Service Priorities and Programmes

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Submitting author: Miss W S TANG
Post title: Registered Nurse, Princess Margaret Hospital, KWC

Great Improvement in Pressure Ulcer Management with a Multidisciplinary Approach

WONG KP (1)(3), LAW Susan (2)(3), TANG WS (1)(3)
(1) Quality & Safety Department, Princess Margaret Hospital (2) Wound Management, Princess Margaret Hospital (3) Pressure Ulcer Management Subcommittee, Princess Margaret Hospital

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Introduction

From 4Q10-3Q11, persistent high level of pressure ulcer rate 0.74 was found in Princess Margaret Hospital compared with 0.43 which was the mean of all hospital in HA. It's known most HAPUs could be reduced through systemic pressure ulcer management in evidence-based method. Since pressure ulcer development was multifactorial, a multidisciplinary approach was adopted.

Objectives

To provide continuity of skin care and minimize the pressure ulcer rate by multidisciplinary approach

Methodology

Firstly, a new management team and structure to prevent and treat pressure ulcers was initiated. The team including physician, surgeon, dietitian, occupational therapist, Quality & Safety personnel and nursing representatives from different departments led by wound specialist showed their determination to improve patient care. Secondly, a structured "Pressure Ulcer Round" on monthly base with designated pressure care liaison nurse (PCLN) was pioneered. This was a bold attempt with the team to "Go & See" and explore the practice in different departments. It worked by providing multidisciplinary recommendations on effective strategies on pressure ulcers management; established a caring culture on pressure ulcers to boost up staffs' awareness and creating an valuable learning opportunities to PCLNs. Thirdly, to enhance nursing and supporting staffs' knowledge on skin care, eleven video clips with various scenarios on pressure ulcer management were developed and uploaded on web as easy reference for frontline staff. Fourthly, to build up a good learning and sharing culture, there were quarterly journal sharing and case conference among PCLNs. Fifthly, in-depth investigation and comprehensive case study for each high-staged HAPU case would be reported to concerned parties for improvement. Furthermore, "HAPU Alert" of interesting cases would be published to highlight learning points for raising staff awareness on pressure ulcer prevention and serve as a platform for case sharing among departments. Lastly, series of "Educational

Pamphlet on Pressure Ulcer Management" and cue cards were developed to empower patients and their carers' understanding on pressure ulcers care.

Result

It was an ongoing project. With those strategies implemented, in the period 4Q2011-3Q2012, HAPU rate dropped to 0.68 with significant improvement up to 8% achieved. Continuous monitoring would be performed to observe its effectiveness. The preliminary result was encouraging. The support and involvement of different disciplines was essential. With their expertise, the team can make a meaningful difference in pressure ulcers management.