Pressure Ulcer Prevention Protocols and Evidence-Based Interventions Reduce Pressure Ulcers at Sacrum and Heel

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Methods

The QI intervention was implemented in two medical/surgical units and an inpatient geriatric rehabilitation unit. The objectives of the QI initiative were to ensure a standardized approach to HAPU prevention, and that high-risk patients received interventions for HAPU prevention.

Clinical Setting: The QI initiative was implemented in the medical/surgical and geriatric rehabilitation clinical settings: two medical/surgical units (13-beds and 24-beds) and a 18-bed inpatient geriatric rehabilitation unit.

Standard of Care: Prior to the QI intervention, standard of care for patient management was to consult Occupational Therapy whether a mattress or off-loading device was indicated.

QI Interventions: Risk-stratified interventions were developed based on patient risk according to the Braden sub-scale scores. The Director of Rehabilitation and Unit Managers developed protocols for risk-stratified QI interventions. The objective of the QI initiative was to ensure a standardized approach to HAPU prevention.

- Intervention for hospital-acquired sacral pressure ulcer (HAPU) prevention was a turn and position system designed to assist in frequent patient repositioning without excess shear and friction.
- Intervention for hospital-acquired heel pressure ulcer (HAPU) prevention was a heel off-loading device designed to maintain a neutral position of the foot and leg, and reducing risk of plantar flexion contracture and external rotation.

Point Prevalence Surveys: Prior to the QI intervention, point prevalence surveys were conducted on the two medical/surgical units and inpatient geriatric rehabilitation unit to capture baselines for comparison and assessment. Thirty days after launching the QI intervention, point prevalence surveys were conducted to assess the impact and/or effectiveness of the risk-stratified interventions on HAPU prevalence.

Educational: Staff was educated by both the product representative and Occupational Therapy on use of the Braden subscale for risk assessment and the protocols developed for the QI intervention and risk-stratified interventions. In addition, in-service education was provided on appropriate application and utilization of turn and position and heel off-loading devices.

Results

Comparison of the before and after point prevalence surveys revealed a 45.5% reduction in HAPUs and 68.8% reduction in HAPUs (Figure 1).

Conclusion

The QI intervention was successful in implementing a standardized, evidence-based approach to HAPU prevention in the medical/surgical and geriatric rehabilitation patient population. The risk-stratified protocols using the validated Braden subscale for risk identification were useful for ensuring high-risk patients received interventions for HAPU prevention. Implementation of the Accreditation Canada ROP for HAPU prevention requires interprofessional collaboration to ensure validated risk assessment tools are utilized in conjunction with risk-stratified, evidence-based interventions.

Acknowledgments/Disclosure

The authors would like to acknowledge the dedicated efforts of the following individuals and their teams: Debbie MacIsaac, ICU/ER Manager; Andrea MacDonald, GARU/Med-Surg/Stroke Unit Manager; Ashley Cameron, Assistant Manager, Inpatient Medical Units. Sponsorship to attend the Conference was received from Sage Products, LLC.

References


Presented at: CAWCC and CAET 20th Annual Conference, Toronto, Ontario, Canada; October 30, 2014-November 2, 2014