A Journey of Prevention of Pressure Ulcer

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Introduction
Pitfalls of unfamiliarity of Electronic Pressure Ulcer Reporting System; poor documentation; infrequent use of pressure relieving devices; incomplete assessment; knowledge deficit with unskillful pressure ulcer preventive practice were revealed.

Objectives
Objectives: 1. To examine the phenomenon of pressure ulcer 2. To explore the risk factor in favor of pressure ulcer development 3. To evaluate the feasibility and effectiveness of the reformed pressure ulcer prevention system

Methodology
Pressure ulcer prevention system was reformed with new workflow and delineation of individual responsibility; accurate assessment with counter-checking; training with knowledge on use of pressure relieving devices and proper turning skill; proper documentation and registry with pre-set label and reminder cards.

Result
Survey findings showed a down trend of pressure ulcer incident rate (28%) of Cat B cases (i.e. case with pressure ulcer discovered after 72 hours of admission which reflected the non-accomplishment of pressure ulcer preventive practice). Risk factors also identified with specification of female patient; aged 68; KPS score 45; long length of stay (19days); and coccyx was the common site of pressure ulcer development. Audit on supporting staffs’ practice showed 100% compliance rate with accurate knowledge and proper turning skill. The reformed system was proved to be feasible and effective as the snapshot audit showed 100% of pressure ulcer assessment for new admitted cases with regular review, in which only 5% cases with missing data found. 100% of cases with Norton Score < 14 received pressure ulcer preventive measures in which turning of position and use of pillow were the most common preventive strategies employed.