Patient participation supports pressure injury awareness and prevention

Patient story

Pressure injuries, also known as pressure ulcers or bed sores, are a major cause of preventable harm for patients using health care services.

Whether a person is in hospital, aged residential care or receiving home care, pressure injuries can be distressing, debilitating and, in the worst case, life-threatening.

Pressure injuries can develop very quickly (in as little as four hours) so early preventative action is essential.

All health professionals, family/whānau members and patients have an important role to play in prevention. With the right knowledge and care, most pressure injuries can be avoided.

This is one of a series of pressure injury patient stories prepared by the Health Quality & Safety Commission to raise awareness of the issue. The stories highlight ways to improve practice and make pressure injury prevention a key priority and part of a daily care routine.

In March 2017, David Jackson* underwent a bilateral (double) hip replacement.

The surgery was a success. However, during his stay David's limited mobility and lack of preventative actions, such as the provision of an air mattress (a special mattress that relieves pressure), contributed towards the development of a pressure injury on his sacrum.

'The surgery went very well. I spent about three hours in recovery, then I was back on the orthopaedic ward,' says David.

Once on the ward, David couldn't move much for the first couple of days.

'When you've had both hips replaced, you really can't move. You're lying in bed immobile for a lengthy period of time,' says David.

'It was the first time I had been in hospital, so I didn't know anything about pressure injuries. I didn't know what to expect when it came to care in the hospital.

'The doctors and nurses didn't talk about pressure injuries with me. It wasn't discussed prior to or during the stay.

'So, I didn't know that things might not be right. I also couldn't feel anything due to the epidural I'd had,' he adds.

'I received a hospital booklet with a list of things to be aware of following a total hip replacement. The main concern was infection and deep vein thrombosis.

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'There wasn't any mention of pressure injuries in the book and I don't remember the surgeon talking about it prior. I would have thought it was a good idea to have information about it,' adds David.

'Thinking about it now, I should have been put on an air mattress,' he says.

On the third day, when David was due to go home, his nurse noticed a skin tear on the crease of his bottom.

David was given an air cushion to take home to make him more comfortable. But just 24 hours later a district nurse visited David at home and noticed a pressure injury had developed near the skin tear.

It was identified as a stage two pressure injury. In addition to the air cushion, the district nurse ordered an air mattress to prevent the wound getting worse and to help David get more comfortable when sitting or lying down.

'... pressure injury prevention should be a priority and patients should be well-informed about the risk.'

Over the next seven weeks, the district nurse visited twice weekly to dress the pressure injury.

David believes he would have been more comfortable in his recovery if he hadn't had a pressure injury.

He felt it limited his ability to exercise and go out, because he was uncomfortable even if he took the air cushion with him. Instead, he stayed at home until the pressure injury began to heal.

Eight weeks after surgery, David's pressure injury healed. But the memory of it will last longer.

He is adamant that pressure injury prevention should be a priority and patients should be well-informed about the risk.

Helen Costello is Associate Director of Nursing for Practice Development at Capital & Coast District Health Board (CCDHB), where David had his surgery.

She says David's story has highlighted the importance of communication and engagement.

'Engagement and communication with David about pressure injury risk should have been better, both before admission and during his stay,' says Helen.

'Staff are meant to do regular skin checks and these can sometimes occur when they check a patient's wound or epidural site. Unfortunately, David did not have his skin checked to the standard we would expect,' explains Helen.

CCDHB now uses a three-step skin-check process to support staff to more appropriately engage the patient in their care.

'This is where you ask the patient whether they feel any pressure or discomfort where their body presses on the bed or chair,' says Helen.

'Then you have an opportunity to educate the patient, family or staff about what we do to reduce the risk of pressure injury. We use the SSKIN intervention to guide us.

'Next you perform the physical skin check by assessing and checking areas at high risk of pressure injury,' she explains.

'Sadly, David still developed a pressure injury while in our care. Not being put on an air mattress would have contributed towards this.

As a result of David's experience, CCDHB will improve its surgery pre-assessment alert system to make pressure relieving mattresses available and provided to patients who need them when they leave the operating theatre. By the time a patient has an admission date, an alert will be raised to notify whether a pressure-relieving mattress is required. This also applies if a patient requires an epidural pain relief following surgery.

'It's about making sure we have robust preventative processes and empowering the patient to know what is going to happen and what the risks are.'

The SSKIN intervention is a set of evidence-based interventions for preventing and managing pressure injuries. When used together, these interventions can significantly improve patient health outcomes and their quality of life.

S – SURFACE: Make sure the patient has the right supportive surface mattress, cushions and correct-fitting medical devices in place to reduce harm.

S – SKIN INSPECTION: Conducting a regular skin check provides the earliest indicator of pressure damage. The frequency of this check depends on the individual patient's risk factors, particularly if their condition deteriorates.

K – KEEP MOVING: Patients need to change their position often. At least two-hourly for those who are not mobile and more often for those with known pressure injuries.

I – INCONTINENCE: Keep the patient's skin clean and dry.

N – NUTRITION: Ensure patients are eating properly and are well hydrated.

In addition, patients will now receive pressure injury prevention information with the hip surgery booklet they are given prior to hospital admission. Pressure injury prevention information will also be part of the pre-admission education session.

'It's about making sure we have robust preventative processes and empowering the patient to know what is going to happen and what the risks are, particularly when they will require prolonged time in bed,' she adds.

'We are incredibly sorry and disappointed this happened to David,' says Helen.

'It highlighted a number of improvements required to prevent this happening to others,' she says.

Tips to reduce pressure injury risk from CCDHB:

- Implement a three-step skin check (see page 5). This will engage the patient in their care, while you undertake the assessment. The pressure injury prevention and management working group at CCDHB believes that, if the three-step skin check is embedded into every nurse's practice, across every area, this will make a real difference in reducing pressure injury risk.
- Staff and patients need clear information about pressure injury prevention and management. Help staff and patients to understand what factors can influence pressure injuries and how they can be prevented. Look at your resources and educational material: how can you improve them? Can they be accessed easily? Can they be offered in different ways? Ensure information includes tips for involving the patient, family, whānau and carers.
- Gaining strong leadership and support for your pressure injury prevention programme is vital to give it the priority and awareness it needs.

For more information about pressure injury prevention and management go to:

www.hqsc.govt.nz/our-programmes/pressure-injury-prevention

www.acc.co.nz/assets/provider/acc7758-pressure-injury-prevention.pdf

www.nzwcs.org.nz

www.nzwcs.org.nz/resources/publications/10-guidelines-and-protocols

nhs.stopthepressure.co.uk

www.nursingtimes.net/download?ac=1237263

Whitlock J. 2013. SSKIN bundle: preventing pressure damage across the health-care community. *British Journal of Community Nursing* (Wound Care supplement), September: S32–S39.

** Names have been changed to protect privacy of the patient and their family.*

Pressure Injury (PI) prevention and management - SKIN CHECK

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SKIN CHECK - 3 steps and document care

1. ASK THE QUESTION - if unable to respond start at 2 and proceed to 3

Do you feel pressure or have any discomfort (localised pain):

- where your body is pressing on the bed/chair (elbows, sacrum, bottom, heels, bony prominences, ears, head)?
- where medical devices touch your skin?

2. EDUCATION – patient/family/staff

- **S**urface: right surface in bed and chair, wrinkle free bed sheets and surfaces, minimise pressure damage by using safe handling equipment when turning 'at risk' dependant patients
- **S**kin Inspection: check for discolouration and tell us about soreness
- **K**eep moving: ensure patients are encouraged or assisted to move positions regularly (2 hourly)
- **I**ncontinence: good skin hygiene
- **N**utrition: check right diet and plenty of fluids - linked to Malnutrition Screening Tool (MST).

3. DO THE SKIN INSPECTION – assess and check areas at high risk of pressure injury

If patient has discomfort/pain related to pressure or has reduced mobility or sensation:

- Inspect bony areas in contact with a surface, including under and around medical devices
- Look for changes in usual skin colour - redness or darker tones. With darker skin colour the change may be a purplish/bluish area.
- Test for persistent non blanching redness or darkened coloured skin areas. Gently press on the discoloured area with your finger. The area should go white under your finger and when pressure is released the area should return to red, pink or natural dark skin tone by 3 seconds to indicate good blood flow.
- Feel for localised skin changes such as heat, coolness or swelling that may signal skin breakdown.

NOTE: For each PI complete a PI Incident Sticker if not in progress notes.

NOTE: Visual skin assessment is the earliest indicator for skin vulnerability and PI damage. Skin check frequency is dependent on risk and advice is dependent on patient's needs and clinical judgement.

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