



Service Priorities and Programmes Electronic Presentations

Convention ID: 704

Submitting author: Mr Yuk Sim LUI

Post title: Ward Manager, Prince of Wales Hospital, NTEC

Optimal frequency and methods of repositioning with appropriate use of pressure relieving device reduce the incidence of pressure ulcer

WONG MT(1), IP CY(1), NG WL(1), LUI YS(1), KWOK MLA(1)

(1)Department of Medicine and Therapeutics, Prince of Wales Hospital

Keywords:

pressure relieving device

pressure ulcer prevention

Introduction

Fail geriatric patients are more vulnerable to the development of pressure ulcers, it is resulted in longer hospitalization and increased morbidity and mortality. HKGS Acute care of the elderly reported that 28% of all patients and >40% for age 70 or above are at risk of pressure ulcers for medical admission. Prevention is always the best treatment approach, the optimal frequency and methods of repositioning with appropriate use of pressure relieving device are likely to reduce the incidence of pressure ulcer. Ward Patient Care Assistants are the key members who help in providing regular napkin changing and position turning. However they are found seldom use or not familiar with the use of pressure relieving devices with reasons of innocence or ignorance. Staff education is important to increase their awareness, knowledge and skill on pressure ulcer prevention.

Objectives

A quality improvement program is implemented to enhance pressure ulcer prevention and decrease incident of hospital acquired pressure ulcer formation in medical wards.

Methodology

1. Staff training sessions (with theory and practical section) on proper application of pressure relieving devices in pressure ulcer prevention were organized in Oct and Nov 2015. 2. Audit on pressure ulcer prevention for Ward Patient Care Assistants was carried out in January 2016.

Result

Total 60 Patient Care Assistants attended in 4 training sessions, they all showed enthusiastic participation in practical sessions and they expressed patient role play increasing their understanding on the feeling of position turning of bed ridden patients. For the pressure ulcer prevention audit, total 12 wards were visited with 24 samples collected by random. The overall compliance rate was 97.1 which indicated staff could follow most of the preventive measures for pressure ulcers. There were 2 in 24 cases (91.6% compliance) had been forgotten to apply heel protectors for preventing heel and ankle pressure ulcer, 6 in 22 (72.7% compliance) cases that staff forgot to perform documentation in turning. In overall, there was an improvement in patient

care quality outcome: the incident rates of pressure ulcer in Oct 15 and Nov 15 are 0.57 and 0.53 respectively, it dropped to 0.47 in Dec 2015 after the program implementation.