2021

Reducing Hospital Acquired Pressure Damage on Roskear Ward

Murrell, Holly

Murrell, H. (2021). 'Reducing Hospital Acquired Pressure Damage on Roskear Ward', South West Clinical School Journal, 1 (1).
http://hdl.handle.net/10026.1/19717

https://doi.org/10.24382/9wd3-1q87
South West Clinical School Journal
University of Plymouth

South West Clinical School Journal
Online Journal of the South West Clinical School in Cornwall

Quarter 1 2019/20 WINNER
#400WORDS: KNOWLEDGE+ACTION (IMPLEMENTING EVIDENCE-BASED PRACTICE)

Reducing Hospital Acquired Pressure Damage on Roskear Ward

Holly Murrell[1]
[1]Ward Leader. Royal Cornwall Hospitals NHS Trust, TRURO, TR1 3LJ, UK.
Email: holly.murrell@nhs.net

Submission date: 22nd April 2019 | Accepted for publication: 2nd April 2020

Introduction
I am passionate about providing harm free care whilst working within the Trust's values. The purpose of my improvement project was to reduce the ward's level of hospital acquired grade 2, 3 and 4's pressure damage by using the 'Post Pressure Ulcer Incidence Safety Huddle Form'. I also wanted to increase the knowledge and skills that the nursing staff had in relation to pressure area care (Guy, et al. 2013).

Methods
I gathered the data from 2017 which showed the number of patients who acquired grade 2 pressure damage over the year. All nursing staff were booked to attend the study sessions that the tissue viability team organised. This provided a baseline level of education for the whole team which Uba and Kever (2015) suggested to be a firm starting point and helped to decrease the amount of unwarranted variation between staff knowledge.

Every time an incident report was submitted the nursing team would complete a Post Pressure Ulcer Incidence Safety Huddle, to identify learning from the incident and to be able to share any good practice identified. The safety huddles would take place on the ward and involve the on-duty nursing team. It was suggested by McIntyre, et al. (2012) that the following interventions needed to be in place to prevent pressure damage:

- risk assessment
- skin inspection
- pressure relieving equipment
- repositioning
- management of incontinence and moist skin
- nutritional support

We discussed these interventions during the huddle and reviewed how well they had been implemented and if there was anything we could do better in future.

Results
In the year 2018 we had a 15% reduction in hospital acquired pressure damage in comparison to 2017. As a ward team we felt this was a really positive step in providing harm free care that contributed to better outcomes for patients.
As a team we use the annual 'Stop the Pressure Day' to promote and raise awareness of areas identified in huddles for attention and improvement, specifically moisture lesions, which our oedematous heart failure patients are at high risk from (Clarke, et al. 2017).

Conclusion
In conclusion, I feel that the Post Pressure Ulcer Incidence Safety Huddle contributed to reducing the amount of hospital acquired pressure damage on Roskear Ward. I feel that by sharing this good

practice other areas could use this tool to promote harm free care and to promote better outcomes for our patients

References

Guy, H., Downie, F., McIntyre, L,. Peters, J. (2013) Pressure Ulcer Prevention: Making a Difference Across a Health Authority? British Journal of Nursing, Vol 22, No. Supp12. Pp.12.

McIntyre, L., May R, Marks-Moran, D. (2012) A strategy to reduce avoidable pressure ulcers. Nursing Times 108 (29) pp.14-17.

Clark, M., Semple, M.J., Ivins, N., Mahoney, K. Harding, K. (2017) National audit of pressure ulcers and incontinence-associated dermatitis in hospitals across Wales: a cross-sectional study. BMJ Open 7: e015616.

Uba, A., Kever,L. (2015) Knowledge, attitude and practice of nurses towards pressure ulcer prevention. International Journal of Nursing and Midwifery 7(4) pp. 54–60
