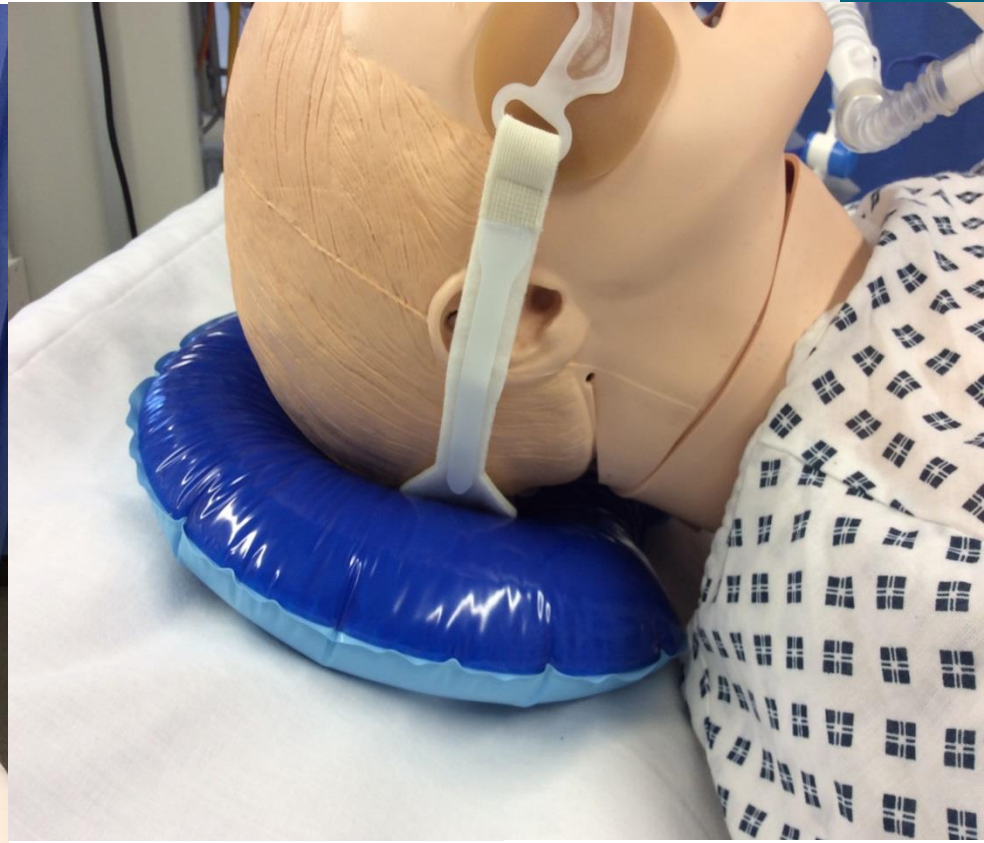










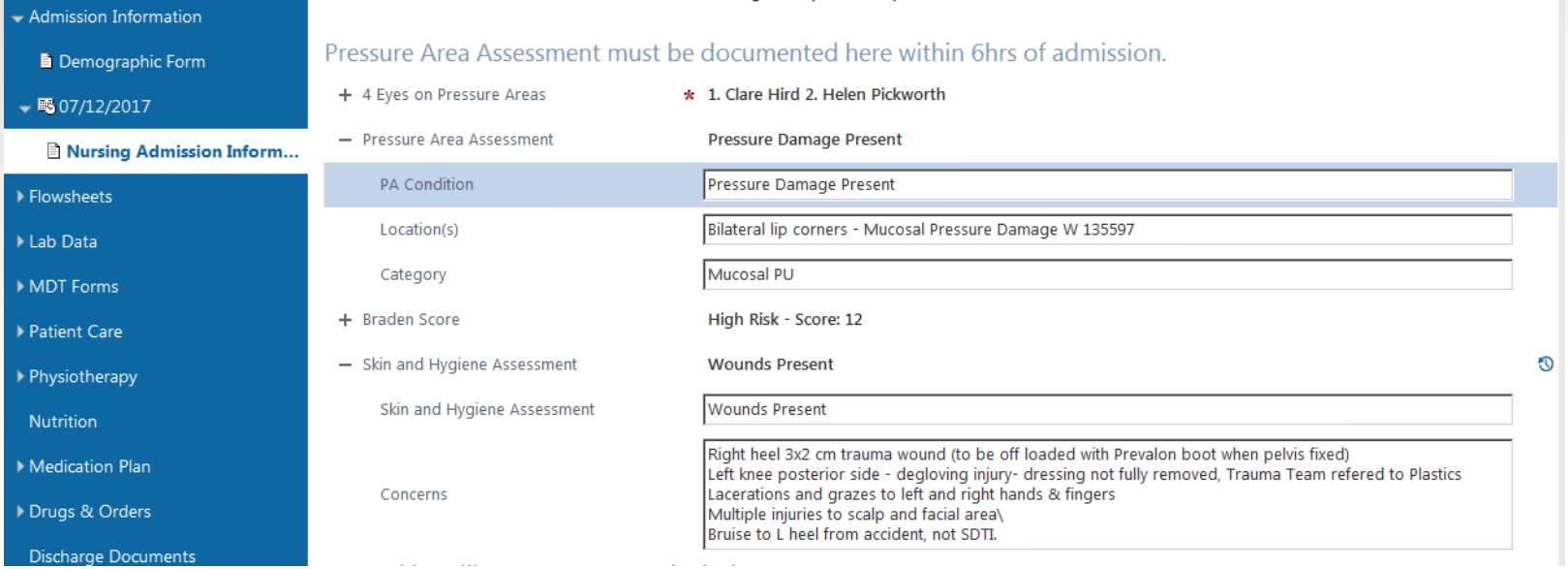



QV
Cream
for dry skin conditions
ego
QV
Gentle Wash
soap alternative for
dry skin conditions
QV
Cream
for dry skin conditions
Appeel
No sting
Medical
Adhesive
Remover
REF 3500

Dokumentace

Pressure Area Care Assessment 4 hrly prn	Pressure Damage Present...			Pressure Damage Present/Coccyx		Pressure Damage Present/Coccyx				
PA Condition	Pressure Damage Present			Pressure Damage Present		Pressure Damage Present				
Location(s)	coccyx, rt shoulder, rt scapular			Coccyx		Coccyx				
Category										
Datix Form?										
Date Completed										
TVN Review						29/7/15				
Prevention	Nimbus mattress; Positioning...			Barrier wipes; Heels elevated...		Barrier wi				
Treatment	Barrier Wipes			Barrier Wipes						
MUST Score										
Feeding Site Assessment 4 hrly prn										
DVT Prophylaxis Assessment				R:Contrai...						

- [ ] <Clear Entry>
- [ ] Aderma - SACRAL
- [ ] Aderma - HEEL
- [ ] Aderma - SHEET
- [ ] Aderma - STRIP
- [ ] Aderma strip under ETT tape
- [x] Barrier wipes
- [x] Heels elevated on pillow
- [x] Nimbus mattress



ETT Pressure Area Care		Skin Condition Assessed				Skin Condition Assessed
Skin Condition		No Pressure				No Pressure
Treatment/Action		Skin Condition Assessed				Skin Condition Assessed
Type of ET Tape		Hollister Anchor Fast				Hollister Anchor Fast
Feeding Site Assessment 4 hrly prn		Fine bore NG				Fine bore NG
Type		Fine bore NG				Fine bore NG
Location		L Nostril				L Nostril
First Marker		58				58
Condition		No Pressure				No Pressure
Treatment/Action		Skin Condition Assessed				Skin Condition Assessed

Analýza dekubitů

Oxford University Hospitals NHS
NHS Foundation Trust

Incident Investigation Report for Hospital Acquired Pressure Ulceration (HAPU)

Please delete all red/purple writing

SIRI 1920-xxx STEIS 20xx/xxxxx
Safeguarding Alert Reference if applicable:
Delete this box if not a Serious Incident

Division:
Ward/Department:
Datix Number: Wxxxxx ID xxxxx
Date of Incident:
Date Category of HAPU Confirmed by the Tissue Viability Team:
Investigation Team:

Involvement and Support of the Patient and/or Relatives (Duty of Candour)
Duty of candour is applicable if an incident has been categorised as moderate or above; but even if duty of candour does not apply, involvement and support of the patient and/or relative should be considered.

Summary of Incident
This section should be a short paragraph and factual
e.g.
- A patient sustained a hospital acquired category four pressure ulcer on the right heel.
- After a two month hospital admission a palliative care patient was diagnosed with a category 3 pressure ulcer to the sacrum.
- Description of the ulcers including dimensions

Pressure Ulcer Location and Dimensions

Please complete the form below in relation to the care assessed, planned, implemented and reviewed. (Assurance audits of patient documentation may be undertaken to ensure consistency in investigation processes)		
Admission information	Date/time of admission to OUH: Reason for admission to OUH: Date/time of admission to clinical area:	
Trust standard	**Detail**	**Compliance with Trust policy: Yes/No/NA**
Reporting	Was all pressure damage, irrespective of origin (category 1 to 4 and suspected deep tissue injury (SDTI)) reported on Datix as soon as identified?	

Medical devices	Was a medical device involved in this incident? If yes, please ensure that the 'Medical Device' box is ticked on the Datix form to reflect this.	
	Were risks associated with the medical device(s) considered?	
Risk assessment	Was the Braden risk assessment completed within 6 hours of admission to the clinical area?	
	Was the initial assessment accurate?	
	Were all assessments repeated weekly as a minimum and were they accurate?	
	If there were any significant changes in the patient's clinical condition that necessitated reassessment of pressure ulcer risk was this completed?	
Further comments		
Pressure ulcer prevention care plan	Was an appropriate care plan instigated to reflect risks as outlined above, including prescribed care of skin under medical devices?	Date of implementation:
	Is there evidence of appropriate review?	
Further comments		
Skin assessment	Was a skin assessment completed within 6 hours of admission to the clinical area?	
	Were skin assessments completed daily or as prescribed in the care plan?	
	Did skin assessment include the areas under any medical devices?	
	Was the care plan reviewed appropriately?	
Further comments		

Repositioning	Was an appropriate repositioning schedule included in a care plan that reflected the patient's risk?	
	Does the documentation consistently demonstrate regular repositioning?	
	Was the repositioning schedule reviewed?	
	Were any concordance issues documented and steps taken to remedy them?	
Further		

comments		
Continence care	Were the patient's continence needs assessed?	
	Was an appropriate plan of care documented?	
	Was the care delivered according to the care plan?	
	Was the care reviewed?	
Further comments		
Nutrition	Was the MUST score completed within 6 hours of admission?	
	Was a care plan instigated if the patient was at risk?	
	Does the documentation reflect reassessment?	

Equipment	Is there documented evidence that an appropriate mattress was in use?	
	Please state the type of mattress and the date of introduction.	
	Any documented issues with use?	
	Please state type of cushion and date of introduction.	
	Was the patient sat out for an agreed period?	
	If heels were the site of damage, were offloading devices in place prior to the discovery of the pressure damage?	
	If yes to the above, please give details of the device and date in use from.	
	Was the equipment used appropriately?	
	If a medical device was the cause of the damage, was the correct device selected and was it used appropriately?	
Further comments	Please state reasons if any delays in equipment implementation identified	
Cast and splinting related pressure damage	Was the cast or splint applied by an appropriately trained individual?	
	Was appropriate follow-up arranged?	
	Did the patient/carers receive written information on how to seek support with any	

	problems associated with the cast/splint?	
	If the cast/splint was removable, was the patient/carer instructed how to remove the cast to check the skin?	
Further comments		
Staffing	Was staffing at agreed levels or risk mitigated?	
	What is the pressure ulcer eLearning compliance % for the clinical area nursing staff?	
Further comments		
Any additional considerations		
Learning points from the review		
Safeguarding matrix score (see below)		

Immediate Actions

Detail actions already taken in bullet points, eg

- Suitable mattress supplied to patient, repositioning chart commenced


thank you
danke
謝謝
ngiyabonga
teşekkür ederim
gracias
merci
obrigado
bedankt
dziękuję
go raibh maith agat
sukriya
kop khun krap
terima kasih
dakujem
arigatô
grazie
tapadh leat
mochchakkeram
mauruuru
hvala
dank je
спасибо
рахмат
Баярлалаа
faafetai lava
kiitos
dankie
dhanyavad
köszönöm
gràcies
chnorakaloutioun
gratias ago
sulpáy
taiku
takk
sagolun
sobodi
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didi madloba
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ありがとう
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ευχαριστώ
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diolch
dhanyavadagalu
shukriya
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мерси
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murakoze
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obrigada
asante
manana
хвала
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bayarlalaa
gràcie
nanni
nandri
dhanyavad
kiitos
dankie
vinaka
спасибі
blagodaram
misaotra
matondo
paldies
grazzi
mahalo
spas
tack
welalin
barka
kia ora
mersi