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Taking off the Pressure !

- Unravelling The Mystery Of Preventing Pressure Ulcers In The Community

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Where We Are In WA

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Perth-Carnarvon 902 km
Perth-Eucla 1,436 km
Perth-Walpole 423 km

- METROPOLITAN
- RURAL
- REMOTE
- BRANCH LOCATIONS

Presentation Content

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- Background
- Project Rationale
- Project Design
- Tools Developed
- Results
- Lessons Learned

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Background

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- Worldwide recognition of costs of pressure ulcers
- Evidence for effectiveness of Clinical Guidelines
- 1996 - 2001 AWMA National Guidelines for Pressure Ulcer Prediction and Prevention
- 1999 - 2000 Prentice and Stacey implemented study on AWMA Guidelines into acute hospitals in Australia

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- Many Silver Chain clients are cared for by non-clinical staff
- Many of these clients have limited mobility
- Poor mobility increases the risk of pressure ulcers
- Currently no standardised pressure ulcer risk management across Silver Chain
- Prediction and prevention of pressure ulcers can be achieved by implementing appropriate guidelines

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Project Design

- Stage 1 : Baseline Prevalence and Staff Knowledge
- Stage 2: Implementation of AWMA Guidelines
- Stage 3 : Follow up Prevalence and Staff Knowledge
- Stage 4 : Second Follow up Prevalence

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Survey of high risk clients for pressure ulcers (identified using the mobility sub-scale of Barthel Index, a standardised measure of ADLs)

- 2002: 175 clients
- 2003: 147 clients
- 2004: 183 clients

Prevalence Survey Methodology

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- One surveyor, tested for inter-rater reliability
- Wound care specialists for clients with wounds
- Surveyor had at least one support visit with specialist

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- This included knowledge and current practices
- Questionnaires sent to all staff in all areas ie Rural, Remote, Residential, Metropolitan Community and Hospice areas
- Two questionnaires were developed for clinical and non-clinical staff

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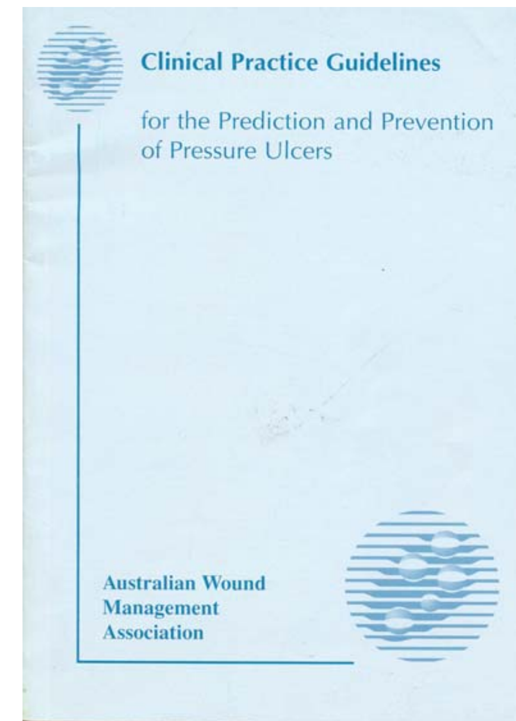
Developed and implemented processes for:

- Risk assessment
- Risk management
- Documentation



To do this education of staff, clients and carers was required

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Documentation – Innovative Range of Tools Developed

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Pressure Ulcer Risk Assessment Management System (PURAMS):

- Assessment Tool adapted for the community
- Equipment protocol linked to risk score and presence/stage of pressure ulcer
- Clear protocol for collecting incidence of pressure ulcers

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CLI-FRM-089

PRESSURE ULCER RISK ASSESSMENT & MANAGEMENT SYSTEM (PURAMS PART A)
CLINICAL & HOSPICE CARE

Name: ....
PID: ....

BRADEN SCALE

					DATE		
					1	2	3
A) Sensory Perception Ability to respond meaningfully to pressure related discomfort.	**1 Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation, **or** limited ability to feel pain over most of body surface.	**2 Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, **or** has a sensory impairment which limits ability to feel pain over ½ of body.	**3 Slightly Limited** Responds to verbal commands but cannot always communicate discomfort or need to be turned, **or** has some sensory impairment or discomfort which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4 No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. **Sensory Perception Score:**			
B) Moisture Degree to which skin is exposed to moisture.	**1 Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2 Moist** *Skin is often but not always moist.* Linen must be changed at least once a shift.	**3 Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4 Rarely Moist** Skin is usually dry; linen requires changing only at routine intervals.			
C) Activity Degree of physical activity.	**1 Bedfast** Confined to bed.	**2 Chairfast** Ability to walk severely limited or non-existant. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3 Walks Occasionally** Walks occasionally during day for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4 Walks Frequently** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.			
D) Mobility Ability to change and control body position.	**1 Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2 Very Limited** Makes occasionally slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3 Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4 No Limitations** Makes major and frequent changes in position without assistance.			
E) Nutrition Usual food intake pattern.	**1 Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, **or** NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2 Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein in-take includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, **or** receives less than optimum amount of liquid diet or tube feed.	**3 Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, **or** is on a tube feeding or TPN regimen, which probably meets most of nutritional needs.	**4 Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.			
F) Friction and Shear	**1 Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2 Potential Problem** Moves freely or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3 No Apparent Problem** Moves in bed and chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	**Braden Score:**			
G) Carer Support	**1 Carer Required but not Available** To promote and maintain skin integrity.	**2 Carer Support Available < 50% Time** To promote and maintain skin integrity.	**3 Carer Support Available > 50% Time** To promote and maintain skin integrity.	**4 No Carer Required** Manages independently or has adequate support to promote skin integrity, ie: nursing home resident. **Carer Support Score:**			
The PURA score equals the Braden Score plus the Carer Support Score				**Pura Score:**			

Assessor's Signature			
	Signature 1	Signature 2	Signature 3

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Early Risk Assessment for All Clients at Risk

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Clinical & Hospice
→ Movement Flag
→ PURA
→ Prevention/Treatment Guidelines
→ Review/Audit

HSS Supported
→ Movement Flag
→ PURA
- → Stage 2-4 PU and Eschar → Clinical Referral → Review/Audit
- → Very High Risk and Stage 1 PU → Refer to GP, OT, Case Manager, etc for support with management → Review/Audit
- → Low to High Risk and No PU → Prevention Guidelines
  - Liaise with Care Aide
  - Carer information
  - Send ILC equipment information

  → Review/Audit

HSS Independent
→ Movement Flag
→ No PURA
→ Send letter to client and ILC equipment information

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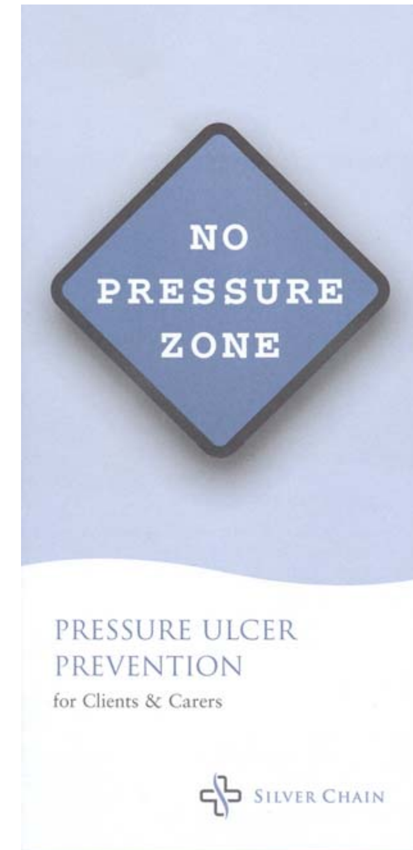
- What is a pressure ulcer?
- Assessing the risk
- Skin assessment and protection
- Prevention equipment
- Common pressure ulcer sites



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Education of Staff

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- Set up for all staff on an ongoing roster in different modes appropriate to type of staff and location
- Separate education sessions for clinical and non-clinical staff
- Equipment demonstrations in the metropolitan area
- Self-directed packs for non-clinical co-ordinators

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	2002	2003	2004
Clients with Pressure Ulcers	42%	38%	19%

	2002	2003	2004
Number of Pressure Ulcers	170	108	51

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	2002	2003	2004
Ulcer documented	31%	67%	71%

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Clients risk assessed in the previous 12 months?

	2002	2003	2004
Yes	20%	71%	69%

Is Current Equipment Appropriate?

	2002	2003	2004
Yes	63%	75%	91%

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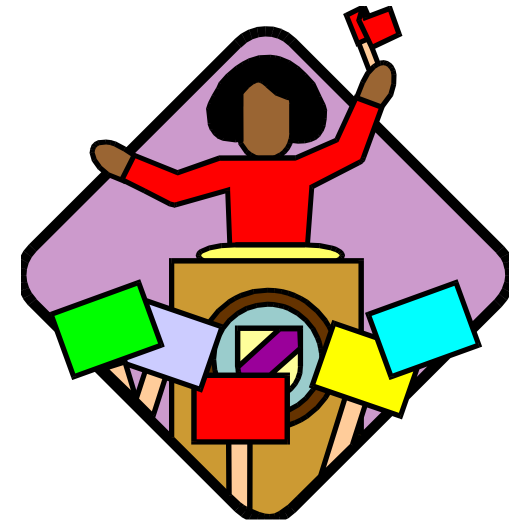
- Ownership by all staff
- Avoid increasing burden on staff
- Regular monitoring and feedback to staff
- Ongoing commitment of resources
- Be flexible!



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At Silver Chain:

- Include pressure ulcer incidence and monitoring of work processes as part of internal audit
- Smart phones to replace paper based system
- Use incidence data to inform budget for purchasing and replacement of pressure reducing /relieving equipment

Elsewhere:

- NICS website - www.nicsl.com.au
- Journal articles and presentations
- Development of a resource kit

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Acknowledgements

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- Australian Council for Safety and Quality in Health Care
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- Silver Chain Foundation
- All clients, carers and staff that took part

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Survey Methodology References

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Contact Details

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